Texas Title V Five-Year Needs Assessment

for the

Maternal and Child Health Services

Title V Block Grant Program

Division of Family and Community Health Services

July 15, 2010

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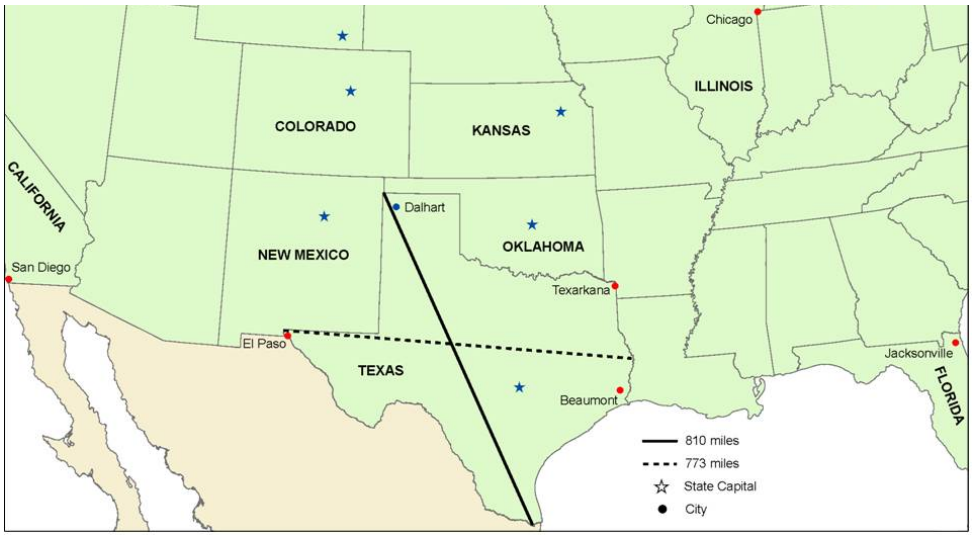
INTRODUCTION

TEXAS: AN OVERVIEW

LAND AREA

Texas' land area is approximately 262,000 square miles, accounting for 7.4% of the total U.S. land area. The area is equal to the land area of all six New England states, Ohio, New York, Pennsylvania, and North Carolina combined. The longest straight-line distance in a general north-south direction is 801 miles from the northwest corner of the Panhandle to the extreme southern tip of Texas on the Rio Grande below Brownsville (Map 1). With the large north-south expanse of Texas, Dalhart, in the northwestern corner of the state, is closer to the state capitals of Kansas (~430 miles), Colorado (~310 miles), New Mexico (~200 miles), Oklahoma (~275 miles), and Wyoming (~390 miles) than it is to Austin (~470 miles), its own state capital. The greatest east-west distance is 773 miles from the extreme east-ward bend in the Sabine River in Newton County to the extreme western bulge of the Rio Grande just above El Paso. This east-west expanse is so large that El Paso, in the western corner of the state, is closer to San Diego, California (~630 miles) than to Beaumont (~740 miles), near the Louisiana state line; Beaumont, in turn, is closer to Jacksonville, Florida (~680 miles) than it is to El Paso. Finally, Texarkana, in the northeastern corner of the state, is about the same distance from Chicago, Illinois as it is to El Paso (~750 miles). Given the size of Texas, the distance some individuals must travel to receive services is a significant barrier to accessing and receiving those services.

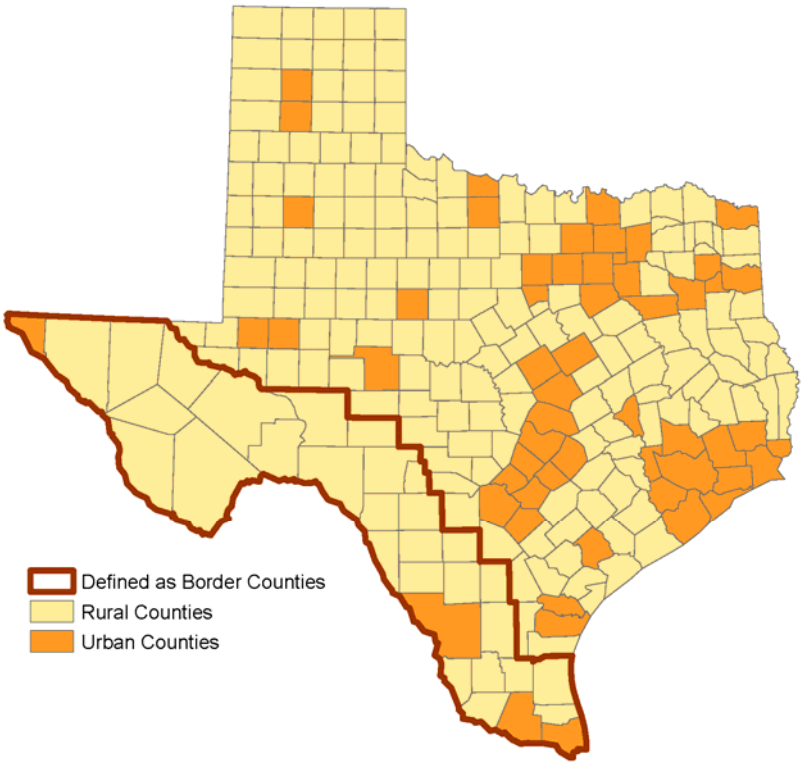
Map 1. Relative Size of Texas



METROPOLITAN, MICROPOLITAN, RURAL, AND BORDER COUNTIES

Texas has a mixture of urban, rural, and border populations (Map 2). The majority of Texans live in urban areas (91.9%). Of the 254 counties in Texas, 156 are rural, accounting for approximately 8.1% of the 2008 Texas population (Office of the State Demographer, 2008). In addition to urban and rural areas, Texas is one of four states that shares a geographic border with Mexico. As defined in the La Paz Agreement of 1983, the border region includes the area within 100 kilometers (or 62 miles) of the Rio Grande River. By this definition, the Texas border region includes 32 of Texas' 254 counties and 10.2% of the Texas population. Of these 32 counties, four are urban. The length of the Texas-Mexico border accounts for 45.1% of the 1,969 mile U.S. - Mexico border. The majority of the population along the entire U.S. - Mexico border resides in 14 pairs of U.S. - Mexico sister cities. Seven of the 14 pairs are located in Texas. The sister cities along the U.S. - Mexico border are linked economically, culturally, and environmentally (e.g., through shared waterways and air sheds). According to the U.S. Department of Transportation, in 2007, there were 26,274,077 trains, buses, trucks, and personal vehicles and 62,054,088 people who entered the U.S. at Texas border checkpoints. Each of these geographic designations presents a unique service delivery challenge. In urban areas, services must meet the demands of a large, concentrated population. Service delivery challenges of rural area residents include the unavailability and inaccessibility of

Map 2. Urban, Rural and Border County Designations

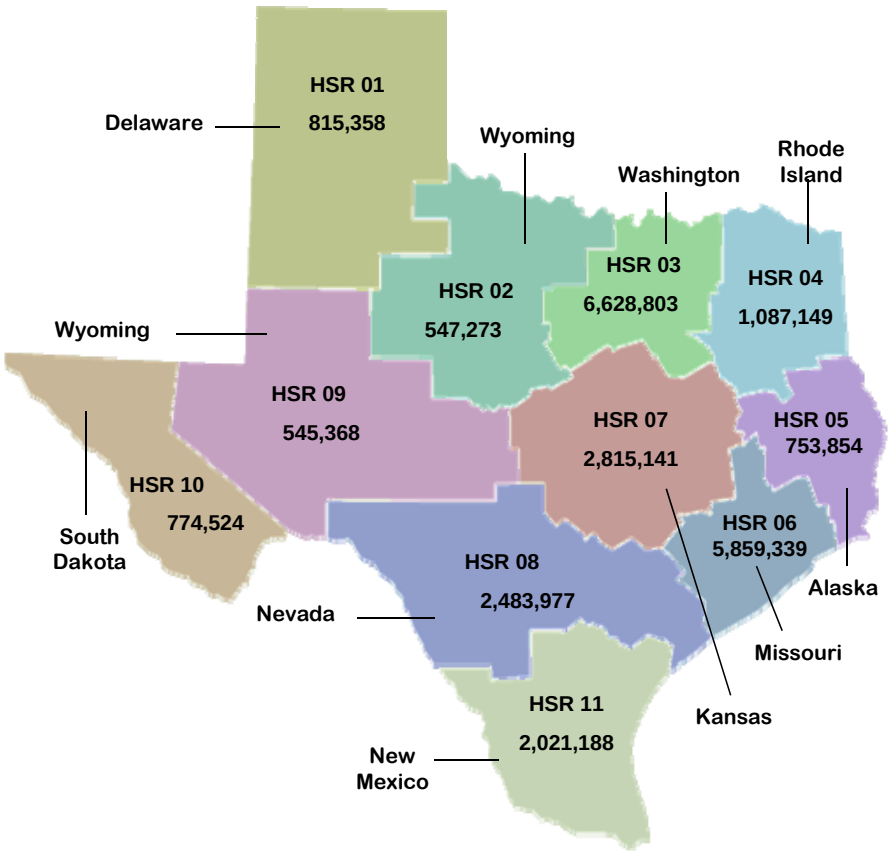


affordable health care, lack of transportation, limited fiscal resources, little or no economic development, and the absence of trained healthcare professionals. While service needs may be similar between those residing in urban and rural areas, cultural norms and values may be different in urban and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

POPULATION

The estimated 2008 Texas population was 24.3 million people, which accounted for 8.0% of the total U.S. population (U.S. Census Bureau, 2008). Texas' population is equivalent to the individual populations of 11 other states combined (Map 3). The populations of two of the Health Service Regions (3 and 6) are large enough to rank as the 13th and 19th most populous states in the U.S, respectively. Texas is also home to six of the 21 largest cities in the U.S. (Houston – 4th, San Antonio – 7th, Dallas – 9th, Austin – 16th, Fort Worth – 19th, and El Paso – 21st).

Map 3. Texas Health Service Regions' 2008 Population Estimates and States with Comparable Populations



Between 1990 and 2008, the Texas population increased 42.5% compared to the overall growth in the U.S. of 22.3%. Between 2000 and 2008, the Texas population increased 16.6% compared to the overall growth in the U.S. of 8.2%. Texas was the seventh fastest growing state between 1990 and 2008 and the sixth fastest growing state between 2000 and 2008. Population growth varies

throughout Texas. Areas surrounding three of the state's largest urban areas, Dallas/Fort Worth, Houston, and San Antonio/Austin experienced some of the most significant growth between 2000 and 2008. According to the Texas State Data Center, Texas' population will exceed 25 million people during the year 2010, and by 2040 will reach a population in excess of 43 million people. Between 2000 and 2020, the Texas population is expected to increase by 45.1%.

As shown in Table 1, the Texas State Data Center estimated that 10.2% (2,472,030) of the 24,326,974 Texas residents in 2008 resided along the Texas Border. Of these 2.5 million border residents, 58.0% of them were less than 35 years old, compared to the non-border population, where only 51.8% of them were less than 35. Similarly, urban counties have a younger population. Of the 22,360,411 Texas residents residing in an urban county, 53.0% were less than 35 years old, compared to 45.6% in rural counties.

Table 1. Texas Resident Population, by Border Status, County Designation, and Age, 2008

		Border Status		County Designation	
Age Group	Total	Border	Non-Border	Urban	Rural
Total, all ages	24,326,974	2,472,030	21,854,944	22,360,411	1,966,563
<18 Years	6,495,224	779,298	5,715,926	6,024,024	471,200
18-24 Years	2,592,807	299,559	2,293,248	2,390,217	202,590
25-34 Years	3,663,238	355,803	3,307,435	3,439,564	223,674
35-44 Years	3,507,281	317,008	3,190,273	3,283,040	224,241
45-64 Years	5,663,254	477,045	5,186,209	5,157,467	505,787
65 Years and Older	2,405,170	243,317	2,161,853	2,066,099	339,071

Source: Population Estimates and Projections Program, Texas State Data Center, Office of the State Demographer, Institute for Demographic and Socioeconomic Research, The University of Texas at San Antonio; February 2010. Available at: http://txsdc.utsa.edu/tpepp/txpopest.php.

POPULATION ALONG THE TEXAS-MEXICO BORDER

Between 1950 and 2000, the U.S. - Mexico border population increased by approximately 10 million people; between 1990 and 2008, the population in the Texas – Mexico border region increased by 44.9%. Populations along the border have increased significantly over the past 20 years, due in part to the *maquiladora* program begun in 1965 (Peach & Adkisson, 2000). This program provided economic incentives to foreign (mostly U.S.-owned) assembly factories located in the border region. With about 1,700 factories operating in Mexico in 1990, the rate of industrial development increased further after the North American Free Trade Agreement (Pagan, 2004). By

2001, the 1,700 factories had more than doubled to nearly 3,800 *maquiladora* factories, 2,700 of which were in Mexican-border states.

The demand for affordable housing in areas along the Texas-Mexico border has contributed to the development of colonias in this region. According to the Texas Secretary of State, colonias are "residential areas along the Texas-Mexico border that may lack some of the most basic living necessities, such as potable water and sewer systems, electricity, paved roads, and safe and sanitary housing." There are approximately 400,000 Texans residing in more than 2,000 existing colonias (Texas Secretary of State, 2010).

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

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

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

The Texas State Data Center estimated the 2008 total female population of Texas at 12,137,007 (49.9% of the overall population). Women of childbearing age (15 to 44 years) comprised 43.5% of the total female population (Table 2). Between 2000 and 2020 in Texas, the population of women 15 to 44 years of age is expected to increase by 32.5%, an increase of 1.4 million women (Population Estimates and Projections Program, 2008).

Table 2. Texas Resident Population, by Sex and Age, 2008

	Total		Male		Female	
Age Group	Number	Percent	Number	Percent	Number	Percent
Total, all ages	24,326,974	100.0	12,189,967	100.0	12,137,007	100.0
<15 Years	5,384,151	22.1	2,748,279	22.5	2,635,872	21.7
15-19 Years	1,866,100	7.7	957,664	7.9	908,436	7.5
20-24 Years	1,837,780	7.6	956,436	7.8	881,344	7.3
25-29 Years	1,881,535	7.7	988,657	8.1	892,878	7.4
30-34 Years	1,781,703	7.3	920,764	7.6	860,939	7.1
35-39 Years	1,813,123	7.5	920,175	7.5	892,948	7.4
40-44 Years	1,694,158	7.0	855,784	7.0	838,374	6.9
45 Years and Older	8,068,424	33.2	3,842,208	31.5	4,226,216	34.8

Source: Population Estimates and Projections Program, Texas State Data Center, Office of the State Demographer, Institute for Demographic and Socioeconomic Research, The University of Texas at San Antonio; February 2010. Available at: http://txsdc.utsa.edu/tpepp/txpopest.php.

RACIAL/ETHNIC COMPOSITION OF TEXAS: FOCUS ON MINORITY GROUPS

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

POPULATION DENSITY

Considerable variations in population density exist throughout Texas, ranging from densely populated areas evidenced in the 25 metropolitan statistical areas to a rural area that has less than 25 people per square mile. The 10 counties with the greatest population density account for 57% of the Texas population with 13,533,994 inhabitants. Outside of these 10 counties, the average population density is 41 people per square mile (Office of the State Demographer, 2008). This presents a unique service delivery

challenge of ensuring sufficient capacity to meet the demand in the most populated areas while also ensuring adequate access in more sparsely populated areas.

POVERTY IN TEXAS

Poverty underlies many health disparities in Texas. Poverty limits access to the "fundamental building blocks" of health such as adequate housing, good nutrition, and the opportunity to seek health services when needed. Health disparities exist among various demographic groups in Texas, including differences across gender, race/ethnicity, education, income, or geographic location. The population groups with the highest poverty levels often have the poorest health statuses (Marmont, 2005).

According to the 2006 American Community Survey, collected by the U.S. Census Bureau, an estimated 16.9% of individuals and 13.3% of families in Texas lived below the federal poverty level (Table 3). The percentage of individuals living in poverty differed significantly by county, ranging from 4.9% in Rockwall County to 44.4% in Starr County. More Hispanic and Black individuals lived in poverty (25.7% and 25.4%, respectively) than Whites (14.3%). Females were more likely than males to be living in poverty, 18.6% and 15.2%, respectively. Over 34% of female-headed households (no husband present) lived in poverty (U.S. Census Bureau, 2006). In 2006, the poverty threshold for a family of four was $20,614 (U.S. Census Bureau, 2009).

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

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

Table 3. Population Below 100% of Federal Poverty Level by Race/Ethnicity, Texas, 2006-2008

	Individuals		Families	
Race/Ethnicity	Number	Percent	Number	Percent
Total	22,887,307	16.9	5,686,517	13.3
White	16,024,614	14.3	4,122,312	10.7
Black	2,574,384	25.4	609,743	21.6
Hispanic	8,217,389	25.7	1,846,036	23.5

Source: U.S. Census Bureau Current Population Survey, 2006 American Community Survey.

UNEMPLOYMENT IN TEXAS

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

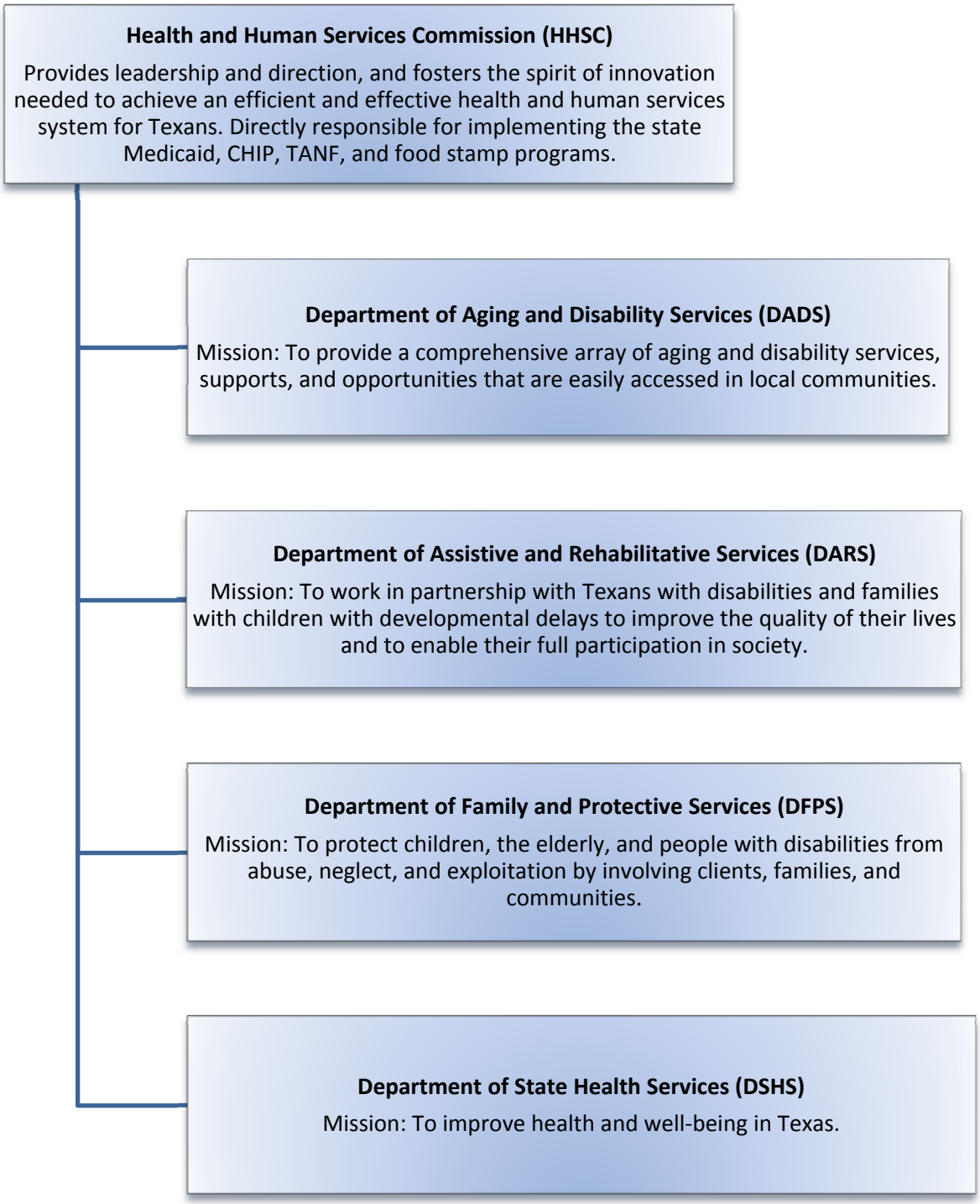
TITLE V AGENCY DESCRIPTION

In Texas, Title V operates within a strategic plan framework articulated by the state government; the Texas Health and Human Services Commission (HHSC), the state agency responsible for oversight and coordination among all health and human services-related state agencies; and the Texas Department of State Health Services (DSHS) (See Appendix A – Acronyms for a list of acronyms used in this document).

DSHS has traditionally facilitated statewide delivery of safety net preventive, primary, and mental health care services for women and infants, children and adolescents, and children and youth with special health care needs through a coordinated system of public health clinics and contracted providers. For many years, the former Texas Department of Health (TDH) was a major provider of direct health care services through its regional clinics. However, beginning in the 1990s, the provision of direct services has been almost entirely transitioned to a variety of contracted, community-level organizations.

In 2004, the delivery of health and human services in Texas was transformed as a result of House Bill 2292, 78th Regular Texas Legislative Session (2003). This legislation consolidated the duties and functions of 12 existing state agencies into 4 new departments under the leadership of HHSC (Figure 1). These administrative changes were implemented to improve services, increase efficiencies, and enhance accountability among the state's health and human services programs.

Figure 1. Health and Human Services Enterprise



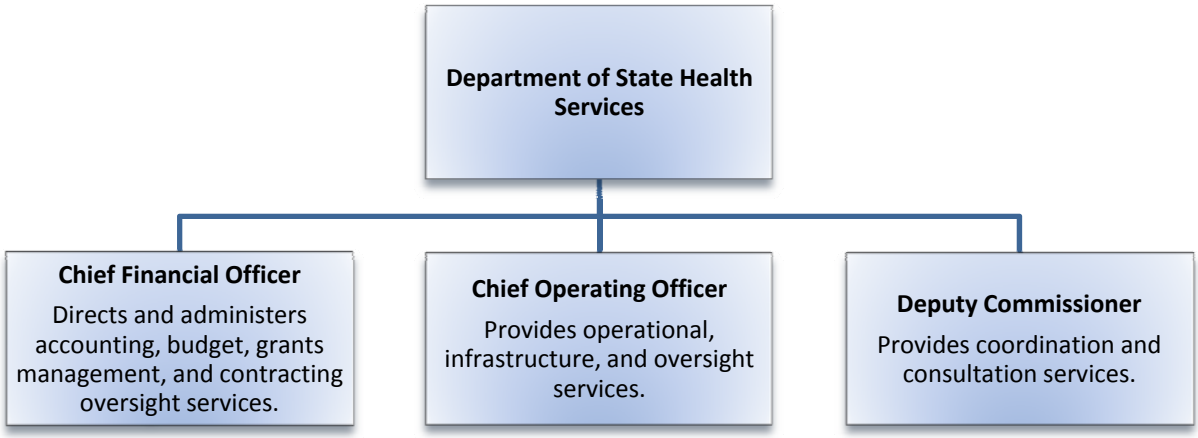
DSHS consists of the former TDH, the Texas Commission on Alcohol and Drug Abuse, the Texas Health Care Information Council, and the community mental health services and state hospital programs formerly operated by the Texas Department of Mental Health and Mental Retardation. This consolidation presented opportunities to integrate primary health care and behavioral health care in an effort to provide a more holistic approach to service delivery.

The Commissioner of Health is David L. Lakey, M.D., who oversees hundreds of health-related prevention, direct care, regulatory, and preparedness programs. The DSHS Council provides guidance to all programs regarding agency policies and rules. DSHS performs its duties through staff located at the state headquarters in Austin and throughout eight geographical Health Service Regions (HSRs) statewide; through contracts with autonomous local health departments, community-based organizations, and other groups with a health-related mission; and in concert with other state agencies and their local partners. Funds for agency activities originate from federal grants and allocations, state general revenue streams, and local funding provided by contractors.

DSHS FINANCIAL, ADMINISTRATIVE, AND SUPPORT SERVICES

Functions related to administration, infrastructure, and coordination for all DSHS programs are organized under three main departmental areas: the Chief Financial Officer, the Chief Operating Officer, and the Deputy Commissioner (Figure 2).

Figure 2. DSHS Financial, Administrative, and Support Services



CHIEF FINANCIAL OFFICER

The Chief Financial Officer serves the key role of administering and directing financial services for all of DSHS to include:

- Accounting Section – agency disbursements, accounts receivable, billing and collection, cash management, maintenance of the agency's books of record, and the preparation of the annual financial statements.
- Budget Section – agency budget, performance measure reporting, federal funds reporting, grants coordination and funds management.
- Client Services Contracting – competitive procurements, evaluation and negotiation, development of client service contracts.
- Financial Policy and Process Development

CHIEF OPERATING OFFICER

The Chief Operating Officer provides administrative, operations, and support services at DSHS to include:

- Information Technology
- Office of General Counsel
- Contract Oversight and Support
- Health Information and Vital Statistics (including Vital Records and the Center for Health Statistics)
- Business Continuity Planning
- Operations Management
- Employee Assistance Program

DEPUTY COMMISSIONER

The Deputy Commissioner oversees the following areas that provide coordination and consultation functions across all DSHS programs:

- *The Center for Consumer and External Affairs* is responsible for external and internal activities concerning communications, stakeholder relations, and legislative communications for DSHS:
    - Communications – media relations, executive and staff communications, advertising and marketing services contracts, crisis and emergency risk communications, translation and interpretation services.
    - Consumer Affairs – customer service, executive correspondence, stakeholder engagement and advisory committees, volunteer and community engagement, donations and permanent improvements, coordinates consumer affairs activities with the HHSC Office of the Ombudsman.

- Government Affairs – legislative liaison, legislative contact policy, legislative training presentations.

- *The Centers for Program Coordination, Policy, and Innovation* work primarily on agency level issues and supports service integration among DSHS programs in the following areas:

  - Policy Analysis and Assessment
  - Process and Program Improvement
  - Online Surveys and Assessments
  - Community Health Assessments
  - Policy and Program Coordination Project Management
  - Rule Process Coordination
  - Medicaid Coordination for DSHS Programs
  - DSHS Council Coordination
  - Health Information Portability and Accountability Act (HIPAA) Privacy Officer

- *The Office of Academic Linkages* seeks to identify, support, and strengthen partnerships between DSHS and academic institutions. Furthermore, this office helps to develop the statewide workforce needed to improve health and well-being in Texas. Areas of focus include:

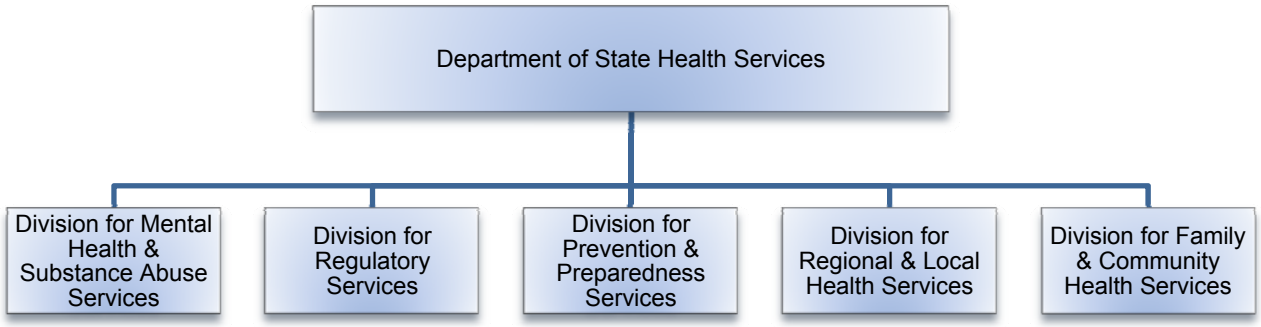
  - Continuing Education Services
  - Workforce Development Activities
  - Preventive Medicine Public Health Residency Program

- *The Office of Border Health* works to enhance agency efforts to promote and protect the health of border residents by reducing community and environmental health hazards along the Texas-Mexico border, in collaboration with communities and U.S. and Mexican local, state, and federal entities.

DSHS DIVISIONS AND PROGRAMS

DSHS programs are organized under five divisions: Mental Health and Substance Abuse, Regulatory, Prevention and Preparedness, Regional and Local Health, and Family and Community Health (Figure 3).

Figure 3. DSHS Divisions



MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

- Community Mental Health Services – contracts with local mental health authorities and NorthSTAR for adult and children's mental health services.
- Substance Abuse Prevention and Treatment – contracts with community providers for substance abuse prevention, intervention and treatment services.
- State Mental Health Hospitals – 10 facilities; 2,477 beds.
- Texas Center for Infectious Disease – Tuberculosis treatment hospital.
- South Texas Health Care System – Outpatient primary care services.

REGULATORY SERVICES

- Food and Drug Safety
- Environmental Health
- Radiation Control
- Health Care Professionals
- Health Care Facilities
- Emergency Medical Services and Trauma Care System

PREVENTION AND PREPAREDNESS SERVICES

- Community Preparedness – natural and man-made emergency preparedness and response.
- Health Promotion and Chronic Disease Prevention – obesity prevention, school health, chronic disease prevention and control.
- Infectious Disease Prevention – HIV and TB services, immunizations, disease reporting, and outbreak investigation and control.
- Environmental Epidemiology and Disease Registries – birth defects, cancer and trauma/EMS registry, environmental health surveillance.
- Laboratory Services – comprehensive public health lab services, newborn screening.

REGIONAL AND LOCAL HEALTH SERVICES

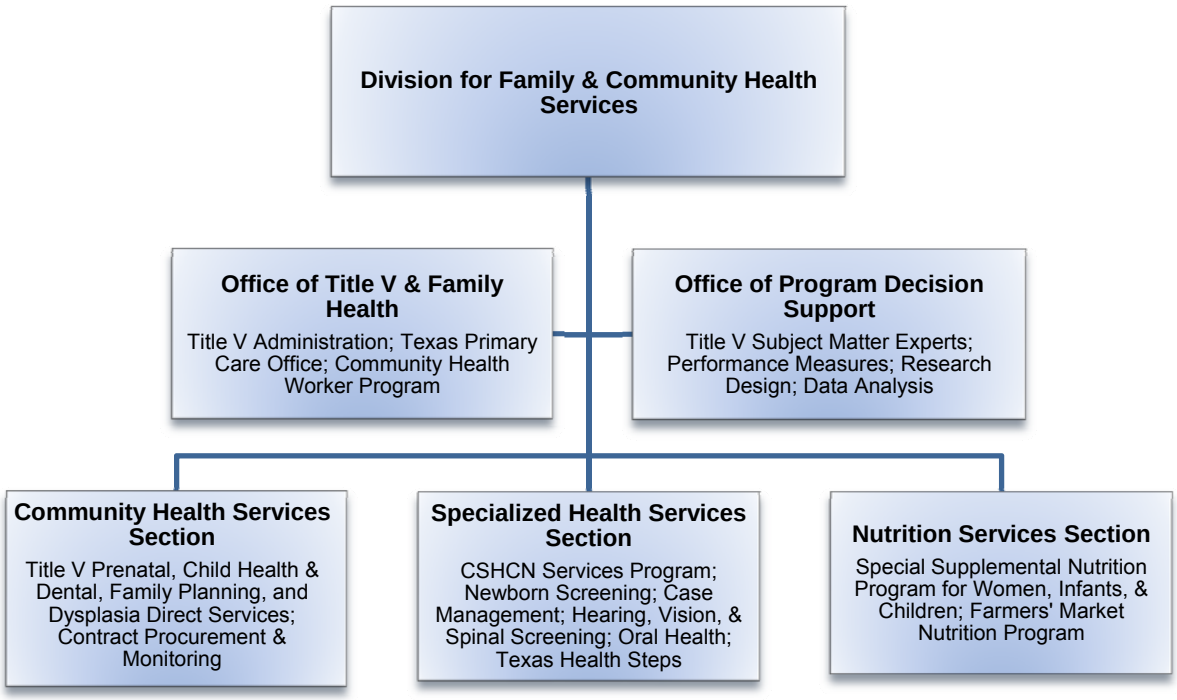
- Health Service Regions – Eight regional offices serve as Local Health Authorities where there is no local health department and serve as a liaison with Local Health Departments. Of the 254 counties in Texas, more than 60 counties depend on DSHS to act as the local health authority.

FAMILY AND COMMUNITY HEALTH SERVICES

- Services for Women, Children, and Families – Breast and Cervical Cancer Services, Family Planning, Prenatal, Texas Health Steps (Medicaid Early Periodic Screening, Diagnosis, and Treatment [EPSDT]), Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).
- Health Care Safety Net Services – County Indigent, Primary Care.
- Direct Services to Persons with Special Health Care Needs – Kidney Health Care, Children with Special Health Care Needs, Epilepsy, Hemophilia Assistance Program.
- Public Health Programs – Federally Qualified Health Center (FQHC) grants, data analysis/research/ surveillance, Title V population-based grants.

The majority of direct health care delivery programs are located in the Division for Family and Community Health Services (FCHS). The Division has three Sections: Specialized Health, Nutrition Services, and Community Health Services. The Office of Title V & Family Health (OTV&FH), which administers the Title V Block Grant for Texas, and the Office of Program Decision Support (OPDS), which includes the Title V subject matter experts (SMEs) and is responsible for the data analysis for Title V performance measures, are also located within FCHS (Figure 4).

Figure 4. FCHS Organizational Structure



TITLE V KEY PROGRAM AREAS

OFFICE OF TITLE V AND FAMILY HEALTH

The Title V Director and the Title V Block Grant Administrator are housed within OTV&FH. These positions manage the general administration and reporting functions for the Maternal and Child Health (MCH) Services Block Grant; consult with Title V-funded programs to ensure that rules, policies, and procedures comply with federal regulations and are delivered in a manner congruent with the intent of Title V; and identify and facilitate opportunities for coordination and integration of resources related to women and children within DSHS and across the Health and Human Services Enterprise. Collaborative work includes partnering with HHSC on Medicaid and the Children's Health Insurance Program (CHIP), as well as with the Office of Program Coordination for Children and Youth to support efforts in coordinating programs and initiatives that serve children and youth across health and human service systems.

In addition to administering Title V, OTV&FH encompasses:

- *The Promotora/Community Health Worker (CHW) Program* coordinates the training and certification process for becoming a certified promotor(a)/CHW.

Often considered a peer, promotores(as) provide outreach, health education, and referrals to local community members. The CHW program coordinates the Promotor(a)/CHW Training and Certification Advisory Committee that is charged with advising the HHSC Executive Commissioner on rules related to the training and regulation of persons working as promotores(as)/CHWs and is available to carry out assigned tasks from the Executive Commissioner. The committee may also recommend qualifying sponsoring institutions or training programs and instructors to DSHS. Committee membership includes four certified promotores(as)/CHWs, two members of the public, two professionals who work with CHWs in a community setting, and a member from the Texas Higher Education Coordinating Board or a higher education faculty member who has teaching experience in community health, public health, or adult education and has trained CHWs.

- *The Texas Primary Care Office (TPCO)* is strategically placed within OTV&FH to encourage improved coordination in access to primary care services for women, children, and families. TPCO has oversight of statewide initiatives such as the Conrad 30 J-1 Visa Waiver, National Health Service Corps, state physician and dental loan repayment programs, the FQHC Incubator Program, and functions related to the federal designation of Health Professional Shortage Areas and Medically Underserved Areas.

OFFICE OF PROGRAM DECISION SUPPORT

OPDS works to inform, develop, and implement evidence-based practices leading to an improved understanding and response to the health-related needs of women and children in Texas. Five subject matter experts in the areas of women's and perinatal health, child health, adolescent health, child fatality review, and clinical issues for these populations are funded through Title V to provide consultation to internal and external partners and to plan and implement initiatives that address critical health issues.

In addition to subject matter expertise, OPDS provides MCH epidemiology support for all Title V program areas to include expert statistical analysis, data management and performance measure reporting, geographical/spatial analysis, research design, consultation and evaluation, and literature reviews. OPDS is responsible for the State Systems Development Initiative (SSDI). The SSDI grant is a data integration grant to support the activities of Title V, WIC, Breast and Cervical Cancer Services, and other MCH-related programs. OPDS is also responsible for the Texas Pregnancy Risk Assessment and Monitoring System (PRAMS). PRAMS data serve as a valuable resource to researchers and policy makers interested in how maternal attitudes and behaviors are associated with infant mortality and morbidity trends in Texas.

SPECIALIZED HEALTH SERVICES SECTION

The Title V Children with Special Health Care Needs (CSHCN) Director is located in the Purchased Health Services Unit of the Specialized Health Services Section and also serves as Manager of the Systems Development Group and Medical Director of the Children with Special Health Care Needs Services Program. The Systems Development Group coordinates efforts with other stakeholders, programs, and agencies; facilitates the statewide Medical Home Workgroup; facilitates a Transition Team (including state agency staff and other stakeholders); administers and oversees statewide community-based services contractors providing case management, family supports and community resources, and clinical and medical home supports for Children and Youth with Special Health Care Needs (CYSHCN) and their families; conducts needs assessments and provides education and promotes awareness regarding the Title V tenets, Title V CSHCN performance measures, and the needs of CYSHCN and their families; conducts special, innovative service and research projects; operates the Glenda Dawson Donate Life Texas Registry (organ donation); and provides policy development, administrative support, and subject matter expertise for programs, workgroups, committees, agencies, and individuals serving CYSHCN and their families.

The Title V Director, Title V CSHCN Director, and the management team within FCHS work together to identify the best alternatives to address the needs of the MCH population in Texas.

DSHS SERVICE DELIVERY

Using Title V funds, as well as other funding sources, the majority of MCH direct health care safety net services provided by DSHS are through contracts with local health departments, public hospitals and hospital districts, Federally Qualified Health Centers, and other community-based agencies to assure that these services are available. Each contract contains a statement of work that specifies the standards of the services to be provided and the performance measures to be addressed. In the case of direct health care benefits within the CSHCN Services Program, a fee-for-service claims payment system funded by Title V and state general revenue is used to reimburse enrolled providers for services rendered.

The Community Health Services Section (CHS) consists of two Units:

- The Preventive and Primary Care Unit (PPCU) is responsible for developing and implementing operational policy and procedures and for providing technical assistance to contractors for the following Title V-funded programs: family planning, prenatal, child health and dental, and dysplasia. In addition, CHS

administers breast and cervical cancer screening and diagnosis, primary health care, county indigent health care, and epilepsy services. Clinical oversight for the Title V-funded programs is provided by an on-staff board-certified obstetrician/ gynecologist medical consultant and a team of nurses to ensure that clinical protocols and policies utilized by contractors are consistent with nationally-recognized standards, current scientific literature, and Texas statute. Day-to-day programmatic oversight for CHS Title V-funded programs is provided by program staff that develops program policies and procedures, participate in the procurement process for determining direct service contractors, and conduct contractor and staff technical assistance and training.

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

The Specialized Health Services Section consists of three Units:

- The Purchased Health Services Unit (PHSU) develops and administers health care benefits and services through the CSHCN Services Program, as well as provides medical expertise and consultation to providers of CYSHCN. As noted previously, the Title V CSHCN Director is located within PHSU. PHSU also administers a client services program for persons with end stage renal disease and the State organ donation registry and awareness program and oversees eligibility determination, enrollment services, third-party billing, and provider reimbursement for programs within PHSU. The CSHCN Services Program enrolls and reimburses individual health care benefit providers on a fee-for-service basis. Since October 2001, the CSHCN Services Program has had a waiting list for health care benefits as a result of budgetary constraints. Depending on financial projections, the CSHCN Services Program may offer health care benefits limited in scope, amount, or duration to clients on the waiting list. In addition to health care benefits, the CSHCN Services Program provides case management services to CYSHCN and their families, including those on the waiting list for health care benefits and also those not eligible for the CSHCN Services Program health care benefits, utilizing both regional DSHS staff and contracted providers. The CSHCN Services Program also provides family supports through both the fee-for-service health care benefits and through contractors. In addition the Program funds contractors to provide community resources and clinical and medical home supports.
- The Health Screening and Case Management Unit (HSCMU) administers federally-mandated preventive health services (Early Periodic Screening, Diagnosis, and Treatment [EPSDT]) to Medicaid eligible clients from birth through age 20 years through the Texas Health Steps program. Client services include medical and dental care and case management. HSCMU also develops

and administers mandated screening programs, including spinal, vision, lead, and hearing as well as case management services.

- The Newborn Screening Unit (NBS) oversees testing, follow-up, and case management resulting from screening all newborns in Texas for 29 inheritable and other disorders. An abnormal laboratory or hearing screening result triggers follow-up and case management services to ensure that the baby receives confirmatory testing and treatment, if needed. Additionally, NBS provides assistance to uninsured children identified with an abnormal screen to ensure access to confirmatory testing or treatment. This unit also administers Title V-funded genetics services including laboratory testing and diagnosis to help prevent and/or inform low-income families about genetic disorders, follow-up and support services if needed, and genetic counseling.

The Nutrition Services Section provides overall direction, policy development, and policy enforcement for WIC and the Farmers' Market Nutrition Program. The section consists of two units:

- The Nutrition Education/Clinic Services Unit establishes standards and policies for WIC clinical services, develops targeted WIC nutrition and breastfeeding promotion, and oversees WIC infant and cereal rebate contracts. The unit also establishes WIC allowable foods in accordance with federal regulations, including oversight and approval of infant formula issuance.
- The Food Issuance and Redemption Services Unit establishes standards and policies for WIC-authorized grocers and maintains provider base for grocers and farmers market associations. The unit also processes payment to grocers and manages claims adjudications and reconsiderations.

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

SECTION 1: PROCESS FOR CONDUCTING NEEDS ASSESSMENT

GOALS AND VISION

Determining needs for women, infants, children, adolescents, and children and youth with special health care needs is an ongoing process that is essential to relevant program planning and development, effective and efficient implementation, and accurate monitoring of interventions. The Maternal and Child Health (MCH) Title V Five-Year Needs Assessment (Needs Assessment) process was guided by the overarching vision and mission of DSHS and its Division for Family and Community Health Services (FCHS) which is responsible for the majority of Title V activities:

DSHS Vision: *A Healthy Texas*

DSHS Mission: *To improve health and well-being in Texas.*

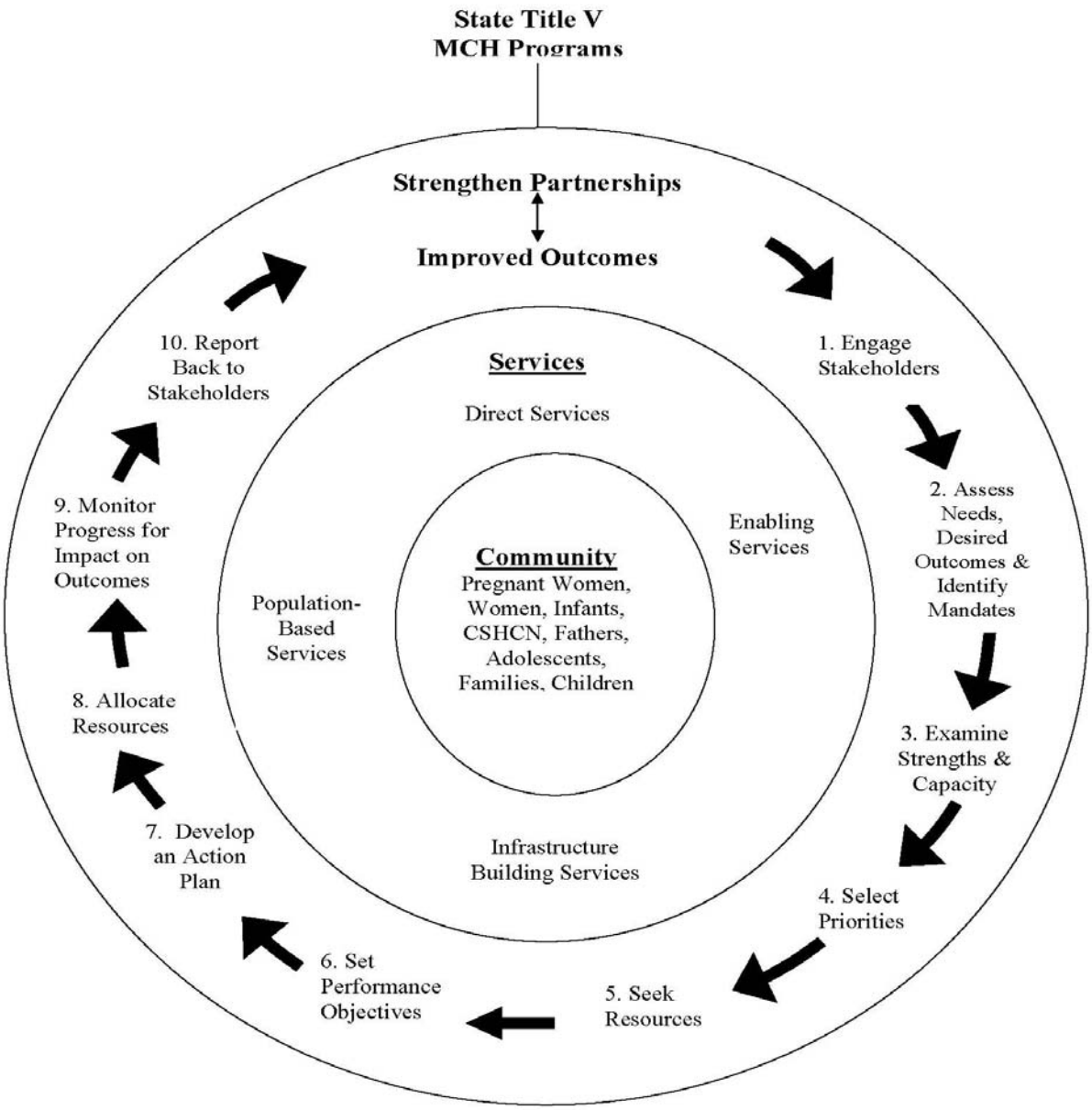
FCHS Mission: *To improve the health and well-being of Texas families by increasing access to health care through community collaboration, with a focus on prevention.*

The Needs Assessment methodologies were developed through an internal work group with a focus on the vision and mission statements above and were designed to be consistent with the MCH Services Title V Block Grant Guidance provided by the Health Resources and Services Administration (HRSA). In addition, work group members considered other states' needs assessments and resources, such as *the Review of the Title V 5 Year Needs Assessment Process in the States and Jurisdictions* (Health Systems Research, Inc., 2006), to assess and determine methods most well-suited to Texas. Overall goals identified early in the process included:

- Commitment to include all potential internal and external stakeholders in all stages of the process;
- Development of a project management plan that ensures vertical and horizontal communication within DSHS and among partners;
- Overarching focus on core MCH values of family-centered, community-based, culturally competent services to all families;
- Utilization of shared decision making processes among participants, including the DSHS Executive Team, the Title V Five-Year Needs Assessment Steering Committee, and the Needs Assessment Planning Group;
- Commitment to use most current quantitative and qualitative data available; and
- Employ program resources to address the priority needs identified.

The process was designed to be consistent with the HRSA, Maternal and Child Health Bureau (MCHB) conceptual framework, *State Title V MCH Program: Needs Assessment, Planning, Implementation, and Monitoring Process* (DHHS, Health Resources and Services Administration). Figure 1-1 illustrates these steps:

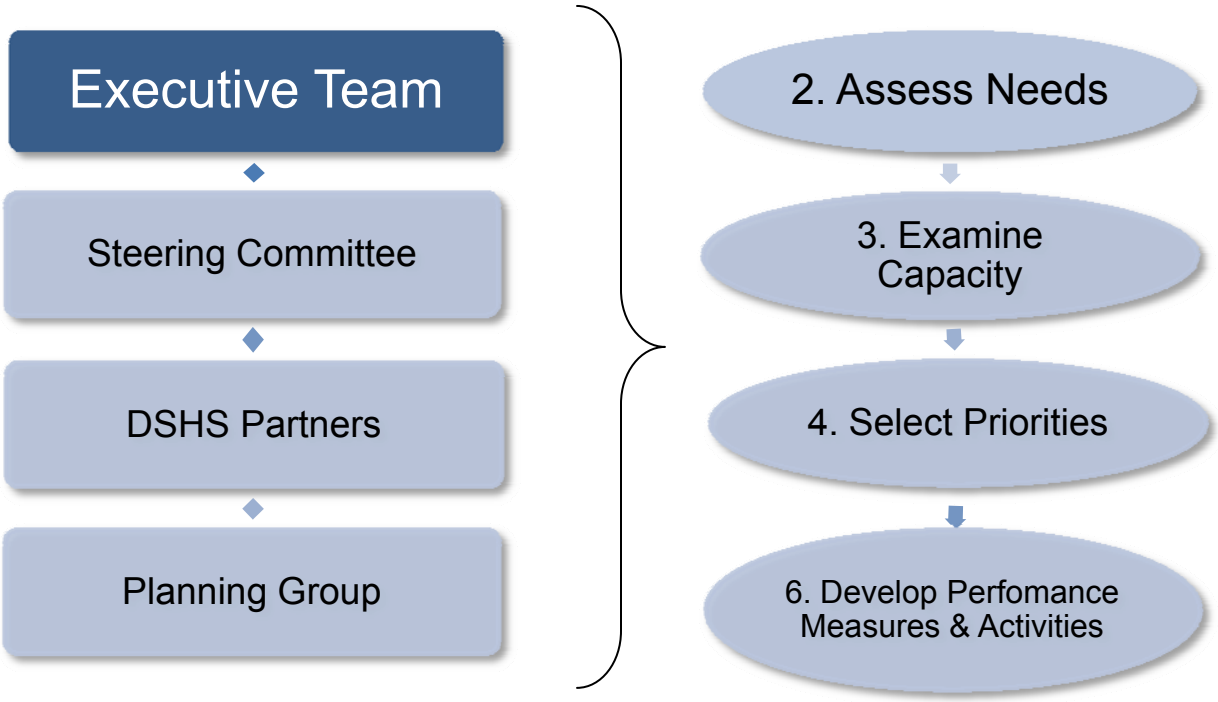
Figure 1-1. MCHB Conceptual Framework



LEADERSHIP

To ensure involvement of and communication with internal stakeholders, the Needs Assessment leadership team consisted of DSHS staff within and across various levels of the agency. This team provided significant input and guidance particularly in steps two, three, four, and six of the conceptual framework. Figure 1-2 illustrates the four essential groups included the process.

Figure 1-2. Needs Assessment Leadership Team



Furthermore, Figure 1-3 details the roles and responsibilities for each component of the leadership team as it relates to the Needs Assessment process.

Figure 1-3. Needs Assessment Leadership Team Roles and Responsibilities

EXECUTIVE TEAM

Within DSHS, Executive Leadership has developed a means of organizing and directing agency initiatives through a hierarchy of tiered designations. Different designations result in different levels of coordination among Commissioner's Direct Reports (CDR) team members. Through these designations, initiatives are provided tailored strategic and operational oversight, documentation and reporting requirements, and project management support and monitoring. CDR team members include the agency's Associate Commissioner, Deputy Commissioner, Chief Financial Officer, Chief Operating Officer, and the Assistant Commissioners that direct each of the five divisions.

The Needs Assessment was designated as a Tier One Initiative in September 2009 because of the importance in planning for the future direction of state Title V efforts and

the high level of stakeholder involvement that was needed. This designation also implies that the success of the project depends on awareness and strategic and operational involvement by all of the CDRs. With the potential influence on MCH services in Texas, the public perception of actions taken based on the results, and the dependencies among existing public health programs, this process warranted greater involvement among all divisions of the agency. The Title V Director provided updates regarding the Needs Assessment at the CDR Executive Strategy Meeting once every four months.

NEEDS ASSESSMENT STEERING COMMITTEE

In an effort to ensure a comprehensive, agency-wide approach to the Needs Assessment, each of the five DSHS divisions identified at least one representative to serve on the Needs Assessment Steering Committee in addition to the Title V Director and Title V CSHCN Director. A total of 15 agency staff participated on the Steering Committee and attended quarterly meetings. Steering Committee members served as liaisons for division leadership to ensure timely communication regarding Needs Assessment activities and to obtain and provide feedback to the Office of Title V and Family Health (OTV&FH) from the programs within their respective divisions as needed. Members participated in an agency-wide capacity assessment of current resources available to meet the needs identified in the ten priority MCH statements that resulted from the stakeholder input process. The input and guidance that the Steering Committee provided was an invaluable part of the Needs Assessment process.

DSHS TITLE V PARTNERS

DSHS Title V Partners functions as a coordinating group for the various programs within DSHS which serve MCH populations. The HHSC Office of Program Coordination for Children and Youth is also a member of this coordinating group. Led by the Title V Block Grant Administrator with leadership from the Title V Director and Title V CSHCN Director, the group meets on a quarterly basis to share program updates, provide feedback and program expertise on Title V initiatives, and identify opportunities to collaborate across agency programs. Specific to the Needs Assessment process, programs were provided status updates on key activities, assisted in communication efforts with internal and external stakeholders, and gave input on the priority statements developed and the resulting activity plans.

NEEDS ASSESSMENT PLANNING GROUP

The group largely responsible for the overall design and day-to-day implementation of the Needs Assessment process was the Needs Assessment Planning Group.

Consisting of the Title V Director, the Title V CSHCN Director, the Office of Program Decision Support (OPDS) Director, the Title V Block Grant Administrator, four additional representatives from FCHS, and one non-DSHS employee, the Texas Family Delegate for the Association of Maternal and Child Health Programs, the Planning Group met on a weekly basis for much of the time period between November 2008 and March 2010. While a significant time commitment, active participation on the Planning Group proved critical in keeping the process on-track, and frequent meetings served as an ideal forum to optimize the collective knowledge of the group.

METHODOLOGY

In September 2008, Title V staff began initial discussions related to the Needs Assessment, reviewing a variety of resources and examples of other state needs assessments. Following this review and after considering available staff resources, a decision was made to outsource components of the process for greater efficiency. It was determined that existing DSHS MCH staff would be capable of completing the data review and analysis; therefore, the focus of an outsourced component was limited to the implementation of an external stakeholder input process to obtain recommendations for establishing the state priorities for the next five years.

In November 2008, following initial discussions with the Public Policy Research Institute (PPRI) at Texas A&M University, an interagency contract was developed with the following key elements:

- Collection and presentation of qualitative data concerning MCH/CYSHCN needs gathered through a series of 50 Community Listening Sessions held at strategically designated sites throughout Texas. Related tasks included recruiting participants, determining dates and securing meeting space for each session, and documenting the data collected.
- Analysis of data collected using an agreed upon methodology.
- Design and administration of a survey among willing focus group invitees and participants. This survey quantified the importance of identified needs using a survey developed by the Contractor and approved by DSHS.
- Implementation of a two-day summit to prioritize and identify top needs in the MCH/CYSHCN populations. Related tasks included developing and distributing pre-meeting “homework” for summit participants, determining dates and locations, facilitating the meetings, and documenting proceedings.
- Development of a list of prioritized needs based upon a shared methodology.
- Implementation of regional stakeholder meetings to allow for public comment concerning the priority MCH/CYSHCN needs. Related tasks included recruiting participants, determining dates and securing meeting spaces for each session, and documenting data collected.

Beginning In November 2008, the Needs Assessment Planning Group began meeting weekly to identify and operationalize implementation steps and strategies to carry out the Needs Assessment processes. Standing agenda items for the weekly meetings included status updates on assignments, communication strategies with other stakeholders (including the Steering Committee and Executive Leadership), and the oversight and management of the PPRI contract and its deliverables.

STAKEHOLDER INVOLVEMENT

CHS CONTRACTOR ROUNDTABLES

Prior to the implementation of the larger stakeholder input process, OTV&FH staff had the opportunity to gather stakeholder input during the statewide DSHS Community Health Services (CHS) Roundtables. The CHS Roundtables are a set of meetings hosted bi-annually by CHS to provide programmatic updates, professional development, and networking opportunities to DSHS contractors that provide direct health care services to women and children in the state. By electing to collect input for the Needs Assessment during the CHS Roundtables, OTV&FH accomplished two goals: (1) to target key stakeholders who, as entities serving the target populations with DSHS oversight, could provide a firsthand assessment of needs; and (2) to assure the input provided represented all regions of the state. The Roundtable locations – Austin, Dallas, Houston, Lubbock, and McAllen – provided a diverse cross-section of Texas communities.

Qualitative data was collected from these stakeholders using a method called Force Field Analysis (Lewin, 1943), in which the desired states for women and infants, children and adolescents, and CYSHCN were presented and in small groups the participants discussed both driving and restraining forces within their communities that were working for and against the desired states for each MCH target population. Data from these sessions yielded the following key findings:

- Women and Infants
    - The most commonly identified driving force for women and infants was the perceived success of immunization programs, including availability and timeliness of immunizations and tracking systems. In addition, a significant driving force focused on prenatal care. Respondents cited strengths such as the availability of early prenatal care, access to Title V MCH prenatal and Children's Health Insurance Program (CHIP) Perinatal providers, and services provided by the Medicaid Women's Health Program.
    - Regarding restraining forces, a majority of respondents cited problems with access to health care, including lack of access to prenatal care, lack of (or limited) access to health care in general, and lack of health care

educators or providers. This issue also correlates directly to additional responses related to problems with funding and resources on the infrastructural level. Health education was another commonly identified area of concern. Respondents noted lack of knowledge of resources and lack of education as priority restraining forces in this category.

- Children and Adolescents
    - The most commonly identified driving force category for children and adolescents was health education. Responses included the availability of education in a clinical setting, education on at-risk behavior, and media communications on teen health.
    - The most commonly identified restraining force was a lack of sex education in schools. Groups also mentioned several "socio-environmental" as factors that work against the desired state including a family's financial situation, easy access to Internet/TV, and a lack of parental guidance.
- Children and Youth with Special Health Care Needs
    - A majority of participants reported the infrastructure that is in place for CYSHCN is a definite driving force for this population. Examples provided were available services/programs in schools and within the community and technological advances that improve quality of life.
    - Access to health care was the most commonly identified restraining force. Participants discussed long wait lists for programs, lack of access to specialists/providers, and transportation issues. Most likely related to access, the groups consistently mentioned that resources and funding were a restraining force as well.

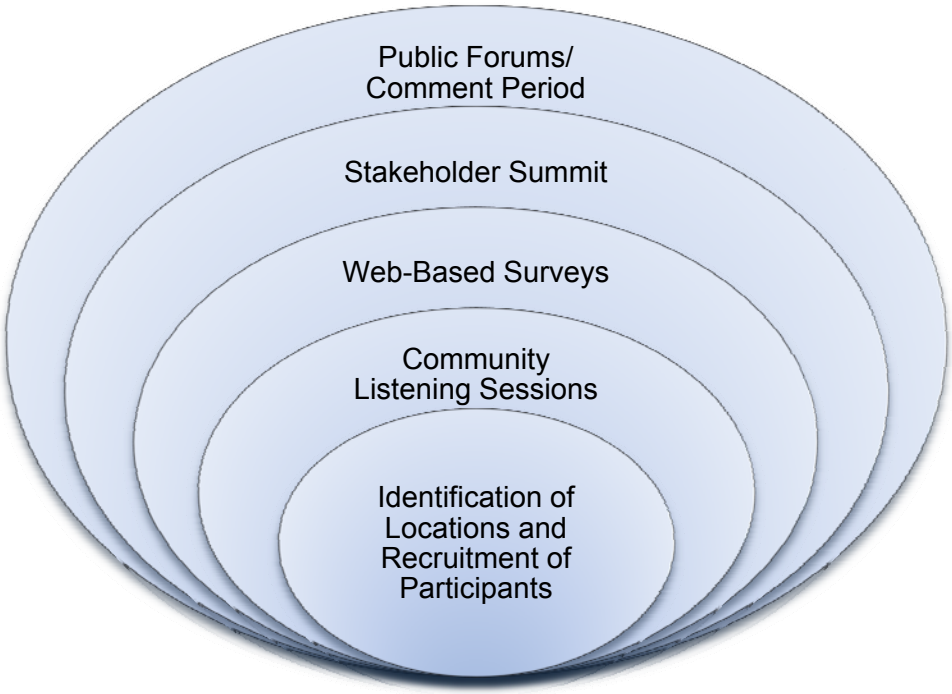
The input provided by participants at the CHS Roundtables was combined with the qualitative data collected during the Stakeholder Input Process described in the remainder of this section to develop the priority needs.

STAKEHOLDER INPUT PROCESS DESIGN

To engage stakeholders in a culturally-appropriate, inclusive manner with the goal of submitting a set of prioritized recommendations to DSHS regarding the needs of the MCH/CYSHCN populations in Texas, PPRI developed a multi-stage design to select, refine, rank, prioritize, and finalize a list of needs. This multi-stage approach combined both qualitative and quantitative social science research techniques to ensure the overall validity and reliability of the Needs Assessment prioritization process (Public Policy Research Institute, Texas A&M University, 2010). See Appendix B – PPRI Final Report for additional information on the stakeholder input process coordinated by PPRI described in this portion of the Needs Assessment.

Figure 1-4 shows the consecutive stages of the stakeholder input process and illustrates how the information at each stage helped inform the next stage in the process.

Figure 1-4. Stakeholder Input Process Design



In preparation for the Community Listening Sessions stage of the stakeholder input process, DSHS staff provided PPRI an extensive list of existing MCH stakeholders that was used as a starting point to develop a more robust list to use for recruitment purposes. PPRI staff added to the list by obtaining contact information from various sources for organizations such as:

- School districts
- Criminal justice system
- Faith-based organizations
- Community-based organizations
- Cultural organizations
- Indigent health clinics
- State and local chapters of national organizations
- Mental health providers
- Substance abuse providers
- DSHS direct service contractors
- Education Service Centers
- School-Based Health Centers
- Local WIC agencies
- Early Childhood Intervention programs
- School Health Networks
- Rape crisis centers
- Housing authorities
- Safe kids coalitions
- Chambers of commerce
- County judges
- City government

COMMUNITY LISTENING SESSIONS

The process of collecting stakeholder input for the priority MCH needs began with PPRI hosting 50 Community Listening Sessions in 19 different locations across the state from March 2009 to July 2009. Consumers, health and social service providers and administrators, advocates, and other stakeholders were actively recruited by PPRI to participate in the facilitated sessions and discuss the health-related needs of the MCH population in their local communities. A total of 439 participants attended the sessions.

In contrast to a typical focus group format where facilitators present a pre-determined set of questions or ideas, the Community Listening Sessions were designed to encourage free-flowing, interactive discussion among participants. A two-member team from PPRI facilitated each session. With input from the Needs Assessment Planning Group, PPRI developed a training guide in order to prepare PPRI facilitators to conduct the sessions in a consistent manner.

During the planning and recruitment for the Community Listening Sessions, PPRI used several strategies to ensure input provided during the sessions was representative of all MCH populations and types of stakeholders:

- There were at least two sessions at each of the 19 locations, one for consumers and advocates, and one for providers and administrators.
- In addition to the standard two sessions per location, select locations had two additional sessions focused specifically on CYSHCN needs. In the end, PPRI found that, even with the targeted sessions, participants recruited to focus on CYSHCN needs often expressed needs related to the broader MCH population and vice versa.
- The Needs Assessment Planning Group selected the counties in which the sessions were held based on existing MCH and CYSHCN statistics in the geographical distributions of metropolitan, micropolitan, rural, and border communities in Texas.
- In some locations, such as the counties that share a border with Mexico and Bexar County where San Antonio is located, the sessions were conducted in both English and Spanish.
- DSHS discouraged its employees from attending the sessions to help assure that stakeholders felt comfortable in expressing their thoughts and opinions.
- PPRI conducted outreach for the sessions through telephone contact, flyers, a website that provided additional details, and a toll-free telephone number to respond to questions. In some communities, PPRI used newspaper and radio advertisements to bolster attendance. Registered participants received a reminder call about the session two days before the session date.

- The registration process screened all session participants for their language or accessibility needs, and PPRI provided accommodations, including translators, for any session at which a participant indicated such needs.
- The process identified stakeholders who were unable to attend a session and gave them the opportunity to provide input during the next phase of the stakeholder input process.

As a result of the recruitment efforts, a total of 572 individuals signed up to attend the Community Listening Sessions and 439 participated in a session. Most of the participants were female between 34 and 60 years of age and of White or Hispanic race/ethnicity. Additionally, participants came from 59 different counties in Texas. A total of 252 of the Community Listening Session participants indicated they were willing to continue to serve as stakeholders during subsequent stages of the stakeholder input process.

In considering the distribution of counties, DSHS used four geographical categories, defined as follows:

- Metropolitan – an urban core consisting of at least 50,000 residents.
- Micropolitan – an urban core consisting of between 10,000 and 50,000 residents.
- Rural – open country and settlements with fewer than 2,500 residents.
- Border – area within 100 kilometers (or 62 miles) of the Rio Grande River.

Table 1-1 lists the counties where PPRI held Community Listening Sessions, organized by geographical category. When the same county location is listed under both MCH and CYSHCN, PPRI conducted four sessions - two for the MCH population and two for the CYSHCN population.

Table 1-1. List of Venues for Community Listening Sessions by Texas County

Metropolitan		Micropolitan		Rural		Border	
MCH	CYSHCN	MCH	CYSHCN	MCH	CYSHCN	MCH	CYSHCN
Lubbock	Lubbock	Scurry	n/a	Gaines	Jasper	Hidalgo	Hidalgo
Potter	Harris	Wharton		Jasper		Webb	El Paso
Harris	Dallas	Navarro		Gonzales		El Paso	
Dallas		Lamar		Panola			
Bexar				Red River			
Travis							
Tom Green							

Data on demographic indicators, health system capacity indicators, performance measures, and key health status and outcome indicators such as infant mortality rates and Social Security Income eligibility informed the Needs Assessment Planning Group in selecting the locations for the Community Listening Sessions.

It is important to note that during the original timeframe for the Community Listening Sessions, H1N1 was identified as a public health emergency requiring the full attention of all available DSHS staff and resources. PPRI and DSHS agreed to suspend the original schedule of sessions until more information was available on the size and scope of the outbreak. Once more information was available that supported a reduced risk for disease transmission in group settings, PPRI and DSHS agreed to reduce the number of community listening sessions and revise the schedule to maintain the original timeframe for the subsequent stages. The remaining sites continued to be geographically representative of the diverse population groups in the state. PPRI made special efforts to encourage participation of stakeholders, particularly those already recruited for the cancelled sessions, to call a toll-free number and provide information on MCH needs in their communities. PPRI also provided recruited participants from the cancelled sessions the opportunity to participate in a subsequent web-based survey.

The sessions were between one and two hours in length and PPRI documented stakeholder input on flipcharts as well as through audio-recording. Facilitators conveyed a relaxed, open atmosphere and ensured that no single person dominated the discussion. Each session began with an ice-breaker to help establish rapport within the group. Facilitators then asked one or more of the following questions to initiate discussion:

For general MCH sessions:

- In your communities, what do you think is needed to improve the physical and mental health of women, including mothers and pregnant women?
- In your communities, what do you think is needed to improve the physical and mental health of infants, young children, and teens, including children with disabilities or special health care needs?

For CYSHCN-specific sessions:

- In your communities, what do you think is needed to improve the physical and mental health of children who have disabilities or special health care needs? What about their families?
- In your communities, what do you think is needed to improve the physical and mental health of young children and teens?
- In your communities, what do you think is needed to improve the physical and mental health of women, including mothers and pregnant women?

CONTENT ANALYSIS OF COMMUNITY LISTENING SESSIONS

DSHS charged PPRI to provide a condensed list of unduplicated need statements captured during the Community Listening Sessions. PPRI conducted an analysis based upon the current methodological literature for content analysis of qualitative, open forum discussion and past experience with similar projects. The steps in the content analysis process are outlined in Figure 1-5.

Figure 1-5. Content Analysis Steps Conducted by PPRI

"Debriefing" Activities	
Activities: • Research teams complete standard templates to record the qualitative data collected during the sessions. Recreate a sample of debriefs to check for inter-coder reliability.	Goal: Reliably capture and record all possible need statements and context.

Initial Coding	
Activities: • Senior researchers create and code lists of all possible need statements and sub-topics. • Check lists for inter-coder reliability.	Goal: Reliably code all possible need statements and context.

Focused Coding	
Activities: • Senior researchers recode lists of need statements to account for conceptual overlap. • Check each coding for inter-coder reliability. • Conduct computer-aided text analysis to provide secondary reliability check on coding and identify conceptual similarities missed by human coders.	Goal: Review conceptual consistency and overlap among need statements via human and computer-aided methods to consolidate or refine need statements.

Final Analysis	
Activities: • For the final report, PPRI performs descriptive analysis and model needs statement occurrence, using hierarchical or nested likelihood models.	Goal: Understanding the patterns and contexts of need statements.

This analysis resulted in a list of 63 need statements stemming from the general MCH sessions and 39 need statements stemming from the CYSHCN-focused sessions. When PPRI compared these two lists, 71 distinct statements emerged representing the combined needs of the entire MCH population in Texas. In no particular order, these statements are listed in Table 1-2.

Table 1-2. Final List of Need Statements from Community Listening Sessions

Need Statements
Improve the availability and quality of mental health services and resources.
Provide parents, including teen parents, with relevant parenting information and skills.
Improve counseling resources (e.g., support groups) for Title V families.
Enhance transportation services for families with limited access to transportation.
Provide more affordable health insurance coverage for Title V eligible populations.
Promote awareness and public knowledge about health services and providers available in the community.
Collaborate and coordinate with community organizations and services to keep 2-1-1 (or other centralized system) information current and accurate.
Promote nutrition, physical activity, and obesity prevention for teens.
Provide affordable childcare services, including after-hour childcare and after-school programs.
Address the cultural and language barriers for individuals seeking health care information or services, including increased funding for the promotoras program.
Improve accessibility to health care services at clinics by reducing barriers like long wait times, complex eligibility procedures, limited office hours, and difficult medical forms.
Address issues with finding information about and getting appointments with Medicaid providers and Medicaid case management.
Create or promote support programs and social networking opportunities for adult and teen parents, including those with CSHCN.
Improve social supports (e.g., support groups, counseling groups and mentors) and clinic facilities to provide medical services for pregnant teens.
Improve awareness and availability of prenatal health care services for women.
Improve substance abuse rehabilitation and treatment facilities and services in the community.
Simplify the Medicaid coverage requirements, eligibility procedures, and application process.

Need Statements
Promote early intervention and screening for mental health disorders, including autism and ADD/ADHD.
Increase accessibility to affordable dental care for Title V families.
Provide shelters, medical care, and social services for domestic violence victims and families.
Increase access to low-cost prescriptions and medications.
Increase the number of specialists providing affordable care.
Increase training for health care providers and organizations that provide services for CSHCN.
Provide case management services for mothers including pregnant mothers, families, and CSHCN.
Assess and evaluate the needs and barriers for local health care programs.
Improve the overall access and quality of CHIP.
Improve the accessibility to affordable obstetricians/gynecologists.
Increase and support community clinics serving women, infants, and children in rural areas, including subsidized clinics for low-income populations.
Address the lack of respite care services for families with CSHCN.
Educate newly immigrated population in the United States concerning their rights to health care services.
Provide sex education program opportunities in the community.
Improve access (e.g., reduce costs and increase awareness) to family planning services.
Increase support initiatives for breastfeeding.
Improve reimbursement rates to providers for government funded health care services or programs.
Provide more low-cost preventive health screenings for women, including Pap smears, mammograms, and other routine care.
Develop and provide appropriate follow-up care for women and children after each diagnosis.
Provide and promote early intervention and prevention programs for all children under the age of five.
Provide public education and public awareness on what Title V funding covers.

Need Statements
Develop more prevention-based programs for all target populations.
Educate and provide services for both men and women about pregnancy and pregnancy prevention.
Promote vaccination, immunization, and wellness check-up programs for children.
Improve health care services for the homeless population.
Improve the awareness, accessibility (e.g., expand eligibility), and quality of the WIC program.
Inform and educate relevant population about policy and program changes and implementations.
Address the shortage in nurses, especially in non-urban areas.
Provide quality foster care and child protection services for children.
Improve school health programs through coordination with local health care agencies and organizations.
Improve awareness and availability of postnatal health care services for women.
Provide better access to meal or food bank programs in the community, including programs for children while not in school.
Improve community outreach (e.g. education programs, health fairs, and awareness campaigns) for existing health care programs and services.
Increase awareness of health risks associated with chronic disease.
Increase the number of social workers and social service organizations in the community.
Promote a holistic approach for health care services for women and children.
Provide education and awareness about the health risks associated with substance abuse.
Provide education and funding to help prevent infant mortality.
Improve communication and coordination among local and state health care agencies.
Increase the number of affordable public and private pediatric providers.
Increase the number of primary care services available for all Title V families.
Recruit and retain high-quality health care providers and administrators.

Need Statements
Create or promote social support programs (e.g., recreation, counseling, family support services) for CSHCN.
Improve transition services for CSHCN when moving from school to post-school activities (including education, employment, community integration, and adult services).
Increase funding for veterans' health care programs.
Improve the quality of the Medicaid Medical Transportation Program.
Integrate stakeholder input into Title V program and policy guidelines.
Increase awareness of available maternity services in the community.
Address the problem of individuals going to the emergency room for non-emergency care.
Provide more therapy services, including occupational therapy, alternative therapy, and physical therapy.
Reallocate funds and resources to maternity services for parents with CSHCN.
Promote local vocational programs and vocational therapy for children and adults with disabilities.
Address lack of local residential heath care (e.g., group homes) for CSHCN.
Promote awareness and public knowledge of health services and programs for high-risk pregnancies.

Table 1-3 displays the most frequently occurring need statements by geographical category and the number of times the need was mentioned. The 10 statements listed in Table 1-3 represent about 40% of all responses provided at the Community Listening Sessions. Improving the availability and quality of mental health services and resources was either the most or second-most frequently occurring need statement for each of the four geographical categories. Specifically in metropolitan areas, the need statement occurring most often focused on providing affordable health insurance coverage for Title V eligible populations. In border and micropolitan locations, improving counseling resources and promoting nutrition, physical activity, and obesity prevention for teens were also frequently mentioned. For rural locations, the second- and third-most frequently mentioned need statements were enhancing transportation services for families with limited access to transportation and collaborating and coordinating among community organizations and services to keep centralized information and referral systems current and accurate.

Table 1-3. Frequently Occurring Need Statements by Geographical Category

Need Statement	Metropolitan		Micropolitan		Rural		Border		Total	
	#	%	#	%	#	%	#	%	#	%
Improve the availability and quality of mental health services and resources.	22	6.5	18	8.8	12	16.2	12	6.1	64	6.8
Provide parents, including teen parents, with relevant parenting information and skills.	14	4.1	9	4.4	10	5.1	11	5.6	44	4.7
Improve counseling resources (e.g., support groups) for Title V families.	12	3.5	11	5.4	4	2.1	13	6.6	40	4.3
Enhance transportation services for families with limited access to transportation.	17	5	6	2.9	11	5.6	6	3	40	4.3
Provide more affordable health insurance coverage for Title V eligible populations.	23	6.8	6	2.9	7	3.6	3	1.5	39	4.2
Promote awareness and public knowledge about health services and providers available in the community.	17	5	6	2.9	3	1.5	7	3.6	33	3.5
Collaborate and coordinate with community organizations and services to keep 2-1-1 (or other centralized system) information current and accurate.	11	3.2	5	2.4	11	5.6	4	2	31	3.3
Promote nutrition, physical activity, and obesity prevention for teens.	3	0.9	9	4.4	6	3.1	12	6.1	30	3.2
Provide affordable childcare services, including after-hour childcare and after-school programs.	8	2.4	7	3.4	9	4.6	4	2	28	3
Address the cultural and language barriers for individuals seeking health care information or services, including increased funding for the promotoras program.	11	3.2	5	2.4	3	1.5	9	4.6	28	3

OBSERVATIONS FROM COMMUNITY LISTENING SESSIONS

PPRI described the following observations and lessons learned from the Community Listening Sessions in a report submitted to DSHS (Public Policy Research Institute, Texas A&M University, 2010):

- The Community Listening Sessions provided DSHS the opportunity to hear concerns and issues from the perspectives of local consumers and stakeholders in ways that might not be evident from other data collection techniques.
- An important side-benefit of the Community Listening Sessions was the creation of an active, informed set of stakeholders from across the state who are now invested in MCH issues.
- Compared to past efforts in Texas, DSHS made vast improvements in the collection of direct stakeholder input through the use of research-based qualitative techniques, particularly with traditionally hard-to-reach populations.
- While PPRI and DSHS worked together to minimize barriers to participation, future stakeholder input processes should consider providing incentives or employing alternative communication avenues, such as conference calls, that reduce the burden of time away from work and family and travel to a location.
- To help externally contracted staff better facilitate this type of session, it would have been helpful to conduct focus groups or interviews with DSHS staff prior to the sessions to familiarize the facilitators on local issues and provide them a context for the information to be provided by stakeholders.

WEB-BASED SURVEYS

In August 2009, PPRI administered the first of two web-based surveys to all 439 Community Listening Session participants. Referred to as Survey A, PPRI developed the instrument in consultation with the Needs Assessment Planning Group and used LimeSurvey®, an online, open source survey application. Instructions asked participants to select from the 63 need statements generated from the general MCH Community Listening Sessions the five most important statements to improve the health of women, infants, and children in Texas. Subsequently, instructions directed participants to select from the 39 need statements generated from the CYSHCN-focused Community Listening Sessions the five most important statements to improve the health of CYSHCN in Texas. The survey instrument also asked participants to suggest additional needs that were not previously listed (See Appendix B – PPRI Final Report for a copy of the survey instrument). Respondents had one week to respond, and there were 121 responses (27.5% response rate).

While Survey A reconfirmed the implied importance of some of the need statements related to the frequency of occurrence shown in Table 1-3, other statements emerged

as important needs as well. Since this was the first opportunity the Community Listening Session participants had to examine the responses generated from all sessions, participants may have favored views of other stakeholders when taking the broader perspective into account. Table 1-4 lists the top 16 MCH and Table 1-5 lists the top 15 CYSHCN need statements resulting from Survey A. These statements were used as the basis for Survey B, with the number of statements in Survey B selected because of a natural breakpoint that occurred in frequency of ranking response.

Table 1-4. Web Survey A - Ranked MCH Need Statements

Rank	Need Statements
1	Simplify the Medicaid coverage requirements, eligibility procedures, and application process.
2	Improve the availability and quality of mental health services and resources.
3	Improve communication and coordination among local and state health care agencies.
4	Increase accessibility to affordable dental care for Title V families.
5	Increase and support community clinics serving women, infants, and children in rural areas, including subsidized clinics for low-income populations.
6	Promote awareness and public knowledge about health services and providers available in the community.
7	Promote early intervention and screening for mental health disorders, including autism and ADD/ADHD.
8	Provide and promote early intervention and prevention programs for all children under the age of five.
9	Enhance transportation services for families with limited access to transportation.
10	Address the problem of individuals going to the emergency room for non-emergency care.
11	Develop more prevention-based programs for all target populations.
12	Improve reimbursement rates to providers for government-funded health care services or programs.
13	Increase access to low-cost prescriptions and medications.
14	Improve access (e.g., reduce costs and increase awareness) to family planning services.
15	Improve the overall access and quality of CHIP.
16	Provide parents, including teen parents, with relevant parenting information and skills.

Table 1-5. Web Survey A - Ranked CYSHCN Need Statements

Rank	Need Statements
1	Improve the availability and quality of mental health services and resources.
2	Enhance transportation services for families with limited access to transportation.
3	Improve transition services for CSHCN when moving from school to post-school activities (including education, employment, community integration, and adult services).
4	Provide and promote early intervention and prevention programs for all children under the age of five.
5	Promote early intervention and screening for mental health disorders, including autism and ADD/ADHD.
6	Provide parents, including teen parents, with relevant parenting information and skills.
7	Provide affordable child care services, including after-hour child care and after-school programs.
8	Improve accessibility to health care services at clinics by reducing barriers like long wait lines, complex eligibility procedures, limited office hours, and difficult medical forms.
9	Address lack of respite care services for families with CSHCN.
10	Increase accessibility to affordable dental care for Title V families.
11	Promote a holistic approach for health care services for women and children.
12	Improve reimbursement rates to providers for government-funded health care services or programs.
13	Increase access to low-cost prescriptions and medications.
14	Increase the number of specialists providing affordable care.
15	Provide more therapy services, including occupational therapy, alternative therapy, and physical therapy.

Survey A also allowed participants to provide additional need statements that they considered to be important to the MCH population. Table 1-6 lists the additional statements that emerged from Survey A.

Table 1-6. Web Survey A - Additional Need Statements

Need Statement
Address the issue of environmental contaminants that interfere with health and child development.
Provide educational programs (such as Parents as Teachers) for stay-at-home moms and parents.
Continue the CHIP program and increase access to CHIP.
Educate women of childbearing age on importance of folic acid intake to prevent birth defects.
Promote a health care approach that involves a single primary care provider to coordinate routine and preventative health care for women and children throughout their lifetime.
Provide additional funding for cancer treatment.
Provide violence prevention services and teen dating violence services such as counseling, shelter, prevention education, etc.

In September 2009, PPRI administered Survey B to 258 participants that either indicated during the Community Listening Sessions an interest to participate further in the stakeholder input process or were invited by DSHS to ensure participation by key state-level partners and advocacy groups. Survey B asked participants to rank in order of importance the top ten from a list of 16 MCH and 15 CYSHCN need statements. The list of need statements originated from the results from Survey A discussed previously. A total of 141 participants responded to this second web-based survey, producing a nearly 55% response rate. The results of Survey B are detailed in Table 1-7 and Table 1-8.

Table 1-7. Survey B - Ranked MCH Need Statements

Rank	Need Statements
1	Simplify the Medicaid coverage requirements, eligibility procedures, and application process.
2	Improve the availability and quality of mental health services and resources.
3	Increase and support community clinics serving women, infants, and children in rural areas, including subsidized clinics for low-income populations.
4 (tie)	Enhance transportation services for families with limited access to transportation.

Rank	Need Statements
4	Provide additional funding for cancer treatment.
5 (tie)	Educate women of childbearing age on importance of folic acid intake to prevent birth defects.
5	Provide and promote early intervention and prevention programs for all children under the age of five.
6	Improve communication and coordination among local and state health care agencies.
7 (tie)	Continue the CHIP program and increase access to CHIP.
7	Promote awareness and public knowledge about health services and providers available in the community.
8	Increase accessibility to affordable dental care for Title V families.
9	Promote early intervention and screening for mental health disorders, including autism and ADD/ADHD.
10	Address the problem of individuals going to the emergency room for non-emergency care.

Table 1-8. Survey B - Ranked CYSHCN Need Statements

Rank	Need Statements
1	Improve the availability and quality of mental health services and resources.
2 (tie)	Educate women of childbearing age on the importance of folic acid intake to prevent birth defects.
2	Promote early intervention and screening for mental health disorders, including autism and ADD/ADHD.
3	Address lack of respite care services for families with CYSHCN.
4	Enhance transportation services for families with limited access to transportation.
5	Improve transition services for CYSHCN when moving from school to post-school activities (including education, employment, community integration, and adult services).
6	Provide and promote early intervention and prevention programs for all children under the age of five.
7	Provide affordable child care services, including after-hour child care and after-school programs.
8 (tie)	Continue the CHIP program and access to CHIP.
8	Increase accessibility to affordable dental care for Title V families.

Rank	Need Statements
9 (tie)	Provide educational programs (such as Parents as Teachers) for stay-at-home moms and parents.
9	Provide parents, including teen parents, with relevant parenting information and skills.
10	Improve accessibility to health care services at clinics by reducing barriers like long wait lines, complex eligibility procedures, limited office hours, and difficult medical forms.

Survey B again asked participants to provide additional need statements that they considered to be important to the MCH population. Table 1-9 lists the additional statements that emerged from Survey B.

Table 1-9. Survey B - Additional Need Statements

Need Statement
Increase availability of screening, diagnosis, and treatment for children affected by Fetal Alcohol Spectrum Disorder (FASD).
Enhance education and financial support of breastfeeding initiatives, including promotion of primary care that treats mothers and infants as a breastfeeding unit.
Add funding for dysplasia services for all ages back into the Title V program.
Screen parents, especially those in the at-risk population, to see if they are able to execute care for children with mental health and ADHD issues.
Recruit and train pediatricians with the expertise and willingness to care for medically fragile infants despite low reimbursement rates.
Educate women of childbearing age on importance of folic acid intake to prevent birth defects.

OBSERVATIONS FROM WEB-BASED SURVEYS

In its report, PPRI described the following observations and lessons learned from the web-based surveys (Public Policy Research Institute, Texas A&M University, 2010):

- Surveys A and B helped to confirm and refine the need statements that emerged from the Community Listening Sessions, as well as provided focus for the next stage of the stakeholder input process.
- There were clear differences across minority (self-reported non-white) respondents, respondents from rural and border locations, and respondents who were reported as consumers, family members of consumers, or advocates compared to the group as a whole in their prioritization of need statements. For instance, in Survey A, while most respondents identified important needs like improving mental health services, improving access to transportation services, and simplifying Medicaid eligibility requirements and paperwork (across the MCH and CYSHCN lists), consumers and advocates were more likely to identify issues

with accessing dental services, increasing coordination and communication across health care agencies, and improving parenting information and skills. Similarly, minority respondents were likely to identify issues with the numbers of and support for community and low-income clinics, the need for early intervention and screening services, and improving transition services for the CYSHCN population. Finally, the respondents from rural and border areas focused on the needs for more prevention-based programs and increased reimbursement rates for health care providers.

- While the overall response rate for the surveys and the participation rate in the subsequent Stakeholder Summit were high, respondents described above, particularly consumers and their family members, were the most likely groups to drop out of the process somewhere along the way. Future efforts should consider ways either to consolidate the process or incentivize the process to minimize attrition and maximize representative input.

TITLE V STAKEHOLDER SUMMIT

To determine the final list of need statements to be presented at the statewide Title V Stakeholder Summit (Summit), the Needs Assessment Planning Group worked closely with PPRI to comprehensively examine and contextualize the results from the steps completed to this point. Additionally, OPDS staff conducted a parallel quantitative and qualitative data analysis they later provided to participants as “homework” to prepare for the Summit. Using this information, the Needs Assessment Planning Group determined that the Summit activities would focus on the12 need statements listed in Table 1-10.

Table 1-10. Title V Stakeholder Summit – Need Statements Provided to Participants

Need Statements
Improve the availability and quality of mental health services and resources.
Enhance education and financial support of breastfeeding initiatives, including promotion of primary care that treats mothers and infants as a breastfeeding unit.
Increase and support community clinics serving women, infants and children in rural areas, including subsidized clinics for low-income populations.
Promote awareness and public knowledge about health services and providers available in the community.
Promote a health care approach that involves a single primary care provider to coordinate routine and preventative health care for women and children throughout their lifetime.
Address the issue of environmental contaminants that interfere with health and child development.
Improve transition services for CSHCN when moving from school to post-school activities (including education, employment, community integration, and adult services).
Provide parents, including teen parents, with relevant parenting information and skills.

Need Statements
Increase accessibility to affordable dental care for Title V families.
Promote early intervention and screening for mental health disorders, including autism and ADD/ADHD.
Address the problem of individuals going to the emergency room for non-emergency care.
Provide violence prevention services and teen dating violence services such as counseling, shelter, prevention education, etc.

A statewide representative sample of respondents to Survey B who indicated they were interested in attending the Summit was invited via email one month prior to the event. Those who confirmed they would be able to attend received a second detailed email with information about lodging, transportation, and travel reimbursement. To minimize any cost barriers to attending, PPRI was contractually required to provide transportation and lodging reimbursement for out-of-town participants, and they also provided meals for all participants during the Summit. Participants also received a web link to access reading material ("homework") that introduced the need statements and provided a quantitative context for these needs in Texas.

The Summit was held on November 4 and 5, 2009 in Austin. A total of 62 stakeholders participated in the day-and-a-half meeting. The first day of the Summit consisted of five small-group discussion sessions. Two PPRI staff facilitated each group with a DSHS staff member present as a consultant or resource person. PPRI pre-assigned small group participants to ensure diversity in geography, participant type (e.g., health care administrator, health care provider, advocate, or consumer), and whether the participant self-reported a particular interest in CYSHCN issues. The objective was to expose participants to a variety of perspectives across the state and across the different types of participants.

In these small group sessions, the facilitators asked participants to take a statewide perspective and collectively consider each of the 12 pre-determined need statements from the viewpoint of six different scalable attributes: magnitude, trend, severity, health disparity, effort, and acceptability. Facilitators asked each group to agree to a point on the attribute scales for each need statement considered and discussed. Figure 1-6 outlines the attributes and scale used for each need statement during the small group exercise.

Figure 1-6. Title V Stakeholder Summit – Small Group Exercise Attributes and Scales

A. Magnitude

1	2	3	4	5
Impacts few individuals in the MCH population		Impacts a moderate number of individuals in the MCH population		Impacts many individuals in the MCH population

Probing Questions:

Considering the MCH population, which includes women and infants, children and adolescents, and children with special health care needs, how many individuals does this issue impact?

B. Trend

1	2	3	4	5
Little or no decline in the situation for the MCH population		Stable for the MCH population		A great deal of decline in the MCH population

Probing Questions:

Is the issue getting better, remaining stable, or getting worse for the whole MCH population?

C. Severity

1	2	3	4	5
Little or no consequences on the health of the MCH population		Some consequences on the health of the MCH population		Many consequences on the health of the MCH population

Probing Questions:

How severe is this issue and its resulting impact on the health of the MCH population statewide? Consequences for example include indicators like – morbidity / mortality / cost / for individual, family, and or society, associated risks, etc., adverse educational outcome What are the health and welfare consequences of not addressing this need for the individual, family, and/or society?

D. Health Disparity

1	2	3	4	5
Little or no disparity within the MCH population		Some disparity within the MCH population		A great deal of disparity within the MCH population

Probing Questions:

Does this issue address a unique geographic or health disparity? Does this issue disproportionately affect a subgroup based on race and ethnicity, gender, education, income, geographic location, disability status, and / or sexual orientation?

E. Effort

1	2	3	4	5
Little or no effort needs to be focused on the issue		Adequate effort is focused on the issue		A great deal more effort needs to be focused on the issue

Probing Questions:

What is the level of effort currently in place to address this issue statewide in the MCH population? To what extent is the scope and reach of these efforts? Are there enough resources, (funds, staffing, expertise, etc) being committed to the issue?

F. Acceptability

1	2	3	4	5
Little or no acceptance/ support in regards to the issue		Some acceptance/support		A great deal of acceptance/support

Probing Questions:

Is there support to address this issue on a statewide basis? Is there public or political support for this issue?

Following the scaling exercise, facilitators asked each group to brainstorm up to three additional need statements and complete the same scaled attributes for these new statements as well. The facilitators captured highlights from the discussions on flipcharts. PPRI processed the input from the small group discussions during the evening of the first day and captured highlights from across all of the small group sessions.

On the second day of the Summit, all attendees participated in a plenary session where PPRI staff shared highlights from the previous day's small group discussions, including the additional need statements proposed by each group. PPRI staff pointed out commonalities as well as disparities among the groups in terms of the scaled attributes determined for each statement. Facilitators asked participants to comment and share insight on the results of the facilitated exercise.

Finally, facilitators asked participants to complete an individual ranking exercise, taking into consideration the "homework" and the participatory discussion that took place during the course of the Summit, using a Q-Sort tool to help participants individually rank the need statements from most to least important. Once all participants completed the tool, facilitators shared the preliminary ranking results with all participants and the Summit was adjourned following closing remarks from a DSHS representative (See Appendix B – PPRI Final Report for more details about the techniques and tools used during the Summit).

Table 1-11 lists the final recommendations, in ranked order, of the Summit participants regarding the priority MCH needs for Texas.

Table 1-11. Title V Stakeholder Summit Ranked Recommended Need Statements

Rank	Need Statements
1	Improve and simplify the public health application and renewal process, such as Medicaid, CHIP, and Title V programs.
2	Improve the availability and quality of mental health services and resources.
3	Promote early intervention and screening for mental health services and resources.
4	Improve transition services for CSHCN when moving from school to post-school activities (including education, employment, community integration, and adult services).
5	Increase accessibility to affordable dental care for Title V families.
6	Implement the holistic approach for health care and social services using a care navigator and flexible funding support.
7	Define, promote, and support (including reimbursement rates) a comprehensive coordinated approach for health and dental care and occupational services for women and children.
8	Address the problem of going to the emergency room for non-emergency care.
9	Provide parents, including teen parents, with relevant parenting information and skills.
10	Promote awareness and public knowledge about health services and providers available in the community.
11	Increase and support community clinics serving women, infants, and children in rural areas, including subsidized clinics for low-income populations.
12	Improve substance abuse rehabilitation treatment capacity for youth and adults.
13	Enhance transportation services for families with limited access.

Rank	Need Statements
14	Promote a health care approach that involves a single primary care provider to coordinate routine and preventive health care for women and children throughout their lifetime.
15	Promote healthier lifestyles by expanding evidence-based prevention programs.
16	Enhance education and financial support of breastfeeding initiatives, including promotion of primary care that treats mothers and infants as a breastfeeding unit.
17	Address the issue of environmental contaminants that interfere with health and child development.
18	Recruit and train dental and health care practitioners to care for CSHCN, including financial incentives for the practice.
19	Provide affordable childcare services, including after-hour childcare and after-school programs, for CSHCN.
20	Use outcomes-based indicators and evidence-based interventions to achieve improved outcomes.
21	Expand the numbers and types of primary care services available for Title V families (e.g., fee-for-service).
22	Create or promote support programs and social networking opportunities for adult and teen parents, including CSHCN.
23	Need for least restrictive lifetime services for CSHCN, including respite and transition care.
24	Provide violence prevention services and teen dating violence services such as counseling, shelter, prevention education, etc.

OBSERVATIONS FROM THE TITLE V STAKEHOLDER SUMMIT

PPRI describes the following observations and lessons learned from the Summit in a report submitted to DSHS (Public Policy Research Institute, Texas A&M University, 2010):

- A major success of the Summit was helping the participants to further understand, clarify, and make choices about the relative importance of the MCH population needs. The primary focus of the Summit encouraged participants to think about these needs from a statewide perspective, in contrast to the local focus captured during the Community Listening Sessions. Placing the participants in mixed groups in terms of geographic location and type of participant helped reinforce that objective. Based on the stakeholder feedback forms, several participants commented that this was useful in helping them think beyond their local communities in assessing the most critical MCH and CYSHCN needs in Texas.
- Participants perceived the prior “homework” material sent to familiarize them with the broader state and national contexts for the need statements to be a helpful gesture which aided the participants’ knowledge base for discussion and prioritization; although, some participants criticized the “homework” saying that

the need statements and reading material needed to coincide with each other more meaningfully.

- The combined use of the facilitation techniques and the Q-Sort tool helped ensure that all stakeholders contributed and gained from the participatory experience, and that each participant worked within a logical and informed framework focused on specific expectations. The structure of the process facilitated efficiency in generating, organizing, and prioritizing ideas and feedback in a very short period of time.
- A consistent issue expressed by Summit participants was that the attribute scales used in the small group discussions were too "distracting" (in terms of the time it took the group to reach agreement on each numerical score in the scale) or "abstract." Participants mentioned that future efforts might focus more on a qualitative appraisal and discussion of each need statement free from the constraints imposed by the scales.
- A benefit of the Summit was the networking opportunities that occurred for the participants. Many expressed a desire to have additional time for networking.

DSHS EMPLOYEE SURVEY

Although DSHS staff were requested not to participate in the stages of the stakeholder input process described up to this point, their feedback concerning the needs of the MCH population was still an important component in determining the 10 priority areas for the next five years. During November 2009, the Needs Assessment Planning Group developed an on-line survey tool that incorporated the need statements gathered during the Community Listening Sessions as well as the national and state performance measures from the Title V Block Grant. The survey was sent to an estimated 12,000 DSHS employees using Survey Monkey®. Survey recipients had two weeks to complete the survey. A total of 1,114 opened the web link, 1,104 began the survey, and 884 completed every question in the survey.

The Needs Assessment Planning Group classified the need statements into the four levels of the MCH pyramid: infrastructure-building, population-based, enabling, and direct health care services. Within each pyramid level, the survey asked respondents to select the five most important needs for both the general MCH and CYSHCN-specific populations.

The survey asked respondents to identify the DSHS program area in which they worked and the number of years they have been in their current position. Respondents also were asked how many years total they have worked at DSHS, if they were a manager or supervisor of other DSHS staff, and the Health Service Region in which they worked.

Given the opportunity to rank public health needs for women and children in Texas, DSHS employees selected health insurance, obesity prevention, and affordable child

care as most important for both the MCH and CYSHCN populations. Many employees surveyed provided additional public health needs in their open-ended responses. These responses centered on increasing the quality of and access to health care, increasing the number of doctors or other health care providers, and fulfilling needs that are related to funding or health insurance, among many other responses. Table 1-12 and Table 1-13 detail the top five responses concerning the MCH and CYSHCN populations by MCH pyramid level (See Appendix C – DSHS Employee Title V Needs Assessment Survey for further details).

Table 1-12. DSHS Employee Survey - Top Five MCH Need Statements by Pyramid Level

Pyramid Level	Need Statement	Response Percent*
Infrastructure Building	Availability of child health insurance.	48.0%
	Simplify the Medicaid coverage requirements, eligibility procedures and application process.	47.8%
	Improve the availability and quality of mental health services and resources.	47.6%
	Increase the number of affordable public and private pediatric providers.	47.2%
	Provide more affordable health insurance coverage for Title V eligible populations.	41.9%
Population-Based	Decreasing teen pregnancy rates.	36.5%
	Reduce childhood obesity.	31.1%
	Address the problem of individuals going to the emergency room for non-emergency care.	28.8%
	Develop more prevention-based programs for all target populations.	27.6%
	Provide parents, including teen parents, with relevant parenting information and skills.	26.6%
Enabling	Provide affordable childcare services, including after-hour childcare and after-school programs.	70.6%

Pyramid Level	Need Statement	Response Percent*
	Provide better access to meal or food bank programs in the community, including programs for children while not in school.	52.9%
	Provide quality foster care and child protection services.	46.1%
	Improve substance abuse rehabilitation and treatment facilities and services in the community.	45.4%
	Improve social supports (e.g., support groups, counseling groups and mentors) and clinic facilities to provide medical services for pregnant teens.	41.0%
Direct Health Care	Increase access to low-cost prescriptions and medications.	53.4%
	Improve accessibility to health care services at clinics by reducing barriers like long wait times, complex eligibility procedures, limited office hours, and difficult medical forms.	46.1%
	Provide more low-cost, preventive health screenings for women including PAP smears, mammograms and other routine care.	45.8%
	Increase and support community clinics serving women, infants and children in rural areas, including subsidized clinics for low income populations.	36.7%
	Increase the number of specialists providing affordable care.	31.3%

*Indicates the percentage of total responses that were in the top five need statements selected by respondents.

Table 1-13. DSHS Employee Survey - Top Five CYSHCN Need Statements by Pyramid Level

Pyramid Level	Need Statement	Response Percent*
Infrastructure Building	Increase training for health care providers and organizations who provide services for CSHCN.	77.4%
	Improve school health programs through coordination with local health care agencies and organizations.	76.4%
	Assess and evaluate the needs and barriers for local health care programs.	75.6%
	Increase the percent of children with special health care needs whose families report their community-based service systems are easy to use.	65.6%
	Address the shortage of nurses, especially in non-urban areas.	64.6%
Population-Based	Promote early intervention and screening for mental health disorders, including autism and ADD/ADHD.	60.7%
	Promote nutrition, physical activity, and obesity prevention for teens.	58.0%
	Develop more prevention-based programs for all target populations.	54.8%
	Promote immunization and wellness programs for children.	51.3%
	Promote awareness and public knowledge about health services and providers available in the community.	51.1%
Enabling	Provide affordable childcare services, including after-hour childcare and after-school.	56.6%
	Promote local vocational programs and vocational therapy for children and adults with disabilities.	51.0%
	Create or promote social support programs (e.g. recreation, counseling, family support services) for CSHCN.	43.9%

Pyramid Level	Need Statement	Response Percent*
	Increase percent of children with special health care needs whose families have adequate private and/or public insurance for the services they need.	43.8%
	Enhance transportation services for families with limited access to transportation.	42.8%
Direct Health Care	Increase access to low-cost prescriptions and medications.	67.9%
	Improve accessibility to health care services at clinics by reducing barriers like long wait times, complex eligibility procedures, limited office hours, and difficult medical forms.	59.8%
	Improve the availability and quality of mental health services and resources.	58.4%
	Increase the number of specialists providing affordable care.	55.4%
	Provide more therapy services, including occupational therapy, alternative therapy, and physical therapy.	54.7%

*Indicates the percentage of total responses that were in the top five need statements selected by respondents.

PROPOSED PRIORITY NEEDS

Detailed information regarding the methodology and process for developing the Priority Needs is detailed in Section 5: Selection of State Priority Needs.

PUBLIC FORUMS

The last phase of the stakeholder input process was a series of Public Forums that PPRI held in each of the eight regional headquarter cities during January and February 2010. The purpose of the Forums was to solicit feedback regarding the process of gathering stakeholder input and the list of 10 proposed priority statements. PPRI used the stakeholder contact list that was generated throughout the previous stages of the process as the basis for recruitment for the Public Forums. Additionally, PPRI distributed flyers and posters to targeted locations within the host cities and promoted the Forums through the PPRI Title V Needs Assessment website. Recruitment tools listed the PPRI toll-free number and specially-designed website for more information.

The 10 proposed priority statements presented at the Public Forums are listed, in no particular order, in Table 1-14.

Table 1-14. Proposed Priority Need Statements

Priority Need Statements
Support and develop health care infrastructure that provides coordinated access to services in a culturally competent manner, addressing health issues across the life course.
Increase the availability of quality mental health and substance abuse services.
Increase the number of youth with special health care needs who receive necessary services to transition to all aspects of adult life.
Increase access to dental care.
Support community-based programs that strengthen parenting skills and promote healthy child and adolescent development.
Support the development of community-based systems that provide essential enabling services needed to improve health status.
Promote the expansion of new or existing evidence-based interventions to address maternal and child health needs.
Use population-based services including health promotion and disease prevention interventions to improve health outcomes of the MCH population.
Ensure all children, including children with special health care needs, have access to a medical home and other health care providers through increased training, recruitment, and retention strategies.
Improve the organization of community-based systems of care for children with special health care needs.

In an effort to accommodate differing schedules at each of the locations, PPRI held two sessions consisting of the same agenda: one from 3:30 – 4:20 pm and one from 4:30 – 6:00 pm. Light refreshments were served and free parking was available for all attendees.

The Needs Assessment Planning Group, in partnership with PPRI, determined the structure and content for the Forums. They developed a PowerPoint® presentation and speaker notes to help guide the discussion. The agenda for each session included:

- Welcome and Introductions (PPRI)
- Overview of Title V (DSHS)
- Overview of Stakeholder Input Process (PPRI)

- Presentation of Proposed Priority Statements (DSHS)
- Open Discussion and Feedback (All Attendees)

Table 1-15 lists the locations and dates of the Public Forums as well as the number that attended each session. Though the second session of each forum was less well-attended, anecdotally the majority of participants were consumers and many expressed opinions related to CYSHCN.

Table 1-15. Public Forums: Dates, Locations, and Attendance

Date	Location	Facility	Attendance	
			1st Session	2nd Session
January 25, 2010	Houston	West Gray Recreation Center	21	4
January 26, 2010	San Antonio	Mexican American Unity Council	19	2
February 2, 2010	Lubbock	Mahon Library Downtown	38	11
February 4, 2010	Arlington	Bob Duncan Community Center	32	3
February 5, 2010	Temple	Temple Public Library	27	1
February 8, 2010	El Paso	Philanthropy Theater	10	2
February 10, 2010	Harlingen	Harlingen Public Library	17	7
February 12, 2010	Tyler	Harvey Convention Center	8	Cancelled due to weather conditions

The overall feedback provided at the Forums was overwhelmingly positive. Regarding the stakeholder input process, almost one-third of the comments were supportive of the way that information was gathered. Slightly more than one-third of the comments were questions concerning topics such as how Community Listening Session locations were selected, how participants were recruited, and if there was a cross-representation from the populations served. Finally, the remaining one-third of comments expressed concern regarding factors that may have had a perceived effect on Community Listening Session participation, such as accessibility of locations, how the session locations were publicized, and potential issues with language barriers.

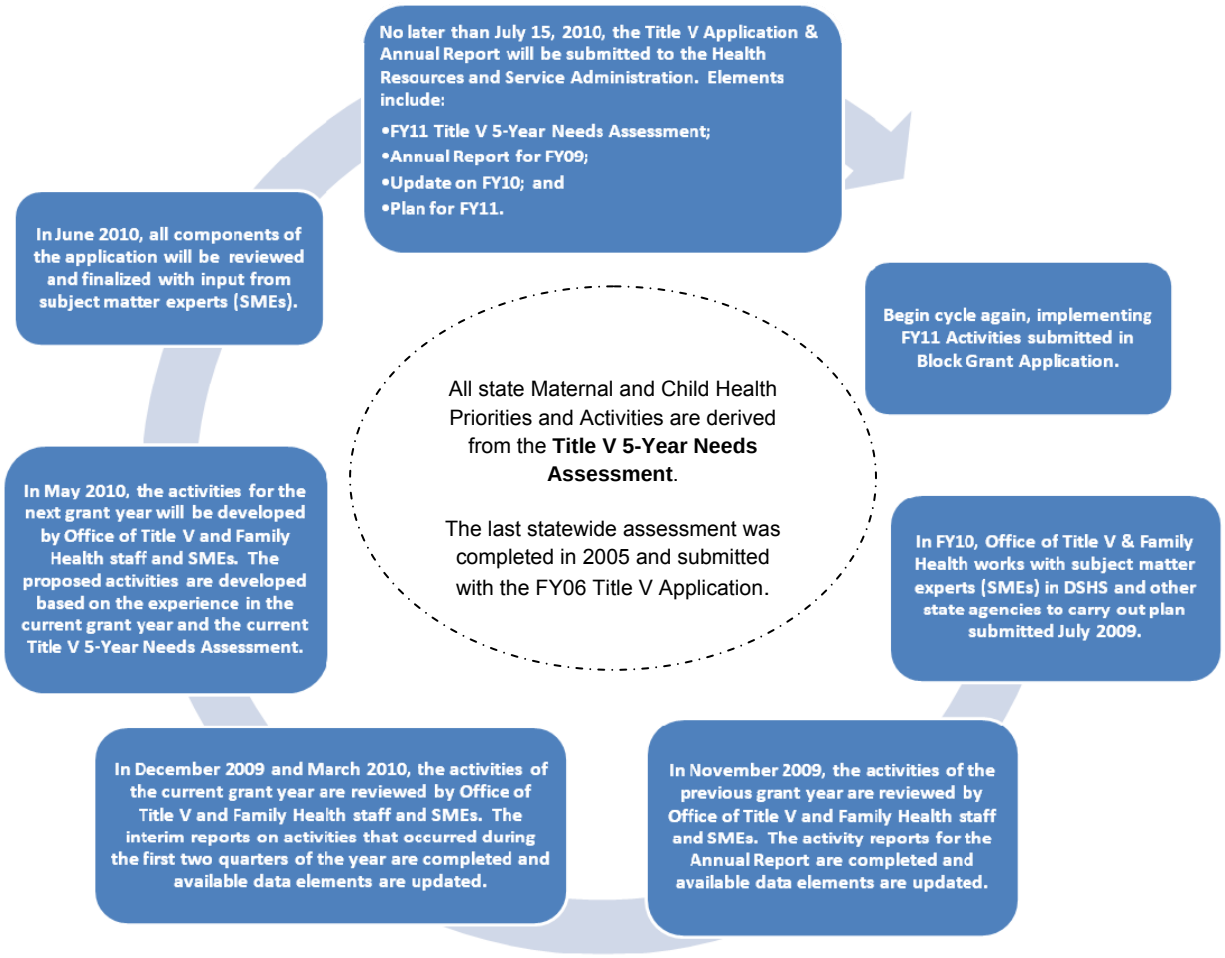
Most of the feedback about the 10 proposed priorities was positive and the clarification questions and criticisms that attendees offered focused on a few priority statements. For instance, nearly one-half of all the comments praised the priority of accessing dental

care, while a number of comments were requests to know specifics about how the priorities would be implemented and what activities would be put in place to help address them. Almost one-half of the comments focused on how one or more priorities would impact the local community or participant's field of work. Most of these types of comments concentrated on the priorities concerning a lack of mental health providers, barriers to health services for undocumented individuals, and infant mortality issues. Finally, several comments addressed questions about the Title V funding distribution process, particularly the criteria used to determine funding allocation (See Appendix B - PPRI Final Report for the complete list of comments).

ADDITIONAL METHODOLOGY DISCUSSION

Figure 1- 7 illustrates how the remaining steps in the MCHB conceptual framework, such as establishing performance measures and identifying activities, were executed by DSHS MCH staff.

Figure 1-7. SFY 2010 MCH Title V Block Grant Cycle



Taking into consideration the quantitative and qualitative data collected and the reviews of control, influence, or feasibility of systems capacity resulted in the list of priority needs that was presented to stakeholders during the aforementioned Public Forums. The process of determining the priority needs is discussed in detail in Section 5, Selection of Priority Needs.

The Needs Assessment Steering Committee and Planning Group and the DSHS Title V Partners examined the priority needs for alignment with Title V national performance measures (NPM) and incorporated the priority needs into NPM activity plans. They used priority needs that did not align with NPMs to develop Title V state performance measures (SPM) and developed activity plans to address these needs. Therefore, the SFY 2011 activity plans reflected stakeholder input, consideration of agency capacity, and MCH subject matter experts' expertise and reviews of best practices.

Adequate and appropriate resources will be allocated for the implementation of activity plans by DSHS Central and Regional Offices and contracted direct service providers selected through competitive requests for proposal (RFP) processes. In order to monitor progress on the annual plan, all entities receiving Title V funds are subject to a contract monitoring system that ensures progress towards meeting annual NPM/SPM targets. Moreover, programs that do not have a direct reporting responsibility to OTV&FH, but have associated activities to support NPMs/SPMs, are routinely involved in collaborative relationships with the MCH subject matter experts. This collaborative mechanism facilitates a two-way exchange of information between the MCH subject matter experts and the implementers of MCH activities. In addition to facilitating receipt of quarterly progress reports on Title V activity plans, the MCH subject matter experts provide periodic feedback on progress to all programs that implement MCH activities.

METHODS FOR ASSESSING MATERNAL CHILD HEALTH POPULATIONS

QUANTITATIVE METHODS

The identification and review of quantitative data was conducted by OPDS. Types of data reviewed to determine need included trends of selected health indicators and outcomes data, such as rates of infant mortality, maternal mortality, teen pregnancy, and confirmed child abuse or neglect; available health capacity indicators; literature reviews; and recommendations from a variety of governmental reports and strategic plan documents related to MCH. Data were cross-analyzed by available and relevant population characteristics, such as age, race/ethnicity, socio-economic status, gender, and geographic setting in order to make meaningful deductions.

QUALITATIVE METHODS

The Stakeholder Input Process that was extensively detailed in this section was designed to be as inclusive as possible of the full array of partners, providers, consumers, and other stakeholders interested in and impacted by MCH issues. Additionally, MCH subject matter experts integrated information gleaned from ongoing consultations with collaborative partners and participation in MCH-related workgroups and advisory groups. These partnerships and groups have internal and external origins, as well as statewide and national focus. OTV&FH staff conducted a review and inventory of information on MCH-related activities conducted by state agencies, stakeholder organizations, and other sources in Texas.

Information specific to the CYSHCN population can be found under the heading Supplemental CYSHCN-Specific Needs Assessment Process in this section.

METHODS FOR ASSESSING STATE CAPACITY

The Needs Assessment Planning Group completed a review of existing needs assessment models to assess capacity. The Planning Group discussed implementation options and developed a hybrid of several models that could be used for this exercise. With the focus on stakeholder input as a guide, DSHS chose to evaluate capacity according to the proposed priorities that resulted from the Needs Assessment process. Using the members of the Steering Committee as contact points for each division, an assessment tool was provided to gauge capacity in areas related to funding, staffing, policies, information systems, and partnerships. In addition, divisions were asked to assess the alignment of these proposed priorities with existing division goals.

Related to resource allocation, DSHS uses an ongoing budget review process incorporating state legislative performance measures and expenditures on a quarterly basis to assess and monitor appropriate allocation of resources. Within FCHS, leadership has established monthly meetings with all section directors to review and discuss expenditures in program areas receiving Title V financial support. The group explores and recommends opportunities for collaboration, ways to eliminate duplication of services, and future means of leveraging existing funding streams. Additionally, a formal process is in place to monitor and report grant-related expenditures and project utilization of allocated funds.

In addition, DSHS conducts functional reviews of program areas as needed to identify possible efficiencies. Recommendations from these functional reviews are incorporated into organizational structure that will further the mission of the agency. The DSHS

Center for Program Coordination and Policy Innovation provides support for these agency efforts.

DATA SOURCES

The following data sources were used in the development of the Needs Assessment.

TEXAS NATALITY FILES (1996-2006)

Texas Natality Files are collected by Texas Vital Statistics at DSHS. The natality files consist of all births (whole population) that occurred in Texas during a given year. They are a resource for researchers and policy makers interested in tracking patterns in preterm births, low birth weight births, newborn screenings completed, utilization of prenatal care, and teen pregnancy in Texas. Birth rates can be calculated at the county and city level.

TEXAS MORTALITY FILES (1999-2006)

Texas Mortality Files are collected by Texas Vital Statistics at DSHS. The death files consist of all deaths (whole population) that occurred in Texas during a given year. The death files are a resource for researchers and policy makers interested in tracking patterns in suicides, deaths caused by intentional or unintentional injuries, or deaths caused by chronic disease. The birth and death files can be linked in order to investigate infant mortality or deaths of young children. Death rates can be calculated at the county and city level.

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (2000-2008)

The Behavioral Risk Factor Surveillance System (BRFSS) is a federally-funded telephone survey of randomly selected Texas adults (18 years of age and older) to collect data on lifestyle risk factors that contribute to leading causes of death and chronic diseases. Texas has included “state-added” questions in order to track Title V state performance measures. Questions allow for monitoring of the *Healthy People 2010* objectives in smoking, obesity, high blood pressure, exercise, vaccinations, seat belt use, chronic conditions, negative health behaviors, and general well-being. BRFSS data provides information for researchers and policy makers interested in patterns in physical and mental health status, access to health care, and utilization of health care services. The Texas sample is collected and structured in a manner representative of all adults who are Texas residents; therefore it is representative of the entire population of Texas. Data may be examined in smaller geographic units, such as urban-rural differences, DSHS Health Service Region (HSR), or border residence status.

TEXAS YOUTH RISK BEHAVIOR SURVEILLANCE SYSTEM (2005-2009)

The Texas Youth Risk Behavior Surveillance System (YRBSS) is a federally-funded classroom based paper survey conducted to track health-risk behaviors and social problems among youth (age 12-18) in the U.S. Public and private health authorities at the federal and state levels rely on YRBSS to identify public health problems, design policy and interventions, set goals, and measure progress toward those goals. This surveillance can be used to monitor the *Healthy People 2010* objectives for smoking, overweight, exercise, seat belt use, fruit/vegetable consumption, alcohol consumption, drug use, sexual activity, and other risk factors so that intervention priorities can be established and the long-term impact of health promotion programs can be monitored. The YRBSS is used nationwide under the direction of the Centers for Disease Control and Prevention (CDC); therefore the survey methods and much of the questionnaire are standardized. As a result, comparisons can be made to other states, cities and the nation as a whole. Recent survey waves are from 2007 and 2009.

TEXAS INFANT SLEEP SURVEY (2009)

Texas Infant Sleep Survey is a telephone survey conducted of mothers of infants to examine their knowledge and practices about their infant's sleep habits. This survey is representative of mothers of infants in Texas. Information on these variables is difficult to obtain elsewhere. The survey includes questions about infant sleep position, co-sleeping with parents or other family members, and the presence of items in the infant's crib. Several questions ask mothers their reasons for making choices about infant sleeping practices or co-sleeping. Other question topics include presence of a smoker in the home, advice from health professionals about infant sleep position, and familiarity with the Back to Sleep campaign.

NATIONAL SURVEY OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS (2005-2006)

The Texas sample of the National Survey of Children with Special Health Care Needs (NS-CSHCN) is collected and structured so that it is representative of all CYSHCN in Texas. Although participants in the Texas sample of CYSHCN are recruited from across the state, the data is not representative of smaller geographic units, such as at the county or city level. As its respondents may not be representative of the population of families affiliated with the CSHCN Services Program, the data is not sensitive to change for use in program evaluations. Data include access to services, medical home, transitional assistance, financial burden to family, and health insurance coverage.

DSHS PARENT SURVEY (2009)

CSHCN Services Program staff developed a written survey instrument for the purpose of gathering information from parents and family members on the quality of health care and related services they received and the unmet needs they had. The survey used convenience sampling methods, and its content focused on the Title V CSHCN NPMs/SPMs. Parents of CYSHCN or persons 21 years of age and younger with a special health care need completed English or Spanish versions of the survey during the fall of 2008 and spring of 2009. Program staff entered responses using QuestionPro®. A total of 501 parents and family members completed the survey. Responses to multiple choice questions were analyzed according to respondents' native languages and by HSR. Responses to all open-ended questions were grouped categorically. Question topics included parents' need for help in finding health care, doctor-parent communications, abilities to obtain necessary equipment for a child, insurance coverage, quality of insurance, respite care, care coordination, and living plans once a child turns 18 years old.

DSHS PROVIDER SURVEY (2009)

Staff with the CSHCN Services Program developed an online survey instrument to measure the extent that CSHCN providers understood and demonstrated accord with the Title V CSHCN NPMs/SPMs and to help guide development of future Title V activities. The survey used convenience sampling. Provider respondents included a large array of health professions and, for the purposes of analysis, were grouped into four main provider types: physician, nurse, social worker, and all others. Conducted during the spring of 2009, survey participants entered responses using QuestionPro®. A total of 259 providers completed the survey. Responses were analyzed according to provider type and whether the respondent indicated being a CSHCN Services Program provider. Responses to open-ended questions were grouped categorically. While the survey neither sought nor obtained a statistically representative sample of providers serving CYSHCN, the data suggested that the respondent population was both geographically and professionally diverse.

DSHS COMMUNITY RESOURCE COORDINATING GROUPS SURVEY (2009)

Staff with the CSHCN Services Program developed an online survey instrument to measure the extent that Community Resource Coordinating Group (CRCG) participants understood and demonstrated accord with the Title V CSHCN NPMs/SPMs. CRCGs are local interagency groups comprised of public and private agency representatives, consumers, and family members. The survey used convenience sampling of CRCG

participants, and the response rate approximated 10% of the active participants statewide. Respondents were from a variety of public agencies and private organizations, and for the purposes of analysis were grouped into six key categories. Conducted during the spring of 2009, the survey used QuestionPro®. A total of 215 CRCG participants completed the survey. Data was analyzed according to respondents' organizational categories; however, the sample size was insufficient to examine smaller geographic units.

Additional information concerning the parent, provider, and CRCG surveys may be found under the heading Supplemental CYSHCN-Specific Needs Assessment Process in this section.

LINKAGES BETWEEN ASSESSMENT, CAPACITY, AND PRIORITIES

When examining the recommended prioritized needs from stakeholders, several statements were identified that were outside the purview of Title V and DSHS. These statements were shared with the appropriate agencies responsible for their administration and oversight. However, these statements were still considered in the development of the final priority needs with the intent that DSHS MCH staff would still have a role in addressing them given their involvement in a wide variety of MCH collaborative efforts.

As previously noted, the priority needs were examined for alignment with NPMs and were incorporated into NPM activity plans. Those priority needs that did not align with NPMs were used to develop SPMs and state activity plans were developed to address these needs. SFY 2011 activity plans were developed based on stakeholder input gathered, the consideration of agency capacity, and MCH subject matter experts' expertise and reviews of best practices.

DISSEMINATION

The Needs Assessment Planning Group determined early in the planning process that stakeholder input would serve as the fundamental basis of this Needs Assessment. Therefore, for the first time, opportunities for stakeholder input were built into every stage of the Needs Assessment process. Extensive efforts were implemented for input to be inclusive of as many partners, providers, consumers, and other stakeholders interested and impacted by MCH issues as possible. A wide variety of methods and venues were used to gather input and provide updates to stakeholders: community meetings, state-level meetings, group presentations, web-based surveys, facilitated exercises, email communication, newsletter articles, and website information.

One of the deliverables to DSHS stemming from the PPRI contract was the collective distribution list of stakeholders that was gathered and utilized throughout the stakeholder input process. This list will be used and expanded in the future to continue to engage and gather input from stakeholders. In fact, during April 2010, the list was used to notify stakeholders that a draft of the Needs Assessment was posted to the DSHS Title V website for public comment accompanied by a survey to gather feedback. Once finalized, the Needs Assessment will again be posted on the DSHS Title V website for public consumption and notice sent to stakeholders.

STRENGTHS AND WEAKNESSES OF PROCESS

STRENGTHS OF METHODS AND PROCEDURES

- Strong partnership among MCH-related programs within DSHS.
- Commitment to inclusion of broad array of internal and external stakeholders.
- Continuous internal and external communication efforts.
- Identified early on as an effort essential to the mission of the agency and having influence across all areas of the agency.
- Flexibility of resource utilization, including outsourcing components that are above and beyond annual grant requirements.
- Stakeholder input served as the cornerstone of the process.
- Shared decision-making structure (i.e. Executive Leadership, Steering Committee, Planning Group, and DSHS Title V Partners) that supports consensus-building among MCH partners.
- In-house research, data analysis, and subject matter expertise regarding MCH populations.

WEAKNESSES OF METHODS AND PROCEDURES

- A strong focus on external stakeholder input required an extensive time commitment on the part of DSHS staff.
- Utilization of a conventional method of assessing capacity required staff resources beyond existing capacity.
- Monitoring external contractor responsibilities and ensuring the integrity of the Needs Assessment components as designed.
- Competing priorities resulted in compromises in planned activities.
- Limitations on birth and death file data.

SUPPLEMENTAL CYSHCN-SPECIFIC NEEDS ASSESSMENT PROCESS

In addition to the Needs Assessment Process described throughout this section, the DSHS Children with Special Health Care Needs (CSHCN) Services Program conducted additional needs assessment activities beginning in summer 2008 and continuing throughout 2009 as a subset of the overall Title V Five-Year Needs Assessment. In conducting these activities, CSHCN Services Program staff employed the following four primary methods:

- Agency, Stakeholder Organizations, and Other Sources – Information from state agencies, stakeholder organizations and other sources related to the health and well being of CYSHCN in Texas.
- Primary and Secondary Health Status Data – Analyses of primary and secondary health status data from the 2001 and 2005-2006 NS-CSHCN and other national and state sources.
- Independent Surveys of Key Stakeholders – Surveys of parents, providers, CRCG participants.
- Guidance and Subject Matter Expertise for the Needs Assessment Planning Group – Guidance and subject matter expertise on behalf of CYSHCN and their families within the Needs Assessment Planning Group for the stakeholder input process, the DSHS employee survey, the DSHS division-level capacity assessment, the Needs Assessment Steering Committee, and other activities.

AGENCY, STAKEHOLDER ORGANIZATIONS, AND OTHER SOURCES

Key sources within DSHS included CSHCN Services Program staff; other FCHS Division program staff, including staff from OTV&FH and OPDS; the Mental Health and Substance Abuse (MHSA) Division's Texas Mental Health Transformation Working Group and the Office of Children's Mental Health; and the Center for Health Statistics.

Related to CYSHCN, primary non-DSHS sources within Texas government included the following:

- Texas Health and Human Services Commission (HHSC)
- Department of Aging and Disability Services (DADS)
- Department of Assistive and Rehabilitative Services (DARS)
- Department of Family and Protective Services (DFPS)
- Hogg Foundation for Mental Health
- Texas A&M University Center on Disability and Development
- Texas A&M University Center for Housing and Urban Development
- Texas Council on Autism
- Texas Council for Developmental Disabilities (TCDD)
- Texas Department of Insurance
- Texas Education Agency (TEA)

- Texas Governor's Committee on People with Disabilities
- Texas Legislative Budget Board
- Texas State Data Center
- The University of Texas Center for Disability Studies

Related to CYSHCN, Texas stakeholder and advocacy organization sources included:

- Advocacy, Inc.
- Center for Public Policy Priorities
- Children's Defense Fund – Texas
- CHIP (Children's Health Insurance Plan) Coalition
- CSHCN Services Program Community-Based Services Contractors
- Disability Policy Consortium
- Raising Texas
- Texans Care for Children
- Texas Association of Community Health Centers
- Texas Autism Advocacy
- Texas Children's Mental Health Forum
- Texas Mental Health America
- Texas Medical Association
- Texas Pediatric Society
- Texas Parent to Parent
- The Primary Care Coalition
- The ARC of Texas
- United Cerebral Palsy

Other sources included the following:

- Annie E. Casey Foundation, 2009 KIDS Count Data Book
- Catalyst Center, State-at-a-Glance Chartbook on Coverage and Financing for Children and Youth with Special Health Care Needs, Boston University School of Public Health, 2007
- Clay and Carol Boatright, Greater Plano and Colin County Special Needs Survey, 2006
- Institute for Child Health Policy, University of Florida
- Children with Special Health Care Needs: Quality of Care in the Medicaid Managed Care and Children's Health Insurance Programs in Texas, 2009
- State Care Coordination Programs for Children with Special Health Care Needs, results from the Web-based Survey with the State Title V Children with Special Health Care Needs Directors, October 2007
- The Texas STAR Managed Care Organization and Primary Care Case Management Child Enrollee CAHPS® Health Plan Survey Report, FY 2007
- Kaiser Foundation, State Health Facts, Children's Health Fact Sheets, 2005-2007

- National Adolescent Health Information Center, 2008 Fact Sheet on Health Care Access & Utilization: Adolescents and Young Adults
- National Center for Special Education Research, National Longitudinal Transition Study 2 Reports and Data Tables
- National Council on Disability, National Disability Policy: A Progress Report, 2009
- National Survey of Children with Special Health Care Needs
- Robert Wood Johnson Foundation, Trust for America's Health, Shortchanging America's Health: A State-by-State Look at How Federal Public Health Dollars Are Spent and Key State Health Facts, March 2009
- Social Security Administration
- United States Department of Justice, 2008 Letter on Texas State Schools

CSHCN Services Program staff attended and reported about meetings of key statewide advisory councils/groups or collaborative initiatives in which DSHS has partnership roles. In these forums, staff worked to increase awareness of the Title V CSHCN NPMs/SPMs as the groups identified and considered the needs of CYSHCN in Texas and formulated recommendations for service system improvement. Many of these groups issued formal reports, some which were prepared for the 81st Regular Texas Legislative Session (2009).

PRIMARY AND SECONDARY HEALTH STATUS DATA

Using the 2001 and 2005-2006 NS-CSHCN, staff from OPDS and CSHCN Services Program reviewed and studied primary and secondary health status data in several ways. These included a gap and quadrant analysis and comparison of 2001 and 2005-2006 state and national data; examination of frequencies and weighted percents of key CYSHCN variables; CYSHCN qualification criteria for Texas compared with national data and values from selected other states; cross tabulations and chi-square testing of statistical significance for family centered care, medical home, and transition variables according to selected demographic characteristics; development of background information for the Title V Stakeholder Summit; chi-square testing of variables including access to care, having a personal doctor, and going without health care versus life/health outcomes, including days of school missed, financial problems, and parents stopping work; and chi-square analysis of social determinants of health compared with CYSHCN health quality indicators and life/health outcomes.

INDEPENDENT SURVEYS OF KEY STAKEHOLDERS

Staff with the CSHCN Services Program developed methods and instruments to obtain needs assessment data for three key stakeholder populations, including parents of CYSHCN, health care providers, and participants of CRCGs. The following sections describe the methods for each of these populations.

PARENTS OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

To obtain this information, CSHCN Services Program staff developed two sets of instruments: one to be used in a focus group forum and a second to be used with a written survey. The purpose of the Parent Focus Groups and the Parent Survey was to gather information concerning the health care and related services respondents received and the unmet needs they had. The content of both instruments focused on the Title V CSHCN NPMs/SPMs. Staff vetted the survey instruments through the DSHS Institutional Review Board (IRB), which determined that the project was exempt, and staff then piloted the instruments during the 2008 Texas Parent to Parent Annual Conference (See Appendix D – CSHCN Surveys IRB).

Staff employed convenience sampling methodologies, and generally obtained very good levels of participation. Staff solicited participation through the CSHCN Services Program community-based services contractors and other organizations throughout Texas. In order to optimize participation, staff scheduled focus groups and survey distributions to coincide with previously scheduled contractor family support group meetings and/or conferences. By working with contractors to conduct focus groups and distribute surveys in these “natural” settings of high parent attendance, focus, and interest, staff obtained an enhanced parent response to that which had been achieved historically through less personal survey distribution methods.

The focus group instruments consisted of English and Spanish handouts describing the national and state performance measures, the Champions for Inclusive Communities slideshow, “Defining a Community-Based System of Services for Children and Youth with Special Health Care Needs,” about the national performance measures (used with permission), and a facilitator’s script to obtain parents’ ideas and concerns. Staff members served as facilitator and scribes, wrote comments on flip charts for all to see, and compiled and summarized the comments. Staff conducted focus groups in June at the 2008 Texas Parent to Parent Annual Conference in Austin; in October 2008 at the Coalition of Health Services/Uniting Parents in Amarillo; in January 2009 at the West Texas Rehabilitation Center in San Angelo; and in February 2009 at the African American Family Support Conference in Austin. Staff compiled and categorized the responses from the focus groups but did not conduct any statistical analyses due to the informal structure of and low attendance at the forums. The results were consistent with the results of other needs assessment activities. A discussion of the focus groups’ results appears in Section 3: Strengths and Needs of MCH Populations and Desired Outcomes.

The survey instruments consisted of a one-page handout describing the NPMs/SPMs and a 21-item, one-page written survey. The handout and survey were written to a sixth-

grade literacy level and translated into Spanish. Each distribution included both English and Spanish versions. The surveys contained no individually identifiable information, and demographic data were limited only to 3 items: town, ZIP code, and the age of the eldest child with special health care needs. There were 15 closed-ended, multiple-choice items with responses designated by checking a box and 3 items with open-ended responses (See Appendix E - CSHCN Parent Survey Documentation).

CSHCN Services Program staff and contractors administered the surveys, typically distributing paper copies during conferences, meetings of family support groups, or following individual case management appointments. In a few instances, contractors distributed electronic copies to their clients, but these subsequently were printed, completed, and returned by postal mail to the contractor. Instructions stressed that the surveys were not an effort to evaluate any individual, contractor or service provider, but to gather state-level information about services and needs. As surveys were completed, they were sent to the DSHS central office. Staff entered data into an online Question Pro® form designed for that purpose and then compiled and analyzed the results.

There were 501 usable responses for the written surveys, with 396 (79.1%) submitted in English, and 105 (20.9%) submitted in Spanish. Prior to data entry, open-ended Spanish-language responses were translated into English by a staff member who is an American Translators Association-Certified Spanish into English Translator. Town and ZIP code data were used to determine the respondents' residence locations according to HSR.

Responses were distributed across the HSRs, except there were no responses from HSR 11 (Harlingen, Corpus Christi, and the Rio Grande Valley). This occurred primarily because there was limited contractor penetration in HSR 11, and there was a lack of contractor-sponsored activities during the data collection period. The largest number of respondents (24.8%, n=117) was from HSR 10 (El Paso), and there were 29 responses that did not contain enough geographic data to determine HSR. Table 1-16 shows the complete distribution of responses according to HSR.

Table 1-16. Respondents' Health Service Regions (HSR)

HSR		n	Percent
1	Amarillo – Lubbock	60	12.5%
2	Abilene – Wichita Falls	20	4.2%
3	Dallas – Fort Worth	48	10.2%
4	Tyler	41	8.7%

HSR		n	Percent
5	Beaumont - Nacogdoches	7	1.5%
6	Houston	29	6.1%
7	Austin - Temple	84	17.8%
8	San Antonio - Uvalde	43	9.1%
9	Midland – San Angelo	24	5.1%
10	El Paso	117	24.8%
11	Rio Grande Valley	-	-
	Total	472	100%

Frequency missing = 29

Table 1-17 shows respondents according to language and HSR.

Table 1-17. Respondents' Language and Health Service Region (HSR)

	HSR1	HSR2	HSR3	HSR4	HSR5	HSR6	HSR7	HSR8	HSR9	HSR10	Total
English	36	18	43	37	7	28	83	40	23	60	375
%	9.6	4.8	11.5	9.9	1.9	7.5	22.1	10.7	6.1	16.0	79.4
Spanish	23	2	5	4	0	1	1	3	1	57	97
%	23.7	2.1	5.2	4.1	0.0	1.0	1.0	3.1	1.0	58.8	20.6
Total	59	20	48	41	7	29	84	43	24	117	472
%	12.5	4.2	10.2	8.7	1.5	6.1	17.8	9.1	5.1	24.8	100.0

Frequency missing = 29

For those responding in Spanish, cell sizes are very small in most regions, which prevented statistical analysis; however, it is noteworthy that the majority of Spanish respondents were from HSR 1 (23.7%, n=23) and HSR 10 (58.76%, n=57). Further, within each of these regions, the proportion of Spanish respondents is large: HSR 1 (38.9%, n=23) and HSR 10 (48.7%, n=48).

Surveys were analyzed separately for differences in response according to respondents' languages and HSRs. Tables analyzing responses according to languages and HSRs do not have the same total number of Yes responses and are not directly comparable, primarily due to missing HSR data.

The ages of the eldest child with special health care needs spanned all of childhood, but the majority of respondents had children whose ages were from birth through age 10 (56.2%, n=259). Only about one-fourth of respondents (26%, n=120) had children who were age 14 or older. The table below shows the complete distribution of ages, broken into convenient ranges. There was no statistical analysis of the data based on child's age.

Table 1-18. Age of the Eldest Child with Special Health Care Needs

Age Range	n	Percent
Birth through 02	30	6.5%
03 through 05	84	18.2%
06 through 08	95	20.6%
09 through 11	76	16.5%
12 through 13	56	12.2%
14 through 17	73	15.8%
18 through 21	41	8.9%
22 and older	6	1.3%
Total	461	100.0%

Frequency missing = 40

HEALTH CARE PROVIDERS

The purpose of the Provider Survey was to measure the extent that providers understood and demonstrated accord with the Title V CSHCN NPMs/SPMs and to help guide development of future Title V activities. CSHCN Services Program staff developed an email announcement, introductory information, and a 47-item online survey. The surveys contained no individually identifiable information. There were 6 items to obtain demographic information, 39 closed-ended, multiple choice items, and 2 open-ended items. The closed-ended items were grouped into sections according to national and state performance measures. Each section was headed by a simple statement of the applicable national or state performance measure (See Appendix F – CSHCN Provider Survey Documentation).

After vetting the survey through the DSHS IRB and receiving an exemption, staff employed convenience sampling methodologies and generally obtained good levels of participation. Announcements about the survey were sent to providers that offer services to the CYSHCN population in Texas. The program recruited provider response

through the CSHCN Services Program Provider Bulletin, Remittance and Status Report banner messages, and website announcements; Texas Pediatrics Society publications; direct email to provider advocacy organizations, Texas Vaccines for Children providers and local health departments; and the School Health Program's Friday Beat online newsletter.

The CSHCN Services Program conducted the survey in spring 2009, and participants entered responses online using QuestionPro©. A total of 259 providers completed the survey. Staff analyzed responses to all closed-ended items according to respondents' provider types and CSHCN Services Program provider enrollment and responses to open-ended items according to respondents' provider types.

To characterize respondents, the survey asked about practice focus, HSR location, provider type, specialty, CSHCN Services Program enrollment, and whether the respondent was the provider or a member of the provider's staff. The practice focus included children, children and adults, and adults. The majority of respondents (51%, n=130) were practices focusing on children and adults. Forty-seven percent (n=121) were practices focusing on children, and the remaining 2% (n=4) were practices focusing on adults.

There were at least 16 respondents for each HSR, with more than one-half of the respondents coming from HSR 2/3 (Dallas-Fort Worth), HSR 6/5S (Houston), and HSR 7 (Central Texas).

Provider types included a large array of health professions and clinic designations, including physician, physician assistant, advance practice nurse, nurse anesthetist, psychologist, licensed professional counselor, social worker, dentist, physical therapist, occupational therapist, speech language pathologist, federally qualified health clinic, rural health clinic, and other. The practice specialties also included a lot of variety; however, the largest single specialty category was pediatric physician (21% of all physicians and 6% of all respondents). For the purpose of analyzing the data, respondents were grouped according to four main provider types: physicians (27%, n=70), nurses (30%, n=77), social workers (14%, n=37), and all others (29%, n=75).

The survey also asked providers to indicate whether their practices were enrolled in the CSHCN Services Program, as a Texas Vaccines for Children (TVFC) provider, and/or as a local health department. Twenty-five percent (n=64) of those responding to this question indicated they were enrolled in the CSHCN Services Program; however, 36% (n=93) indicated either they did not know or that the item was not applicable. Seventy-two percent (n=186) of those responding said they were TVFC providers, and 15% (n=40) said they were local health departments. For respondents that indicated they

were enrolled in either the CSHCN Services Program or TVFC, the provider type having the largest representation was physician.

The survey asked respondents to indicate whether they were the individual provider licensed as indicated or a staff member responding for the provider as indicated. More than one-half of respondents (59%, n=148) said they were the individual provider licensed as indicated.

While the survey neither sought nor obtained a statistically representative sample of providers serving CYSHCN, the data describing the respondent population suggested that it was both geographically and professionally diverse.

COMMUNITY RESOURCE COORDINATION GROUPS

In Texas, CRCGs are local interagency groups comprised of public and private agency representatives. Together, participants develop service plans for individuals and families whose needs require more intensive interagency service coordination and cooperation and often highlight gaps in the regular service delivery system. CRCGs originated when the Texas Legislature passed Senate Bill 298 into law in 1987. This bill directed state agencies serving children to develop a community-based approach to better coordinate services for children and youth who have multi-agency needs and require interagency coordination. More recently, communities have begun using this approach to serve adults with complex needs. CRCGs are organized and established on a county-by-county basis. CRCG members are from public and private sector agencies and organizations. Many CRCGs also include parents, consumers, or caregivers as members. The HHSC Office of Program Coordination for Children and Youth (OPCCY) coordinates statewide CRCG activities and reporting. A group of state-level agency representatives, the CRCG State Work Group, meets approximately quarterly and provides inter-agency linkages and consultation for CRCG activities and reporting.

The purpose of the CRCG Survey was to measure the extent that CRCG participants understood and demonstrated accord with the Title V CSHCN NPMs/SPMs and to help guide development of future Title V activities. CSHCN Services Program staff developed an email announcement, introductory information, and a 40-item online survey. The surveys contained no individually identifiable information. There were 3 demographic items to characterize respondents, 35 closed-ended, multiple choice items, and 2 open-ended items. The closed-ended items were grouped into sections according to national and state performance measures. Each section was headed by a simple statement of the applicable national or state performance measure (See Appendix G – CSHCN CRCG Survey Documentation).

After vetting the survey instrument through the DSHS IRB and receiving an exemption, the CSHCN Services Program conducted an online survey of CRCG participants in March and April 2009. The OPCCY distributed initial and reminder announcements about the survey via email. Participants entered responses online using QuestionPro©. A total of 215 CRCG participants completed and submitted the survey.

To characterize respondents, the survey asked the focus of the CRCG, HSR, and primary professional or personal affiliation. The focus of the CRCG included those serving children only, those serving children and adults, and those serving adults only. In the instances of CRCGs that serve adults only, older adolescents (over about age 16) with special needs might be included in the service population. There were 213 usable responses to the focus of CRCG item. The majority of respondents (54.5%, n=116) were from CRCGs serving children and adults. Forty-four percent (n=94) were from CRCGs serving children only, and 1.4% (n=3) of respondents were from CRCGs serving adults only.

Each of the HSRs was represented by at least 21 respondents, with about one-half of responses coming from HSR 2/3 (Dallas-Fort Worth), HSR 8 (San Antonio), and HSR 4/5N (East Texas). Depending on an individual respondent's service area, some respondents represented more than one HSR.

The professional or personal affiliation was an optional item in the survey and included a large array of state and local agencies, as well as family member, consumer, caregiver, advocacy organization, faith-based organization, and community action organization. There were 214 usable responses to this item. For the purpose of comparing responses by affiliation, we created six key categories: DSHS Staff Serving CYSHCN (14%, n=30), Mental Health/Mental Retardation (MH/MR) Centers represented by DSHS and DADS (18%, n=39), Public Education represented by school districts, education services centers, and the Texas Education Agency (10%, n=21), Local Juvenile Probation Departments (23%, n=49), Private Sector individuals or entities (16%, n=23), and Affiliation Not Listed (19%, n=39).

The CRCG Survey response rate approximated 10% of active participants in CRCGs statewide, and the data describing the respondent population suggested that it was both geographically and professionally diverse.

STRENGTHS AND WEAKNESSES OF CYSHCN METHODS

The methods for obtaining needs assessment information for the CYSHCN population demonstrated both strengths and weaknesses.

The strengths of the CYSHCN methods included the following:

- Use of the 2005-2006 NS-CSHCN data and its comparison with 2001 NS-CSHCN data. These data resources provide programs with data that withstands the requirements of generally accepted research methodologies, and the NS-CSHCN provides corroboration of both historical and current anecdotal evidence.
- The use of multiple needs assessment methods is comprehensive, doesn't rely on a single data source, and outcomes are complementary.
- Substantial participation of CSHCN Services Program staff in development of statewide needs assessment activities ensured that, to the fullest extent possible, the voice of CYSHCN was represented.
- The CSHCN Services Program sought to make the Parent Survey accessible by using a written format that could easily be reproduced and distributed without needing to have computer access; by translating the documents into Spanish; and by insuring that the documents were written in plain language at a sixth-grade literacy level.
- Announcements and distribution for the Provider and CRCG Surveys were extensive and the distribution of their responses was both geographically and professionally diverse.
- The CRCG Survey represented perhaps the first of its kind, in that it attempted to survey a population of both public and private sector stakeholders closely involved with the population of CYSHCN, but not funded or supported through Title V.
- In the absence of formal stakeholder advisory organizations supported through Title V, e.g. a specific CSHCN Services Program Advisory Committee, the CSHCN Services Program has used numerous partnerships and collaboration with other stakeholder groups, enabling each to benefit by the other's knowledge and strengths.

The following were the weaknesses identified:

- Convenience sampling methodologies for the CSHCN Services Program surveys resulted in respondent samples that were not necessarily representative of the economic, education, racial/ethnic or geographic diversity of the Texas population.
- The Parent, Provider, and CRCG survey formats did not capture individual economic, education, or racial/ethnic data.
- Participation in family focus groups was very limited. Further, the staff leading those groups indicated they got an impression that those participating tended to be reluctant to describe adverse situations or circumstances, because they did

not want “complaints” to reflect poorly on service contractors or other local providers.

- The geographic distribution of responses to the Family Survey did not include HSR 11, and other regions were underrepresented, based on the demographic distribution of families of CYSHCN (The absence of respondents from HSR 11 occurred primarily because the CSHCN Services Program has limited contractor penetration in HSR 11, and there was a lack of contractor-sponsored activities during the data collection period).
- The written format used for the Family Survey required that respondents be literate at the sixth-grade level.
- Web-based surveys used for the Provider and CRCG Surveys required that respondents have computer access.
- Using stakeholder organizations as a source for information may not adequately represent populations that are less vocal, less politically active, or less well-informed.

SECTION 2: PARTNERSHIP BUILDING AND COLLABORATION EFFORTS

Texas is one of the largest states in the U.S., both geographically and in population. There are numerous efforts addressing MCH needs throughout various state and local government and private/non-profit agencies that are being developed and implemented at any one time. While this coexistence is inherent given the size and scope of the state, it often creates challenges in ensuring collaborative efforts are inclusive of key stakeholders from a variety of disciplines and jurisdictions. This is especially true given that state legislation and/or funding grantees charge multiple agencies at both the state and local levels with responsibility for various MCH activities. DSHS staff recognizes the importance of partnership building and collaboration as critical components in addressing MCH needs if these efforts are to be successful. In addition to staff that work to administer the Title V Block Grant, subject matter experts funded by Title V in the areas of women's and perinatal health, child health, adolescent health, child fatality, CYSHCN, and clinical MCH issues (henceforth referred to as DSHS MCH staff), are charged with working collaboratively across programs and agencies, including local MCH programs, other health and human service agencies, and public/private organizations throughout the State of Texas and across the U.S.

This section describes selected formal and informal initiatives at the national, state, and local level that are being employed to address MCH needs. While not every effort is documented, a representative selection of existing collaborative efforts is detailed.

FORMAL COLLABORATION PROCESSES AND PARTNERSHIPS

NATIONAL/MULTI-STATE LEVEL

HRSA REGION VI STATE COLLABORATION

Title V-funded program staff in the Division for Family and Community Health Services (FCHS) has built strong relationships with counterpart states within the federal Department of Health and Human Services Region VI, Health Resources and Services Administration (HRSA) office through regular communication through quarterly meetings or conference calls to share best practices and identify common challenges and potential solutions in meeting the needs of the MCH population. Discussions regarding disaster response, coordinating services with Medicaid and the Children's Health Insurance Program (CHIP), adolescent health initiatives, and medical home efforts have been topics shared at these meetings held with the state MCH and CYSHCN Directors from Arkansas, Louisiana, New Mexico, Oklahoma, and Texas. As a standing agenda item, the group also receives updates from the region's assigned project officer from the Maternal and Child Health Bureau and a representative from the Association of

Maternal and Child Health Programs (AMCHP) to stay abreast of ongoing and new initiatives across the country.

ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS

DSHS supports ongoing participation in AMCHP through membership including the Title V Director, Title V CSHCN Director, Title V Block Grant Administrator, a Family Delegate, and key managers within the FCHS Division. DSHS members serve as representatives on AMCHP committees and workgroups. Furthermore, DSHS staff collaborates with other AMCHP members through conference calls and annual conference participation to build skills, share updates, and obtain information on innovative program designs.

CATALYST CENTER

CSHCN Services Program staff collaborates with the Catalyst Center, responding to surveys on financing health care for CYSHCN and providing presentation materials for Catalyst workshops/conferences. Also, staff partners and shares information with the National Healthy and Ready to Work Center regarding transition issues for CYSHCN and their families.

NATIONAL ACADEMY OF STATE HEALTH POLICY

The Title V CSHCN Director participates as part of the Texas state team in the National Academy of State Health Policy's national patient-centered medical home collaborative. Texas Medicaid's health home pilots are the focus of the Texas participation in this collaborative.

BIG 5 STATE PREMATURITY COLLABORATIVE

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

CDC PRECONCEPTION HEALTH AND HEALTH CARE INITIATIVE

DSHS MCH and research staff participate in the Core State Preconception Health Indicators Initiative Working Group of the Center for Disease Control and Prevention's

Preconception Health and Health Care Initiative Steering Committee. The Working Group is a voluntary collaboration of program/policy leaders and epidemiologists from seven states (California, Delaware, Florida, Michigan, North Carolina, Texas, and Utah) to define preconception health domains and propose measurable preconception health indicators at a state level that can be used to assess, monitor, and evaluate preconception health in all states. The 10 domains are: general health status and life satisfaction; social determinants of health; health care; reproductive health and family planning; tobacco, alcohol and substance use; nutrition and physical activity; mental health; emotional and social support; chronic conditions; and infections.

NATIONAL STAKEHOLDERS COLLABORATIVE

DSHS MCH and Tuberculosis/HIV/Sexually Transmitted Diseases (STD) staff works with the Texas Education Agency (TEA) on a National Stakeholders Collaborative project to address adolescent sexual and reproductive health. The collaboration is sponsored by the AMCHP, the National Alliance of State and Territorial AIDS Directors, National Coalition of STD Directors, and the Society of State Directors for Health, Physical Education, and Recreation. This collaborative project is designed to create an infrastructure, through the strengthening of state-level intra- and inter-agency partnerships, to sustain efforts to address adolescent reproductive and sexual health issues.

SOUTHEAST COALITION ON CHILD FATALITIES

In the previous two years, a DSHS MCH staff member has served as the Chair of the Southeast Coalition on Child Fatalities, a 14-state coalition of Child Fatality Review (CFR) Coordinators, most of which are organized through Title V in their home states. DSHS MCH staff collects comparative information from the participating states, leads sub-committees addressing mutual member issues, and facilitates monthly conference call meetings. Through this collaboration, DSHS MCH staff participates in cooperative injury prevention projects such as the identification of common child death risks across the states.

STATE AND TERRITORIAL INJURY PREVENTION DIRECTORS ASSOCIATION

DSHS MCH staff assisted with preparation for the State and Territorial Injury Prevention Directors Association (STIPDA) state visit that required a review of relevant injury prevention programs in Texas. As a result of the STIPDA review, a Tier One Injury Prevention Initiative was established to develop a report on the state of injury prevention efforts at DSHS that will inform budget planning prior to the next Texas legislative session. Staff from various divisions, sections, and offices within DSHS serves on the Tier One Injury Prevention Initiative.

STATE/LOCAL LEVEL

TEXAS HEALTHY START ALLIANCE

The Texas Healthy Start Alliance is a primary partner in the work DSHS does with women and infants. The Alliance is composed of the six HRSA-funded sites located in Brownsville, Dallas, Fort Worth, Houston, Laredo, and San Antonio. These community-based programs work to reduce infant mortality, low birth weight, and racial disparities in perinatal outcomes and also to screen and refer for perinatal depression. DSHS and the Alliance work together on joint projects such as annual conferences, perinatal depression screening data analysis, and technical assistance and data resources for program planning and implementation.

LEADERSHIP AND EDUCATION IN ADOLESCENT HEALTH PROGRAM

The Leadership and Education in Adolescent Health (LEAH) Program works to improve the health and well-being of adolescents through education, research, program and service model development, evaluation, and dissemination of best practices. DSHS MCH and CSHCN Services Program staff partner with Baylor College of Medicine, the LEAH grantee for Texas, on a variety of initiatives. CSHCN Services Program staff participates on the planning committee for and attends the LEAH Program's annual Chronic Illness and Disability ("Transition") Conference. Title V funding enables the LEAH Program to provide: 1) scholarships for family members of CYSHCN to attend the conference; 2) one-month rotations for 12 internal medicine residents through a transition clinic for older teens and young adults with chronic diseases and disabilities; and 3) implementation and evaluation of an innovative electronic health record adolescent-to-adult health care transition template.

MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM

DSHS, Department of Assistive and Rehabilitative Services (DARS), Department of Family and Protective Services (DFPS), Department of Aging and Disability Services (DADS), and other health and human services agencies have established a system of communication that supports collaborative efforts in planning and the administration of Medicaid, CHIP, and other health and social services for the citizens of Texas. For example, an electronic project alert system has been created to ensure that as programmatic changes occur, all agencies are provided basic information that can be used to determine whether more involvement through communication on project status is sufficient, or whether formal participation on work groups is needed. Efforts are led by staff in HHSC, but each of the four agencies (DSHS, DADS, DARS, and DFPS) has ongoing communication mechanisms in place to promote effective coordination.

As a result of the system, HHSC and DSHS established ongoing communication regarding the CHIP Perinatal waiver program and resulting impact on the Title V-funded prenatal care contracts throughout the state. Since 2007, the two agencies have worked to minimize delays in access to prenatal care, ultimately agreeing that Title V-funded prenatal services contractors provide coverage during the time an application for the CHIP Perinatal benefits is in process.

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

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

INTERAGENCY COORDINATING COUNCIL FOR BUILDING HEALTHY FAMILIES

During the 79th Texas Legislative Session (2005), House Bill 1685 established the Interagency Coordinating Council (ICC) for Building Healthy Families. The ICC is charged with facilitating communication and collaboration concerning policies for the prevention of and early intervention in child abuse and neglect among state agencies whose programs and services promote and foster healthy families. State agencies represented on the Council include HHSC, DSHS, DFPS, DADS, DARS, Texas Youth Commission (TYC), TEA, Texas Workforce Commission (TWC), Office of the Attorney General (OAG), Texas Juvenile Probation Commission (TJPC), and Texas Department of Housing and Community Affairs (TDHCA).

TASK FORCE ON CHILDREN WITH SPECIAL NEEDS

During the 81st Texas Legislature (2009), Senate Bill 1824 established the Task Force for Children with Special Needs to improve the coordination, quality, and efficiency of

services for children with special needs. The task force is charged with developing a comprehensive five-year strategic plan to address the needs of children with chronic illnesses, intellectual or other developmental disabilities, or serious mental illness by improving coordination, quality, and efficiency. It includes representatives from state agencies including, but not limited to, HHSC, DSHS, DFPS, DADS, and TYC; legislators; and public members. Its focus areas include health, mental health, education, juvenile justice, crisis prevention, transitioning youth, long-term care, and early childhood intervention. The FCHS Assistant Commissioner is the DSHS designate to the Task Force and CSHCN Services Program staff serves on some of its subcommittees.

COUNCIL ON CHILDREN AND FAMILIES

The Council on Children and Families was established by Senate Bill 1646 during the 81st Texas Legislature (2009) to help improve the coordination of state services for children. The council brings together high-level leaders from state agencies to establish common goals and activities, seek budgetary efficiencies, and recommend policy implementation. Standing members of the council include representatives from HHSC, DSHS, DFPS, DARS, DADS, TEA, TWC, TJPC, TYC, and the Texas Correctional Office on Offenders with Medical or Mental Impairments. The efforts of similar councils in 24 other states have resulted in outcomes such as eliminating waiting lists for subsidies, increasing adoptions of children in foster care, and improving children's mental health care.

HHSC OFFICE OF PROGRAM COORDINATION FOR CHILDREN AND YOUTH

DSHS MCH and CSHCN Services Program staff works closely with HHSC's Office of Program Coordination for Children and Youth (OPCCY). OPCCY assists in coordinating programs and initiatives that serve children and youth across health and human service systems. In addition, it also oversees the operation of various children's programs and initiatives from the following areas:

- Community Resource Coordination Groups of Texas (CRCGs) – CRCGs are local interagency groups, working together to develop services plans that address gaps and coordinate multi-agency service delivery for children, youth, and adults and their families that require intensive interagency organization and cooperation. In addition to parents, consumers, and caregivers, CRCG members include staff from HHSC, DSHS, DADS, DARS, DFPS, Texas Department of Criminal Justice (TDCJ), TDHCA, TEA, TJPC, TWC, TYC, private child-serving providers, and private adult-serving providers. A Memorandum of Understanding enables and a work group including state-level staff from the signatory agencies assists in the work of and reporting for the local CRCGs.

- Texas Integrated Funding Initiative (TIFI) – DSHS MCH and CSHCN Services Program staff serve as representatives to TIFI which supports flexible funding collaboration between governmental and private sector agencies to serve children and youth with complex mental health needs. TIFI assists in developing systems of care that focus on individualized services that move beyond traditional child-centered mental health services to encompass more comprehensive supports for the entire family. In addition to DSHS, TIFI governmental partners include CRCGs, DFPS, TEA, TJPC, and TYC.
- Office of Early Childhood Coordination – This area within HHSC coordinates two projects in which DSHS MCH staff is involved:
    - Raising Texas is a statewide, collaborative effort to strengthen Texas' system of services for young children and families so that all children enter school healthy and ready to learn. Through the collaborative partnership of 9 state agencies, 16 community based agencies and 60 key stakeholders, a state plan has been developed to improve the current system of services for all children, age birth to 6. DSHS MCH and CSHCN Services Program staff serve on the Raising Texas Initiative supporting the Medical Home and Parent Education and Family Support sub-committees.
    - Healthy Child Care Texas (HCCT) brings together health care professionals, early care and education professionals, child care providers, and families to improve the health and safety of children in child care. The current HCCT initiative has a two-pronged approach to training consultants. It trains qualified individuals to be Child Care Health Consultants (e.g., registered nurses, child development specialists, early childhood education specialists) or Medical Consultants (e.g., physicians, residents, physician assistants, nurse practitioners). The goals for HCCT are to maximize the health, safety, well-being, and developmental potential of all children so that each child experiences quality child care within a nurturing environment, and to help increase children's access to preventive health services, including a medical home.
- Children's Policy Council – The Children's Policy Council assists health and human service agencies in developing, implementing, and administering family support policies and related long-term care and health programs for children. Membership is composed primarily of family members of consumers and is supported by agencies such as HHSC, DSHS, and DFPS. The Council provides recommendations to the state legislature on issues such as:
    - Access of a child or a child's family to effective case management services;
    - Transition needs of children who reach an age at which they are no longer eligible for services;

- Collaboration and coordination of children's services and the funding of those services between state agencies; and
- Effective permanency planning for children who reside in institutions or who are at risk of placement in an institution.

TEXAS COUNCIL FOR DEVELOPMENTAL DISABILITIES

The Texas Council for Developmental Disabilities is a 27-member board dedicated to ensuring that all Texans with developmental disabilities have the opportunity to be independent, productive, and valued members of their communities. The council works to ensure that the service delivery system provides comprehensive services and supports that meet people's needs, is easy to access, is cost effective, and improves people's understanding of disability issues. Council members include individuals with developmental disabilities; governor-appointed parents and guardians; representatives from state agencies such as HHSC, DSHS, DADS, DARS, and TEA that serve people with developmental disabilities; representatives from the state's protection and advocacy system; university centers for excellence in developmental disabilities; and local organizations. The Title V CSHCN Medical Director serves as the DSHS representative to this council.

PROMOTING INDEPENDENCE ADVISORY COMMITTEE

In January 2000, Texas embarked on a Promoting Independence initiative in response to the 1999 U.S. Supreme Court ruling in *Olmstead v. L.C*. Texas' Promoting Independence initiative supports allowing individuals with disabilities to live in the most appropriate care setting available. Among other activities, the Promoting Independence Advisory Committee (PIAC) provides a forum for and is a leader in the movement to reduce the number of children residing in large institutions in Texas. The committee is composed of advocates for people with disabilities and agencies key to the initiative, including HHSC, DADS, DFPS, DARS, DSHS, TDHCA, and TWC.

EARLY CHILDHOOD INTERVENTION ADVISORY COMMITTEE

The Early Childhood Intervention Advisory Committee is supported by DARS and serves Texas families with infants and toddlers with disabilities or developmental delays. The committee advises on and assists with activities which support integrated, efficient, and timely service delivery to the population served. The governor-appointed 24-member committee includes staff from HHSC, DSHS, DADS, DFPS, and TEA. The Title V CSHCN Medical Director serves as one of the DSHS representatives to this council.

TEXANS CARE FOR CHILDREN

Texans Care for Children is a multi-issue children's advocacy group that brings together a vast array of public, private, and nonprofit partners for the sole purpose of improving Texas children's lives. DSHS MCH staff participates on a subcommittee of this group called the Infant Health Alliance. The Alliance is a network of organizations and individuals working together to improve the health of Texas babies. It covers a wide range of topics including health care coverage, preventive care, family support and education, vaccinations, supporting premature babies, and enhancing maternal nutrition. DSHS MCH staff also partners with this group to ensure parent resource guides are made available to Medicaid recipients in accordance with legislative mandate and provides subject matter expertise to ensure the guide is developmentally-appropriate and provides evidence-based public health messages.

INTERAGENCY INFANT HEALTH WORKGROUP

The Infant Health Workgroup, comprised of DSHS MCH staff and DFPS staff in the areas of Child Protective Services (CPS) Investigations, Child Care Licensing, and the Division of Prevention and Early Intervention, was recently formed to address activities related to infant health, including safe sleep. A subcommittee of this workgroup developed a community-based training on safe sleep for infants for use by anyone who works with parents – professionals, paraprofessionals and lay workers. Another subcommittee worked with a social marketing firm to develop a Safe Sleep Environment Assessment training which will be required of all CPS caseworkers.

MEDICAL HOME WORKGROUP

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

TEXAS IMMUNIZATION STAKEHOLDER WORKGROUP

The Texas Immunization Stakeholder Workgroup (TISWG) was formed as a result of recommendations from various studies and legislation passed by the Texas Legislature. Its purpose is to increase public, private, and community partnerships across the state to raise vaccine coverage levels and improve immunization practices for all Texans.

TISWG provides a forum for these diverse partners in the state immunization system to share ideas, perspectives, best practices, and resources to more effectively target efforts to raise vaccine coverage levels.

RAPE PREVENTION EDUCATION GRANT

DSHS MCH staff works closely with the Office of the Attorney General to administer the Federal Rape Prevention Education Grant. Partners in this project include Texas Council on Family Violence, Texas Association Against Sexual Assault, University of Texas Domestic Violence Institute, and local rape crisis centers. Collaboratively, these partners write the state strategic plan, Preventing Sexual Violence in Texas, addressing primary prevention of sexual assault. Staff participating on the capacity building team assists in the identification of best practices in sexual assault primary prevention.

TEXAS CONSORTIUM FOR PERINATAL HIV PREVENTION

DSHS has been instrumental in formulating the Texas Consortium for Perinatal HIV Prevention (TCPHP), which is a statewide perinatal HIV workgroup composed of different agencies, organizations, and health care professionals, including the DSHS Community Health Services medical consultant. The purpose of TCPHP is to reduce or prevent HIV perinatal transmission in Texas through the collaborative efforts of HIV perinatal champions. Some of the larger goals of the TCPHP are to sustain a network of stakeholders, develop and disseminate standards of care recommendations, develop educational tools, and identify centers of excellence, which can be used for referrals and guidance.

TEXAS BREASTFEEDING COALITION

DSHS MCH staff collaborates with the Texas Breastfeeding Coalition, as well as local breastfeeding coalitions, to provide technical assistance including infrastructure and capacity building for communicating and coordinating messages about breastfeeding activities across the state.

DSHS SUICIDE PREVENTION WORKGROUP

DSHS MCH staff provides subject matter expertise to the DSHS Suicide Prevention Workgroup that is charged with developing a statewide suicide prevention strategic plan. Collaborators on the development of this strategic plan include DSHS and community members that are adult and child mental health experts, epidemiologist, physicians, and survivors of suicide.

STATE CHILD FATALITY REVIEW TEAM

A basic precept of child fatality review is that the teams be multi-disciplinary, representing many different governmental agencies. Many of these agencies also participate on the State Child Fatality Review Team Committee (SCFRT). DSHS MCH staff work with the following governmental agencies through the Child Fatality Review Team (CFRTs) and the SCFRT: Texas Department of Motor Vehicles, DFPS, Sheriff's Offices (including sheriffs, officers and victim-witness coordinators), local police jurisdictions, Justices of the Peace, County District Attorney Offices, Medical Examiner Offices (including medical examiners and forensic investigators), Texas Department of Transportation, County Juvenile Services, Texas Department of Public Safety, local fire departments, local chambers of commerce, local Child Welfare Boards, county and local health departments, and county judges. The protection and safety of children are the primary focuses of these multi-disciplinary teams.

PROMOTOR(A)/COMMUNITY HEALTH WORKER TRAINING AND CERTIFICATION ADVISORY COMMITTEE

The Promotor(a)/Community Health Worker (CHW) Training and Certification Advisory Committee is charged with the responsibility of advising the Executive Commissioner of HHSC concerning the training and regulation of persons working as promotores(as) or community health workers. The committee may make recommendations to DSHS on qualifying sponsoring institutions or training programs and instructors. Additionally, the committee carries out any other tasks given to the committee by the Executive Commissioner of HHSC. Committee membership includes four certified promotores(as) or CHWs, two members of the public, two professionals who work with CHWs in a community setting, and a member from the Texas Higher Education Coordinating Board or a higher education faculty member who has teaching experience in community health, public health, or adult education and has trained CHWs. DSHS MCH staff provides administrative support and oversight to the committee.

INFORMAL COLLABORATION PROCESSES AND PARTNERSHIPS

STATE/LOCAL LEVEL

DSHS REGIONAL STAFF

DSHS MCH staff work with the DSHS regional staff to serve as subject matter experts for injury prevention, obesity and nutrition, youth development, adolescent pregnancy prevention, and other current health priorities relevant to the populations. As regional staff develop their work plans for issues such as teen pregnancy prevention and childhood obesity, the DSHS MCH staff may be consulted on the most recent data and

trends associated with their work plan topic. This information is integrated into the development of activities developed at the local level – thus making data-driven decisions for program development.

CSHCN Services Program staff also collaborates with regional case management staff to provide case management services to CYSHCN in Texas. Regional staff partners with central office staff to provide technical assistance and quality monitoring of the CSHCN Services Program's community-based services contractors that provide case management, community resources, and family and clinical supports.

INFANT FEEDING WORKGROUP

DSHS MCH staff provides expertise in breastfeeding and coordinate environmental change activities as part of the DSHS Infant Feeding Workgroup. This workgroup includes Special Supplemental Nutrition Program for Women, Infants and Children (WIC) breastfeeding staff and representatives from the Nutrition, Physical Activity, and Obesity Prevention program (NPAOP) and serves as a collaborative body to integrate and evaluate population-based breastfeeding activities across DSHS. The group is currently working to develop an agency-wide strategic plan to support breastfeeding.

OBESITY PREVENTION WORKGROUP

DSHS MCH staff meets regularly with DSHS obesity prevention programs, including NPAOP and WIC. These meetings ensure that child and adolescent needs are integrated into the department's obesity prevention efforts. The Get Fit Kit is an example of a collaborative childhood obesity prevention project involving staff from various divisions, sections and offices within DSHS. The toolkit was designed to fill a gap in the lack of existing resources for school nurses that addressed physical activity and nutrition with adolescents who were identified as overweight or obese.

OTHER DSHS PROGRAMS

The following are examples of how DSHS MCH staff work collaboratively with other DSHS programs to coordinate and enhance programmatic activities:

- Collaborate with family planning and abstinence-centered programs to identify best practices in adolescent pregnancy prevention.
- Provide adolescent subject matter expertise on materials that are developed or selected to be used as resources in the respective programs. One example is an adolescent friendliness tool for family planning clinics. This tool encourages clinics to examine their facility, policies, procedures, and practices to ensure that adolescents feel welcome and comfortable and that clinic staff has the knowledge and skills to work effectively with adolescents.

- Provide subject matter expertise on adolescent physical, social, and emotional development for the Transition Team led by the CSHCN Services Program. The Team focuses on resource sharing among various DSHS programs, community-based contractors, and other health and human services agencies to improve the transition to adult health care systems for adolescents.
- Provide breastfeeding subject matter expertise to the Statewide Agency Wellness Program (Building Healthy Texans), the State Model Wellness Plan, and the annual State Wellness Conference.
- Work with the following programs to update and release a revised *Information for Parents of Newborns*: CSHCN Services Program, Safe Riders, Newborn Screening, Immunizations, DFPS Child Care Licensing, and DARS Early Childhood Intervention. Providers in Texas are required by law to distribute educational materials related to being a parent of a newborn that includes, but not limited to, information on parenting, child development and injury prevention.

STAKEHOLDER INVOLVEMENT

DSHS is dependent upon and has long valued the importance of partnership building and collaboration among its stakeholders. As is evident in the details provided earlier in this document regarding the needs assessment process (See Section 1: Process for Conducting Needs Assessment), the collection of meaningful stakeholder input relied upon the established partnerships and collaborations listed in this section. These relationships formed the basis for mass distributions of information seeking participation and input of stakeholders throughout the process. Personal contacts between stakeholders and DSHS staff further facilitated the engagement of stakeholders during the process and made the activities more productive.

SECTION 3: STRENGTHS AND NEEDS OF MATERNAL AND CHILD HEALTH POPULATION GROUPS AND DESIRED OUTCOMES

To complete a thorough assessment of the MCH population, DSHS assessed and compared the quantitative and qualitative data needs for pregnant women, mothers and infants, children and adolescents and children and youth with special health care needs. The following discussion focuses on significant health issues within the MCH population as a whole, as well as by sub-population groups such as race/ethnicity, age, and educational attainment status. Progress towards applicable *Healthy People 2010* objectives is also addressed to provide context for understanding the health status of the MCH population in Texas.

PREGNANT WOMEN

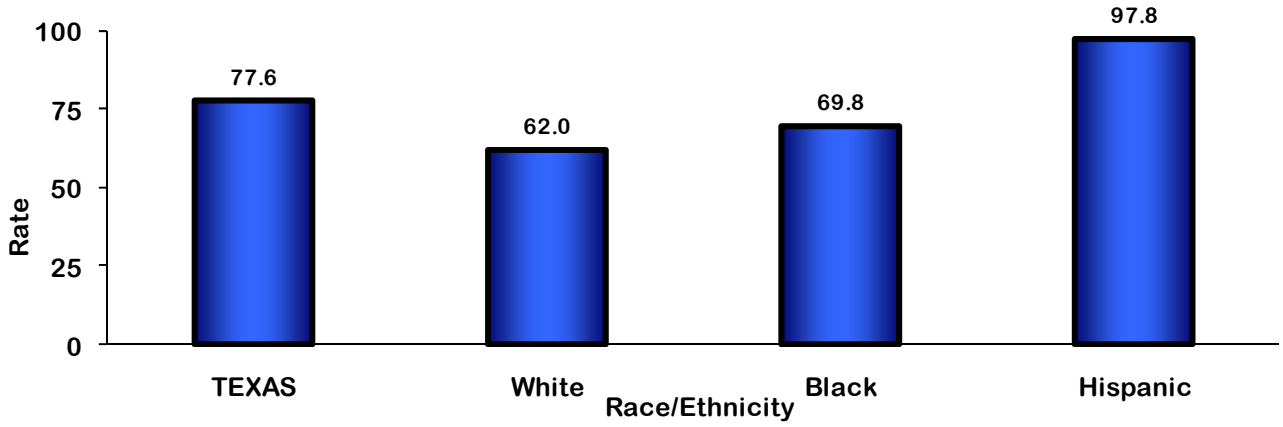
FERTILITY RATES

The fertility rate for Texas residents ranged from a low of 74.8 live births per 1,000 females aged 15 to 44 in 1996 to a high of 77.6 live births per 1,000 females aged 15 to 44 in 2006. In Texas, the fertility rate increased 3.8% from 74.8 in 1996 to 77.6 in 2006. Nationally, the fertility rate increased 6.9% from 64.1 in 1996 to 68.5 in 2006. The fertility rate for Texas was 13.3% higher than the fertility rate for the U.S. in 2006.

Hispanic women had the highest fertility rates of all races/ethnicities. In 2006, the Hispanic fertility rate was 1.6 and 1.4 times as high as the fertility rate for Whites and Blacks, respectively. However, the biggest decrease in fertility rates from 1996 to 2006 was among Hispanics (14.4%). The biggest increase in fertility rates from 1996 to 2006 was among Whites (11.2%).

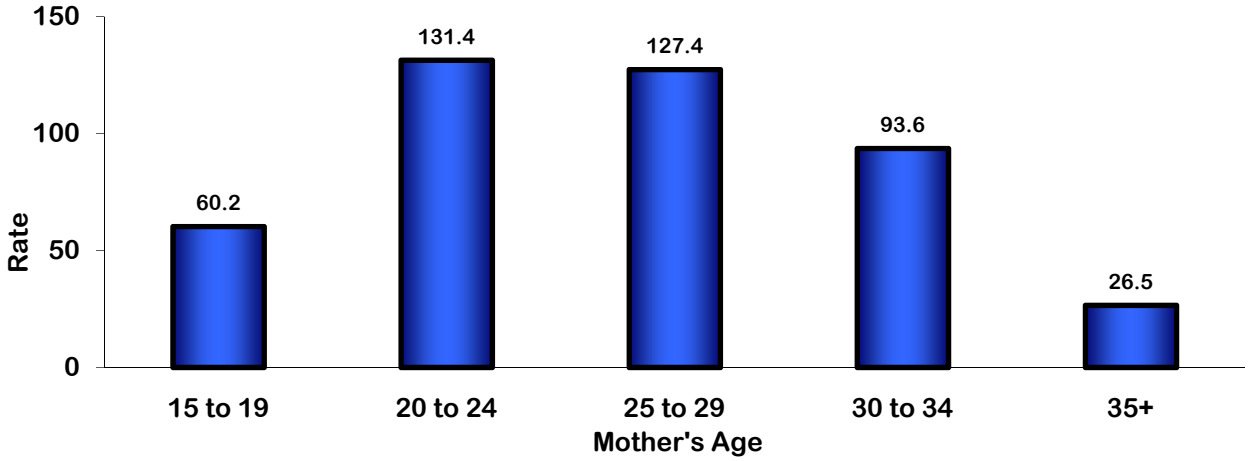
Women 20 to 24 years of age had the highest fertility rates, followed closely by women 25 to 29 years of age. The biggest decrease in fertility rates from 1996 to 2006 was among adolescents 10 to 14 years old (42.1%). The biggest increase in fertility rates from 1996 to 2006 was among women 35 and older (26.9%).

Figure 3-1. Fertility Rates by Race/Ethnicity, Texas, 2006



Fertility rates: number of live births per 1,000 women 15-44 years of age.
Source: Texas Department of State Health Services, Natality Files, 2006.

Figure 3-2. Fertility Rates by Mother's Age, Texas, 2006



Fertility rates: number of live births per 1,000 women 15-44 years of age.
Source: Texas Department of State Health Services, Natality Files, 2006.

Table 3-1. Texas Resident Fertility Rates by Race/Ethnicity and Mother's Age, 1996-2006

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Total	74.8	74.9	76.1	77.3	76.6	75.9	76.3	76.7	76.7	76.7	77.6
Race/Ethnicity											
White	55.8	55.0	55.7	55.7	60.6	59.6	59.5	60.4	60.3	61.3	62.0
Black	69.7	70.3	71.0	70.6	68.6	66.9	67.6	67.6	68.0	67.9	69.8
Hispanic	114.2	115.1	116.9	120.2	103.7	102.7	102.3	100.9	100.1	98.5	97.8
Other	83.9	87.5	87.4	93.2	72.4	70.5	72.3	71.9	70.3	66.4	73.7
Age Group											
10 to 14	1.9	1.6	1.6	1.6	1.4	1.3	1.2	1.1	1.1	1.1	1.1
15 to 19	72.0	71.4	71.5	71.3	68.8	65.6	63.8	61.8	61.3	59.9	60.2
20 to 24	129.0	128.0	130.3	131.7	137.4	135.3	135.3	132.3	130.4	128.8	131.4
25 to 29	128.4	129.8	129.8	131.3	124.8	124.7	126.0	126.7	126.7	126.8	127.4
30 to 34	83.0	84.1	87.9	92.1	91.2	91.1	91.1	93.5	93.4	93.4	93.6
35+	20.9	21.5	22.1	22.3	22.8	22.8	23.4	24.3	24.9	26.0	26.5

Fertility rates: total number of live births per 1,000 women in specified race/ethnicity or age group.

Rates for females aged 35+ are based on female population 35-44 years of age.

Total rates are based on female population 15-44 years of age NOT including women under 15 or over age 44.

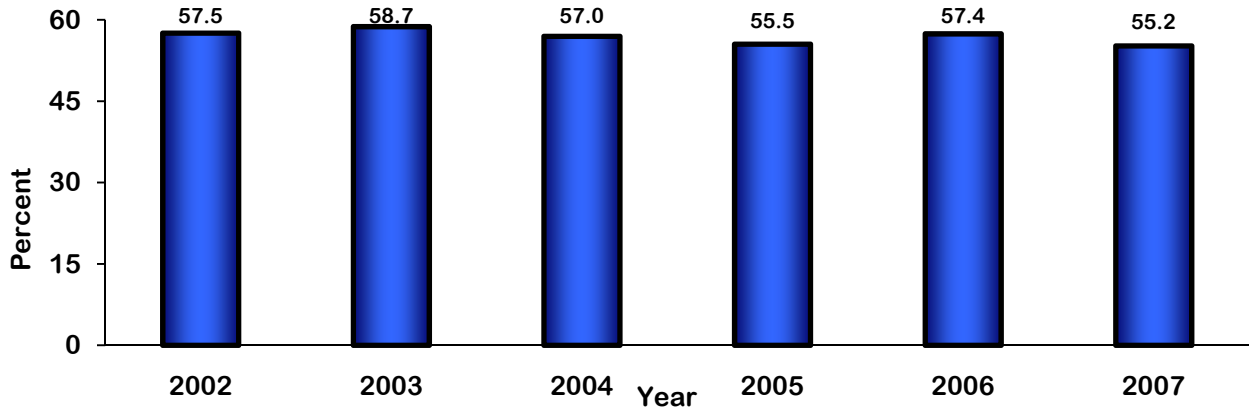
Population Source: Population Estimates and Projections Program, Texas State Data Center, Office of the State Demographer, Institute for Demographic and Socioeconomic Research, The University of Texas at San Antonio. Compiled by the Center for Health Statistics, Texas Department of State Health Services. Available at: http://soupfin.tdh.state.tx.us/people.htm

Natality Source: Texas Vital Statistics Natality File, 1996-2006, Texas Department of State Health Services.

PREGNANCY INTENTION

The percent of mothers who reported that their pregnancies were intended ranged from a low of 55.2% in 2007 to a high of 58.7% in 2003. Approximately 10% of all Texas births were unwanted (mother did not want to be pregnant then or at any other time). The remaining pregnancies were mistimed (mother wanted to be pregnant, but not then).

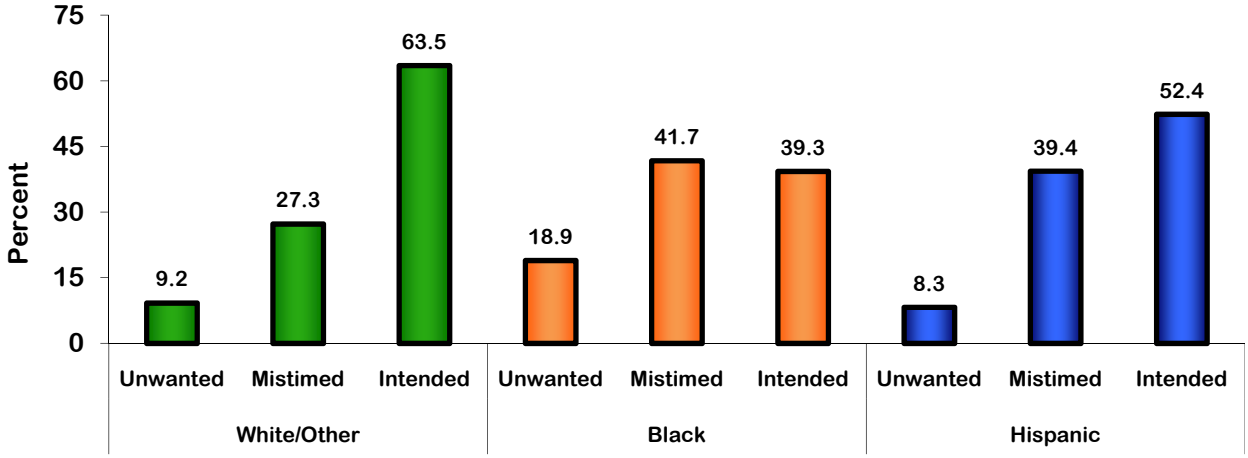
Figure 3-3. Percent of Pregnancies Reported to be Intended
Texas, 2002-2007



Source: Texas Department of State Health Services, Pregnancy Risk Assessment Monitoring System, 2002-2007.

The percent of births reported to be intended was highest among White/Other mothers (63.5%), followed by Hispanic mothers (52.4%) and Black mothers (39.3%). In 2007, the percent of unwanted pregnancies among Black mothers (18.9%) was more than double the percent among White mothers (9.2%) and Hispanic mothers (8.3%).

Figure 3-4. Percent of Pregnancy Intention by Race/Ethnicity, Texas, 2007



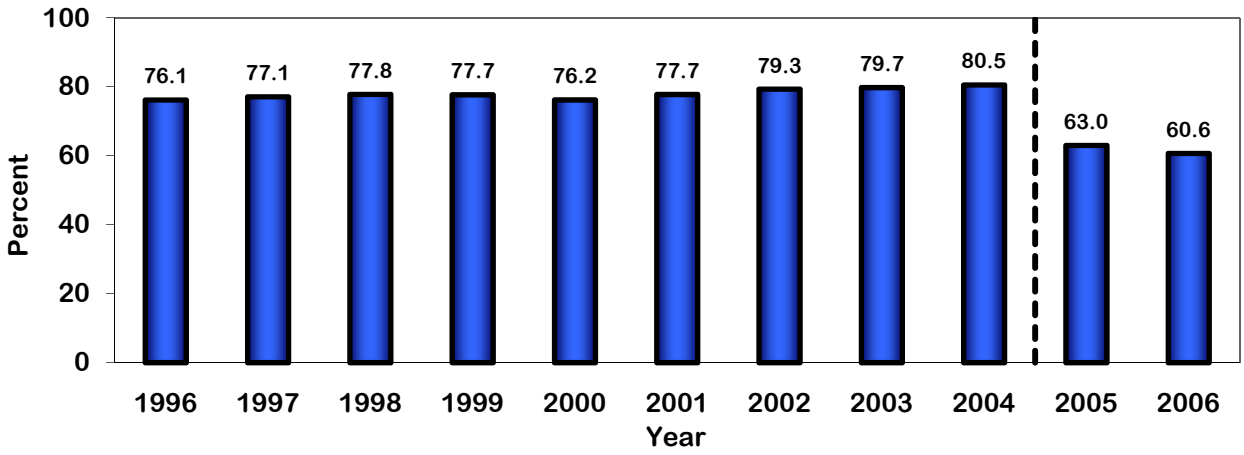
Source: Texas Department of State Health Services, Pregnancy Risk Assessment Monitoring System, 2007.

PRENATAL CARE

FIRST TRIMESTER PRENATAL CARE

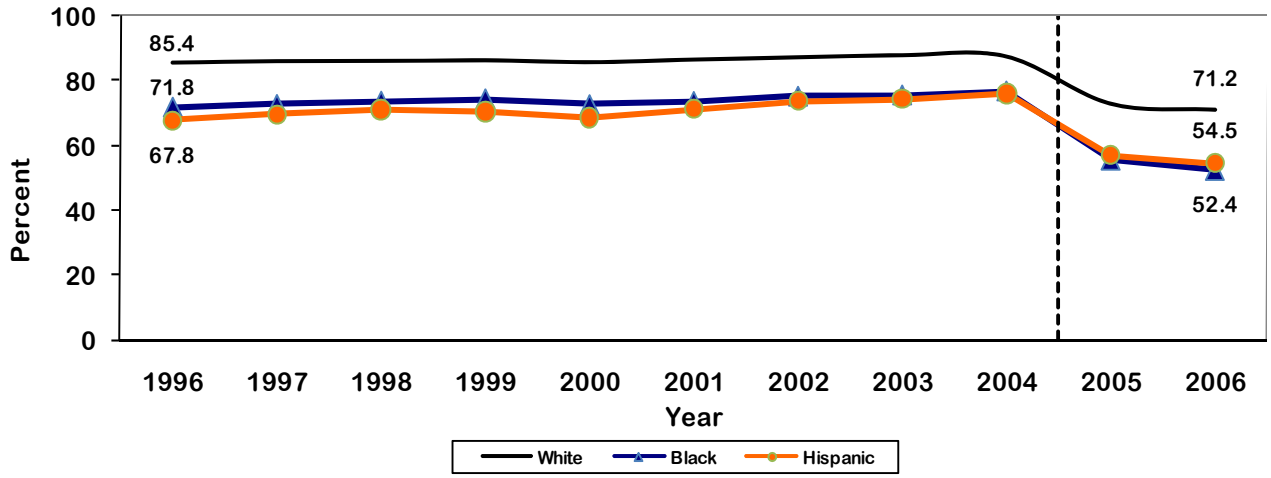
No population group, either in aggregate or by subgroup, met the *Healthy People 2010* objective of 90% of women receiving prenatal care in their first trimester. White women (Figure 3-6) and women age 30 years and older (Figure 3-7) were the nearest to the *Healthy People 2010* objective. Hispanics were less likely to initiate prenatal care in the first trimester than Whites and Blacks. There is a significant disparity in receipt of first trimester prenatal care by age. Approximately 44.7% of women 19 years of age and under sought prenatal care during the first trimester, compared to 63.1% for women 20 years of age or older. Within each racial/ethnic group, there was a positive association between education and receiving prenatal care in the first trimester; higher educational attainment was associated with a higher rate of receiving prenatal care in the first trimester. In each education strata, the percent of women receiving first trimester prenatal care was lowest among Black women. The percent of women receiving first trimester prenatal care was similar between White women who completed high school and Black women who had more than a high school degree. Mistimed and unwanted births pose a challenge to receiving prenatal care in the first trimester. Approximately 80% of women who reported that their pregnancy was on time initiated prenatal care in the first trimester compared to women who reported that their pregnancy was mistimed or unwanted, only 58.9% and 60.7%, respectively.

Figure 3-5. Percent of Women Receiving Prenatal Care in First Trimester, by Year, Texas, 1996-2006



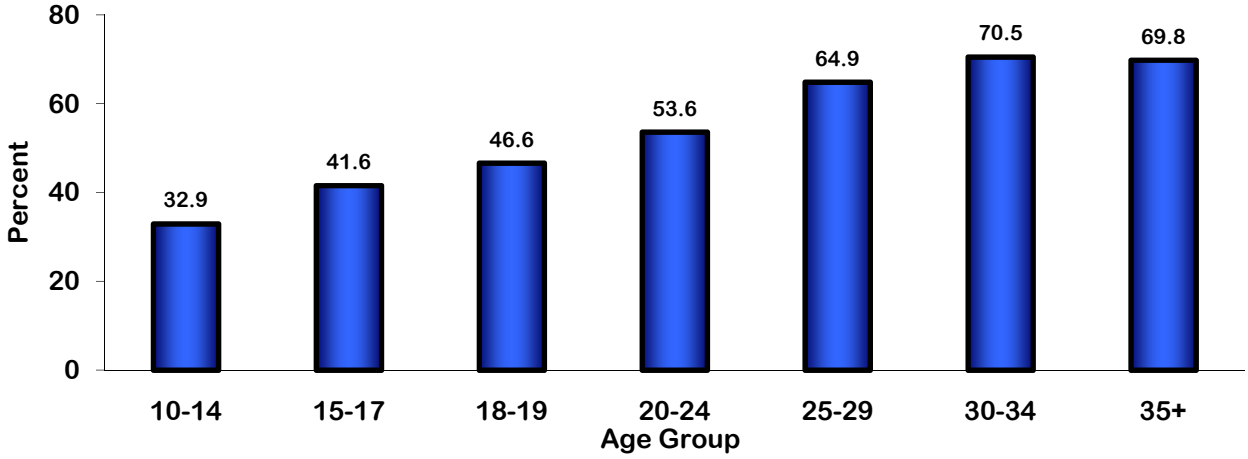
Source: Texas Vital Statistics Natality File, 1996-2006, Texas Department of State Health Services. In 2005, the Texas birth certificate was revised. Therefore, beginning in 2005, Texas prenatal care data are based on the date of first prenatal care visit as reported in the mother's medical record. Prenatal care data from 1996-2004 are based on the month in which prenatal care began. The vertical line in the graph indicates this change in methodology and data between the two periods are not comparable.

Figure 3-6. Percent of Women Receiving Prenatal Care in First Trimester by Race/Ethnicity by Year, Texas, 1996-2006



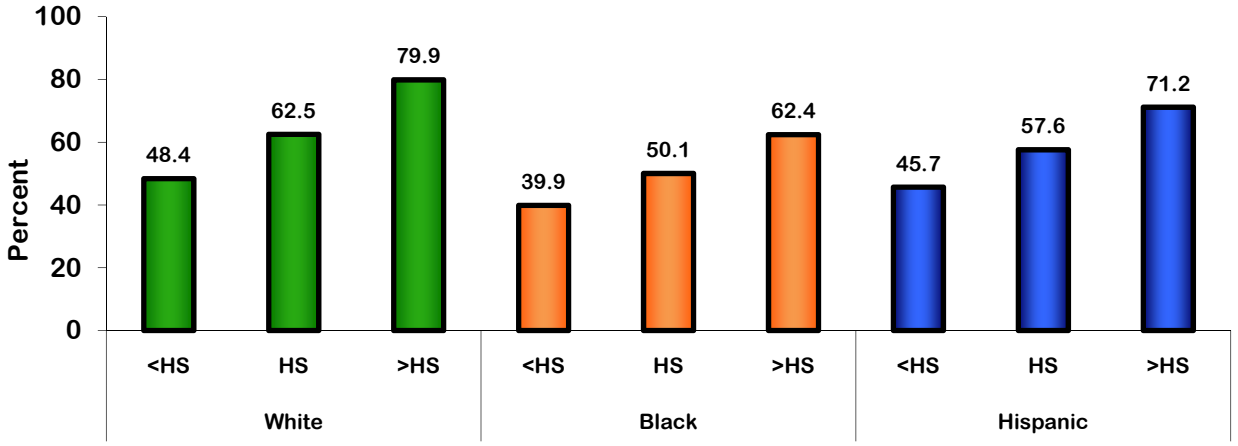
Source: Texas Vital Statistics Natality File, 1996-2006, Texas Department of State Health Services. In 2005, the Texas birth certificate was revised. Therefore, beginning in 2005, Texas prenatal care data are based on the date of first prenatal care visit as reported in the mother's medical record. Prenatal care data from 1996-2004 are based on the month in which prenatal care began. The vertical line in the graph indicates this change in methodology and data between the two periods are not comparable.

Figure 3-7. Percent of Women Receiving Prenatal Care in First Trimester, by Age Group, Texas, 2006



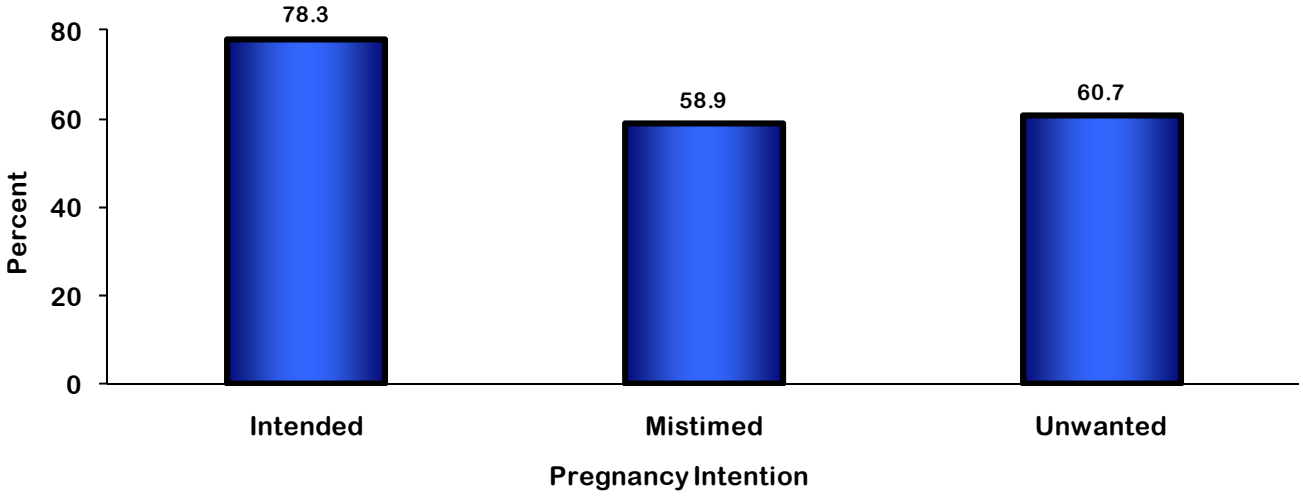
Source: Texas Vital Statistics Natality File, 2006, Texas Department of State Health Services.

Figure 3-8. Percent of Women Receiving Prenatal Care in First Trimester, by Race/Ethnicity and Maternal Education, Texas, 2006



Source: Texas Vital Statistics Natality File, 2006, Texas Department of State Health Services.

Figure 3-9. Percent of Women Receiving Prenatal Care in the First Trimester by Pregnancy Intention, Texas, 2007

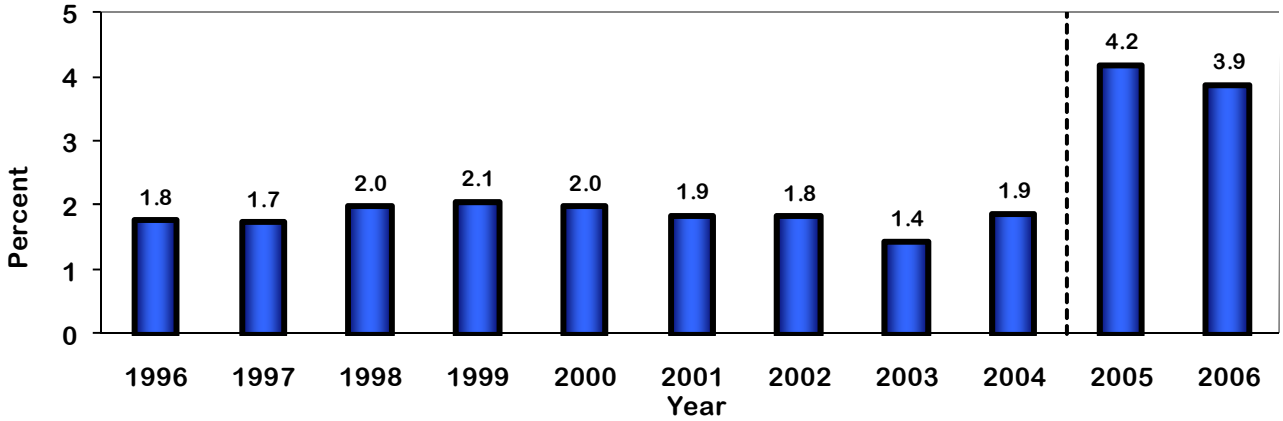


Source: Texas Department of State Health Services, Pregnancy Risk Assessment Monitoring System, 2007.

NO PRENATAL CARE

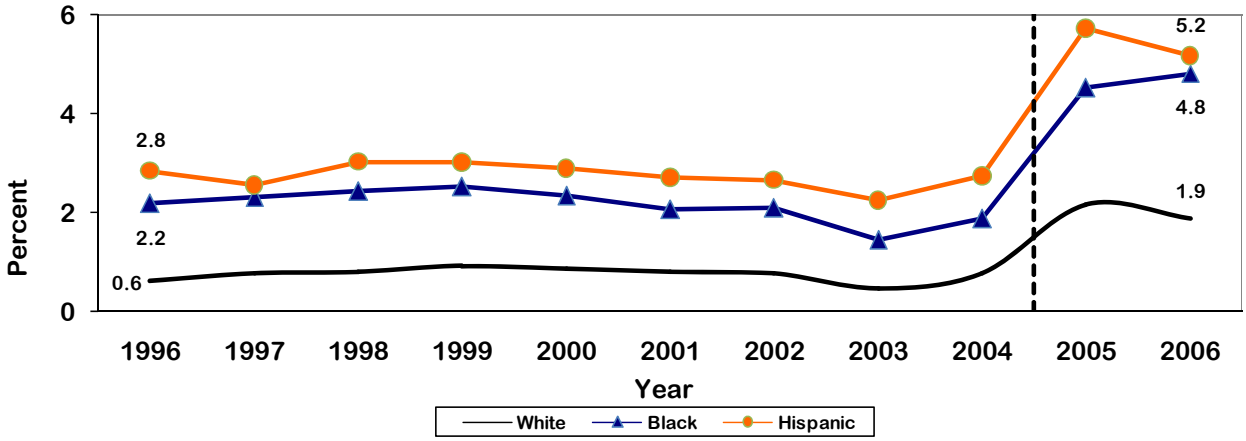
The percent of women who did not receive prenatal care remained relatively stable between 1996 and 2004, ranging from a low of 1.4% in 2003 to a high of 2.1% in 1999. There was a sharp increase in the percent of women receiving no prenatal care in Texas in 2005 (4.2%). Texas implemented the revised 2003 U.S. Standard Certificate of Live Birth in 2005, which could account for some of the differences. Whites (1.9%) were significantly less likely to report that they did not receive any prenatal care, compared with Hispanics (5.2%) and Blacks (4.8%). The percent of women receiving no prenatal care declined as age increased. Within each racial/ethnic group, there was a negative association between education and not receiving prenatal care. In each education strata, the percent of women who did not receive prenatal care was greatest among Black women. The percent of women who did not receive prenatal care was similar between White women who completed high school and Black women who had more than a high school degree.

Figure 3-10. Percent of Women Who Received No Prenatal Care by Year, Texas, 1996-2006



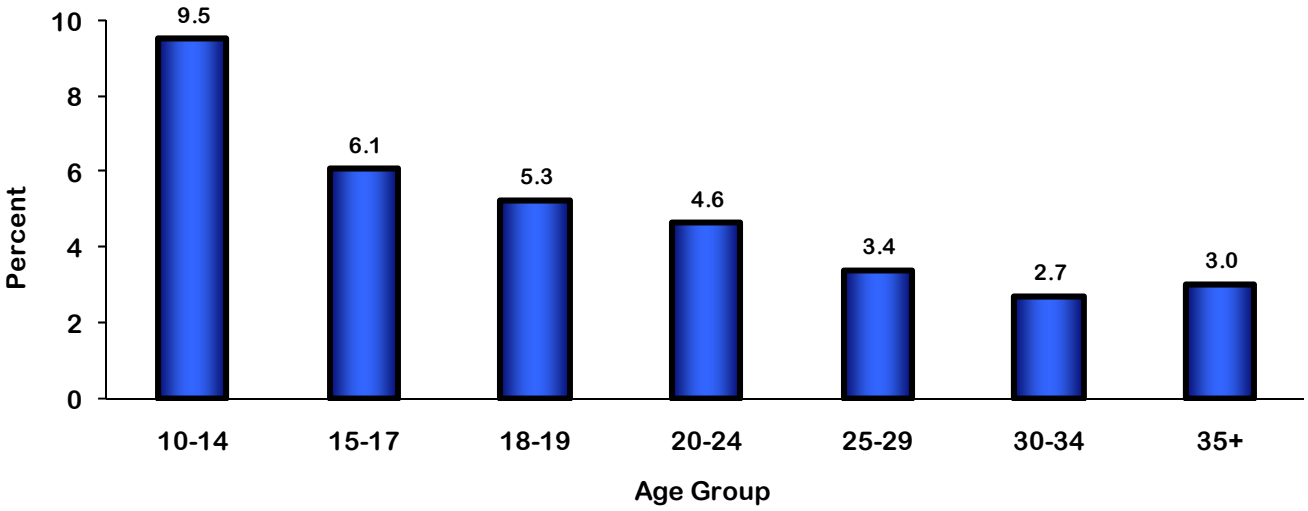
Source: Texas Vital Statistics Natality File, 1996-2006, Texas Department of State Health Services.
In 2005, the Texas birth certificate was revised. Therefore, beginning in 2005, Texas prenatal care data are based on the date of first prenatal care visit as reported in the mother's medical record. Prenatal care data from 1996-2004 are based on the month in which prenatal care began. The vertical line in the graph indicates this change in methodology and data between the two periods are not comparable.

Figure 3-11. Percent of Women Who Received No Prenatal Care by Race/Ethnicity by Year, Texas, 1996-2006



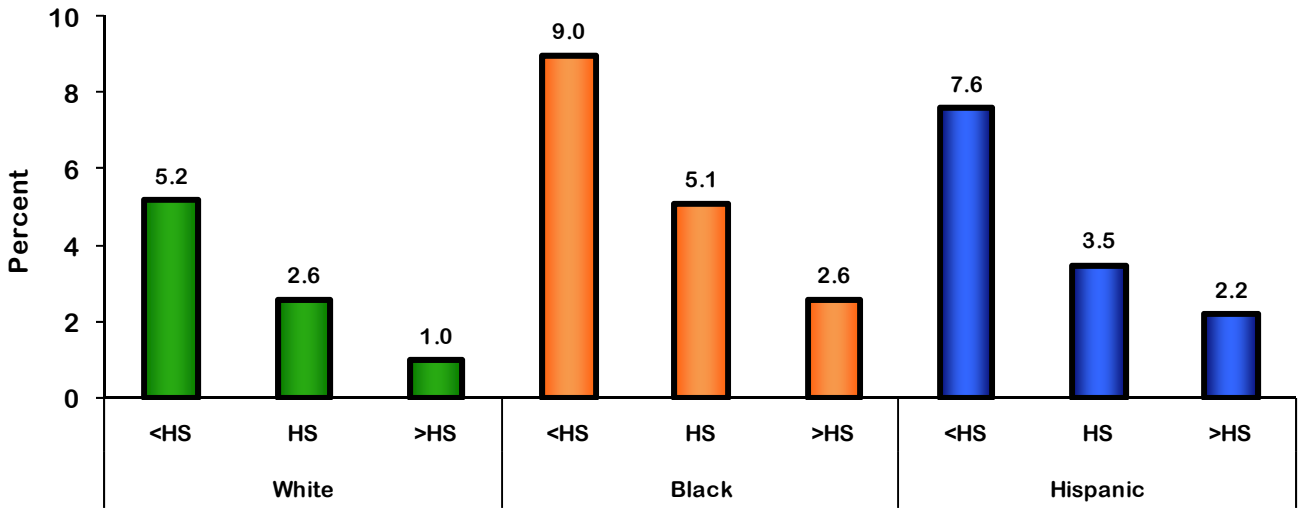
Source: Texas Vital Statistics Natality File, 1996-2006, Texas Department of State Health Services. In 2005, the Texas birth certificate was revised. Therefore, beginning in 2005, Texas prenatal care data are based on the date of first prenatal care visit as reported in the mother's medical record. Prenatal care data from 1996-2004 are based on the month in which prenatal care began. The vertical line in the graph indicates this change in methodology and data between the two periods are not comparable.

Figure 3-12. Percent of Women who Received No Prenatal Care by Maternal Age, Texas, 2006



Source: Texas Vital Statistics Natality File, 2006, Texas Department of State Health Services.

Figure 3-13. Percent of Women who Received No Prenatal Care by Race/Ethnicity and Maternal Education, Texas, 2006

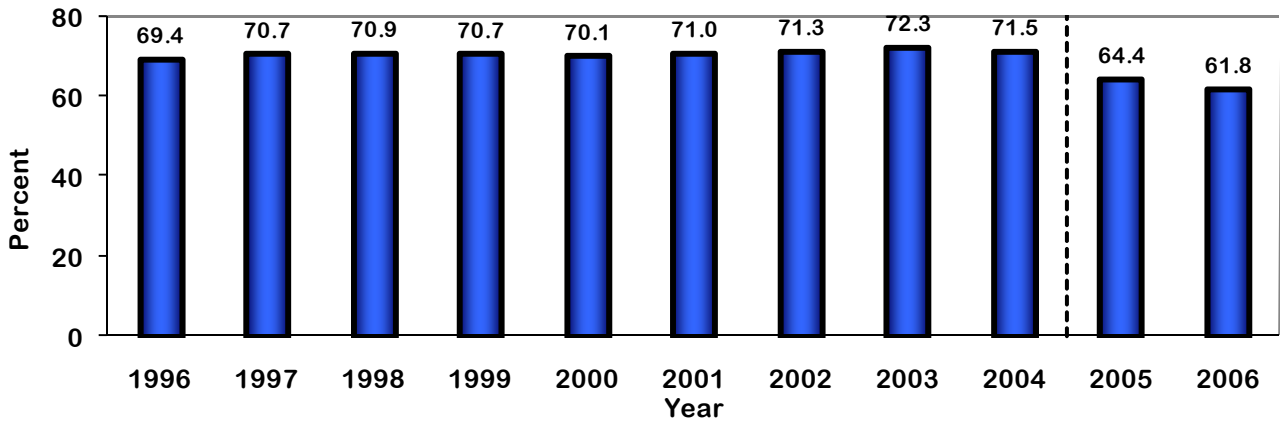


Source: Texas Vital Statistics Natality File, 2006, Texas Department of State Health Services.

ADEQUACY OF PRENATAL CARE (KOTELCHUCK INDEX)

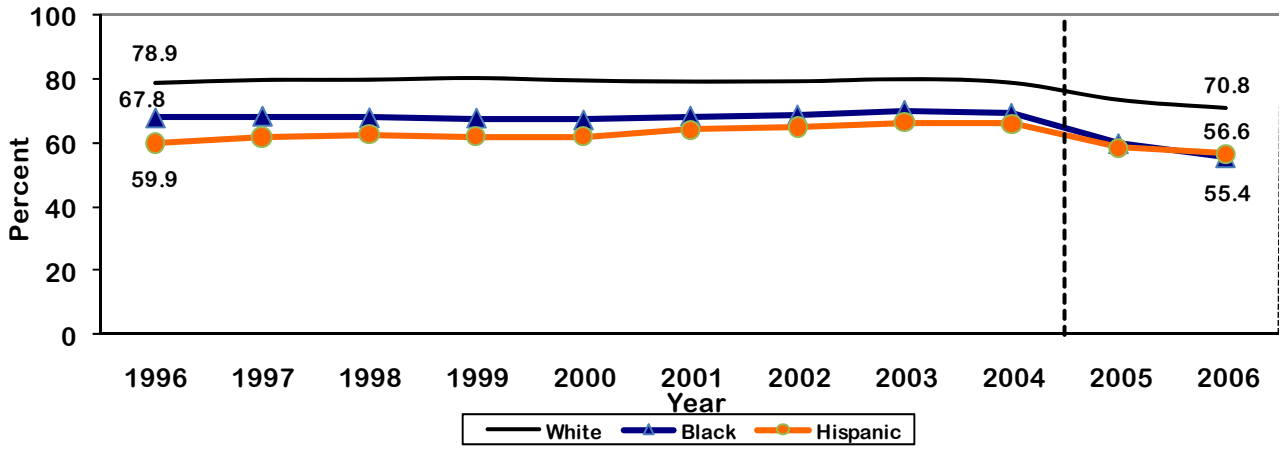
The percent of women who received adequate/intensive prenatal care remained relatively consistent between 1996 and 2004. There was a sharp decrease in the percent of women who received adequate/ intensive prenatal care in Texas in 2005. Texas implemented the revised 2003 U.S. Standard Certificate of Live Birth in 2005, which could account for some of the differences. There is a positive association between age and the percent of women receiving adequate/intensive prenatal care. The percent of women who received adequate/intensive prenatal care was 51.5% higher for those 30 years of age and older compared to those less than 18 years of age. Within each racial/ethnic group, there was a positive association between education and the percent of women who received adequate/intensive prenatal care. In each education strata, the percent of women who received adequate/intensive prenatal care was lowest among Black women. The percent of women who received adequate/ intensive prenatal care was similar between White women who completed high school and Black women who had more than a high school degree.

Figure 3-14. Percent of Women with Adequate/Intensive Prenatal Care, by Year, Texas, 1996-2006



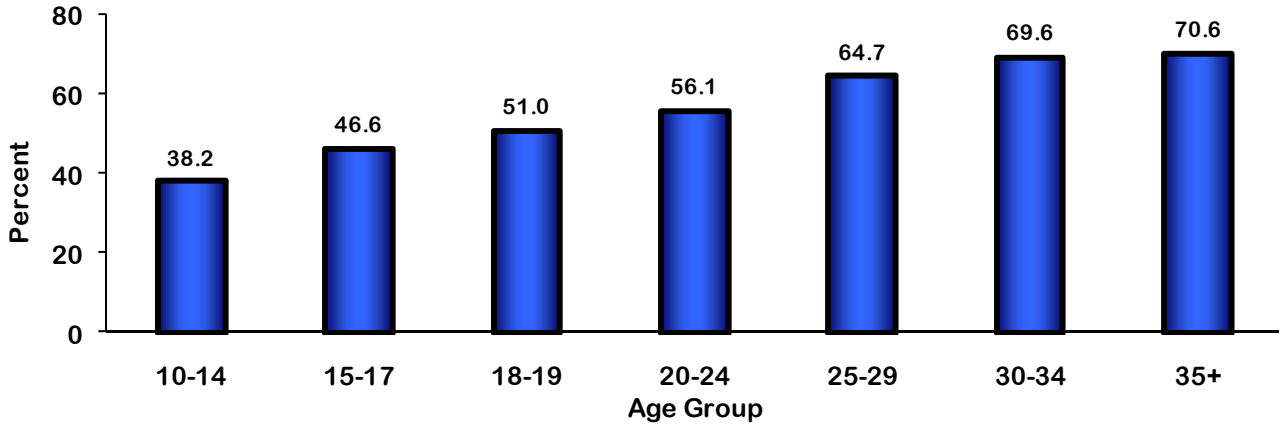
Source: Texas Vital Statistics Natality File, 1996-2006, Texas Department of State Health Services. In 2005, the Texas birth certificate was revised. Therefore, beginning in 2005, Texas prenatal care data are based on the date of first prenatal care visit as reported in the mother's medical record. Prenatal care data from 1996-2004 are based on the month in which prenatal care began. The vertical line in the graph indicates this change in methodology and data between the two periods are not comparable.

Figure 3-15. Percent of Women with Adequate/Intensive Prenatal Care by Race/Ethnicity by Year, Texas, 1996-2006



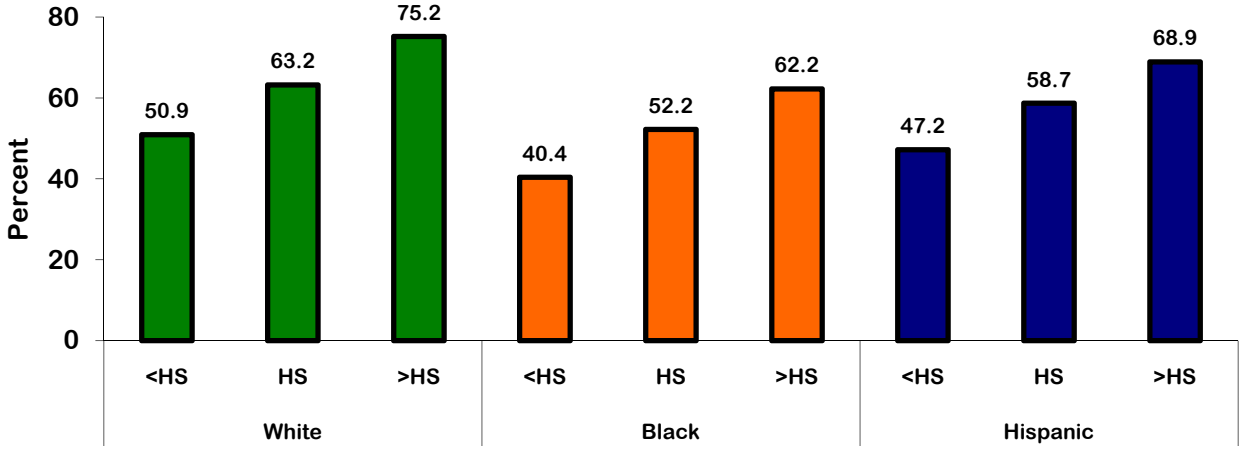
Source: Texas Vital Statistics Natality File, 1996-2006, Texas Department of State Health Services. In 2005, the Texas birth certificate was revised. Therefore, beginning in 2005, Texas prenatal care data are based on the date of first prenatal care visit as reported in the mother's medical record. Prenatal care data from 1996-2004 are based on the month in which prenatal care began. The vertical line in the graph indicates this change in methodology and data between the two periods are not comparable.

Figure 3-16. Percent of Women with Adequate/Intensive Prenatal Care by Maternal Age, Texas, 2006



Source: Texas Vital Statistics Natality File, 2006, Texas Department of State Health Services.

Figure 3-17. Percent of Women with Adequate/Intensive Prenatal Care by Race/Ethnicity and Maternal Education, Texas, 2006



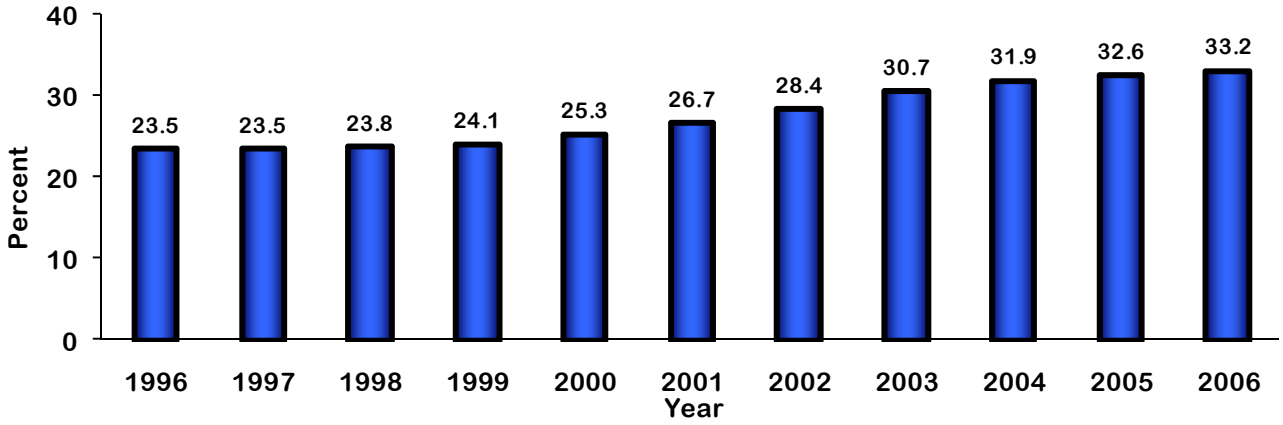
Source: Texas Vital Statistics Natality File, 2006, Texas Department of State Health Services.

DELIVERIES BY CESAREAN SECTION

The percentage of Cesarean section deliveries increased 41.3% between 1996 and 2006 in Texas. Cesarean rates were similar across racial/ethnic strata and increased at similar rates over time. In addition, Cesarean rates increased as maternal age increased. Increases in the Cesarean rate between 1996 and 2006 varied by age. Texans 10 to 14 years old had the least increase at 25.0%. All other age groups experienced at least a 30% increase. Women 18 to 19 years old and women 35 years or older experienced 41.1% and 31.7% increases, respectively. Within each racial/

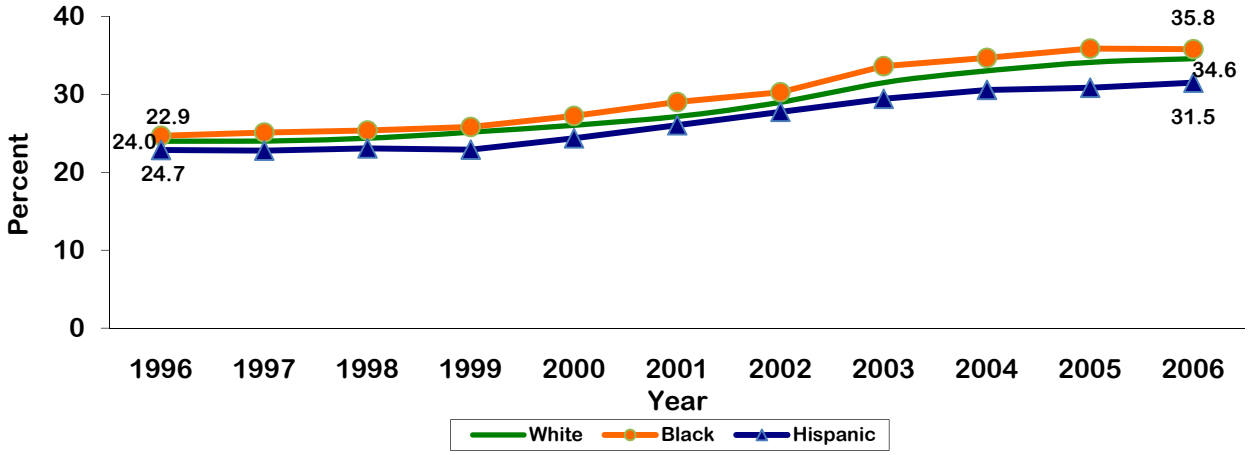
ethnic group, there was a positive association between education and Cesarean sections. Cesarean rates were similar between education strata, regardless of race/ethnicity.

Figure 3-18. Percent of Deliveries by Cesarean Section, by Year, Texas, 1996-2006



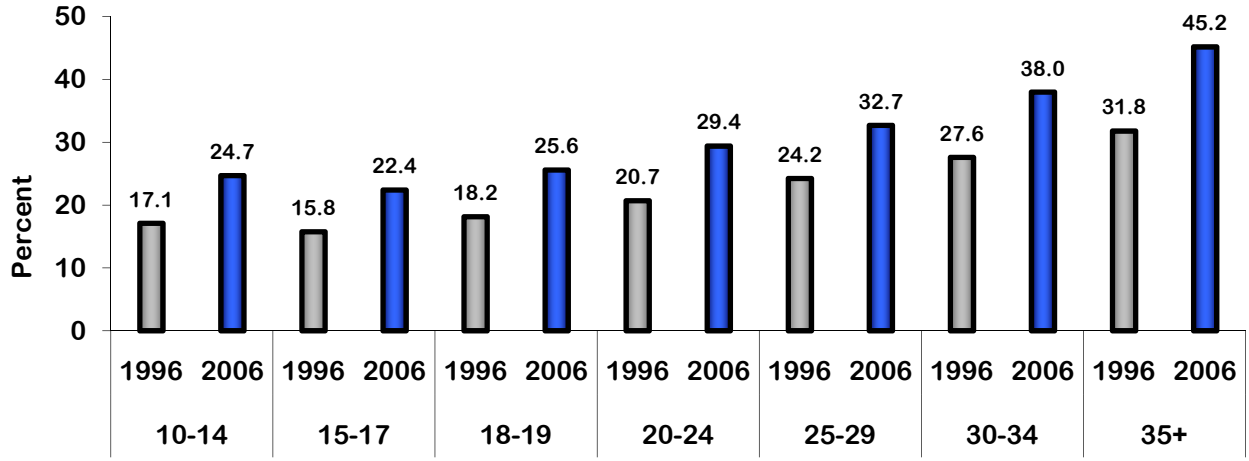
Source: Texas Vital Statistics Natality File, 1996-2006, Texas Department of State Health Services.

Figure 3-19. Percent of Deliveries by Cesarean Section by Race/Ethnicity by Year, Texas, 1996-2006



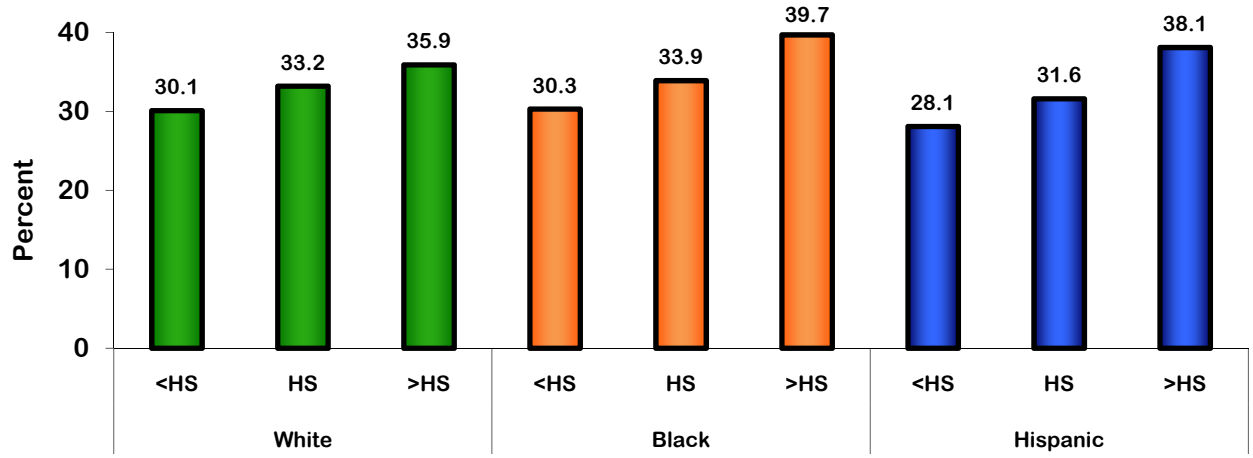
Source: Texas Vital Statistics Natality File, 1996-2006, Texas Department of State Health Services.

Figure 3-20. Percent of Deliveries by Cesarean Section
by Race/Ethnicity by Year, Texas, 1996-2006



Source: Texas Vital Statistics Natality File, 1996 and 2006, Texas Department of State Health Services.

Figure 3-21. Percent of Deliveries by Cesarean Section
by Race/Ethnicity and Maternal Education, Texas, 2006

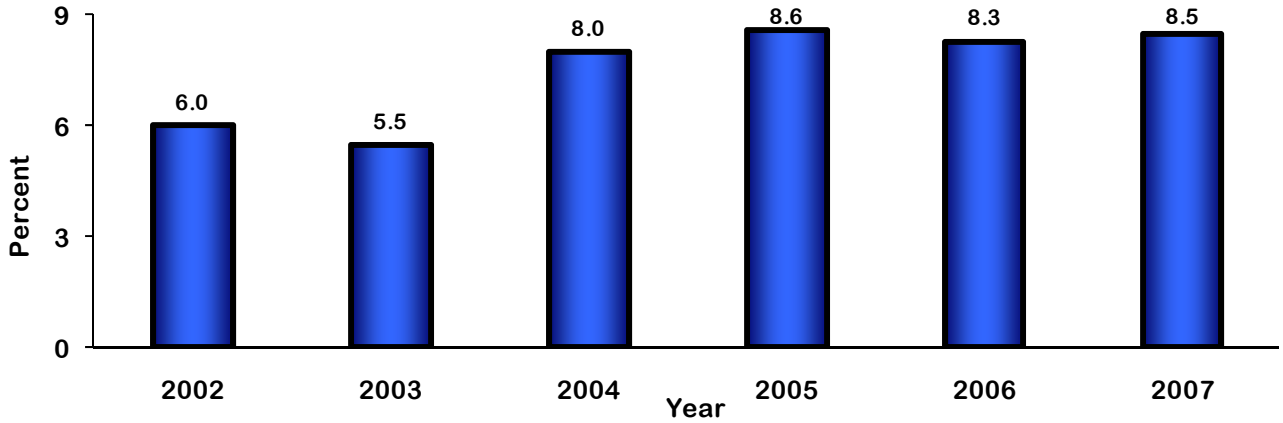


Source: Texas Vital Statistics Natality File, 2006, Texas Department of State Health Services.

ALCOHOL USE DURING PREGNANCY

The percent of mothers who reported drinking during the last three months of pregnancy ranged from a low of 5.5% in 2003 to a high of 8.6% in 2005. There was no statistical difference between the years. Given the sample and the relatively low prevalence of alcohol use during pregnancy, prevalence estimates by race/ethnicity and age are not reliable.

Figure 3-22. Percent of Mothers Who Drank Alcohol
During Last Trimester of Pregnancy, Texas, 2002-2007

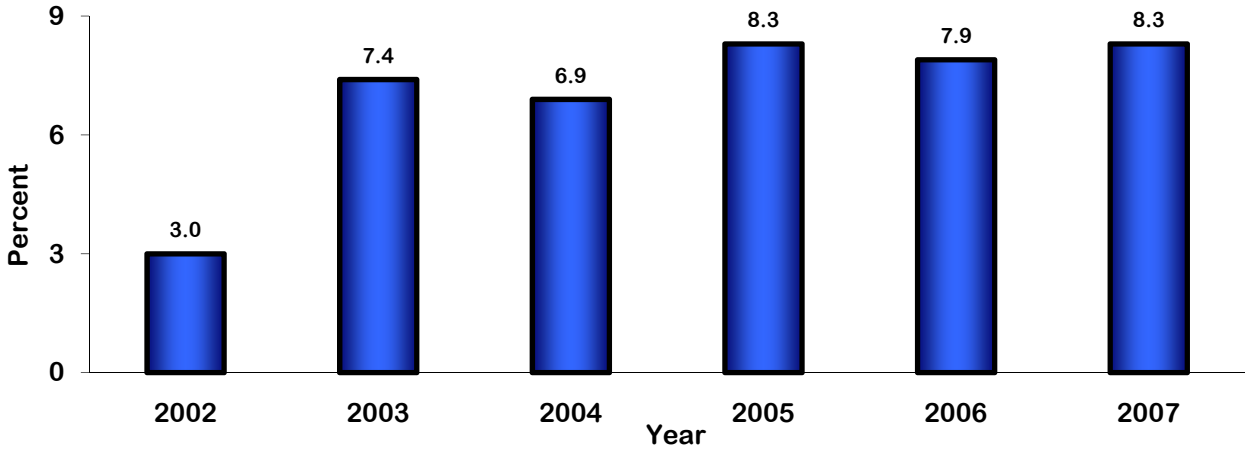


Source: Texas Department of State Health Services, Pregnancy Risk Assessment Monitoring System, 2002-2007.

TOBACCO USE DURING PREGNANCY

The percent of mothers who reported smoking during the last three months of pregnancy ranged from a low of 6.9% in 2004 to a high of 8.3% in 2005 and 2007. There was no statistical difference between the years. Given the sample and the relatively low prevalence of tobacco use during pregnancy, prevalence estimates by race/ethnicity and age are not reliable.

Figure 3-23. Percent of Mothers Who Smoked Cigarettes
During Last Trimester of Pregnancy, Texas 2002-2007



Source: Texas Department of State Health Services, Pregnancy Risk Assessment Monitoring System, 2002-2007.

INFANTS (0 TO 365 DAYS OF AGE)

BIRTH OUTCOMES

LOW BIRTH WEIGHT

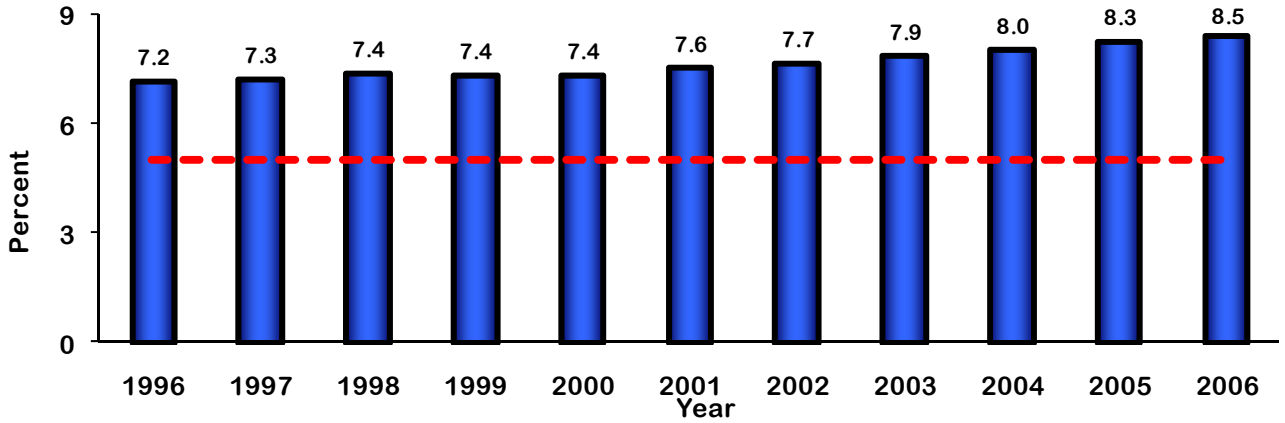
No population group, either in aggregate or by subgroup, met the *Healthy People 2010* objective of reducing the percent of low birth weight births (weighing less than 2,500 grams) to 5.0% or less. The percent of low birth weight births increased in Texas each year from 2000 to 2006. The percent of infants born low birth weight increased 14.9% from 7.4% in 2000 to 8.5% in 2006.

In 2006, the percent of infants born low birth weight to Black mothers (14.2%) was nearly twice the percent of infants born to White (7.6%) and Hispanic mothers (7.7%). Between 2000 and 2006, the percent of infants born weighing less than 2,500 grams increased 18.0% among Whites, compared to 11.6% and 10.3% among Blacks and Hispanics, respectively.

There is a consistent U-shaped pattern in the percent of infants born at a low birth weight by mother's age. Infants of women less than 18 years of age are more likely to be born low birth weight as compared to infants whose mothers are between the ages of 18 and 29 years. Infants born to women who are 30 years of age or older have a greater percent of infants born weighing less than 2,500 grams than infants born to women between the ages of 20 and 29 years, but a lesser percent than infants born to women less than 20 years old. Increases in the percent of infants born weighing less than 2,500 grams by maternal age between 1996 and 2006 exceeded 14.0% in all age groups except those with maternal age of less than 18 years, which experienced an increase of 4.3%.

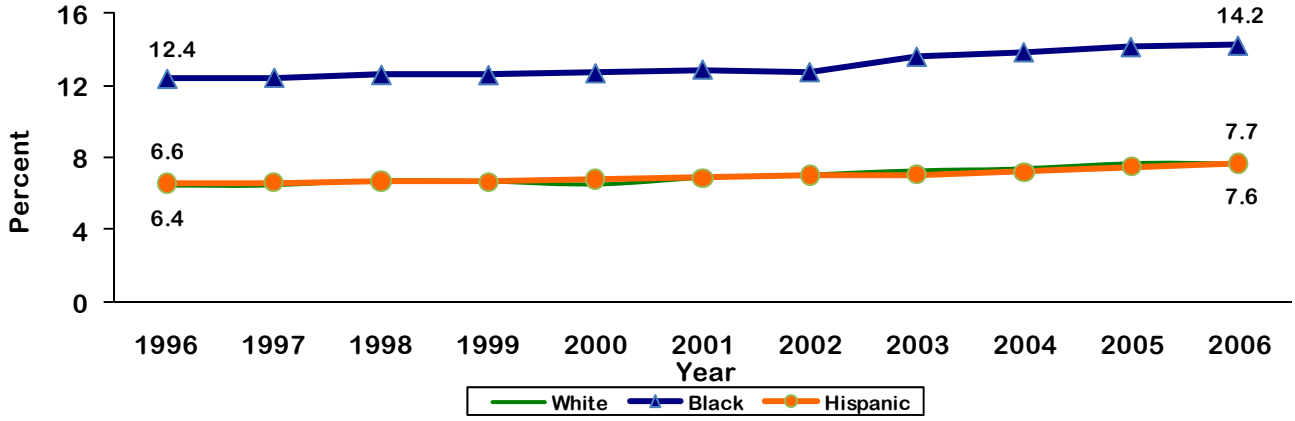
There was a negative association between maternal education and the percent of infants born weighing less than 2,500 grams among Whites and Blacks. The percent of Black infants who were born low birth weight to mothers with less than a high school education was 16.3%, compared to White (10.5%) and Hispanic (7.6%) mothers with the same educational attainment. Blacks had the highest percent of infants born weighing less than 2,500 grams than Whites and Hispanics, regardless of their educational attainment. Among Hispanic infants, there was no association between maternal education and low birth weight.

Figure 3-24. Percent of Infants Born Weighing Less than 2,500 Grams by Year, Texas, 1996-2006



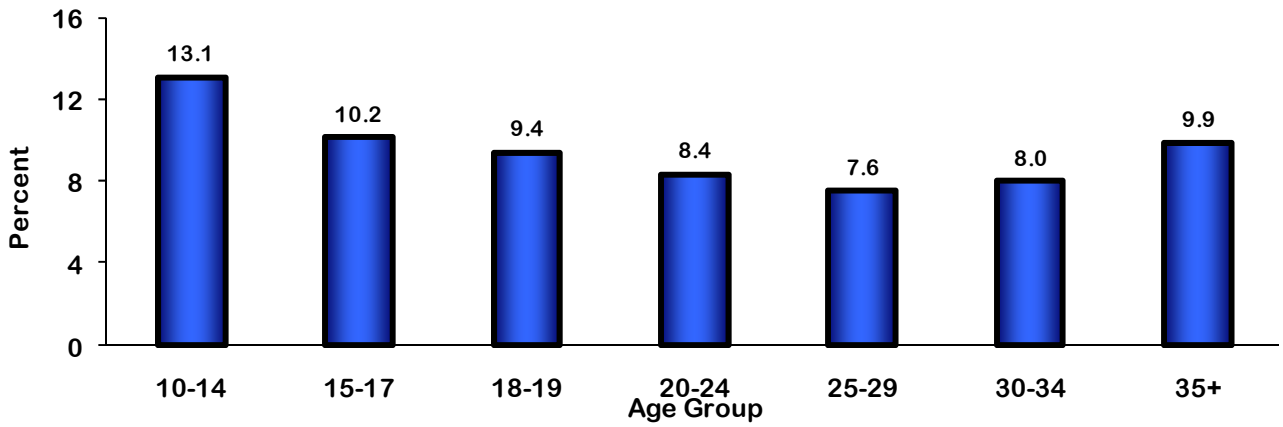
Source: Texas Vital Statistics Natality File, 1996-2006, Texas Department of State Health Services.
Dotted line indicates the *Healthy People 2010* goal.

Figure 3-25. Percent of Infants Born Weighing Less than 2,500 Grams by Race/Ethnicity by Year, Texas, 1996-2006



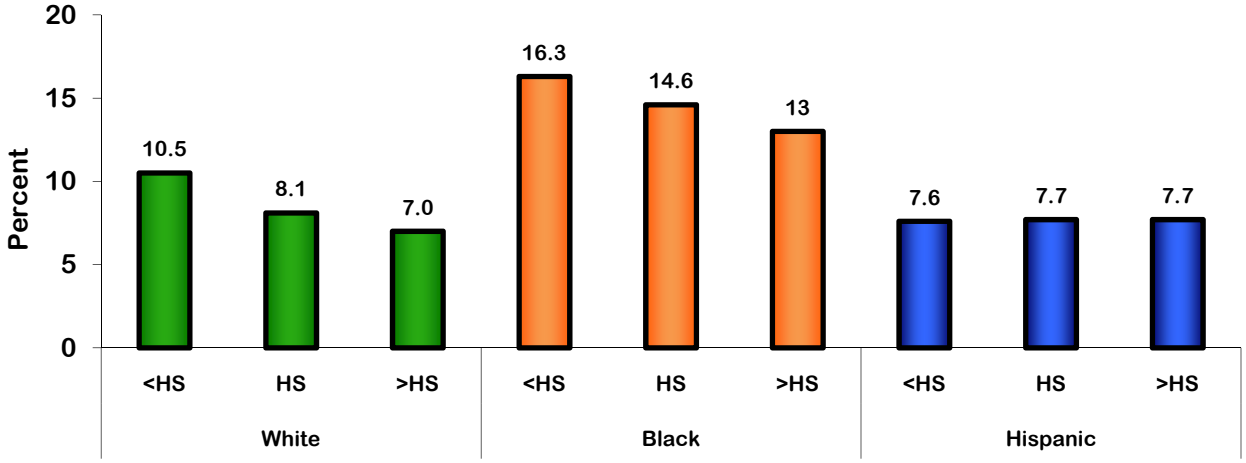
Source: Texas Vital Statistics Natality File, 1996-2006, Texas Department of State Health Services.

Figure 3-26. Percent of Infants Born Weighing Less than 2,500 Grams by Maternal Age, Texas, 2006



Source: Texas Vital Statistics Natality File, 2006, Texas Department of State Health Services.

Figure 3-27. Percent of Infants Born Weighing Less than 2,500 Grams by Race/Ethnicity and Maternal Education, Texas, 2006



Source: Texas Vital Statistics Natality File, 2006, Texas Department of State Health Services.

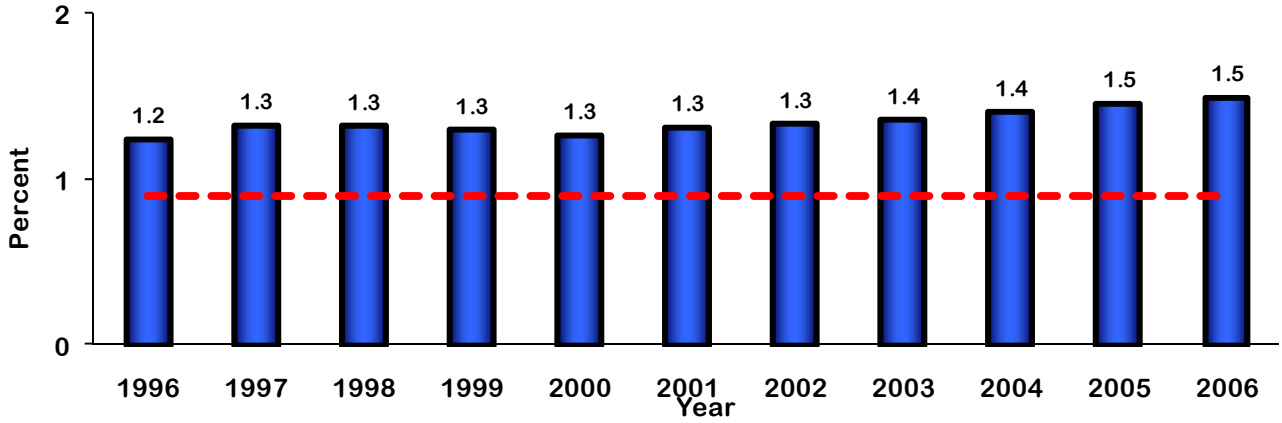
VERY LOW BIRTH WEIGHT

There was not a population group that met the *Healthy People 2010* objective of reducing the percent of very low birth weight births (weighing less than 1,500 grams) to 0.9% or less. The percent of infants born weighing less than 1,500 grams remained constant between 1997 and 2002. The percent increased 0.1% in 2003 and in 2005.

The percent of infants born weighing less than 1,500 grams was similar among Whites and Hispanics. However, the percent of Blacks who were born very low birth weight was approximately 2.5 times that of Whites and Hispanics. The percent of infants born weighing less than 1,500 grams increased among all race/ethnicity groups between 1996 and 2006, with the largest increase evidenced among Whites (30.0% change).

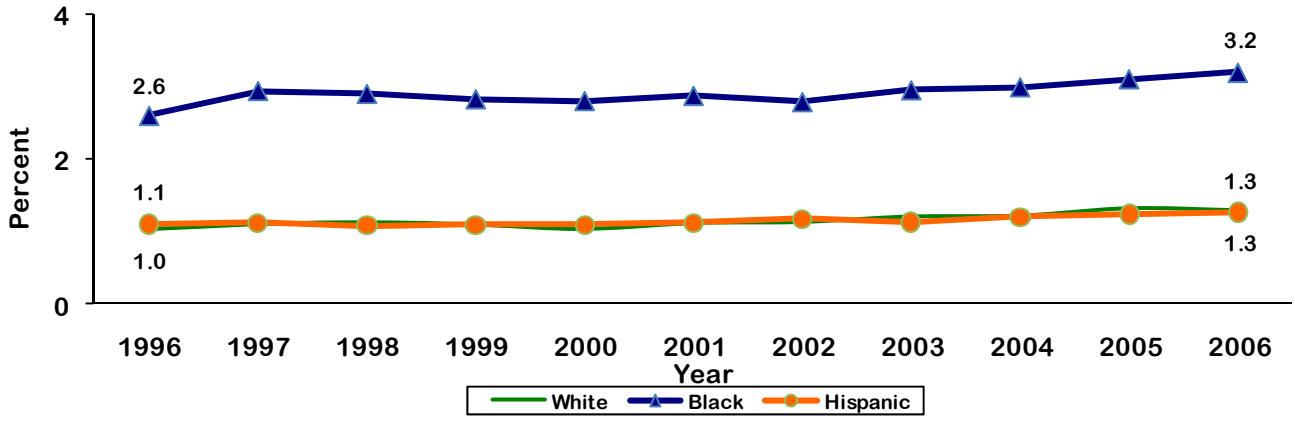
The percent of infants born very low birth weight ranged from a high of 1.9% for mothers 10 to 14 years old and mothers aged 35 and older, to a low of 1.3% for mothers 20 to 24 years old. There was a negative association between maternal education and the percent of infants born weighing less than 1,500 grams among White infants only. The percent of infants born weighing less than 1,500 grams was similar across strata of maternal education among Black and Hispanic infants. Infants born to mothers who were Black and had more than a high school degree were nearly three times as likely to be born very low birth weight than infants who were born to Hispanic mothers who had less than a high school degree.

Figure 3-28. Percent of Infants Born Weighing Less than 1,500 Grams by Year, Texas, 1996-2006



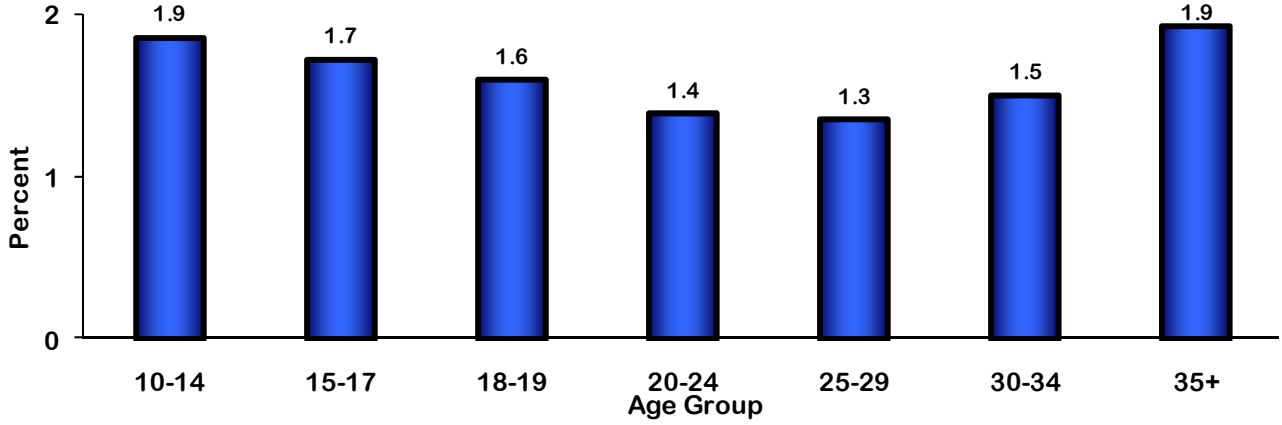
Source: Texas Vital Statistics Natality File, 1996-2006, Texas Department of State Health Services.
Dotted line indicates the *Healthy People 2010* goal.

Figure 3-29. Percent of Infants Born Weighing Less than 1,500 Grams by Race/Ethnicity by Year, 1996-2005



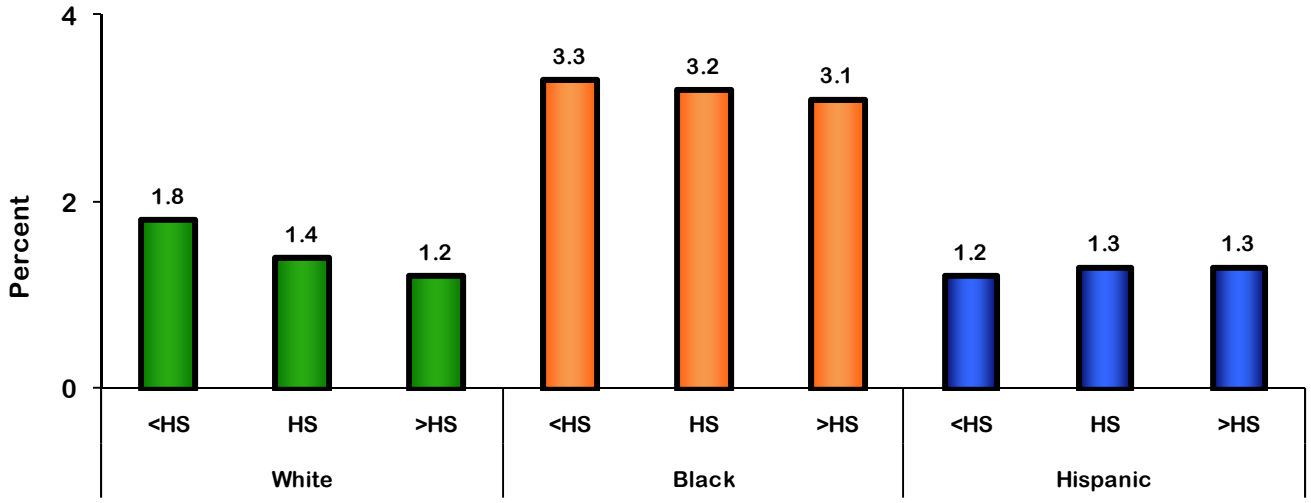
Source: Texas Vital Statistics Natality File, 1996-2006, Texas Department of State Health Services.

Figure 3-30. Percent of Infants Born Weighing Less than 1,500 Grams by Maternal Age, Texas, 2006



Source: Texas Vital Statistics Natality File, 2006, Texas Department of State Health Services.

Figure 3-31. Percent of Infants Born Weighing Less than 1,500 Grams by Race/Ethnicity and Maternal Education, Texas, 2006



Source: Texas Vital Statistics Natality File, 2006, Texas Department of State Health Services.

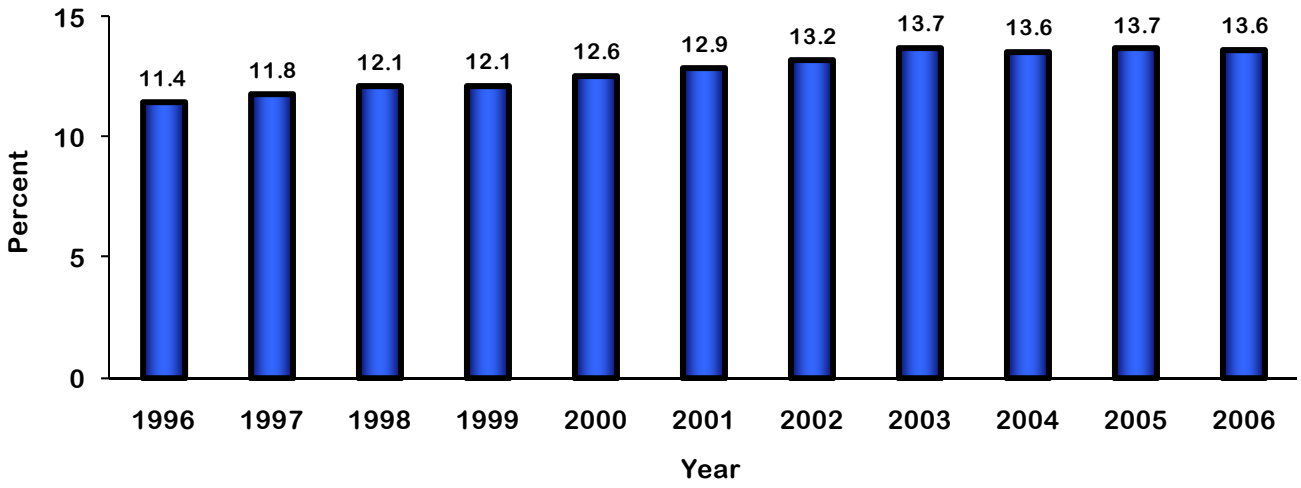
PRETERM BIRTH

There was not a population group that met the *Healthy People 2010* objective of 7.6%. The rate of premature births among Black infants (15.8%) was more than double the *Healthy People 2010* objective. While a greater percent of Black infants are delivered premature, the gap in the rates of premature births between White and Black infants has decreased between 1996 and 2006.

As with other birth outcomes, the greatest rate of premature birth was among mothers between the ages of 10 and 14 years old. The rate of premature births decreased with age through age 34 years. Women 35 years of age and older had premature birth rates similar to women 18 to 19 years of age, but greater than women who delivered in their twenties or early thirties.

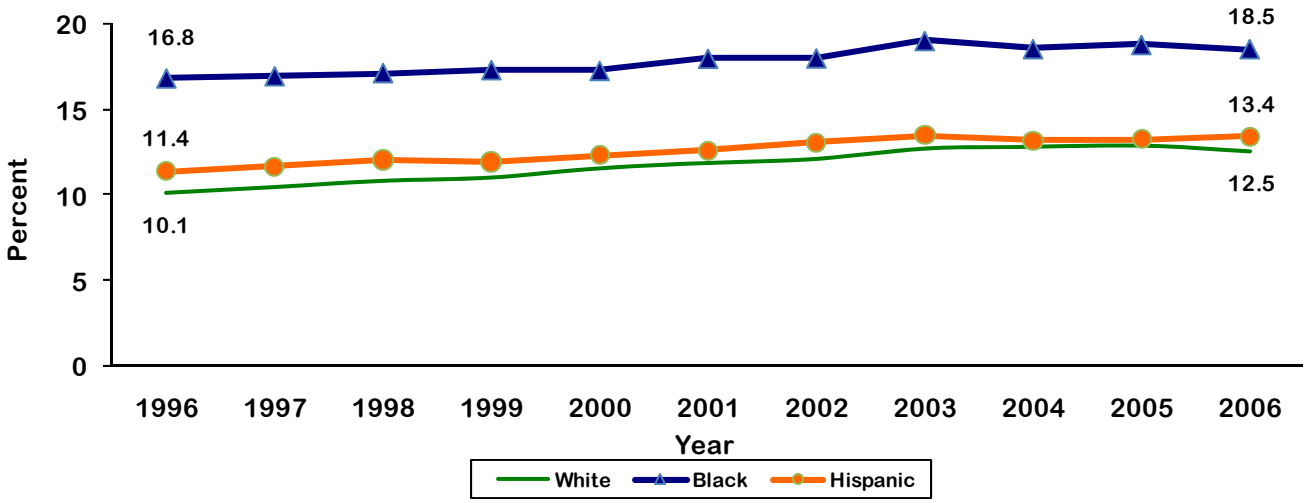
A strong association was not identified between maternal education and preterm birth among any racial/ethnic group. White and Black infants whose mothers had less than a high school diploma had greater rates of preterm birth than those whose mothers reported having at least a high school diploma. Between 1996 and 2003, there was a 17.4% increase in the percent of premature births.

Figure 3-32. Percent of Infants Born Preterm
by Year, Texas, 1996-2006



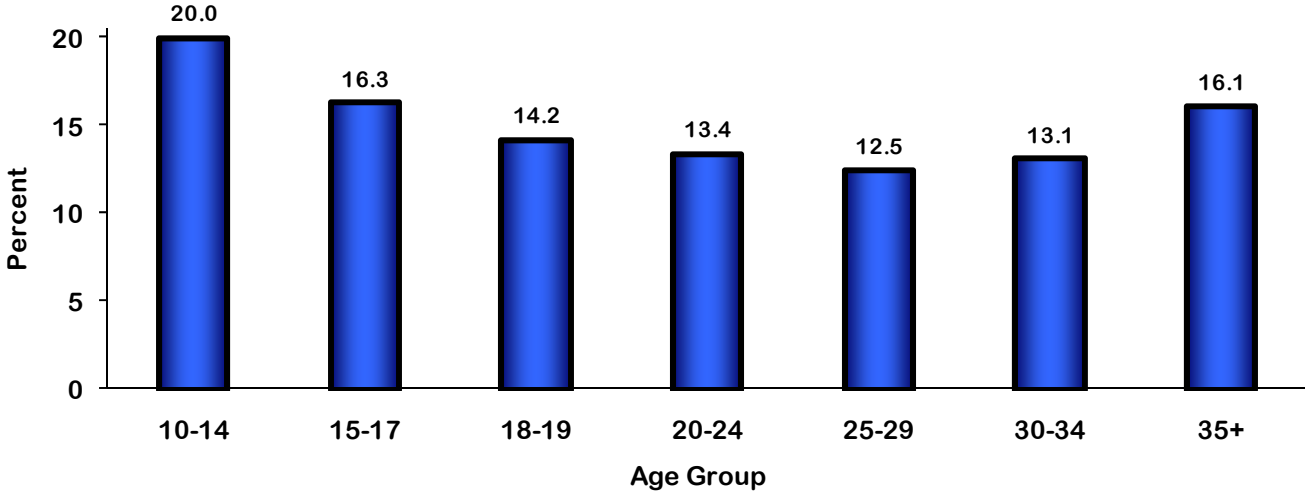
Preterm: <37 completed weeks gestation. The primary measure used to determine the gestational age of the newborn is the interval between the first day of mother's last normal menstrual period (LMP) and the date of birth. If LMP is less than 17 completed weeks, greater than 47 completed weeks, not stated, or implausible with birth weight, then the obstetric estimate of completed weeks gestation is used. Gestational age based on LMP and obstetric estimate are comparable with data based on LMP and obstetric estimate only.
Source: Texas Vital Statistics Natality File, 1996-2006, Texas Department of State Health Services.

Figure 3-33. Percent of Infants Born Preterm
by Race/Ethnicity by Year, Texas, 1996-2006



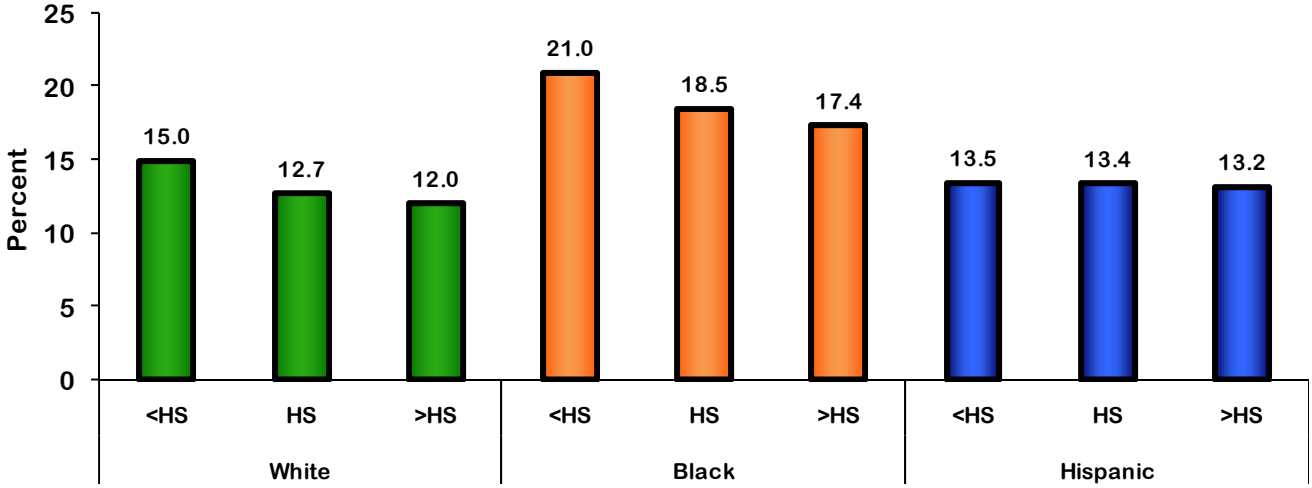
Preterm: <37 completed weeks gestation. The primary measure used to determine the gestational age of the newborn is the interval between the first day of mother's last normal menstrual period (LMP) and the date of birth. If LMP is less than 17 completed weeks, greater than 47 completed weeks, not stated, or implausible with birth weight, then the obstetric estimate of completed weeks gestation is used. Gestational age based on LMP and obstetric estimate are comparable with data based on LMP and obstetric estimate only.
Source: Texas Vital Statistics Natality File, 1996-2006, Texas Department of State Health Services.

Figure 3-34. Percent of Infants Born Preterm
by Maternal Age, Texas, 2006



Preterm: <37 completed weeks gestation. The primary measure used to determine the gestational age of the newborn is the interval between the first day of mother's last normal menstrual period (LMP) and the date of birth. If LMP is less than 17 completed weeks, greater than 47 completed weeks, not stated, or implausible with birth weight, then the obstetric estimate of completed weeks gestation is used. Gestational age based on LMP and obstetric estimate are comparable with data based on LMP and obstetric estimate only.
Source: Texas Vital Statistics Natality File, 2006, Texas Department of State Health Services.

Figure 3-35. Percent of Infants Born Preterm
by Race/Ethnicity and Maternal Education, Texas, 2006

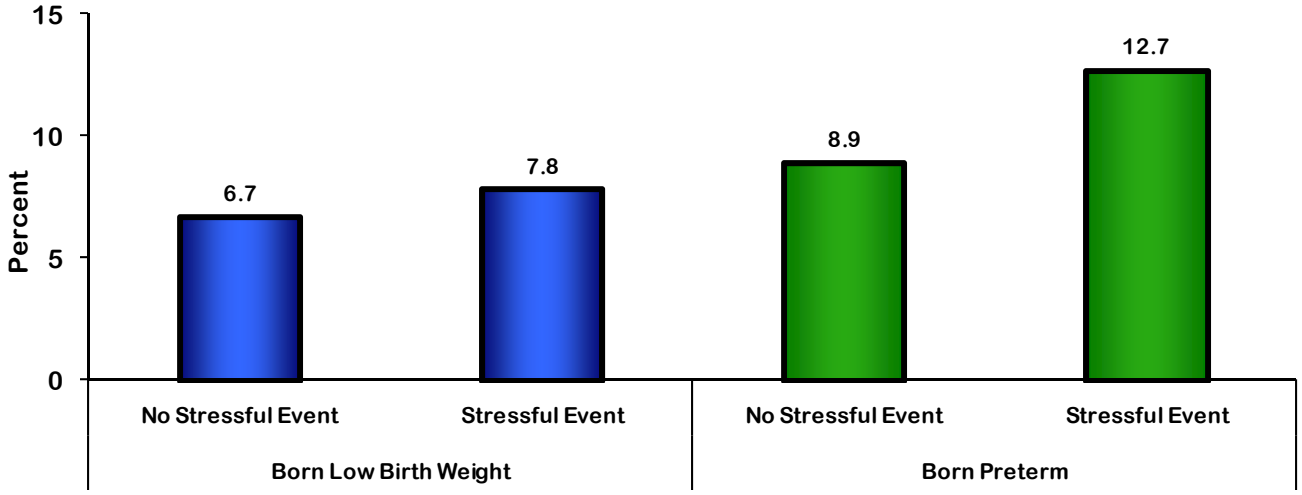


Preterm: <37 completed weeks gestation. The primary measure used to determine the gestational age of the newborn is the interval between the first day of mother's last normal menstrual period (LMP) and the date of birth. If LMP is less than 17 completed weeks, greater than 47 completed weeks, not stated, or implausible with birth weight, then the obstetric estimate of completed weeks gestation is used. Gestational age based on LMP and obstetric estimate are comparable with data based on LMP and obstetric estimate only.
Source: Texas Vital Statistics Natality File, 2006, Texas Department of State Health Services.

STRESS AND BIRTH OUTCOMES

Nearly three-quarters (72.3%) of all Texas women who gave birth in 2007 reported experiencing at least one stressful event during their pregnancy. The presence of a stressful event was associated with a 1.0% increase in the percent of infants born low

Figure 3-36. Percent of Infants Born Low Birth Weight and Born Preterm by Stressful Event, Texas, 2007

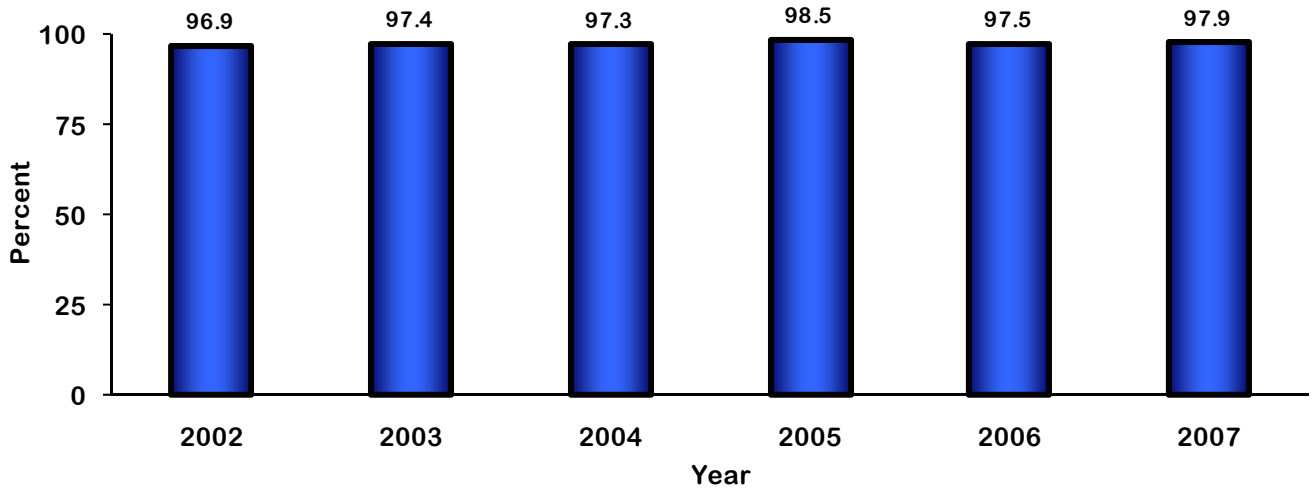


Preterm: <37 completed weeks gestation. The primary measure used to determine the gestational age of the newborn is the interval between the first day of mother's last normal menstrual period (LMP) and the date of birth. If LMP is less than 17 completed weeks, greater than 47 completed weeks, not stated, or implausible with birth weight, then the obstetric estimate of completed weeks gestation is used. Gestational age based on LMP and obstetric estimate are comparable with data based on LMP and obstetric estimate only.
Source: Texas Department of State Health Services, Pregnancy Risk Assessment Monitoring System, 2007.

WELL-INFANT EXAMINATIONS

Between 2002 and 2006, more than 95% of all infants received well-infant examinations, regardless of their race/ethnicity and maternal age. The percent of Texas infants that did not receive a well-baby checkup ranged from a high of 3.4% in 2002 to a low of 1.5% in 2005.

Figure 3-37. Percent of Infants Receiving Well-Infant Examinations, by Year, Texas, 2002-2007

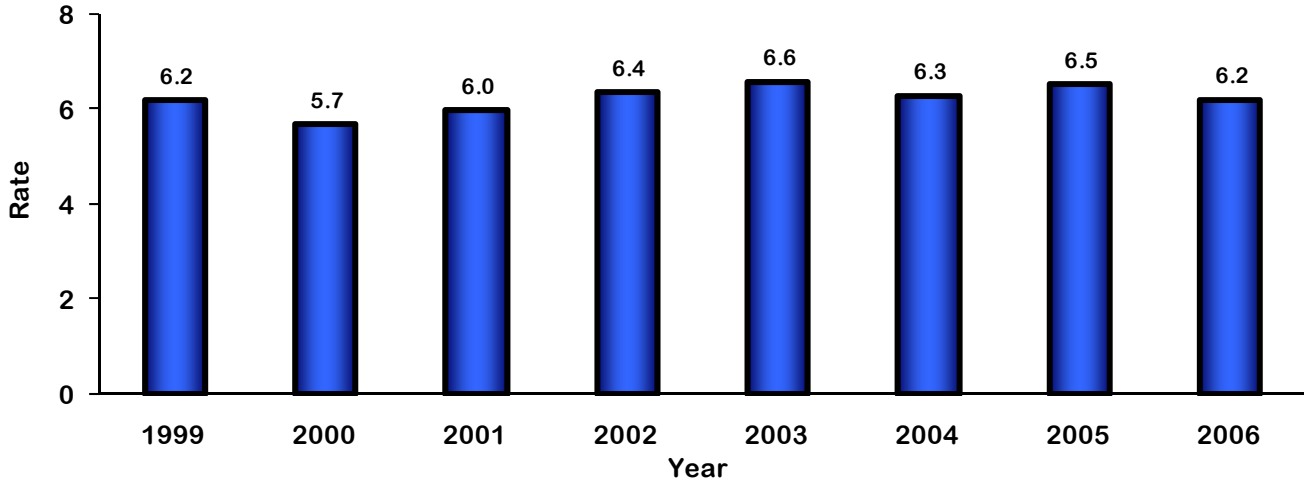


Source: Texas Department of State Health Services, Pregnancy Risk Assessment Monitoring System, 2002-2007.

INFANT MORTALITY

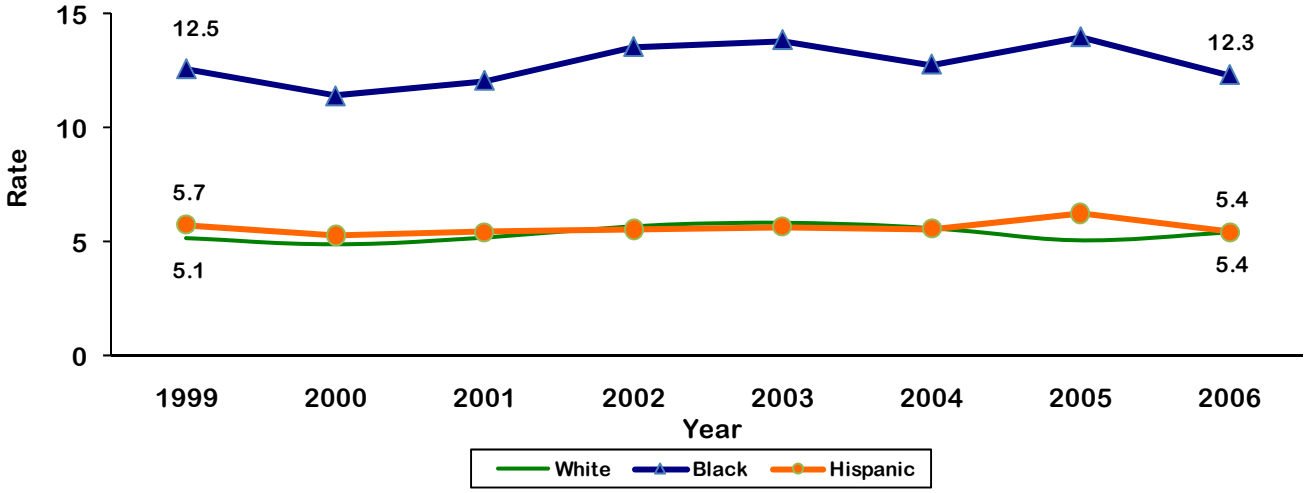
The infant mortality in Texas remained relatively consistent between 1999 and 2006, with a high of 6.6 deaths per 1,000 live births in 2003 to a low of 5.7 deaths per 1,000 live births in 2000. Racial/ethnic disparities in infant mortality rates in Texas are significant, with the rate among Black infants more than double that of White infants since 1998. In 2005, the infant mortality rate among Black infants was more than three times the *Healthy People 2010* objective of 4.5 infant deaths per 1,000 live births.

Figure 3-38. Infant Mortality Rate per 1,000 Live Births by Year, Texas, 1999-2006



Source: Texas Vital Statistics Natality and Mortality Files, 1999-2006, Texas Department of State Health Services.

Figure 3-39. Infant Mortality Rate per 1,000 Live Births
by Race/Ethnicity by Year, Texas, 1999-2006

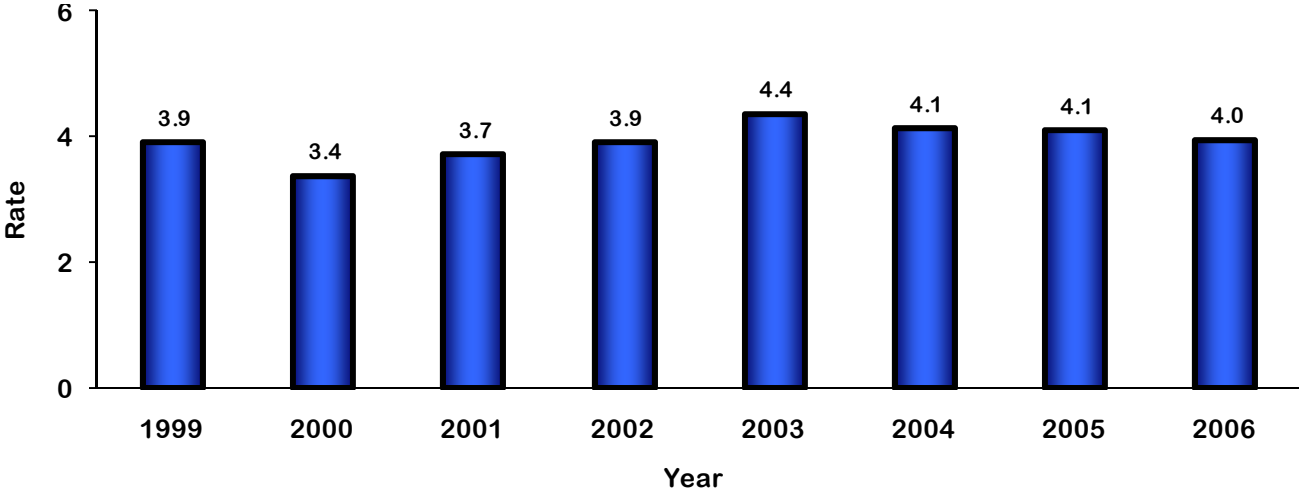


Source: Texas Vital Statistics Natality and Mortality Files, 1999-2006, Texas Department of State Health Services.

NEONATAL INFANT MORTALITY

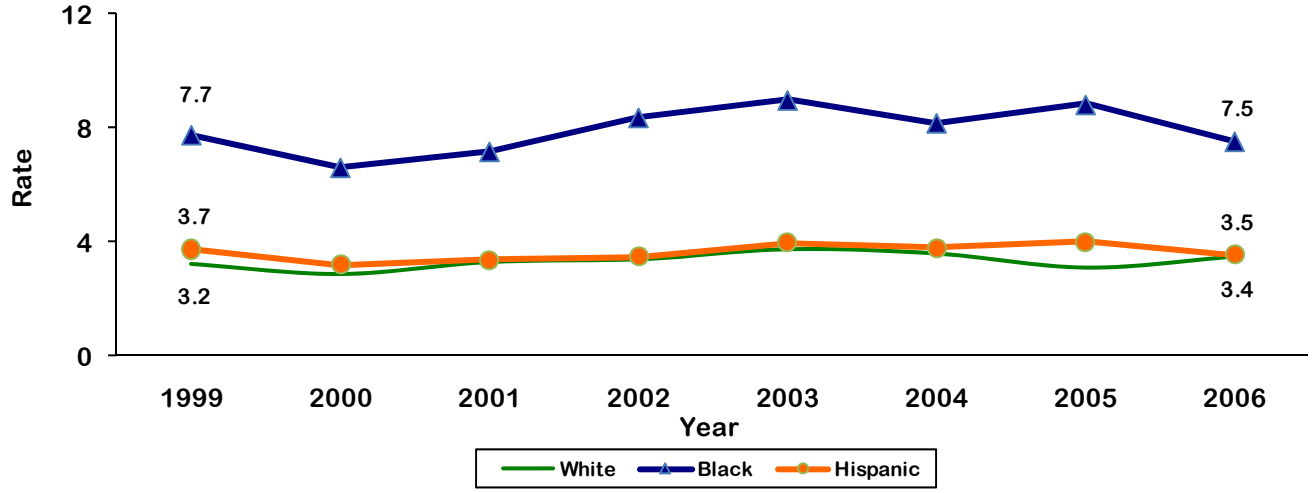
Neonatal mortality (deaths to infants less than 28 days of age) accounts for approximately 63.0% of the overall infant mortality rate in Texas. There was not a population group that met the *Healthy People 2010* objective of 2.9 deaths to infants less than 28 days of age per 1,000 live births. Racial/ethnic disparities in neonatal infant mortality rate are similar to the disparities found in overall infant mortality.

Figure 3-40. Neonatal Infant Mortality Rate per 1,000 Live Births
by Year, Texas, 1999-2006



Source: Texas Vital Statistics Natality and Mortality Files, 1999-2006, Texas Department of State Health Services.

Figure 3-41. Neonatal Infant Mortality Rate per 1,000 Live Births by Race/Ethnicity by Year, Texas, 1999-2006

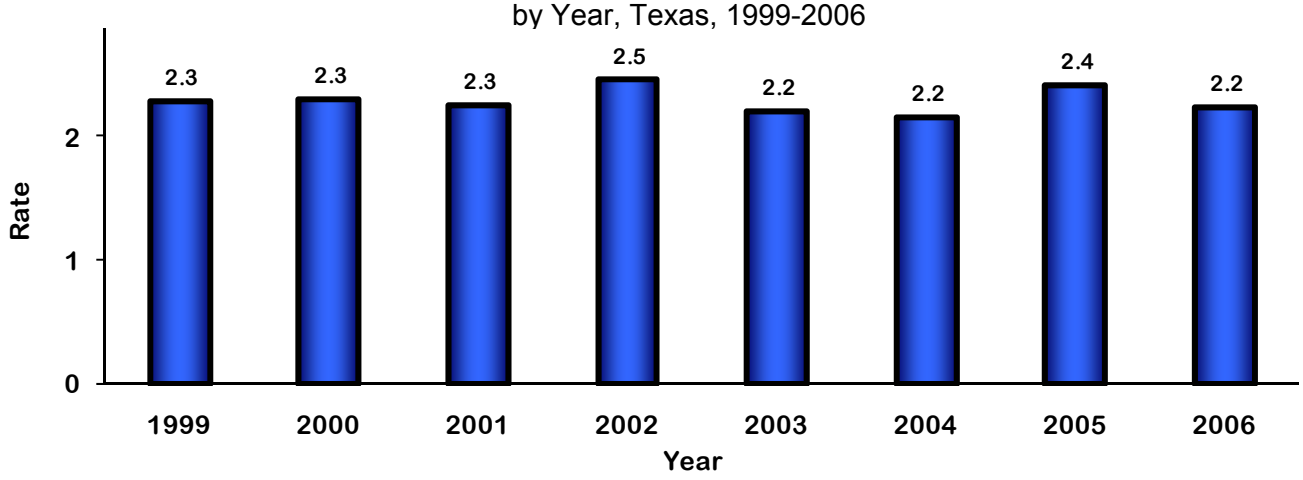


Source: Texas Vital Statistics Natality and Mortality Files, 1999-2006, Texas Department of State Health Services.

POSTNEONATAL INFANT MORTALITY

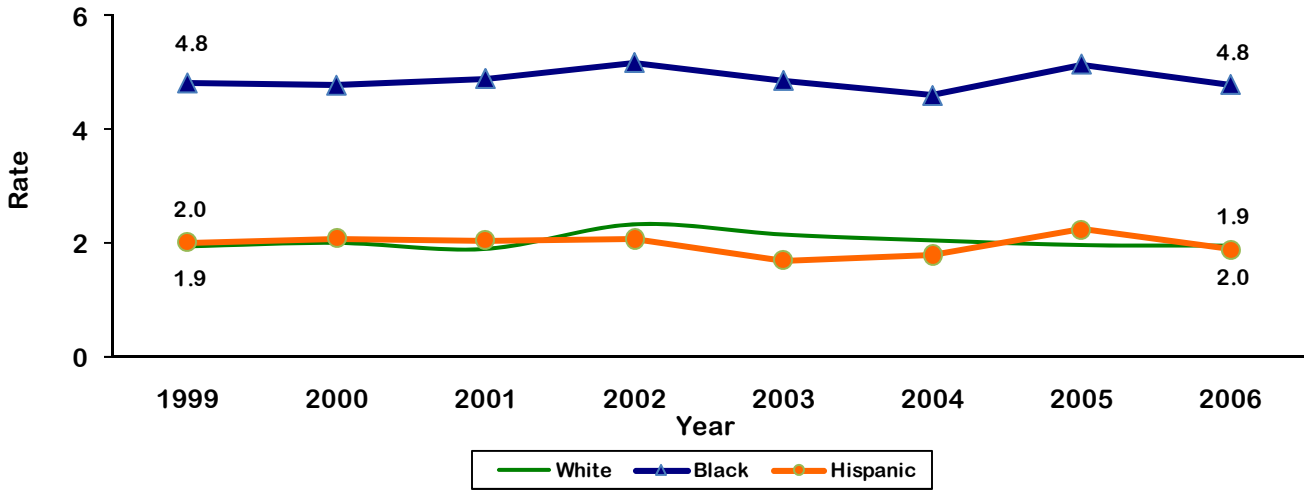
Postneonatal mortality (deaths to infants 28 days of age through 11 months) accounts for approximately 37.0% of the overall infant mortality rate in Texas. There was not a population group that met the *Healthy People 2010* objective of 1.2 deaths to infants 28 days of age through 11 months per 1,000 live births. Racial/ethnic disparities in postneonatal infant mortality rate are similar to the disparities found in overall infant mortality.

Figure 3-42. Postneonatal Infant Mortality Rate per 1,000 Live Births by Year, Texas, 1999-2006



Source: Texas Vital Statistics Natality and Mortality Files, 1999-2006, Texas Department of State Health Services.

Figure 3-43. Postneonatal Infant Mortality Rate per 1,000 Live Births by Race/Ethnicity by Year, Texas, 1999-2006

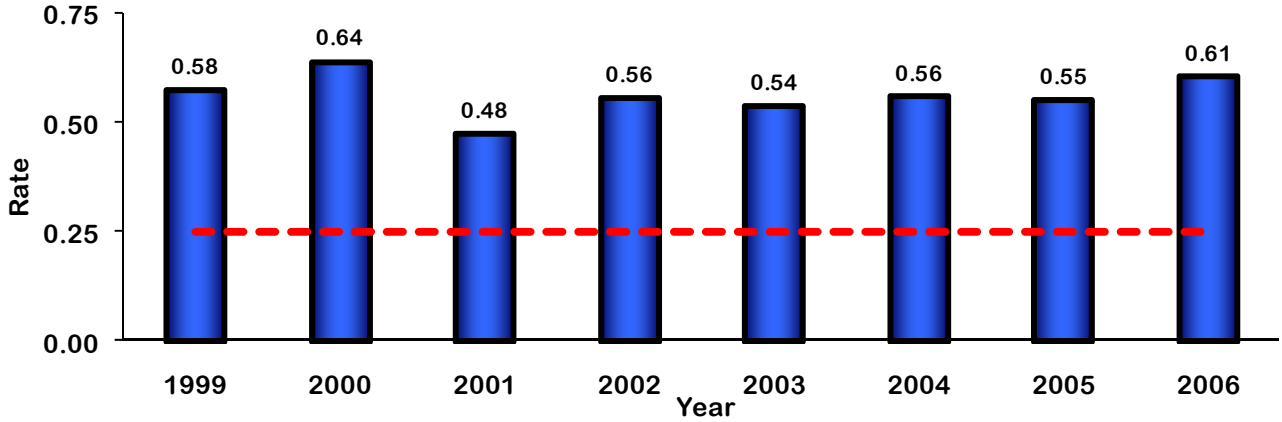


Source: Texas Vital Statistics Natality and Mortality Files, 1999-2006, Texas Department of State Health Services.

SUDDEN INFANT DEATH SYNDROME

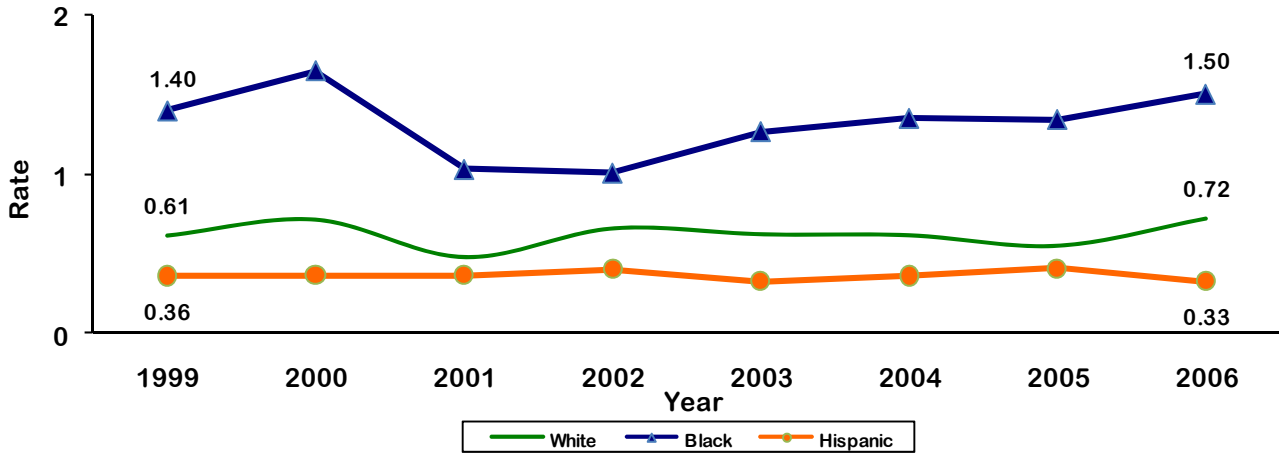
The Sudden Infant Death Syndrome (SIDS) death rate has remained relatively constant over the past eight years in Texas. There was not a population group that met the *Healthy People 2010* objective of 0.25 SIDS deaths per 1,000 live births. SIDS rates among Black infants were consistently greater than 1.0 SIDS deaths per 1,000 live births. In 2005, the rate of SIDS among Black infants was nearly three times that of White infants. As is typical with SIDS, in 2006, 61.0% of all SIDS cases were male.

Figure 3-44. Sudden Infant Death Syndrome Rate Per 1,000 Live Births by Year, Texas, 1999-2006



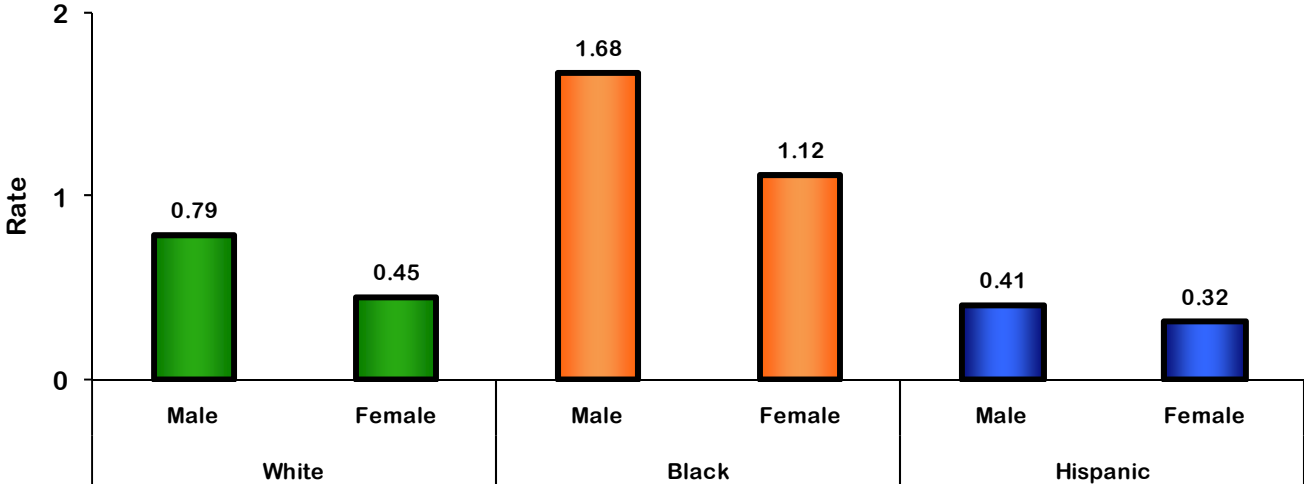
Source: Texas Vital Statistics Natality and Mortality Files, 1999-2006, Texas Department of State Health Services. Dotted line indicates the *Healthy People 2010* goal.

Figure 3-45. Sudden Infant Death Syndrome Rate Per 1,000 Live Births by Race/Ethnicity by Year, Texas, 1999-2006



Source: Texas Vital Statistics Natality and Mortality Files, 1999-2006, Texas Department of State Health Services.

Figure 3-46. Sudden Infant Death Syndrome Rate Per 1,000 Live Births by Race/Ethnicity and Gender, Texas, 2004-2006



Source: Texas Vital Statistics Natality and Mortality Files, 2004-2006, Texas Department of State Health Services.

LEADING CAUSES OF DEATH AMONG INFANTS

There were 7,389 deaths (633.5 deaths per 100,000 population) to infants in Texas from 2004-2006. The three leading causes of deaths for infants in Texas were congenital malformations, deformations and chromosomal abnormalities; disorders related to short gestation and low birth weight, not elsewhere classified; and SIDS. These were the same leading causes for the U.S. during this time period. In Texas, these deaths accounted for 44.1% of all infant deaths.

Table 3-2. Texas Resident Infant Deaths by Cause of Death, 2004-2006

Cause of Death	ICD-10 Code	Number	Rate
Total, All causes of death	-	7,389	633.5
Congenital malformations, deformations and chromosomal abnormalities	Q00-Q99	1,605	137.6
Total, Certain conditions originating in the perinatal period	P00-P96	3,418	293.1
Newborn affected by maternal complications of pregnancy	P01	411	35.2
Newborn affected by complications of placenta, cord and membranes	P02	294	25.2
Disorders related to short gestation and low birth weight, not elsewhere classified	P07	986	84.5
Intrauterine hypoxia and birth asphyxia	P20-P21	94	8.1
Respiratory distress of newborn	P22	191	16.4
Bacterial sepsis of newborn	P36	241	20.7
Neonatal hemorrhage	P50-P52, P54	164	14.1
Other conditions originating in the perinatal period	Residual of P00-P96	1,037	88.9
Sudden infant death syndrome	R95	669	57.4
External causes of mortality	V01-Y89	375	32.2
Accidents (unintentional injuries)	V01-X59	280	24.0
Assault (homicide)	X85-Y09, Y871	82	7.0
Other external causes of mortality	Residual of V01-Y89	13	1.1
All other causes (residual)	-	1,322	113.4

Rate: number of infant deaths per 100,000 live births.

Source: Texas Vital Statistics Natality and Mortality Files, 2004-2006, Texas Department of State Health Services.

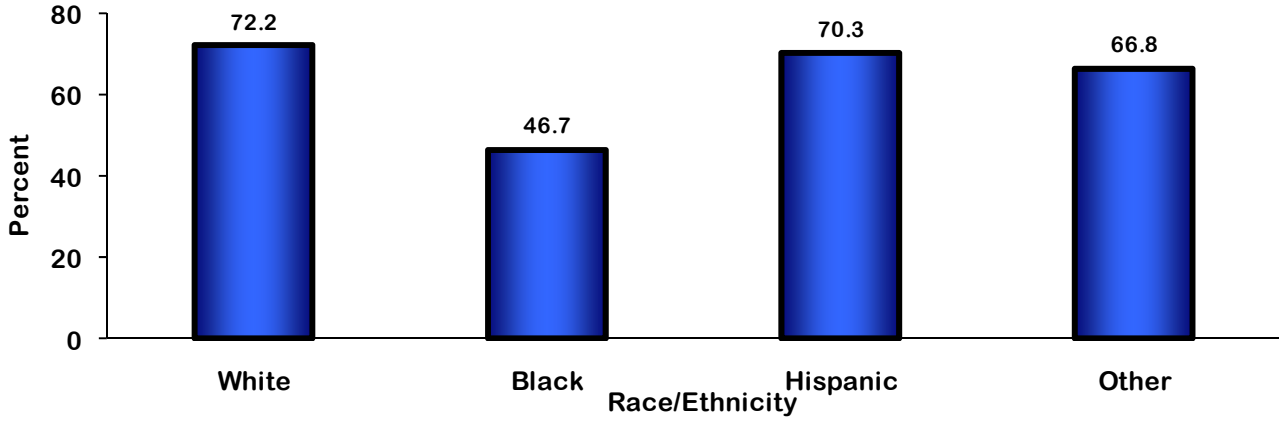
SAFE SLEEP

BACK TO SLEEP

The majority of mothers (68.1%) reported that they usually placed their infants on their back to sleep or nap. The percent of Black mothers (46.7%) who reported placing their

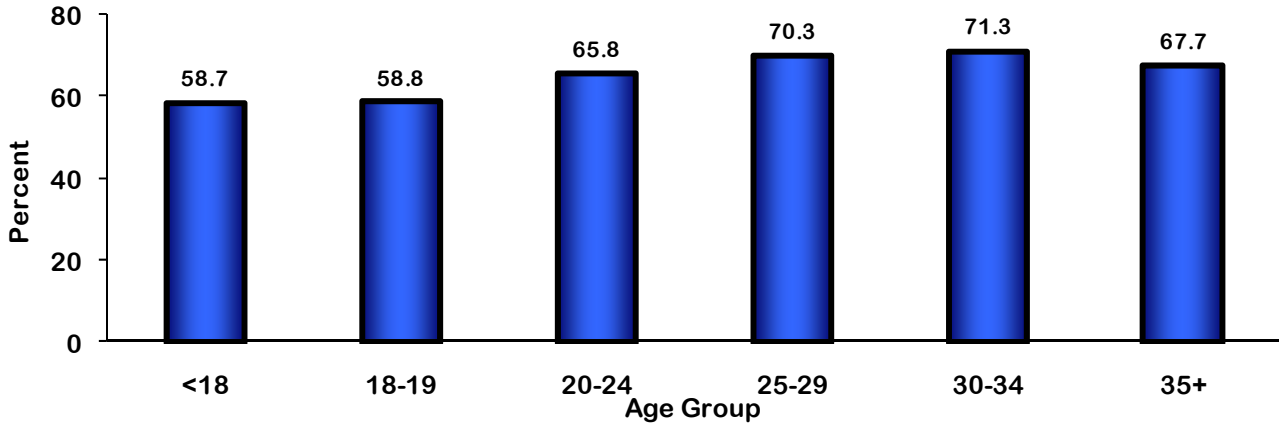
infants on their back to sleep or nap was 35.3% and 33.6% lower than White and Hispanic mothers, respectively. In general, an increase in the mother's age paralleled an increase in the percentage of mothers who reported that they placed their infants on their back to sleep or nap. Women aged 30 to 34 had the highest percentage (71.3%), while mothers younger than 18 had the lowest percentage (58.7%).

Figure 3-47. Percent of Mothers Who Reported They Usually Lay Their Baby on Their Back to Sleep, by Race/Ethnicity, Texas, 2009



Source: Texas Infant Sleep Survey, 2009, Texas Department of State Health Services.

Figure 3-48. Percent of Mothers Who Reported They Usually Lay Their Baby on Their Back to Sleep, by Mother's Age, Texas, 2009

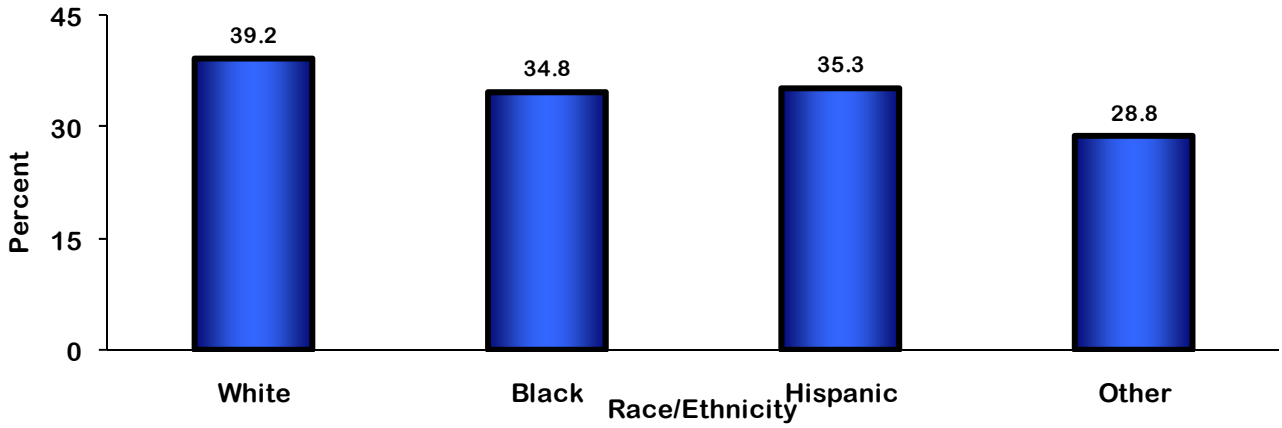


Source: Texas Infant Sleep Survey, 2009, Texas Department of State Health Services.

BABY SHARING BED WITH ANOTHER PERSON

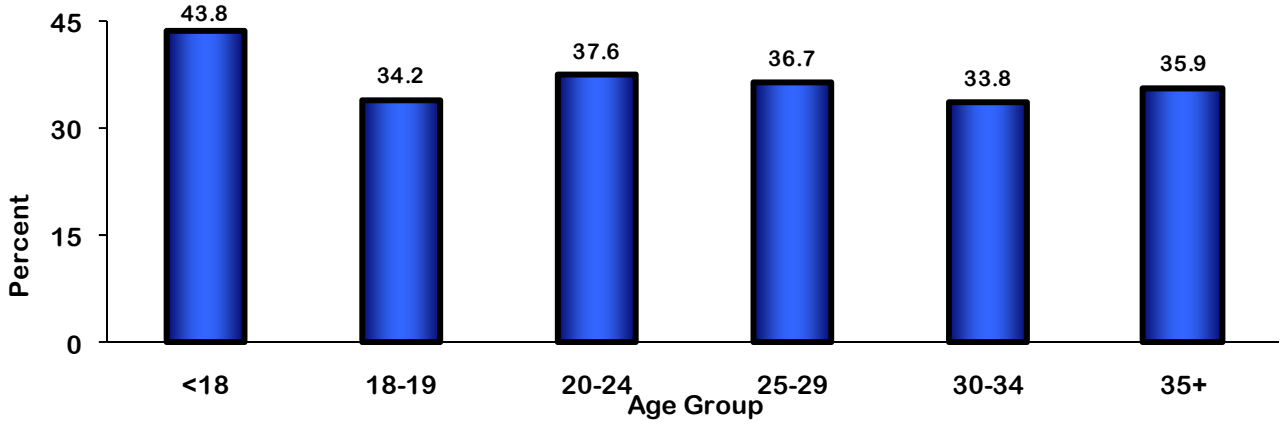
The percent of mothers who reported that a doctor has talked to them about their baby sleeping in a bed with another person was 36.2%. In general, there was not a major difference in the percent of mothers who reported that a doctor had talked to them about their baby sleeping in a bed with another person by race/ethnicity or mother's age.

Figure 3-49. Percent of Mothers Who Reported Their Doctor Talked to Them about Baby Co-Sleeping, by Race/Ethnicity, Texas, 2009



Source: Texas Infant Sleep Survey, 2009, Texas Department of State Health Services.

Figure 3-50. Percent of Mothers Who Reported Their Doctor Talked to Them about Baby Co-Sleeping, by Mother's Age, Texas, 2009

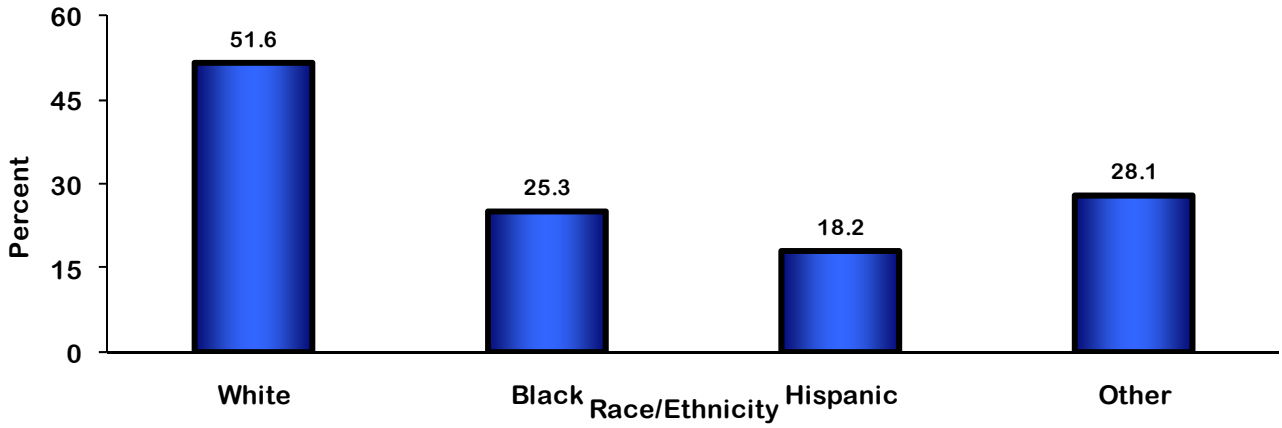


Source: Texas Infant Sleep Survey, 2009, Texas Department of State Health Services.

BACK TO SLEEP CAMPAIGN

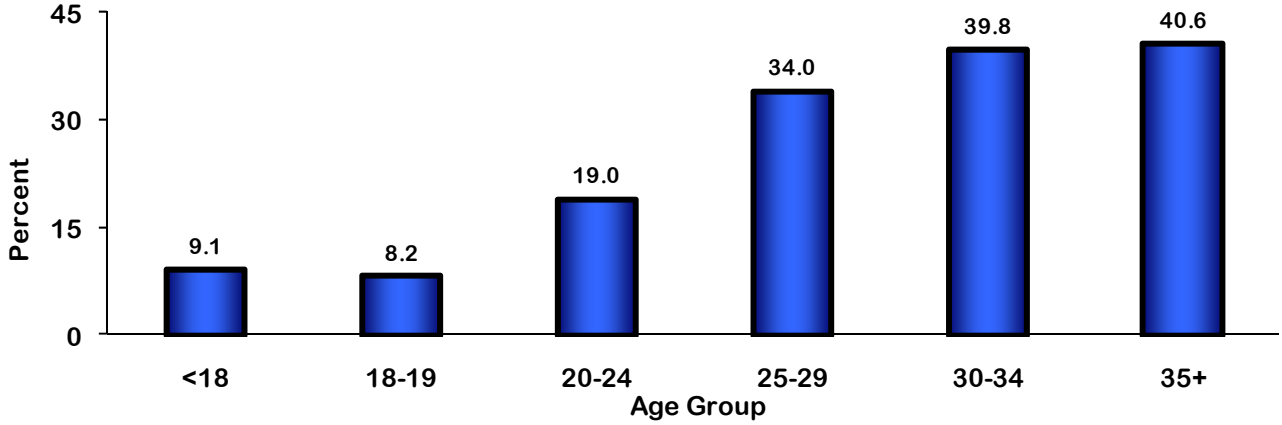
The percent of Texas mothers who reported they had heard or seen messages from the nationally-sponsored "Back to Sleep" campaign was 30.5%. The percent of Hispanic mothers (18.2%) who reported they had heard or seen the "Back to Sleep" campaign was 64.7% and 28.1% lower than White and Black mothers, respectively. In general, an increase in the mother's age paralleled an increase in the percentage of mothers who reported they had heard or seen the "Back to Sleep" campaign increased. Women aged 30 to 34 had the highest percentage (40.6%), while mothers 18 to 19 years old had the lowest percentage (8.2%).

Figure 3-51. Percent of Mothers Who Reported They Had Heard or Seen the "Back to Sleep" Campaign, by Race/Ethnicity, Texas, 2009



Source: Texas Infant Sleep Survey, 2009, Texas Department of State Health Services.

Figure 3-52. Percent of Mothers Who Reported They Had Heard or Seen the "Back to Sleep" Campaign, by Mother's Age, Texas, 2009



Source: Texas Infant Sleep Survey, 2009, Texas Department of State Health Services.

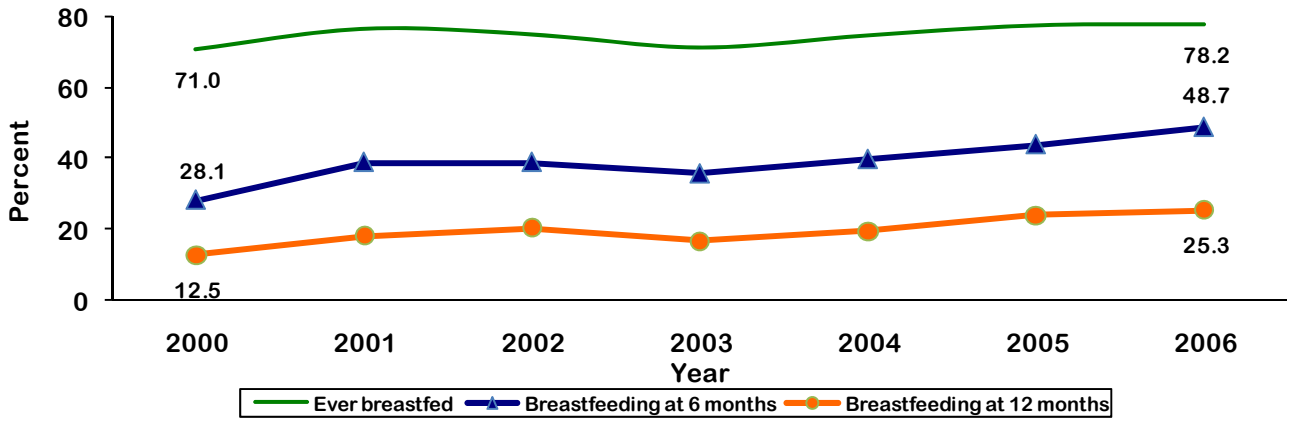
MOTHERS

BREASTFEEDING

ANY BREASTFEEDING

The *Healthy People 2010* objectives for breastfeeding in early postpartum period, at 6 months, and 12 months are 75%, 50%, and 25%, respectively. Texas exceeded the benchmark for breastfeeding in the early postpartum period, but fell short of the goal breastfeeding at 6 months and at 12 months. Texas ranked 17th highest nationally for the percentage of infants breastfeeding in the early postpartum period, 20th highest for the percentage of infants breasting at 6 months and 16th highest for the percentage of infants breastfeeding at 12 months of age.

Figure 3-53. Percent of Infants Ever Breastfed, Breastfeeding at 6 months, and Breastfeeding at 12 months by Year, Texas, 2000-2006

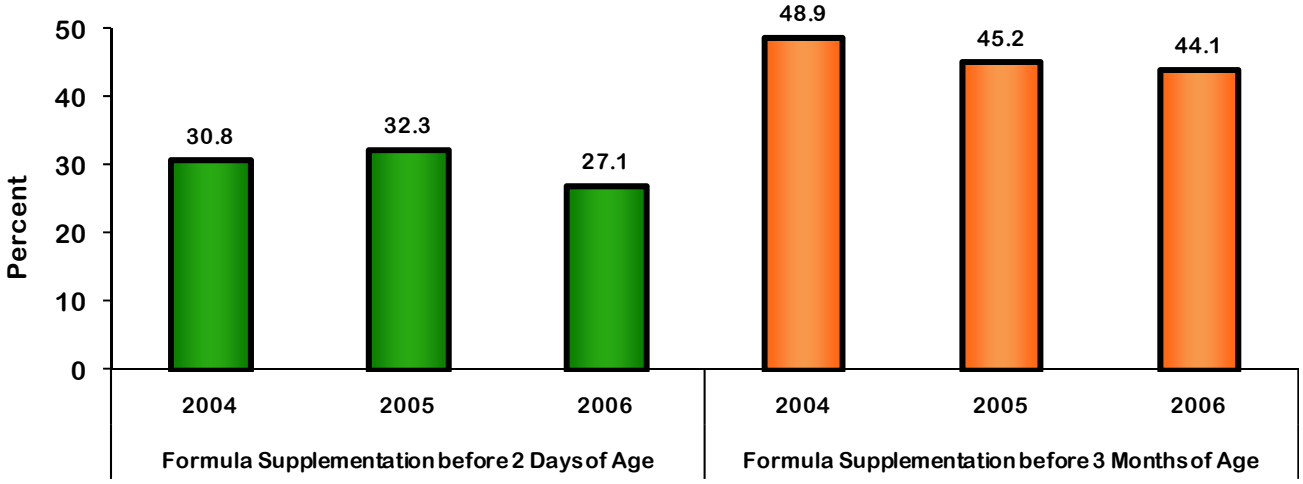


Source: CDC National Immunization Survey, 2000-2006.

FORMULA SUPPLEMENTATION

Texas met the *Healthy People 2010* objective for breastfeeding in the early postpartum period and has shown improvements in the rates of breastfeeding at 6 months and 12 months. Despite these accomplishments, Texas also has high rates of formula supplementation. Texas' rankings for formula supplementation before 2 days (42nd) and before 3 months (47th) are in the bottom 10 of all states.

Figure 3-54. Percent of Infants Receiving Formula Supplementation Before Two Days of Age and Three Months of Age, Texas 2004-2006

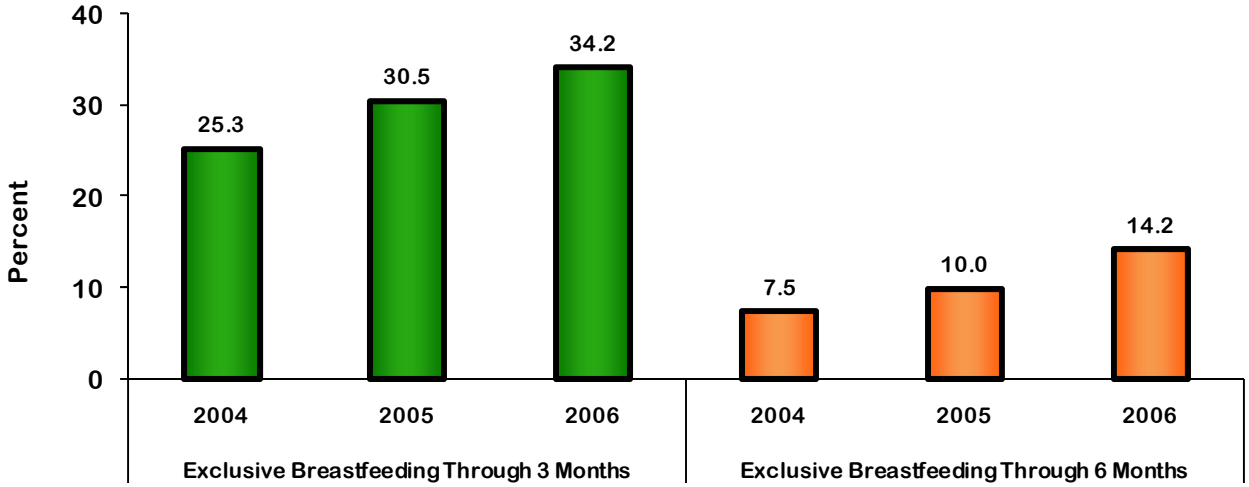


Source: CDC National Immunization Survey, 2004-2006.

EXCLUSIVE BREASTFEEDING

Given the elevated rates of formula supplementation, rates of exclusively breasting in Texas fall significantly below the *Healthy People 2010* objectives. *Healthy People 2010* objectives for exclusive breastfeeding through 3 and 6 months of age are 40.0% and 17.0%, respectively. In 2006, the percent of Texas infants exclusively breastfed through 3 months (34.2%) was 14.5% below the *Healthy People 2010* objective. Similarly, the percent of Texas infants exclusively breastfed through 6 months (14.2%) was 16.5% below the *Healthy People 2010* objective. Texas ranked 21st nationally for exclusive breastfeeding through 3 months and through 6 months of age.

Figure 3-55. Percent of Infants Exclusively Breastfed Through Three Months of Age and Through Six Months of Age, Texas, 2006



Source: CDC National Immunization Survey, 2004-2006.

REASONS MOTHERS STOPPED BREASTFEEDING

To increase duration and exclusively of breastfeeding, it is important to understand why mothers who initiate breastfeeding stop doing so and why some mothers never choose to breastfeed their infant. The data presented in Table 3-3 demonstrate the top three reasons given for not initiating breastfeeding and for ceasing to breastfeed.

Table 3-3. Breastfeeding Initiation and Continuation Barriers, 2007

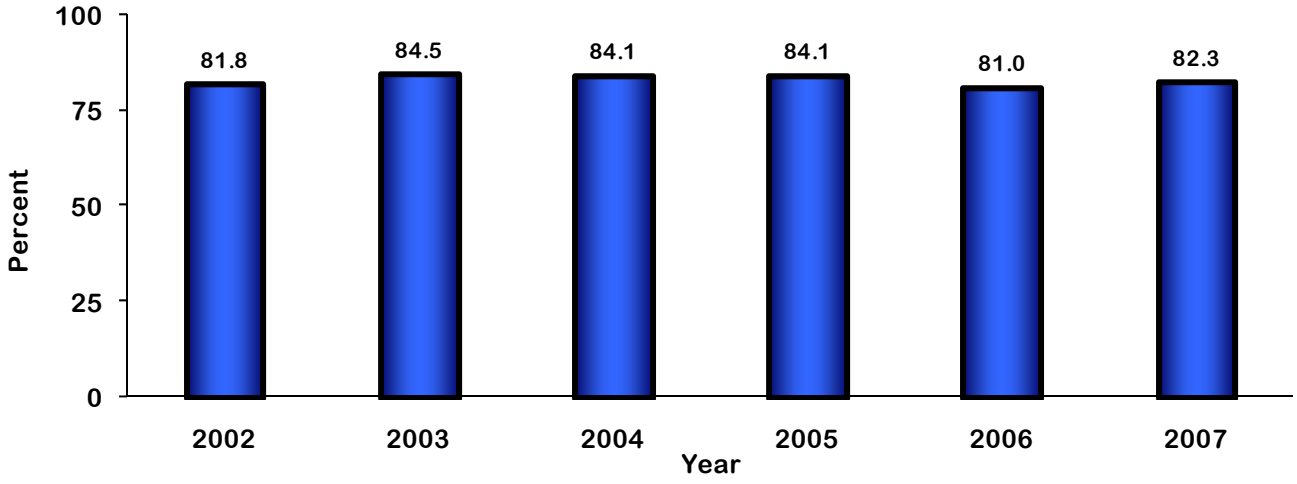
Breastfeeding Initiation Barriers	Breastfeeding Continuation Barriers
I didn't like breastfeeding	I thought I was not producing enough milk
I had other children to take care of	Breast milk alone did not satify my baby
I went back to work or school	My baby had difficulty nursing

Source: Texas Department of State Health Services, Pregnancy Risk Assessment Monitoring System, 2007.

MATERNAL POSTPARTUM EXAMINATION

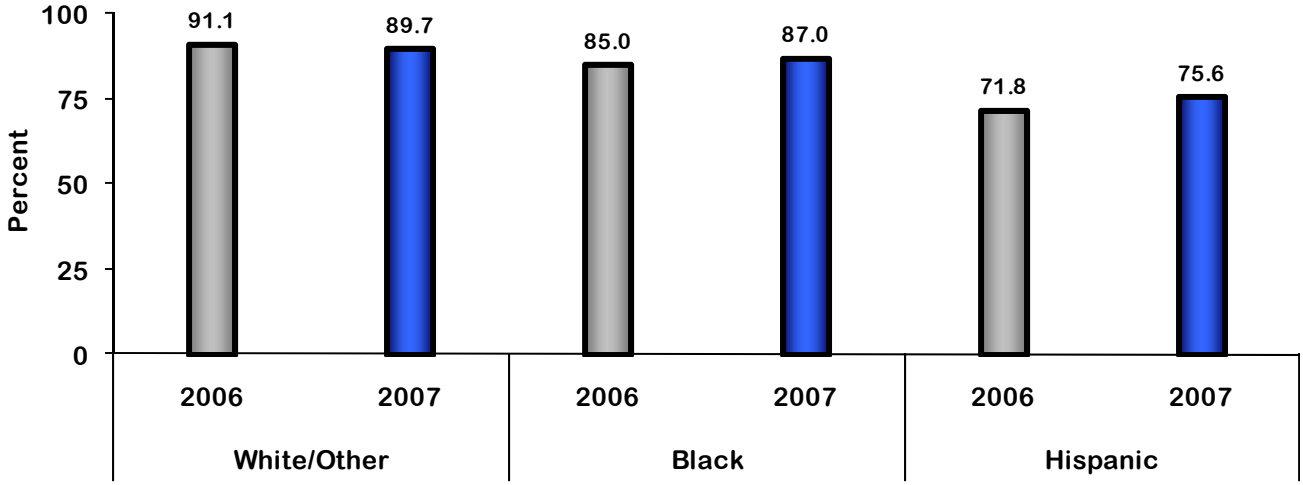
Between 2002 and 2007, approximately 15% to 20% of Texas women did not receive a postpartum checkup following their pregnancy. In 2007, Whites (89.7%) were more likely than Blacks (87.0%) and Hispanics (75.6%) to receive a postpartum checkup following their pregnancy.

3-56. Percent of Mothers Receiving Postpartum Examinations by Year, Texas, 2002-2007



Source: Texas Department of State Health Services, Pregnancy Risk Assessment Monitoring System, 2002-2007.

3-57. Percent of Mothers Receiving Postpartum Examinations by Race/Ethnicity and Year, Texas, 2006-2007



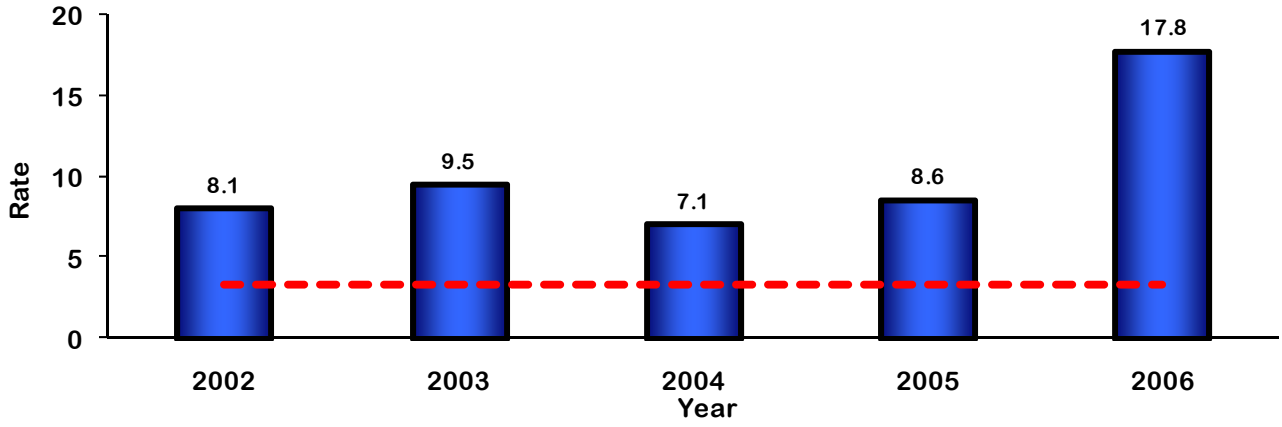
Source: Texas Department of State Health Services, Pregnancy Risk Assessment Monitoring System, 2006 and 2007.

MATERNAL MORTALITY

Maternal causes of death include pregnancies with an abortive or live outcome and include direct and indirect obstetric causes and complications. The World Health Organization defines maternal death as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (National Center for Health Statistics, 2009).

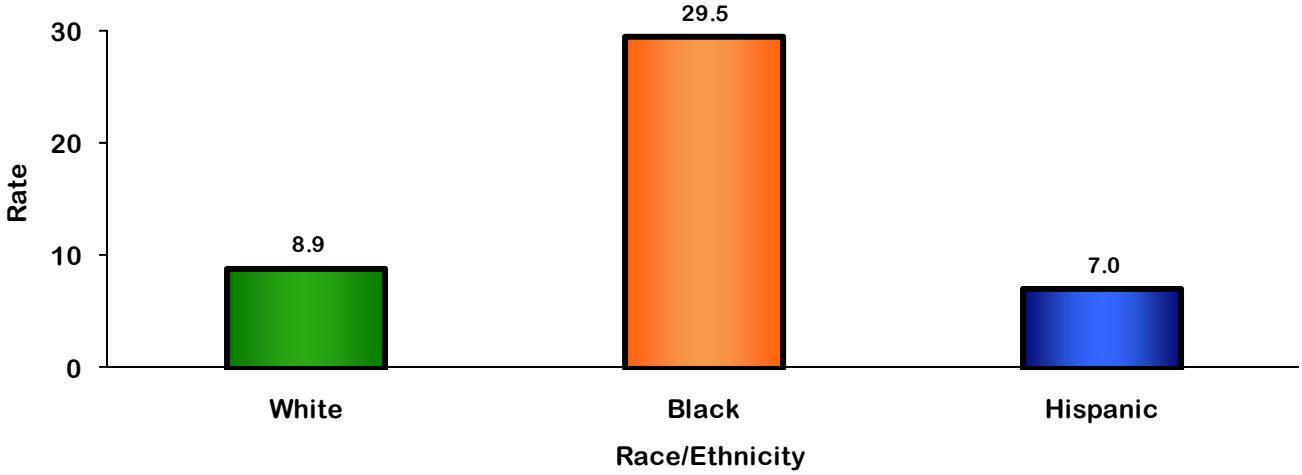
From 2002-2006, there were 197 maternal deaths to Texas residents (death rate of 10.3 deaths per 100,000 live births) based on International Classification of Diseases 10th Revision (ICD-10) codes A34, O00-O95, and O98-O99. These specific causes of death excludes deaths occurring more than 42 days after the termination of pregnancy and deaths of pregnant women due to external causes—unintentional injuries, homicides, and suicides. In 2006, the maternal mortality rate in Texas was 17.8 deaths per 100,000 live births, which was 33.8% higher than the national rate of 13.3 deaths per 100,000 live births. As shown in Figure 3-59, the maternal mortality rate for Black women was 3.3 and 4.2 times higher than the rate for Whites and Hispanics, respectively. Similarly, the maternal mortality rate for women 35 and older (29.5 deaths per 100,000 live births) was 3.8 times as high as the rate for women younger than 35 years old (7.9 deaths per 100,000 live births).

Figure 3-58. Rate of Maternal Deaths, by Year, Texas 2002-2006



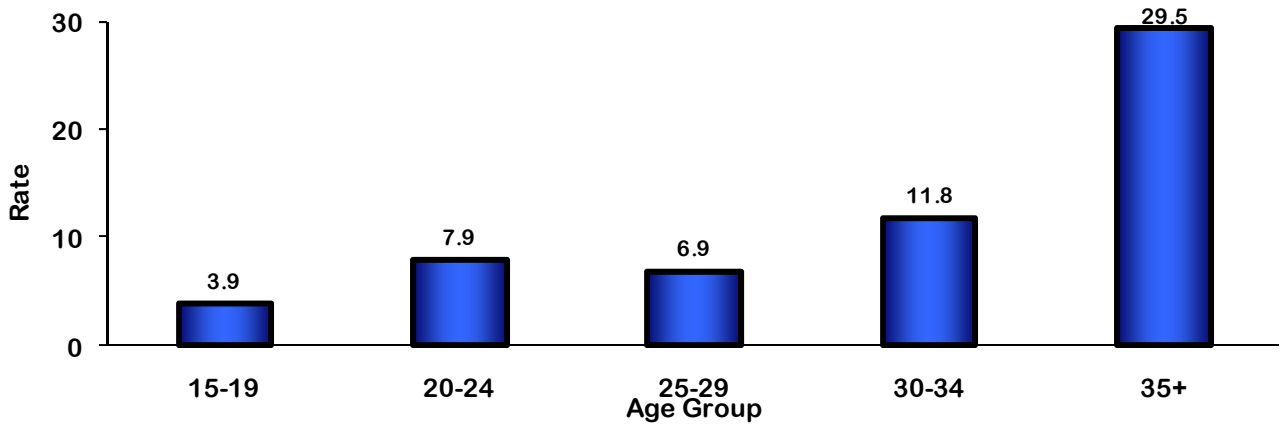
Source: Texas Vital Statistics Natality and Mortality Files, 2002-2006, Texas Department of State Health Services. ICD-10 codes used for maternal deaths: A34, O00-O95, and O98-O99. Dotted line indicates the *Healthy People 2010* goal. In 2006, the Texas death certificate was revised to include a separate question regarding pregnancy status of females. Data are reported if female was pregnant at time of death, within 42 days of death, or 43 to one year prior to death. Data from the response to this question are used in conjunction with cause of death information reported in Part I and Part II on the death certificate to determine the underlying cause of death (ICD-10 code). The separate pregnancy status question on the death certificate resulted in the identification of more maternal deaths in states with the revised death certificate. Deaths: Final Data for 2003, National Vital Statistics Reports, National Center for Health Statistics, Vol. 54, No. 13, April 19, 2006. Texas data for 2006 may not be comparable to Texas data prior to 2006.

Figure 3-59. Rate of Maternal Deaths, by Race/Ethnicity, Texas 2002-2006



Source: Texas Vital Statistics Natality and Mortality Files, 2002- 2006, Texas Department of State Health Services. ICD-10 codes used for maternal deaths: A34, O00-O95, and O98-O99.

Figure 3-60. Rate of Maternal Deaths, by Maternal Age, Texas 2002-2006



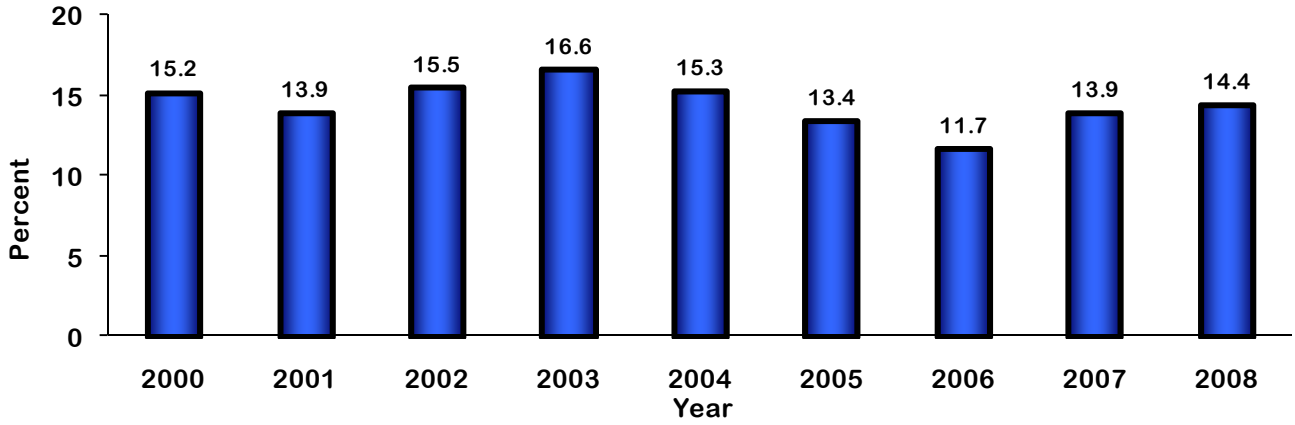
Source: Texas Vital Statistics Natality and Mortality Files, 2002- 2006, Texas Department of State Health Services. ICD-10 codes used for maternal deaths: A34, O00-O95, and O98-O99.

WOMEN OF CHILDBEARING AGE

HEALTH STATUS

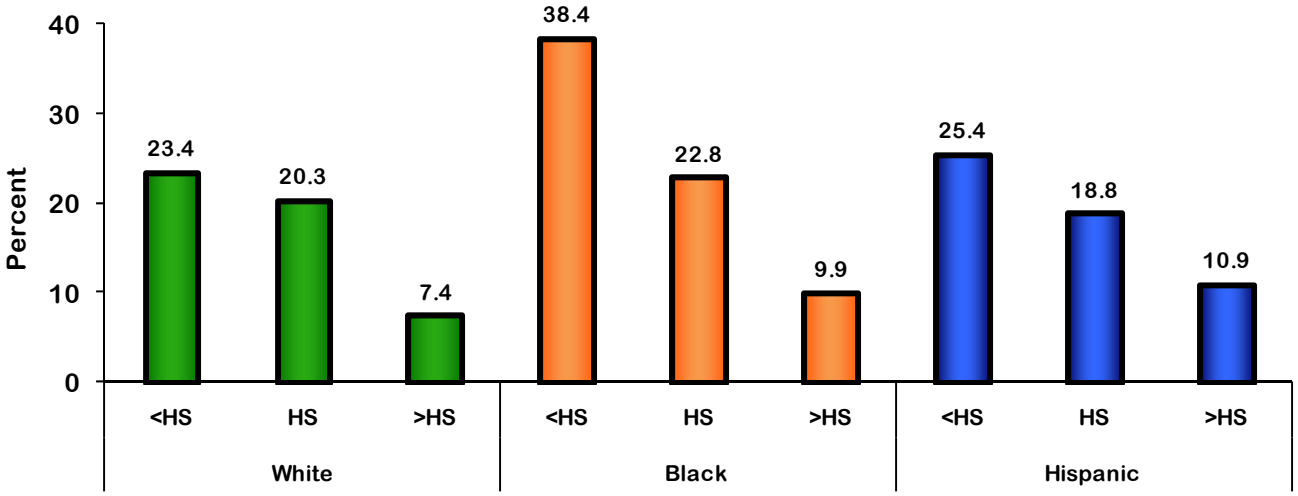
Between 2000 and 2008, the proportion of women of childbearing age (18 to 44 years) who reported fair or poor health status ranged from a high of 16.6% in 2003 to a low of 11.7% in 2006. During this period, 14.4% of women of childbearing age, on average, reported fair or poor health status. There was a negative association between education and fair or poor health status. Regardless of race, women with less than a high school education were more likely to report fair or poor health. Black women (38.4%) were significantly more likely than White women (23.4%) and Hispanic women (25.4%) to report fair or poor health status.

Figure 3-61. Percent of Women 18 to 44 Years of Age Reporting Fair/Poor Health Status, by Year, Texas, 2000-2008



Source: Behavioral Risk Factor Surveillance System, 2000-2008, Texas Department of State Health Services.

Figure 3-62. Percent of Women 18 to 44 Years of Age Reporting Fair/Poor Health Status, by Race/Ethnicity and Education, Texas, 2008



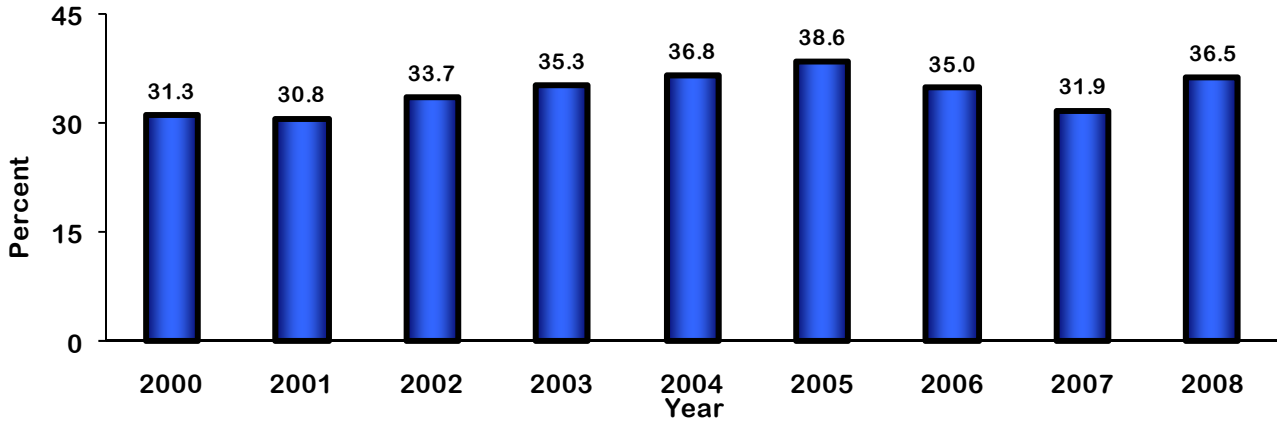
Source: Behavioral Risk Factor Surveillance System, 2008, Texas Department of State Health Services.

WOMEN'S ACCESS TO CARE

NO HEALTH CARE COVERAGE

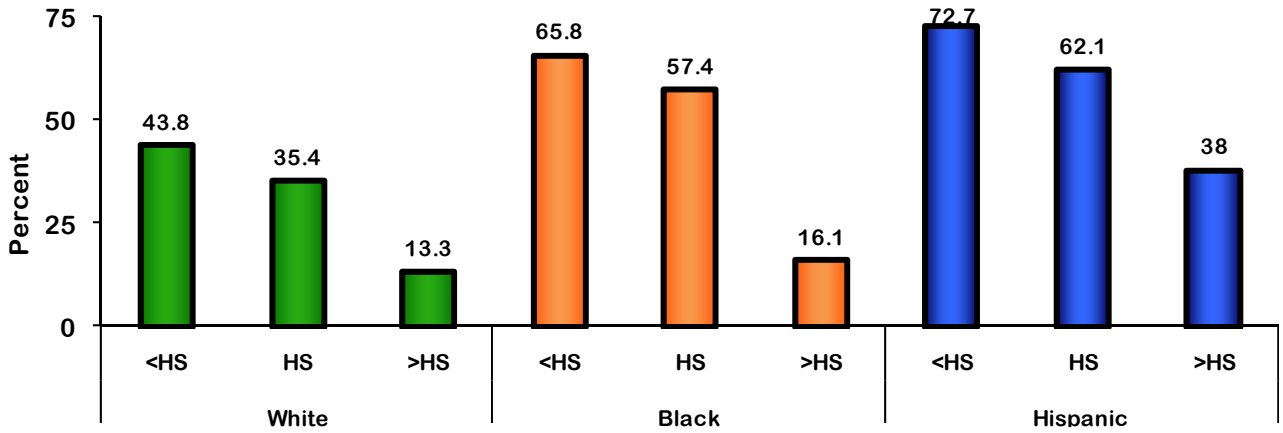
Between 2000 and 2008, the proportion of women of childbearing age (18 to 44 years) who reported that they had no health care coverage ranged from a high of 36.8% in 2004 to a low of 30.8% in 2001. During this period, 34.4% of women of childbearing age, on average, reported that they had no health care coverage. There was a negative association between education and no health care coverage. Hispanic women had the greatest proportions of no health care coverage in each of the education groupings. Among women with more than a high school education, the percent of women who had no health care coverage among Hispanic women (38.0%) was more than double that of White (13.3%) and Black women (16.1%).

Figure 3-63. Percent of Women 18 to 44 Years of Age Without Health Insurance Coverage, by Year, Texas, 2000-2008



Source: Behavioral Risk Factor Surveillance System, 2000-2008, Texas Department of State Health Services.

Figure 3-64. Percent of Women 18 to 44 Years of Age Without Health Insurance Coverage, by Race/Ethnicity and Education, Texas, 2008

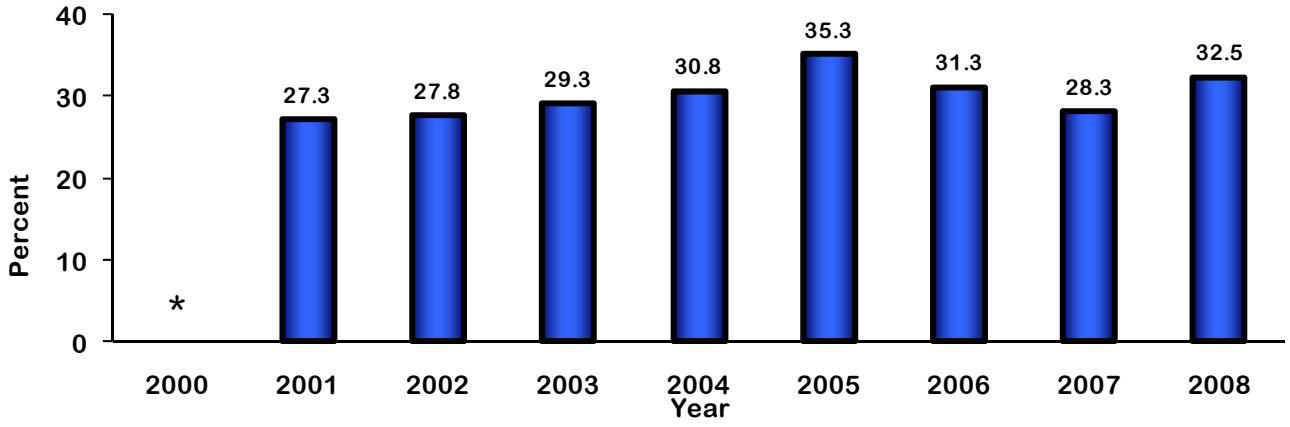


Source: Behavioral Risk Factor Surveillance System, 2008, Texas Department of State Health Services.

NO SOURCE OF USUAL CARE

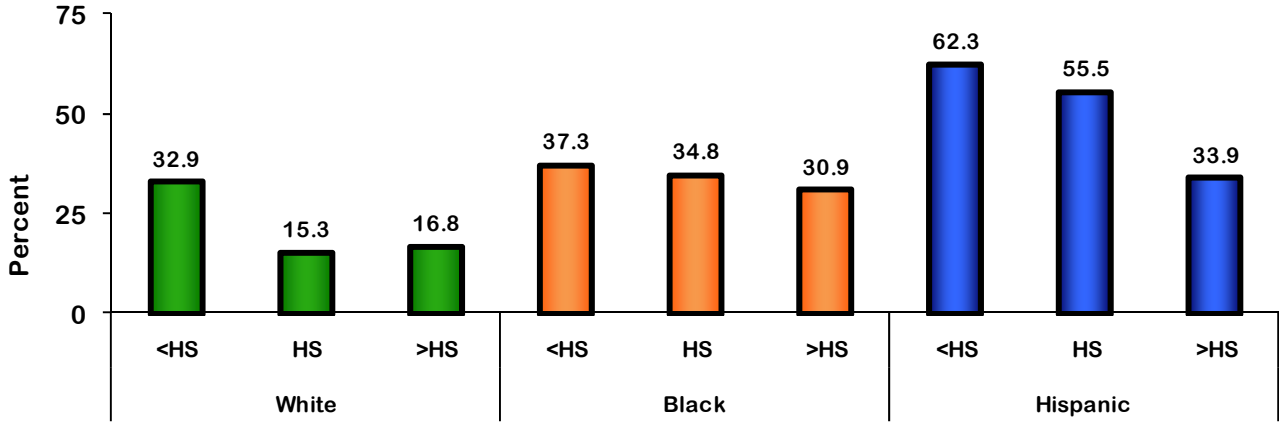
Between 2001 and 2008, the proportion of women of childbearing age (18 to 44 years) who reported that they had no source for usual care ranged from a high of 35.3% in 2005 to a low of 27.3% in 2001. During this period, 30.3% of women of childbearing age, on average, reported that they had no source for usual care. There was a negative association between education and no usual source of health care. Hispanic women had the greatest proportions of having no source for usual care. Among women with more than a high school education, the percent of women who had no source of usual care among Hispanic women (33.9%) was nearly double that of Whites (16.8%), but was relatively similar for Black women (30.9%).

Figure 3-65. Percent of Women 18 to 44 Years of Age Without a Usual Source of Health Care, by Year, Texas, 2000-2008



Source: Behavioral Risk Factor Surveillance System, 2000-2008, Texas Department of State Health Services. The usual source of health care coverage was not asked on the 2000 Behavioral Risk Factor Surveillance System survey.

Figure 3-66. Percent of Women 18 to 44 Years of Age Without a Usual Source of Health Care, by Race/Ethnicity and Education, Texas, 2008



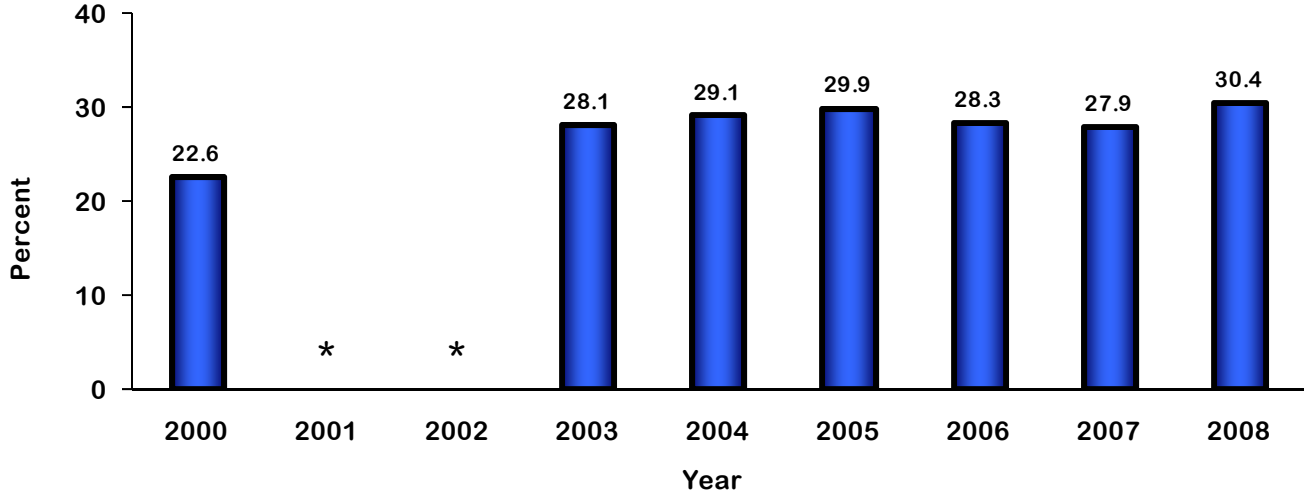
Source: Behavioral Risk Factor Surveillance System, 2008, Texas Department of State Health Services.

DID NOT SEE DOCTOR DUE TO COST

Between 2000 and 2008, the proportion of women of childbearing age (18 to 44 years) who reported that they did not see a doctor due to cost ranged from a high of 30.4% in 2008 to a low of 22.6% in 2007. During this period, 28.0% of women of childbearing age, on average, did not see a doctor due to cost. There was a negative association between education and not seeing a doctor due to cost. Almost 70% of Black women with less than a high school degree and nearly half of all Black women with a high

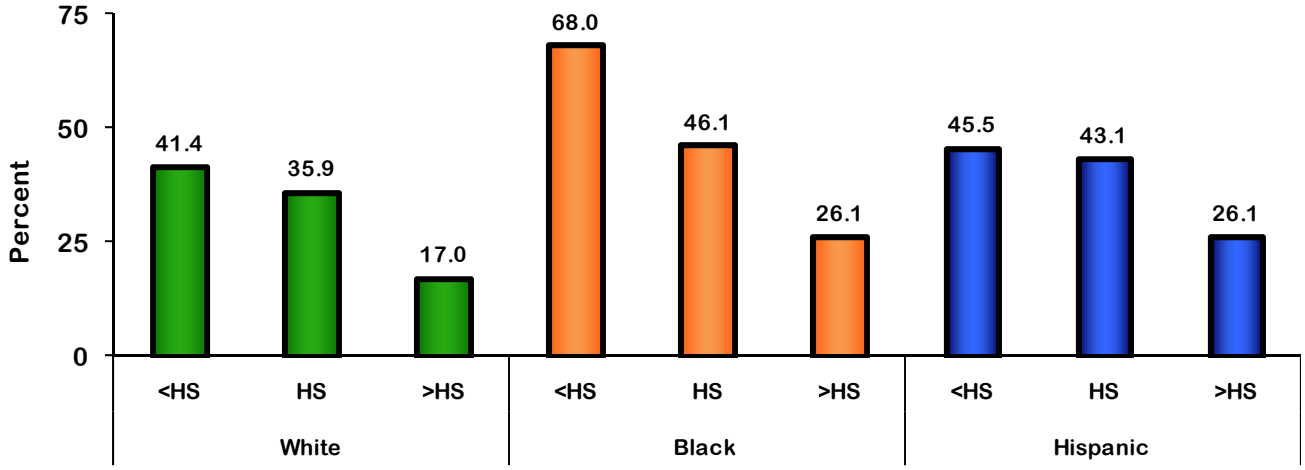
school degree reported not seeing a doctor due to cost, which were the two highest percentages among any group.

Figure 3-67. Percent of Women 18 to 44 Years of Age Without Who Did Not See a Doctor Due to Cost, by Year, Texas, 2000-2008



Source: Behavioral Risk Factor Surveillance System, 2000-2008, Texas Department of State Health Services. The question regarding why you did not see a doctor was not asked on the 2001 and 2002 Behavioral Risk Factor Surveillance System surveys.

Figure 3-68. Percent of Women 18 to 44 Years of Age Who Did Not See a Doctor Due to Cost, by Race/Ethnicity and Education,



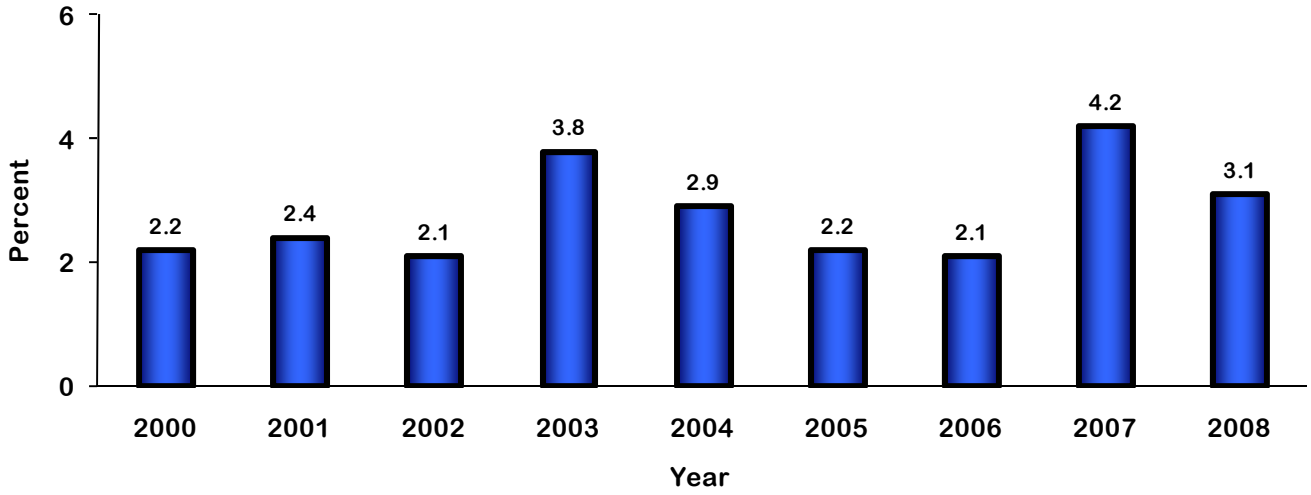
Source: Behavioral Risk Factor Surveillance System, 2008, Texas Department of State Health Services.

CHRONIC HEALTH CONDITIONS

DIABETES

Between 2000 and 2008, the prevalence of diabetes (excluding gestational diabetes) among women of childbearing age (18 to 44 years) ranged from a high of 4.2% in 2007 to a low of 2.1 in 2002 and 2006. During this time period, the diabetes prevalence exceeded 4% only once in 2007. There were no significant differences in diabetes prevalence by race/ethnicity or educational attainment, which may be due to small sample sizes.

Figure 3-69. Diabetes Prevalence among Women 18 to 44 Years of Age, by Year, Texas, 2000-2008

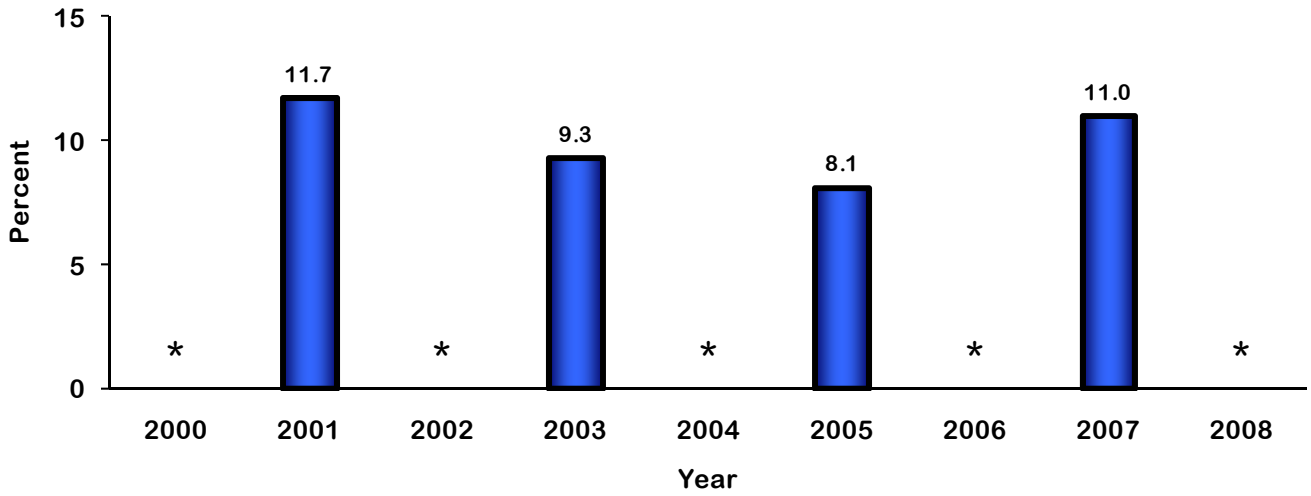


Source: Behavioral Risk Factor Surveillance System, 2000-2008, Texas Department of State Health Services.

HIGH BLOOD PRESSURE

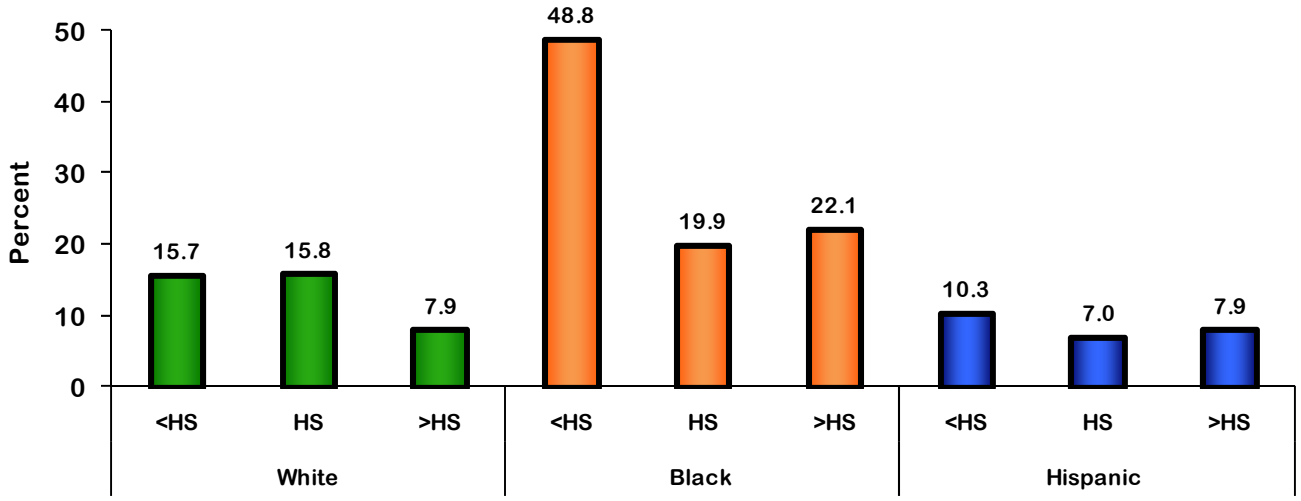
The prevalence of high blood pressure has been measured using the Behavioral Risk Factor Surveillance System (BRFSS) during the odd years between 2000 and 2008. For the four data points that are available for analyses, the average high blood pressure prevalence was 10.0%. The three greatest percentages of women with high blood pressure were among Black women. Black women were more likely to report having high blood pressure, regardless of their educational attainment. Nearly half of all Black women (48.8%) who had less than a high school degree reported that they had high blood pressure.

Figure 3-70. High Blood Pressure Prevalence among Women 18 to 44 Years of Age, by Year, Texas, 2000-2008



Source: Behavioral Risk Factor Surveillance System, 2000-2008, Texas Department of State Health Services. The question regarding high blood pressure is asked every odd year on the Behavioral Risk Factor Surveillance System surveys.

Figure 3-71. High Blood Pressure Prevalence among Women 18 to 44 Years of Age, by Race/Ethnicity and Education, Texas, 2007



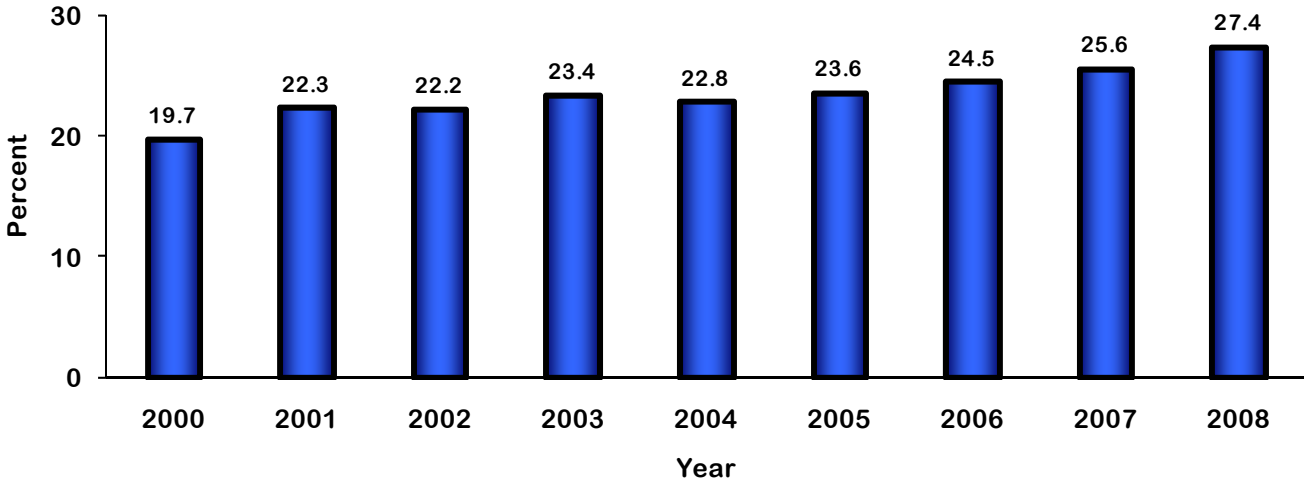
Source: Behavioral Risk Factor Surveillance System, 2007, Texas Department of State Health Services.

OBESITY

Between 2000 and 2008, using self-reported height and weight from respondents, the prevalence of obesity (a body mass index of 30 or higher) among women of childbearing age (18 to 44 years) exceeded 20% in all years except 2000. Between

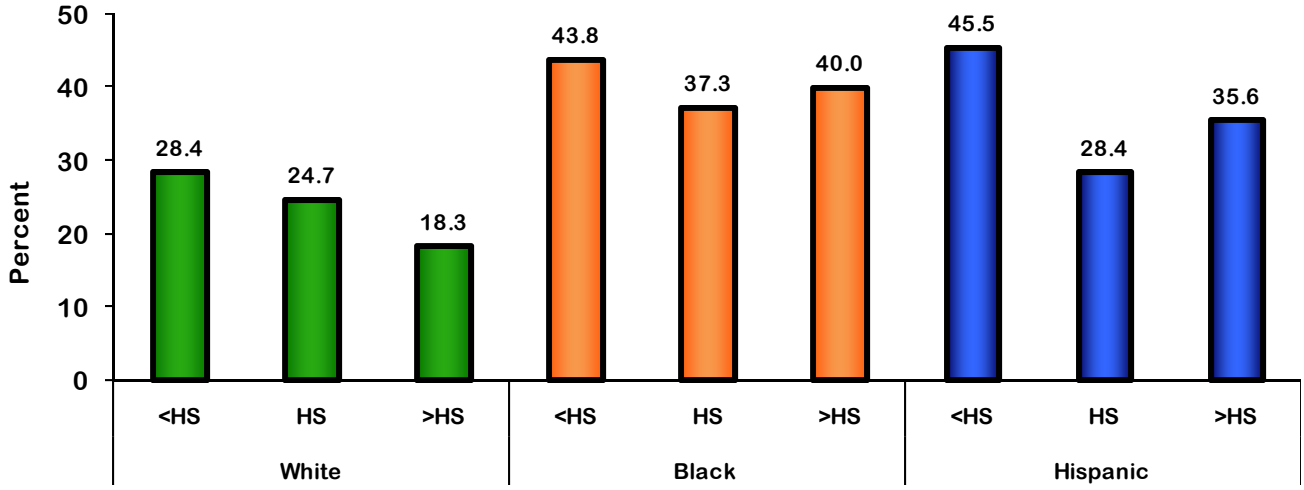
2004 and 2008, the obesity prevalence increased each year. The percent of women of childbearing age who were obese increased from 19.7% in 2000 to 27.4% in 2008, a 39% change. The average obesity prevalence between 2000 and 2008 was 23.5%. There was a clear negative association between obesity prevalence and educational attainment among White women. Black women were 2.0 times as likely to report being obese than White women. Similarly Hispanic women were 1.8 times as likely to report being obese than White women.

Figure 3-72. Obesity (BMI ≥ 30) Prevalence among Women 18 to 44 Years of Age by Year, Texas, 2000-2008



Source: Behavioral Risk Factor Surveillance System, 2000-2008, Texas Department of State Health Services.

Figure 3-73. Obesity (BMI ≥ 30) Prevalence among Women 18 to 44 Years of Age by Race/Ethnicity and Education, Texas, 2008



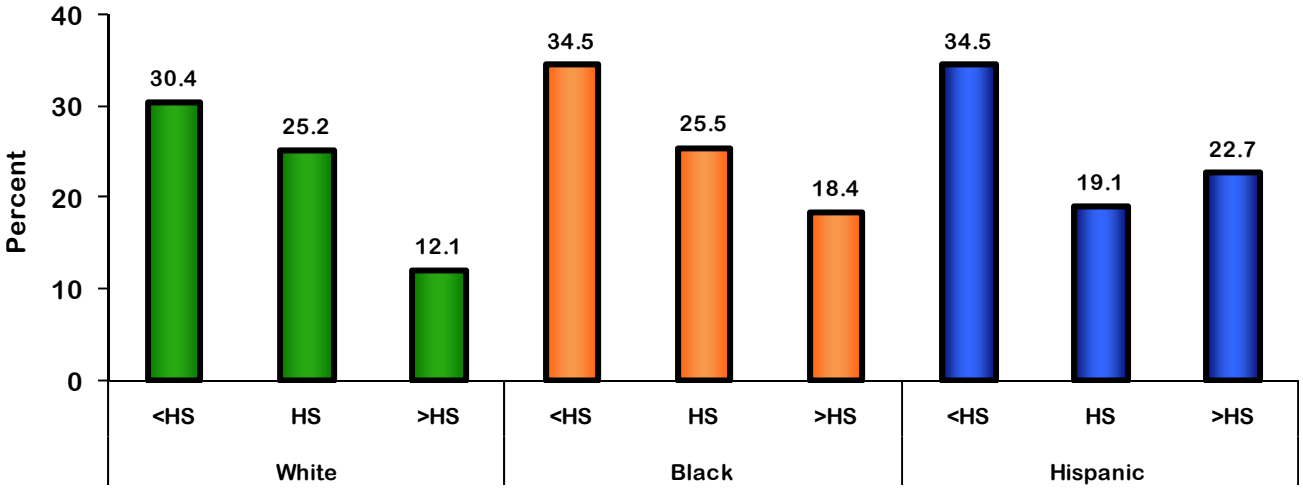
Source: Behavioral Risk Factor Surveillance System, 2008, Texas Department of State Health Services.

MENTAL ILLNESS PREVALENCE

DEPRESSIVE MOOD

Approximately one in five women of childbearing age (18 to 44 years) reported that they felt sad, blue, or depressed on one or more of the preceding 30 days. Among White and Black women, there was a negative association between education and depressive mood. This was not seen among Hispanic women. Hispanic women who graduated high school were almost two times more likely to report a depressive mood than White women with the same educational attainment.

Figure 3-74. Percent of Women 18 to 44 Years of Age Reporting Depressive Mood by Race/Ethnicity and Education, Texas, 2007

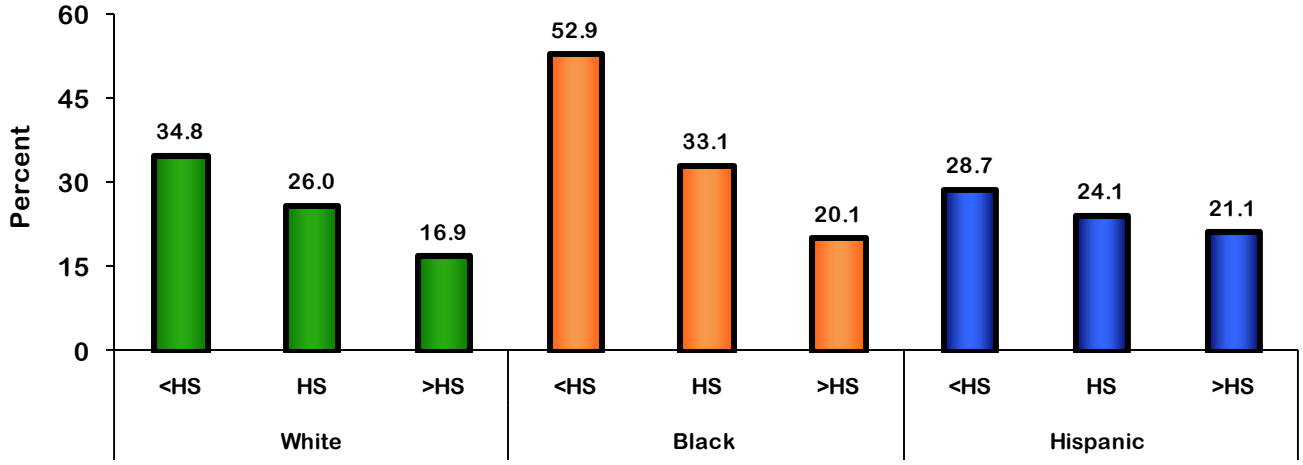


Source: Behavioral Risk Factor Surveillance System, 2007, Texas Department of State Health Services.

INCAPACITATED DUE TO MENTAL ILLNESS

Among all women of childbearing age (18 to 44 years), 23.0% reported that a mental illness or emotional problem kept them from doing their work or usual activities. There was a negative association between incapacitation due to mental illness or emotional problems and education, regardless of race/ethnicity. More than half of all Black women who had less than a high school degree reported that a mental illness or emotional problem kept them from doing their work or usual activities, compared to 34.8% for Whites and 28.7% for Hispanics of the same educational attainment.

Figure 3-75. Percent of Women 18 to 44 Years of Age Reporting Incapacitation due to Mental Illness/Emotional Problem by Race/Ethnicity and Education, Texas, 2007

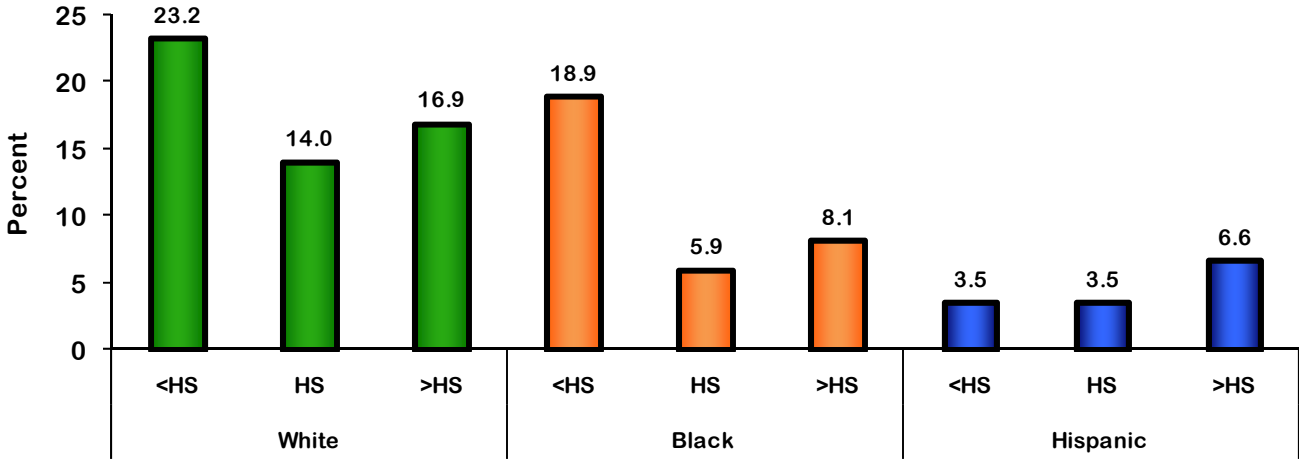


Source: Behavioral Risk Factor Surveillance System, 2007, Texas Department of State Health Services.

TREATMENT OF MENTAL ILLNESS

Among all women of childbearing age (18 to 44 years), 10.6% report using medication for the treatment of a mental illness or emotional problem. In each education group, the greatest percent of women using medication for the treatment of a mental illness or emotional problem was among White women. In each education group, the percent of Hispanic women using medication for the treatment of a mental illness or emotional problem was less than the statewide average and lower than any other racial/ethnic group.

Figure 3-76. Percent of Women 18 to 44 Years of Age Reporting Medication Use for Mental Illness/Emotional Problem by Race/Ethnicity and Education, Texas, 2007



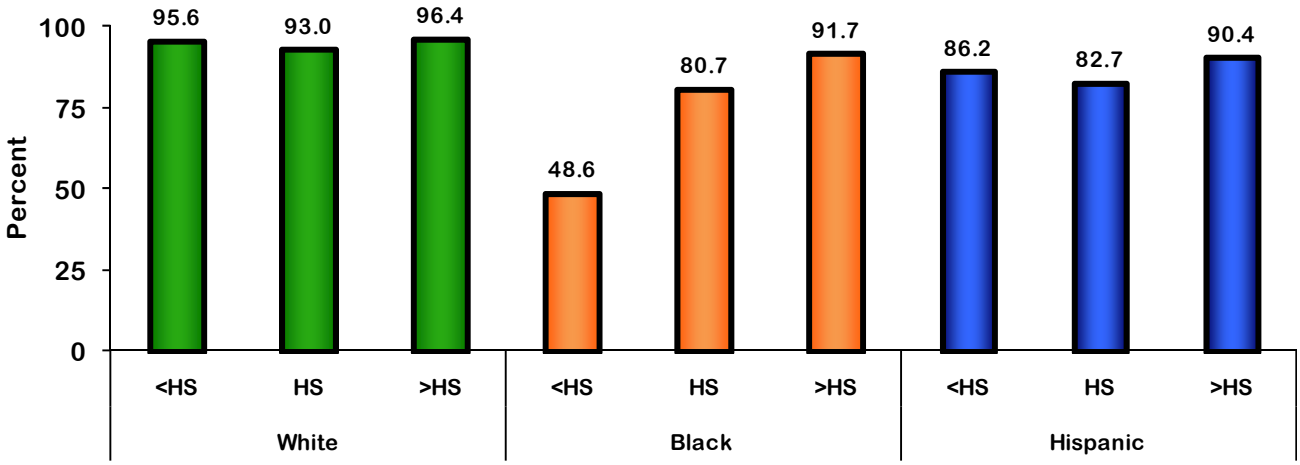
Source: Behavioral Risk Factor Surveillance System, 2007, Texas Department of State Health Services.

ATTITUDES TOWARD MENTAL ILLNESS

CAN TREATMENT HELP

More than 90% of all women and more than 90% of all White women, regardless of their education, agreed that treatment can help those who have mental illness live normal lives. More than 90% of Black and Hispanic women with more than a high school degree agreed that treatment can help those who have mental illness live normal lives. The majority of women stated that they thought treatment could help those with mental illness lead normal lives except for Black women with less than a high school education (48.6%).

Figure 3-77. Percent of Women 18 to 44 Years of Age Who Agree that Treatment Can Help Those with Mental Illness Lead Normal Lives by Race/Ethnicity and Education, Texas, 2007

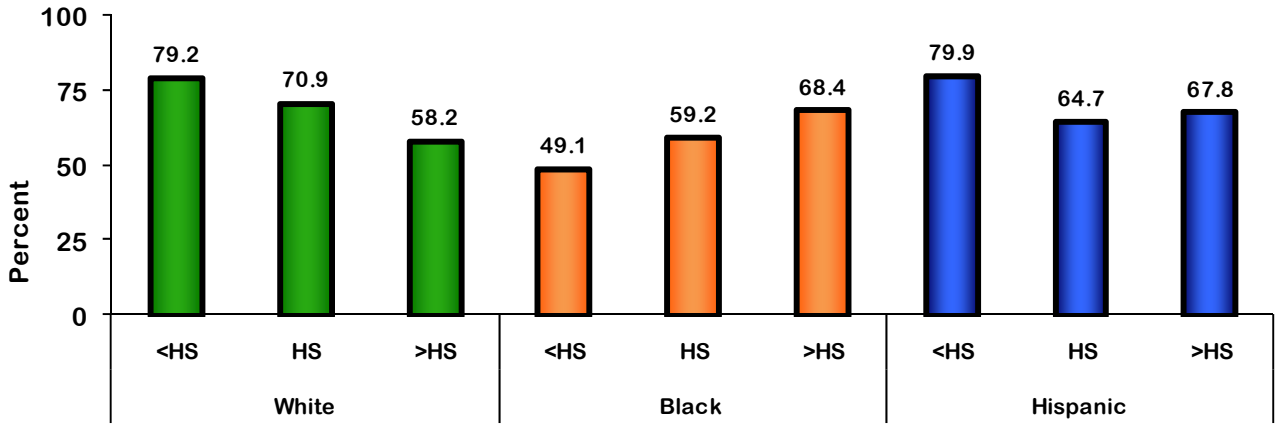


Source: Behavioral Risk Factor Surveillance System, 2007, Texas Department of State Health Services.

SOCIETAL RESPONSE TO MENTAL ILLNESS

Among women of childbearing age (18 to 44 years), 65.9% agreed that people are generally caring and sympathetic to people with mental illness or emotional problems. Among White (79.2%) and Hispanic women (79.9%), women with less than a high school degree had the greatest percent of agreement. However, among Black women, women with more than a high school degree had the greatest percent of agreement (68.4%).

Figure 3-78. Percent of Women 18 to 44 Years of Age Who Agree that People are Caring and Sympathetic to Those with Mental Illness by Race/Ethnicity and Education, Texas, 2007



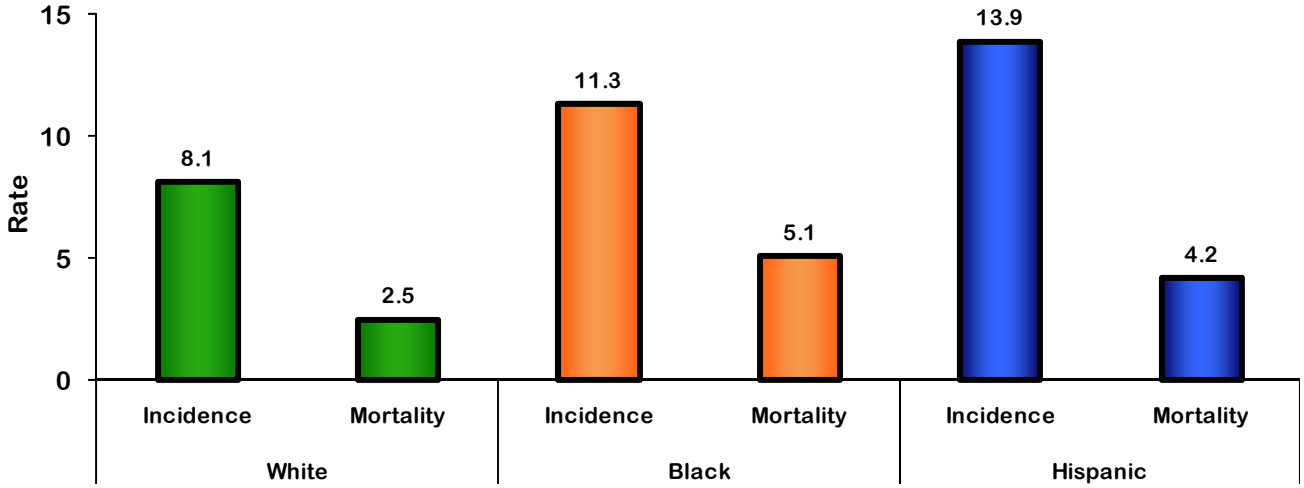
Source: Behavioral Risk Factor Surveillance System, 2007, Texas Department of State Health Services.

CERVICAL CANCER

There were 5,298 Texas women diagnosed with cervical cancer between 2002 and 2006, 45.3% (2,402) of these cases were to women of childbearing age (18 to 44 years). Cervical cancer accounted for approximately 2.5% of all female cancer incidence cases between 2002 and 2006. Hispanic women had the greatest incidence of cervical cancer (13.9 cases per 100,000 female population); nearly double the incidence of White women (8.1 cases per 100,000 female population). There were 1,702 Texas women who died of cervical cancer between 2002 and 2006, 25.1 percent (427) of these cases were to women of childbearing age. While Hispanic women had the greatest incidence of cervical cancer, Black women had the highest mortality rate due to cervical cancer (5.1 deaths per 100,000 female population) which is more than double the rate among White women (2.5 deaths per 100,000 female population).

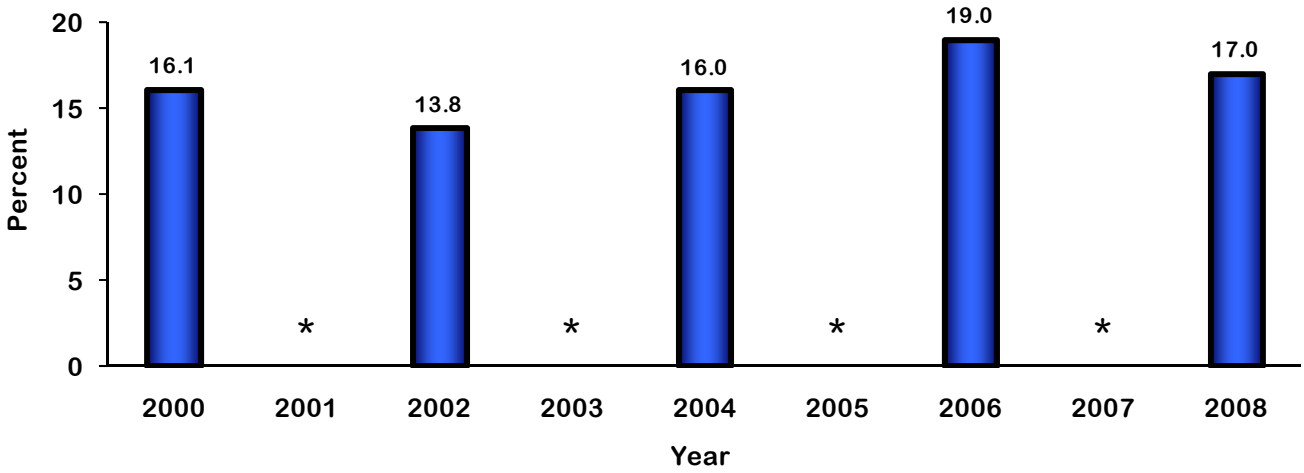
Cervical cancer screening prevalence has been measured each even year between 2000 and 2008. Based on these measures, on average, 16.4% of women of childbearing age had not received a Pap test in the previous three years. White women with less than a high school degree and White women with a high school degree were the least likely groups to report having received a Pap test in the previous three years.

Figure 3-79. Cervical Cancer Incidence and Mortality Rates by Race/Ethnicity, Texas, 2002-2006



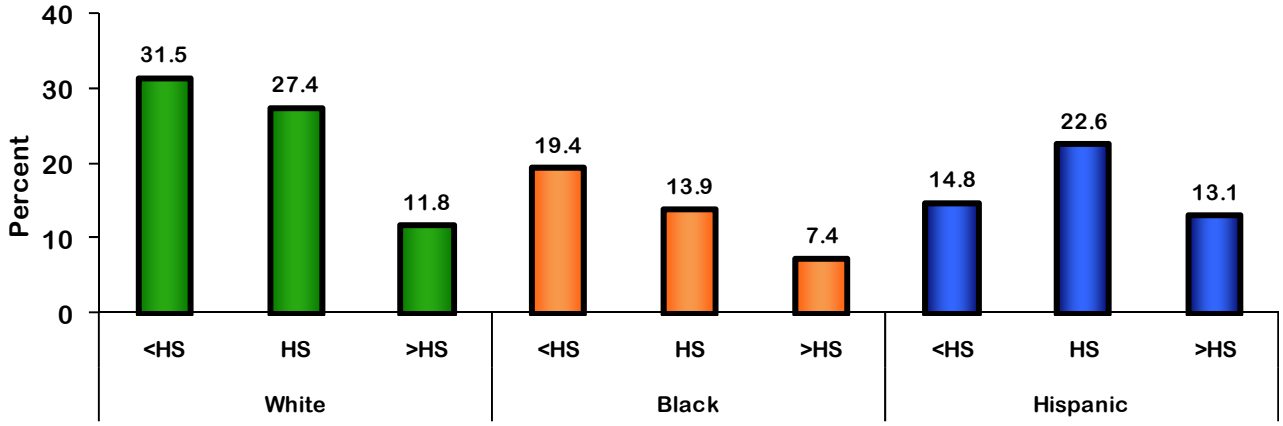
Mortality source: Texas Vital Statistics Mortality Files, 2002-2006, Texas Department of State Health Services.
Incidence source: Texas Cancer Registry, 2002-2006, Texas Department of State Health Services.

Figure 3-80. Percent of Women 18 to 44 Years of Age Without a Cervical Cancer Screen in the Past 3 Years, by Year, Texas, 2000-2008



Source: Behavioral Risk Factor Surveillance System, 2000-2008, Texas Department of State Health Services. The question regarding cervical cancer screening is asked every even year on the Behavioral Risk Factor Surveillance System surveys.

Figure 3-81. Percent of Women 18 to 44 Years of Age Without a Cervical Cancer Screen in the Past 3 Years by Race/Ethnicity and Education, Texas, 2008



Source: Behavioral Risk Factor Surveillance System, 2008, Texas Department of State Health Services.

INTIMATE PARTNER VIOLENCE

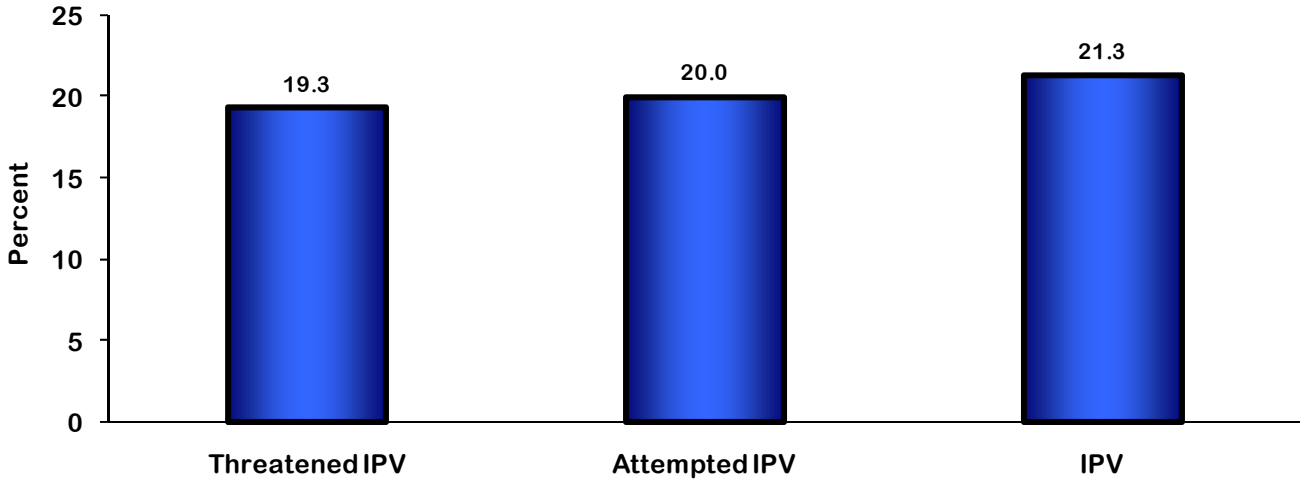
PREVALENCE OF INTIMATE PARTNER VIOLENCE

The 2007 Behavioral Risk Factor Surveillance System (BRFSS) survey asked three questions regarding intimate partner violence (IPV):

- *Has an intimate partner ever threatened you with physical violence?*
- *Has an intimate partner ever attempted physical violence against you?*
- *Has an intimate partner ever hit, slapped, pushed, or kicked, or hurt you in any way?*

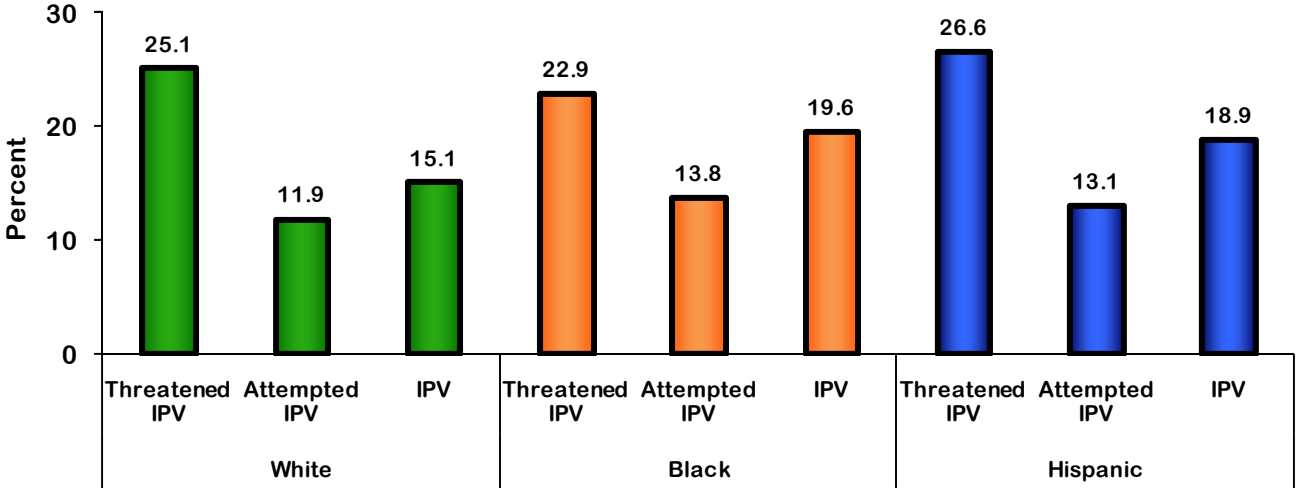
About one-fifth of women reported experiencing threatened IPV, attempted IPV, and IPV. Prevalence of threatened IPV was greatest among Hispanic women, followed by White women and Black women. Prevalence of attempted IPV was greatest among Black women, followed by Hispanic women and White women. Prevalence of IPV was greatest among Black women followed by Hispanic women and White women.

Figure 3-82. Percent of Women 18 to 44 Years Experiencing Threatened IPV, Attempted IPV, and IPV Percent, Texas, 2007



Source: Behavioral Risk Factor Surveillance System, 2007, Texas Department of State Health Services.

Figure 3-83. Percent of Women 18-44 Years Experiencing Threatened IPV, Attempted IPV, and IPV, by Race/Ethnicity Texas 2007



Source: Behavioral Risk Factor Surveillance System, 2007, Texas Department of State Health Services.

SEXUALLY TRANSMITTED INFECTIONS

Chlamydia and gonorrhea are the first and second most commonly reported infectious diseases in the U.S. The incidence of some sexually transmitted infections (STIs) is higher in women than in men. The number of reported chlamydia cases among Texas females increased by 34.8% from 57,444 cases in 2004 to 77,274 in 2008. Females accounted for 78.3% of all the chlamydia cases in 2008. Women are more likely to be

screened for chlamydia during clinical exams for family planning, prenatal care, and routine Pap smear testing. In 2008, among women ages 15 to 44 years, Black women had the highest rate of chlamydia (3,344.1 per 100,000 female population), followed by Hispanic (1,484.5 per 100,000 female population) and White women (744.9 per 100,000 female population) in this age range.

Table 3-4. Number and Rate of Chlamydia Cases Among Females, by Race/Ethnicity and Age, Texas 2008

	Race/Ethnicity							
	Texas		White		Black		Hispanic	
Age Group	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Total, all ages	77,274	1,464.9	16,269	744.9	22,340	3,344.1	32,313	1,484.5
15-24 Years	56,875	3,177.8	12,441	1,726.5	17,259	7,130.6	22,780	3,002.6
25-34 Years	16,028	913.9	3,019	434.8	3,933	1,888.3	7,574	981.7
35-44 Years	2,551	147.3	476	61.9	570	261.8	1,230	190.3

Rate is per 100,000 females per race/ethnicity and age.
Source: *Texas HIV/STD Annual Report, 2008,* Texas Department of State Health Services. Accessed on March 10, 2010 http://www.dshs.state.tx.us/hivstd/stats/pdf/surv_2008.pdf

The number of reported gonorrhea cases among Texas females increased by 34.5% from 12,421 cases in 2004 to 16,712 in 2008. Females accounted for 52.9% of all gonorrhea cases in 2008. The rate for Black women 15 to 44 years of age was over 6 times higher than the rate for Hispanic women and over 8 times higher than the rate for White women. In 2008, among women ages 15 to 44 years, Black women had the highest rate of gonorrhea (1,237.8 per 100,000 female population), followed by Hispanic (192.2 per 100,000 female population) and White women (144.0 per 100,000 female population) in this age range. Regardless of race/ethnicity, women 15 to 24 years of age had the highest rates of gonorrhea, followed by women 25 to 34 years of age.

Table 3-5. Number and Rate of Gonorrhea Cases Among Females, by Race/Ethnicity and Age, Texas 2008

	Race/Ethnicity							
	Texas		White		Black		Hispanic	
Age Group	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Total, all ages	16,712	316.8	3,146	144.0	8,269	1,237.8	4,184	192.2
15-24 Years	11,739	655.9	2,103	291.8	6,081	2,512.4	2,793	368.1
25-34 Years	3,569	203.5	725	104.4	1,590	763.4	1,025	132.8
35-44 Years	814	47.0	202	26.3	321	147.4	222	34.3

Rate is per 100,000 females per race/ethnicity and age.
Source: *Texas HIV/STD Annual Report, 2008,* Texas Department of State Health Services. Accessed on March 10, 2010 http://www.dshs.state.tx.us/hivstd/stats/pdf/surv_2008.pdf

The number of reported syphilis cases among Texas females increased by 150.6% from 180 cases in 2004 to 451 in 2008. Females accounted for 32.1% of all the syphilis cases in 2008. The syphilis rate for Black women ages 15 to 44 years old was over 15 times higher than the rate for Hispanic women and over 13 times higher than the rate for White women. In 2008, among women ages 15 to 44 years, Black women had the highest rate of syphilis (45.4 per 100,000 female population), followed by Hispanic (3.0 per 100,000 female population) and White women (3.5 per 100,000 female population) in this age range.

Table 3-6. Number and Rate of Syphilis Cases Among Females, by Race/Ethnicity and Age, Texas 2008

	Race/Ethnicity							
	Texas		White		Black		Hispanic	
Age Group	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Total, all ages	451	8.5	76	3.5	303	45.4	65	3.0
15-24 Years	196	11.0	25	3.5	143	59.1	25	3.3
25-34 Years	126	7.2	17	2.4	89	42.7	18	2.3
35-44 Years	70	4.0	16	2.1	40	18.4	19	2.9

Rate is per 100,000 females per race/ethnicity and age.
Source: *Texas HIV/STD Annual Report, 2008,* Texas Department of State Health Services. Accessed on March 10, 2010 http://www.dshs.state.tx.us/hivstd/stats/pdf/surv_2008.pdf

HIV/AIDS

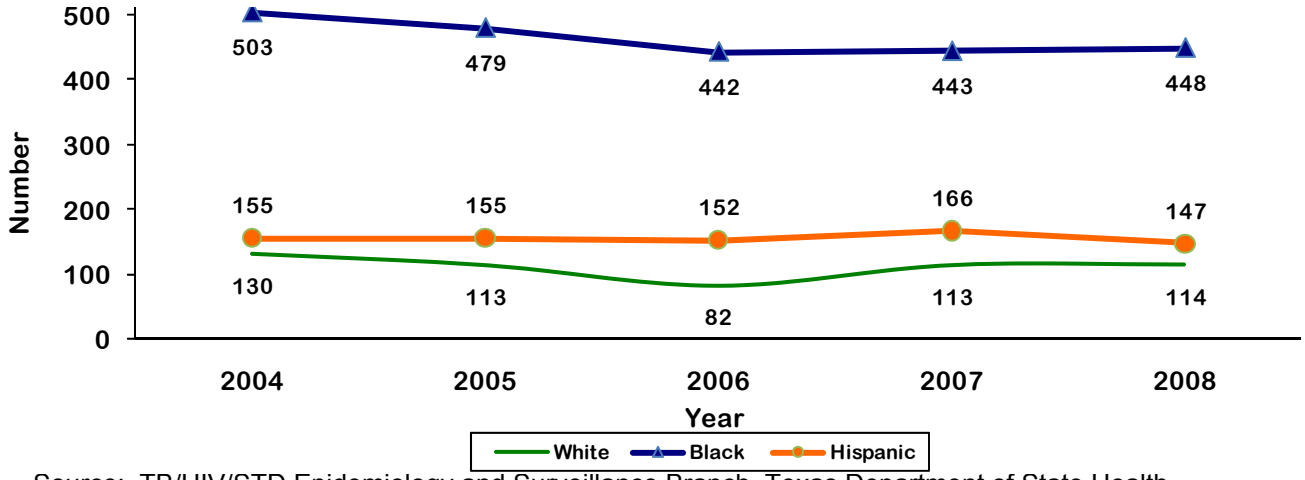
In 2008, there were 13,751 women known to be living with HIV/AIDS in Texas, up 23.4% from 2004 and representing 21.6% of the total number of people living with HIV/AIDS in Texas. The number of females 18 to 44 years of age newly diagnosed with HIV/AIDS remained stable for women from 2004 through 2008 at about 741 diagnoses per year. On average between 2000 and 2008, 41.7% of women of childbearing age (18 to 44 years) reported never having had an HIV test. The rate of new cases of HIV/AIDS among Black females (1,219.8 per 100,000 female population) was 10 times as high as the rate for Hispanics (121.3 per 100,000 population) and 9 times as high as the rate for Whites (127.7 per 100,000 population). The majority of Black women (79.6%) indicated they had been tested for HIV at least once in their lifetime, compared to 50.5% of Hispanics and 54.1% of Whites.

Table 3-7. Number and Rate of Females Living with HIV/AIDS, by Race/Ethnicity and Age, Texas 2008

	Race/Ethnicity							
	Texas		White		Black		Hispanic	
Age Group	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Total, all ages	13,751	260.7	2,790	127.7	8,149	1,219.8	2,640	121.3
15-24 Years	3,084	172.3	526	73.0	1,960	809.8	563	74.2
25-34 Years	4,825	275.1	943	135.8	2,860	1,373.1	952	123.4
35-44 Years	3,409	196.9	755	98.2	1,989	913.6	628	97.1

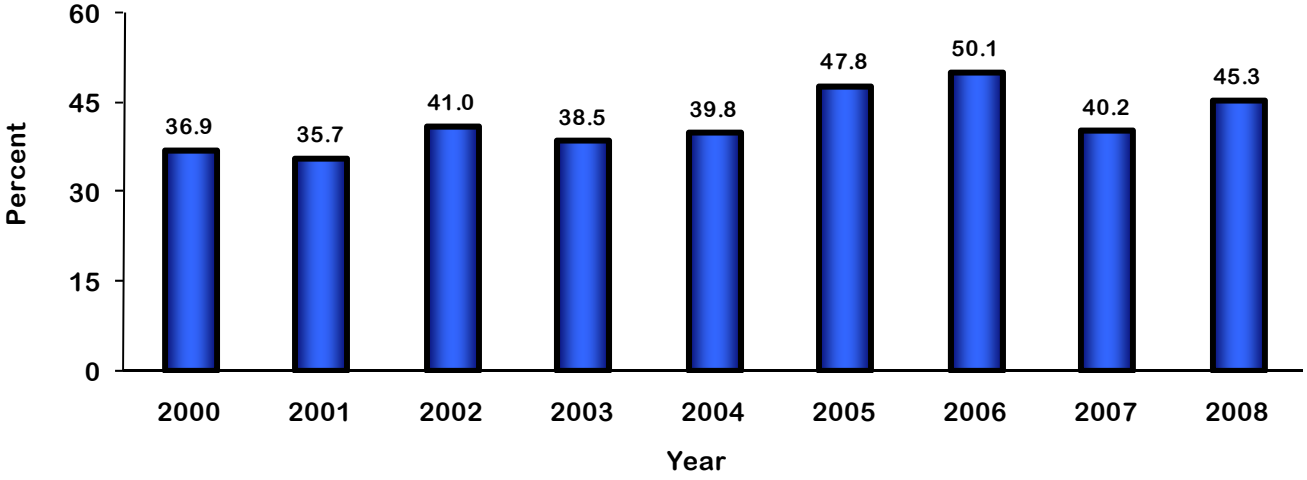
Rate is per 100,000 females per race/ethnicity and age.
Source: TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services.

Figure 3-84. Number of New HIV/AIDS Cases Diagnosed Among Females Age 15-14, by Race/Ethnicity, by Year, 2004-2008



Source: TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services.

Figure 3-85. Percent of Women 18 to 44 Years of Age Who Have Never Had an HIV Test, by Year, Texas, 2000-2008



Source: Behavioral Risk Factor Surveillance System, 2000-2008, Texas Department of State Health Services.

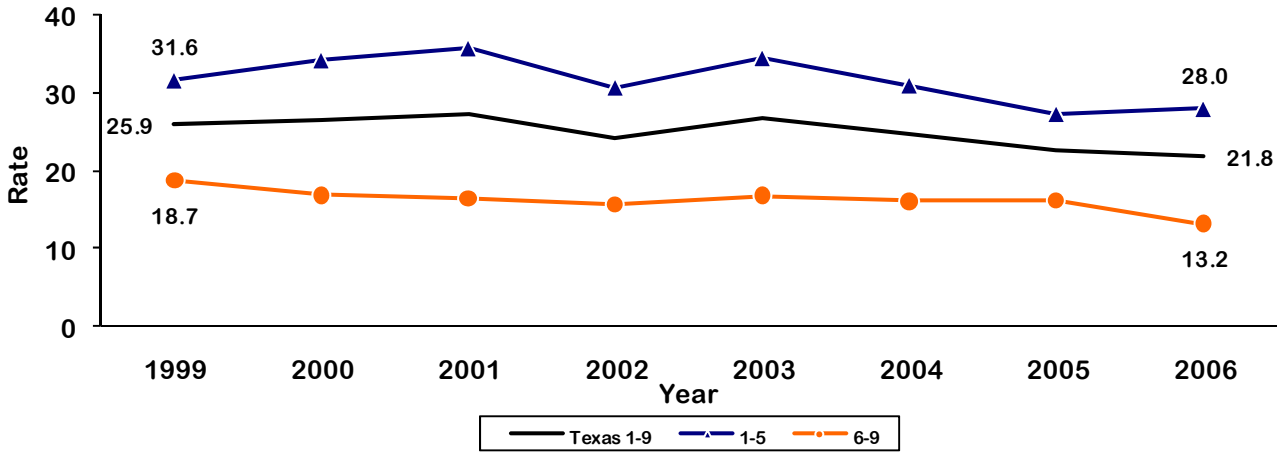
CHILDREN (AGES 1 TO 9 YEARS)

OVERALL MORTALITY

The overall mortality rate among Texas children aged 1 to 9 years old ranged from a low of 22.6 per 100,000 population in 2005 to a high of 27.2 per 100,000 population in 2001. The overall mortality rate decreased by 12.0% from 1999 to 2006 for children aged 1 to 9. The decline among children 6 to 9 years of age (24.6%) was triple that of the decline among child 1 to 5 years of age (8.2%).

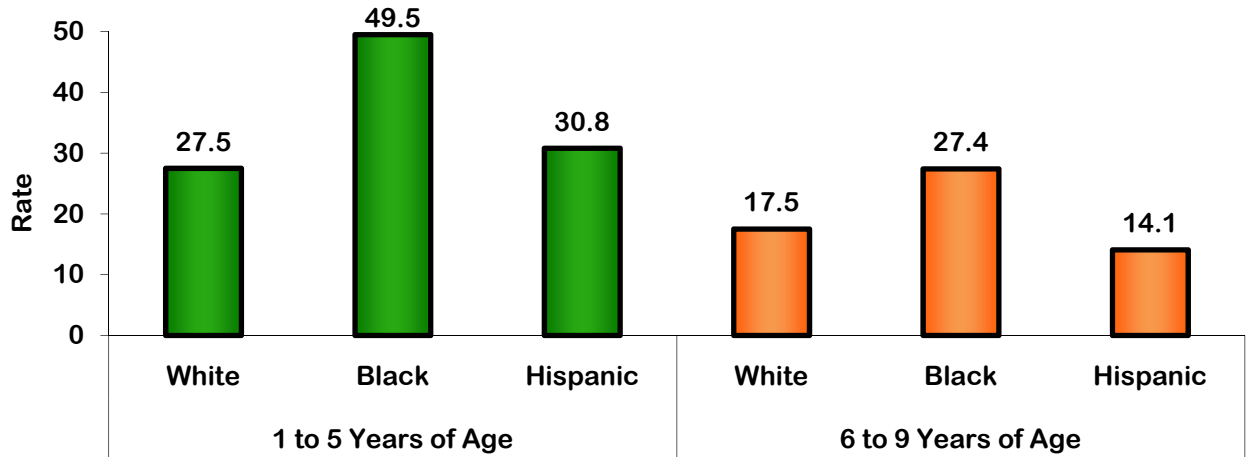
The overall mortality rate was greater among males and children 1 to 5 years of age. Black children have the highest mortality rates, regardless of age or gender. Racial disparities were greater among children 1 to 5 years of age compared to children 6 to 9 years of age. Among males, the mortality rate among Black children was 1.8 times as high as the mortality rate among White children in the 1 to 5 year old age group and 1.6 times as high as in the 6 to 9 year old age group. Among females, the mortality rate among Black children was 2.1 times as high as the mortality rate among White children in the 1 to 5 year old age group and 1.5 times as high as the 6 to 9 year old age group.

Figure 3-86. Mortality Rate per 100,000 by Age by Year, Texas, 1999-2006



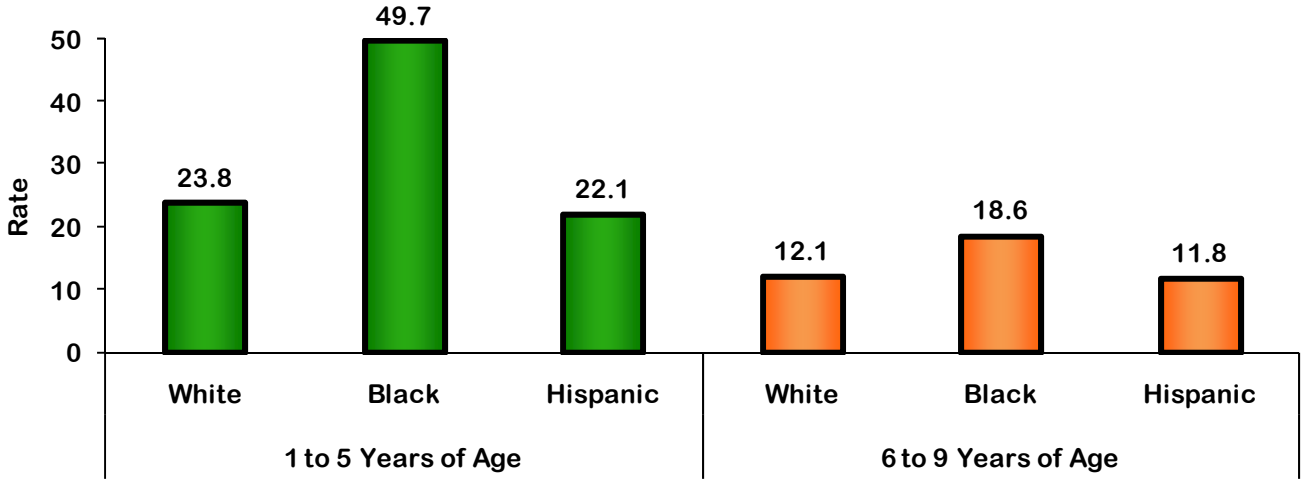
Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

Figure 3-87. Mortality Rate per 100,000
Among Males by Race/Ethnicity and Age, Texas, 2004-2006



Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

Figure 3-88. Mortality Rate per 100,000
Among Females by Race/Ethnicity and Age, Texas, 2004-2006



Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

LEADING CAUSES OF DEATH

From 2004 through 2006, there were 2,134 deaths to Texas residents 1 to 9 years of age. Of these deaths, 1,545 were to 1 to 5 year olds and 589 were to 6 to 9 year olds. The three leading causes of death for this age group were accidents (9.2 deaths per 100,000 population), malignant neoplasms (2.6 deaths per 100,000 population), and assault (1.8 deaths per 100,000 population).

Table 3-8. Texas Resident Deaths to Children 1-9 Years of Age by Cause of Death, 2004-2006

	Total, 1-9 Years Old		1-5 Years Old		6-9 Years Old	
Cause of Death	Number	Rate	Number	Rate	Number	Rate
All Causes	2,134	23.0	1,545	28.7	589	15.1
Accidents	852	9.2	609	11.3	243	6.2
Malignant neoplasms	241	2.6	136	2.5	105	2.7
Assault (homicide)	164	1.8	130	2.4	34	0.9

Rates are per 100,000 population.
Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

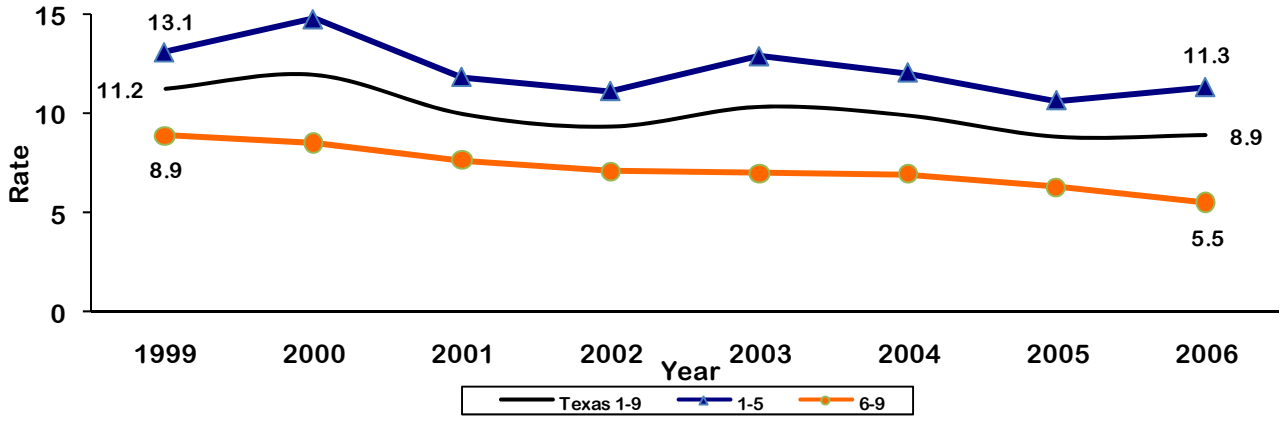
ACCIDENTAL DEATHS (UNINTENTIONAL INJURY)

The unintentional injury mortality rate among Texas children aged 1 to 9 years old ranged from a low of 8.8 per 100,000 population in 2005 to a high of 11.9 per 100,000 population in 2000. The unintentional injury mortality rate decreased by 20.9% from 1999 to 2006 for children aged 1 to 9. The decline among children 6 to 9 years of age (38.3%) was nearly three times the decline among child 1 to 5 years of age (13.6%).

The unintentional injury mortality rate was greater among males and children 1 to 5 years of age. Black children have the highest unintentional injury mortality rates, regardless of age or gender. Among males, the mortality rate among Black children was 1.5 times higher than the mortality rate among White children in the 1 to 5 year old age group and 1.8 times higher in the 6 to 9 year old age group. Among females, the mortality rate among Black children was 1.7 times higher than the mortality rate among White children in the 1 to 5 year old age group and 2.2 times higher in the 6 to 9 year old age group.

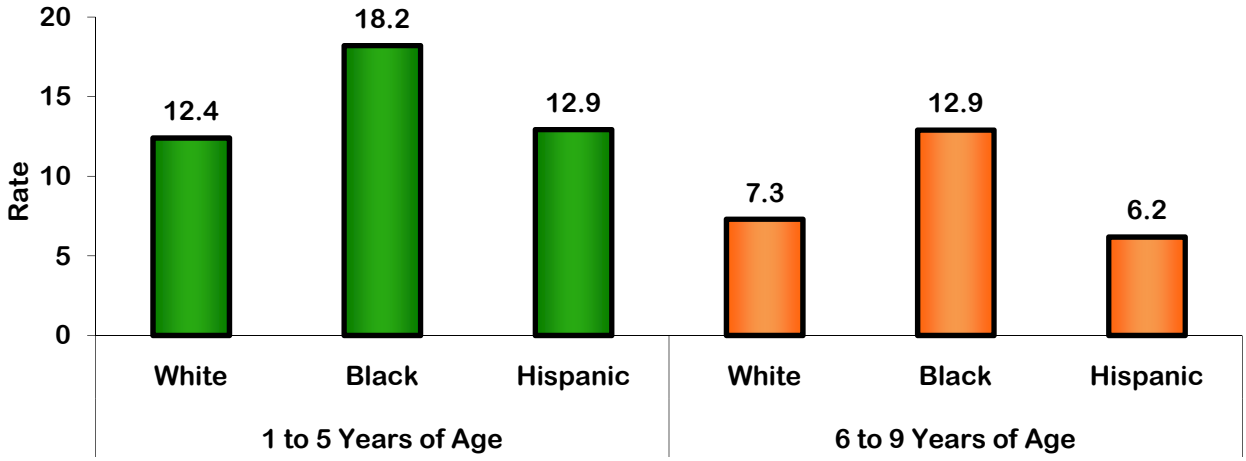
From 2004 to 2006, there were 852 accidental deaths to children aged 1 to 9 years old. Of these 852,449 (52.7%) were motor vehicle accident deaths and 193 (22.7%) were accidental drowning. The remaining 24.6% of the accidental deaths were due to a variety of causes of death.

Figure 3-89. Unintentional Injury Death Rate Per 100,000 Population, by Age, by Year, Texas, 1999-2006



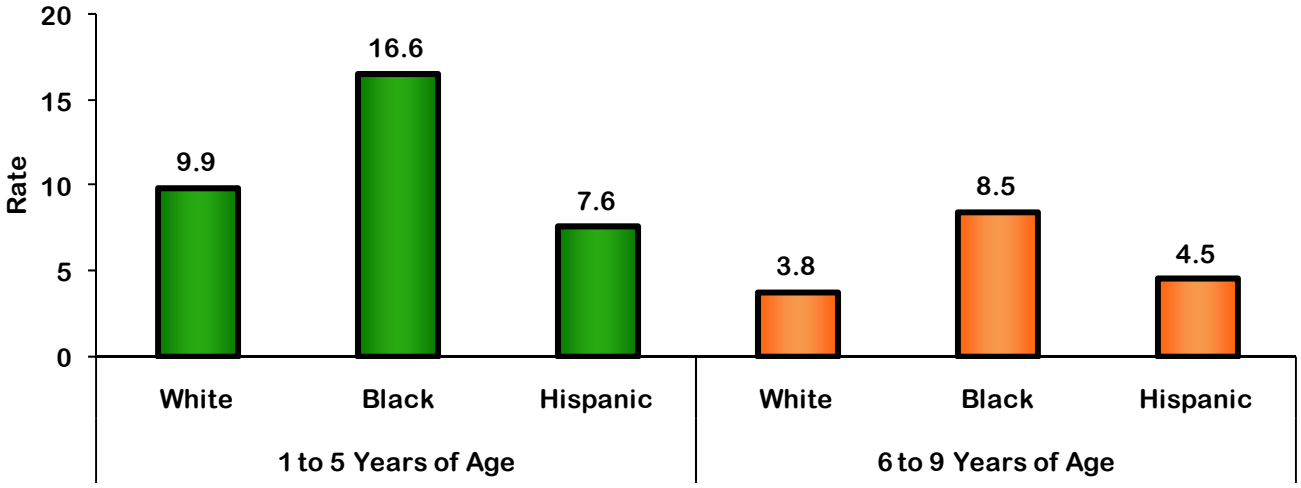
Source: Texas Vital Statistics Mortality File, 1999-2006, Texas Department of State Health Services.

Figure 3-90. Unintentional Injury Death Rate Per 100,000 Among Males by Race/Ethnicity and Age, Texas, 2004-2006



Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

Figure 3-91. Unintentional Injury Death Rate Per 100,000
Among Females by Race/Ethnicity and Age, Texas, 2004-2006



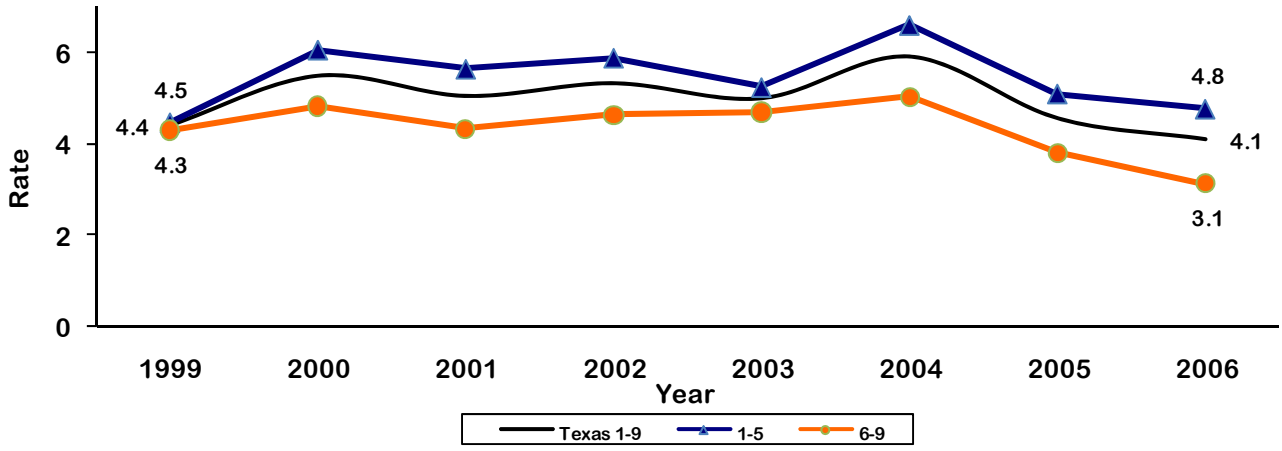
Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

MOTOR VEHICLE CRASH DEATHS

The motor vehicle crash mortality rate decreased by 7.0% from 1999 to 2006 for children aged 1 to 9. In the 1 to 5 year old age group, the rate of motor vehicle crash deaths increased 6.7% between 1999 and 2006. In the 6 to 9 year old age group, the rate of motor vehicle crash deaths decreased 27.3% between 1999 and 2006.

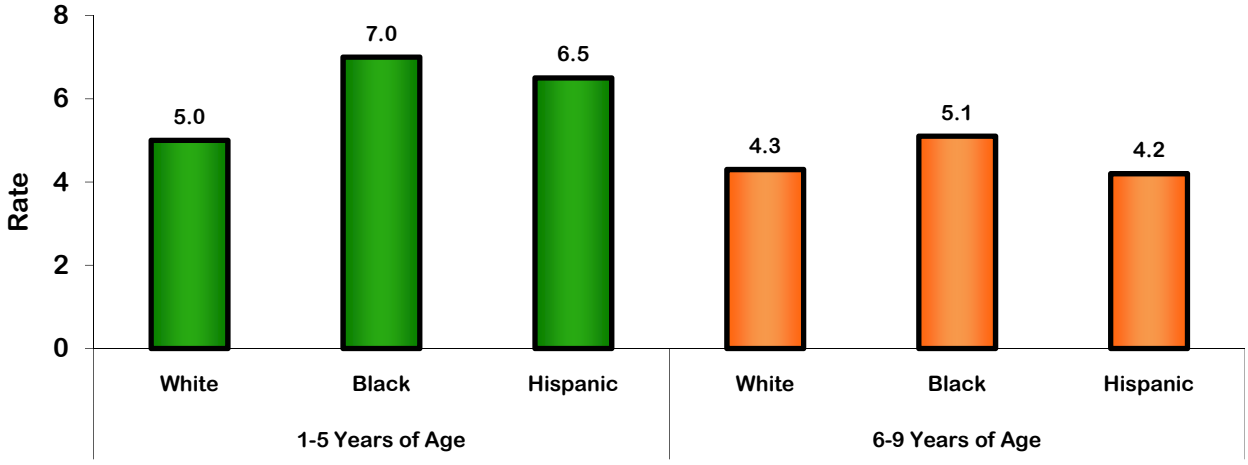
The greatest rate of motor vehicle crash deaths was among Black children. The rate of motor vehicle crash deaths was higher among children 1 to 5 years of age compared to 6 to 9 years of age. Racial disparities between Black children and the children of the racial/ethnic group with the lowest rate were greater among female children than male children. Among female children 1 to 5 years of age, the rate of motor vehicle crash deaths among Black children was 1.8 times higher compared to children of the racial/ethnic group with the lowest rate. Among female children 6 to 9 years of age, the rate of motor vehicle crash deaths among Black children was 1.7 times higher compared to children of the racial/ethnic group with the lowest rate. Among male children, the rate of motor vehicle crash deaths was 1.4 times higher for Black children 1 to 5 years of age and 1.2 times higher for Black children 6 to 9 years of age.

Figure 3-92. Motor Vehicle Crash Death Rate Per 100,000 Population, by Age, by Year, Texas, 1999-2006



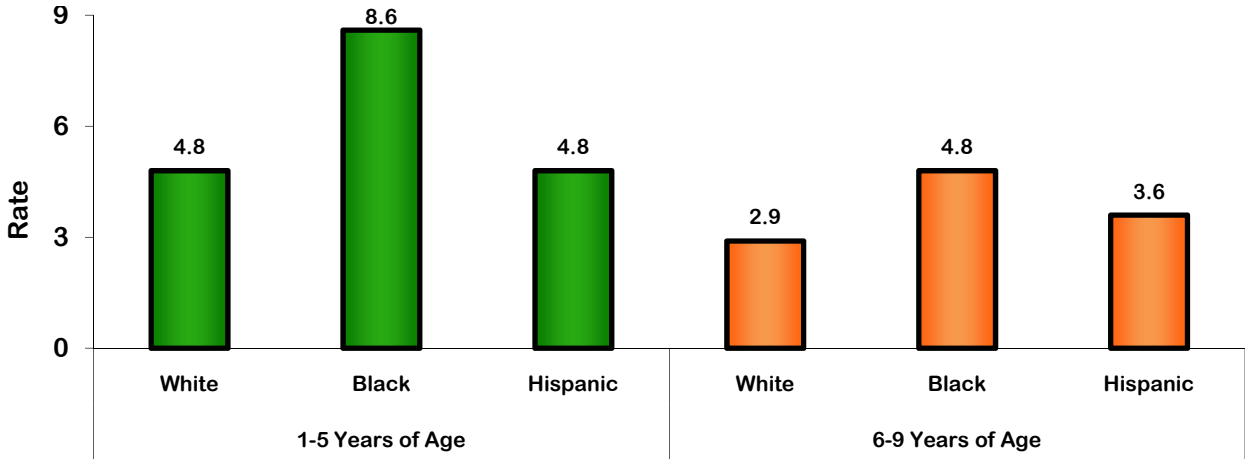
Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

Figure 3-93. Motor Vehicle Crash Death Rate Per 100,000 Population Among Males by Race/Ethnicity and Age, Texas, 2004-2006



Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

Figure 3-94. Motor Vehicle Crash Death Rate Per 100,000 Population Among Females by Race/Ethnicity and Age, Texas, 2004-2006



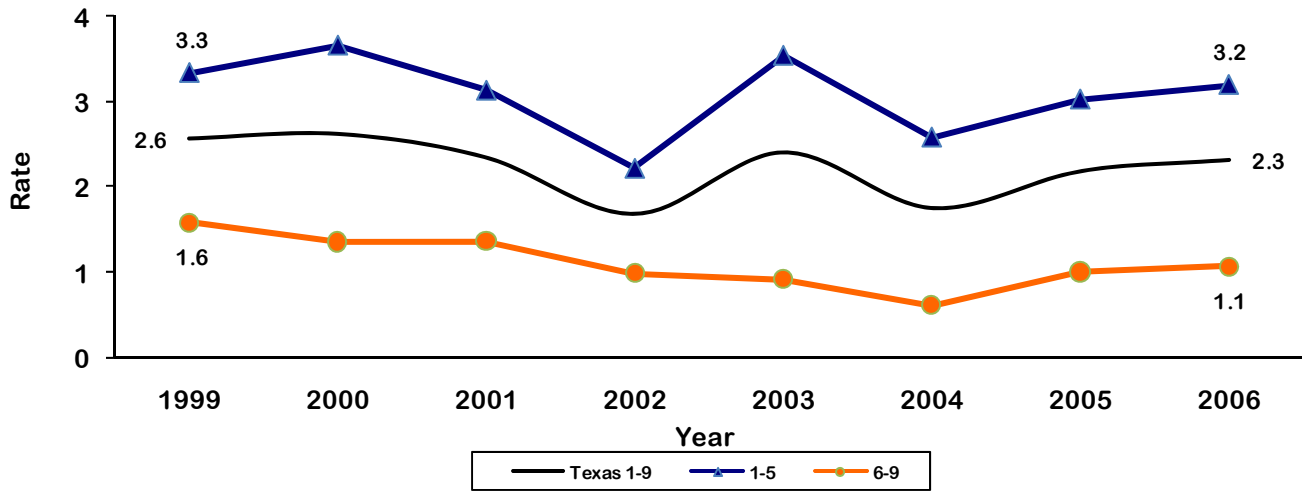
Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

ACCIDENTAL DROWNING DEATHS

The accidental drowning mortality rate decreased by 9.8% from 1999 to 2006 for children aged 1 to 9. In the 1 to 5 year old age group, the rate of accidental drowning deaths increased 4.2% between 1999 and 2006. In the 6 to 9 year old age group, the rate of accidental drowning deaths decreased 32.6% between 1999 and 2006.

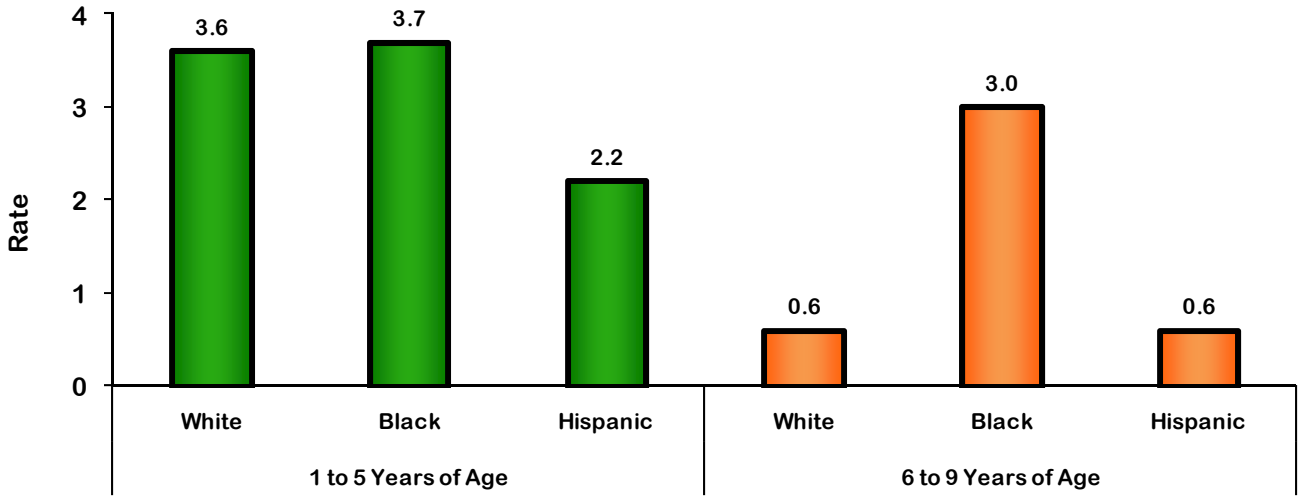
The rate of accidental drowning was greater among males than females. Among male children, Hispanic children had the lowest rates of accidental drowning. Racial disparities were less pronounced in the 1 to 5 year old age group compared to the 6 to 9 year old age group. Among the 1 to 5 year old age group, the rate of accidental drowning was 1.7 times higher among Black male children compared to Hispanic male children. Among the 6 to 9 year old age group, the rate of accidental drowning was more than 5.0 times higher among Black male children compared to Hispanic male children. Among female children, the rate of accidental drowning was greater among children 1 to 5 years of age compared to 6 to 9 years of age. While the disparities are greater among the female children, the patterns of racial disparities are similar to those among male and female children 1 to 5 years of age.

Figure 3-95. Accidental Drowning Death Rate Per 100,000 Population, by Age, by Year, Texas, 1999-2006



Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

Figure 3-96. Accidental Drowning Death Rate Per 100,000 Population, by Race/Ethnicity and Age, Texas, 2004-2006



Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

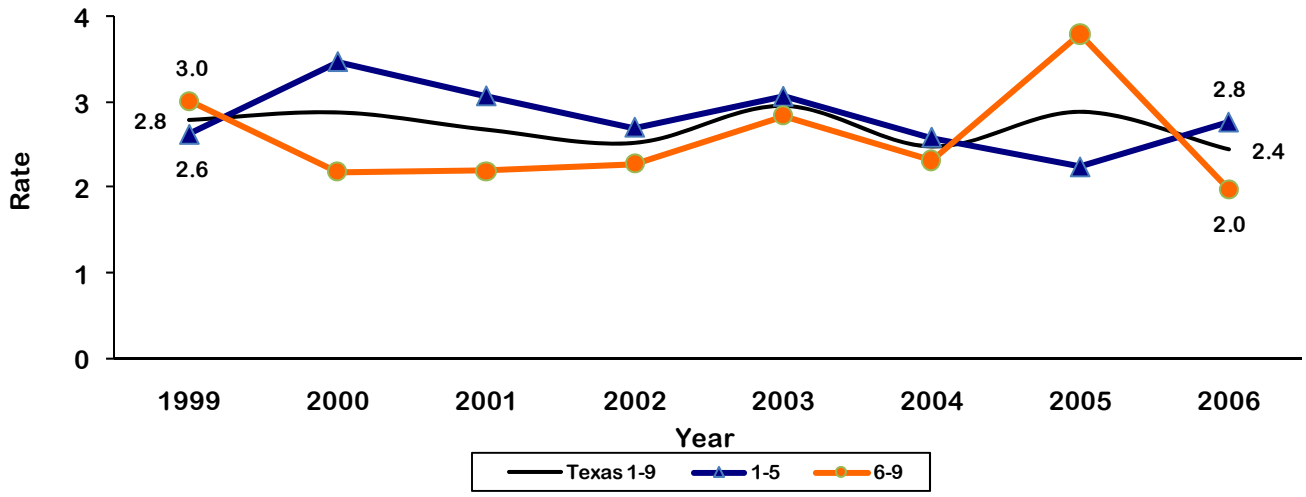
MALIGNANT NEOPLASM (CANCER)

The malignant neoplasm mortality rate among Texas children aged 1 to 9 years old ranged from a low of 2.4 per 100,000 population in 2006 to a high of 3.0 per 100,000 population in 2003. The malignant neoplasm mortality rate decreased by 12.8% from 1999 to 2006 for children aged 1 to 9. The malignant neoplasm mortality rate increased

by 5.4% from 1999 to 2006 for children aged 1 to 5, while decreasing 34.3% in children 6 to 9 years old during this same time period.

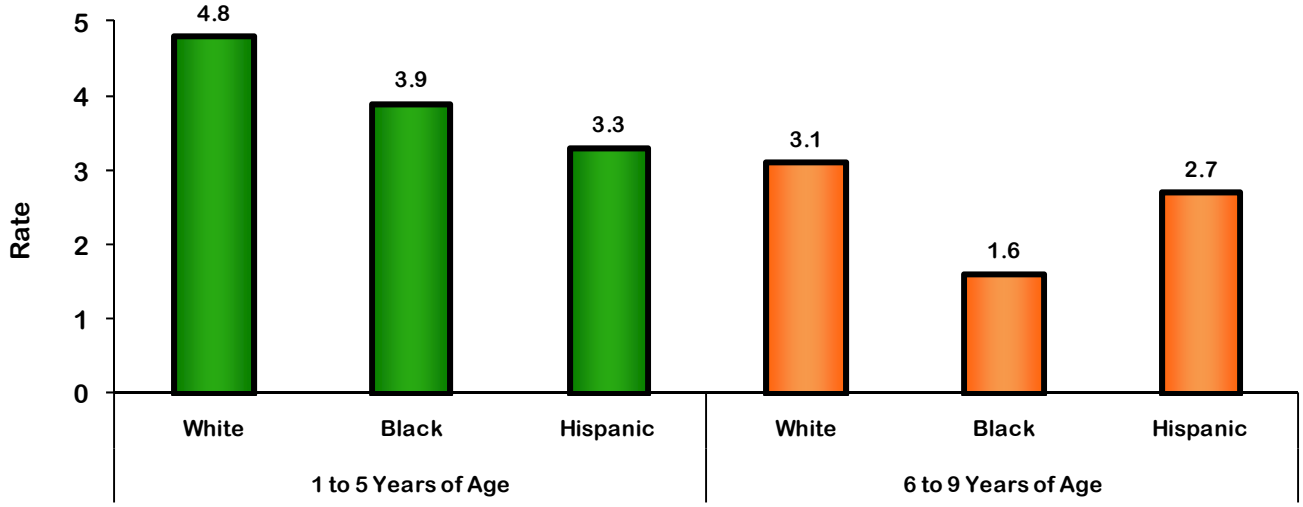
The malignant neoplasm mortality rate was greater among children 1 to 5 years of age, regardless of gender. White children have the highest malignant neoplasm mortality rates, regardless of age or gender. Among children aged 1 to 5 years old, the mortality rate among White children was 1.5 times higher than the mortality rate among Hispanic children. Among children aged 6 to 9 years old, the mortality rate among White children was almost twice as high as the mortality rate among Black children.

Figure 3-97. Malignant Neoplasm Death Rate Per 100,000 Population, by Age, by Year, Texas, 1999-2006



Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

Figure 3-98. Malignant Neoplasm Death Rate Per 100,000 Population, by Race/Ethnicity and Age, Texas, 2004-2006



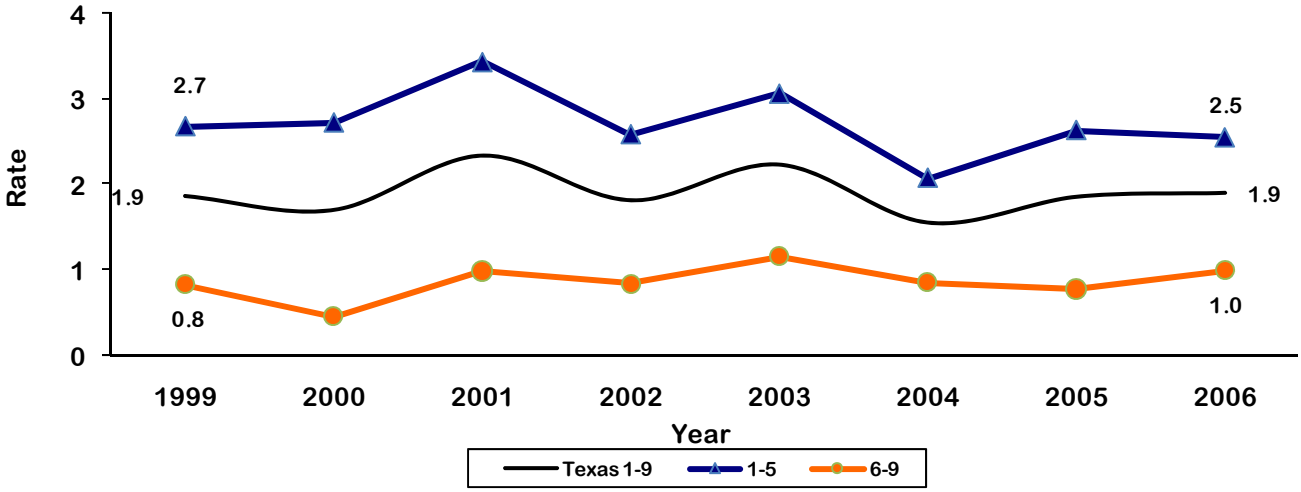
Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

HOMICIDE

While there have been fluctuations in the homicide rates between 1999 and 2006 in the 1 to 5, 6 to 9, and the overall 1 to 9 year old age groups, there was no difference in the homicide rates between 1999 and 2006 in the 1 to 5 year age group and only slight absolute increases in the 1 to 9 and 6 to 9 year old age groups.

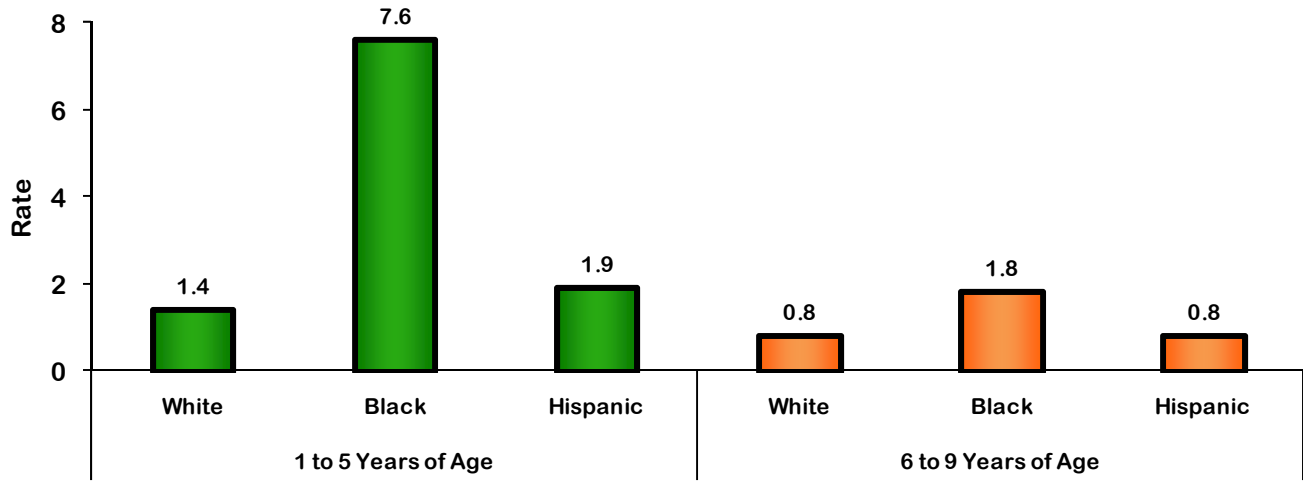
Regardless of gender, among children 1 to 5 years of age, Black children had significantly higher rates of homicide than children of any other racial/ethnic group. Among 1 to 5 year old males, the homicide rate among Black children was more than three times greater than among White children. Among 1 to 5 year old females, the homicide rate among Black children was ten times greater than that of White children. Among 6 to 9 year old children, racial disparities were significantly less than the disparities found among 1 to 5 year old males and non-existent among females.

Figure 3-99. Homicide Rate Per 100,000 Population, by Age, by Year, Texas, 1999-2006



Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

Figure 3-100. Homicide Rate Per 100,000 Population, by Race/Ethnicity and Age, Texas, 2004-2006



Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

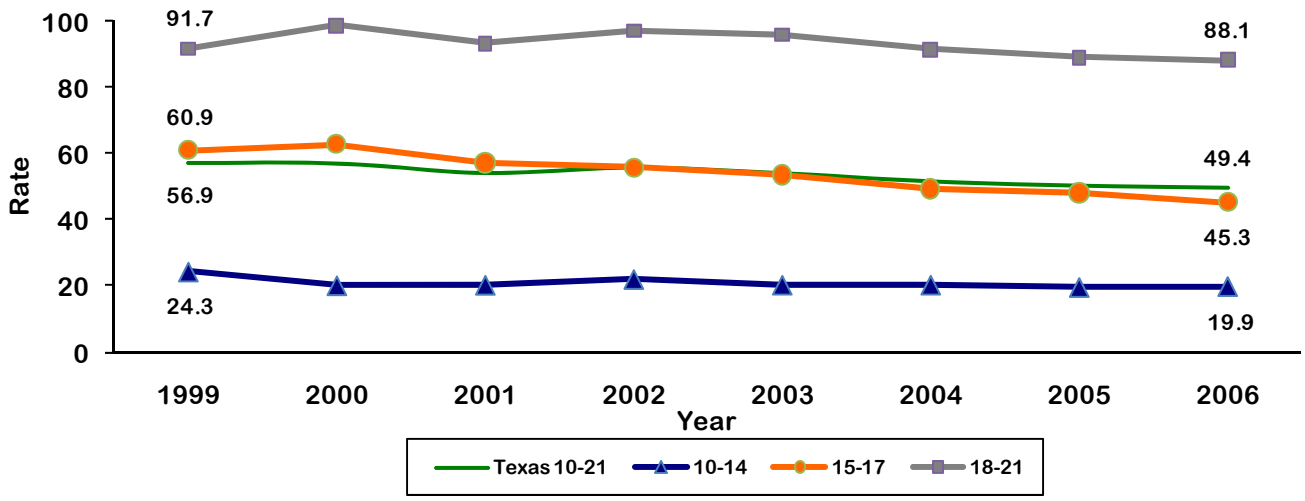
ADOLESCENTS (AGES 10 TO 21 YEARS)

OVERALL MORTALITY

The overall mortality rate among Texas adolescents aged 10 to 21 years old ranged from a low of 49.4 per 100,000 population in 2006 to a high of 56.9 per 100,000 population in 1999. The overall mortality rate decreased by 13.3% from 1999 to 2006 for adolescents aged 10 to 21. The decline among adolescents 15 to 17 years of age (25.7%) was more than 6 times greater than the decline among adolescents 18 to 21 years of age (3.9%).

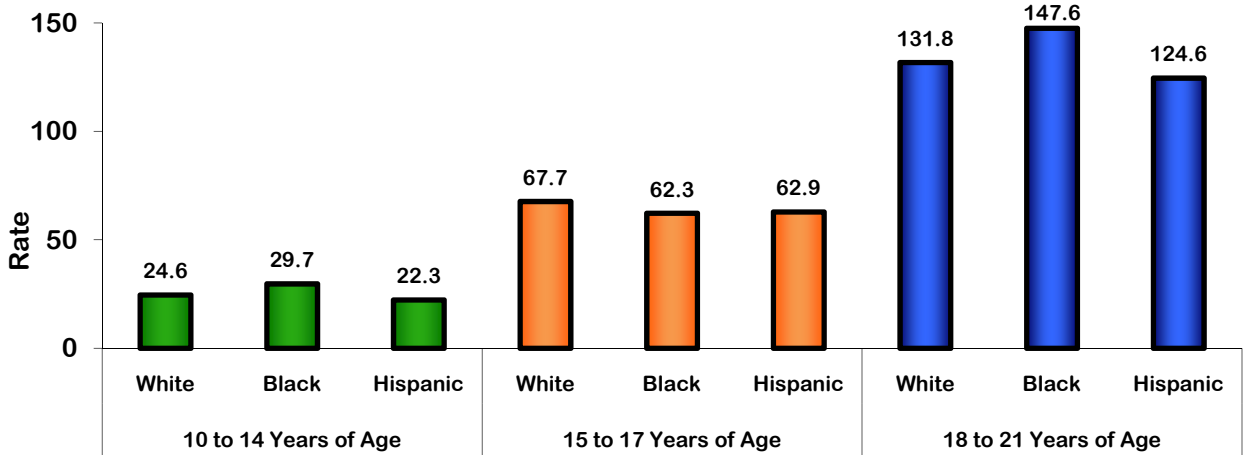
The overall mortality rate was greater among adolescents 18 to 21 years of age. Racial disparities were greater among females, regardless of age. Among females aged 10 to 14 years old, the mortality rate among Blacks was 1.7 and 2.8 times as high as that of Whites and Hispanics, respectively. Among females aged 15 to 17 years old, the mortality rate among Blacks was 3.5 and 3.8 times as high as that of Whites and Hispanics, respectively. Among females aged 18 to 21 years old, the mortality rate among Blacks was 2.5 and 4.3 times as high as that of Whites and Hispanics, respectively.

Figure 3-101. Mortality Rate per 100,000 by Age by Year, Texas, 1999-2006



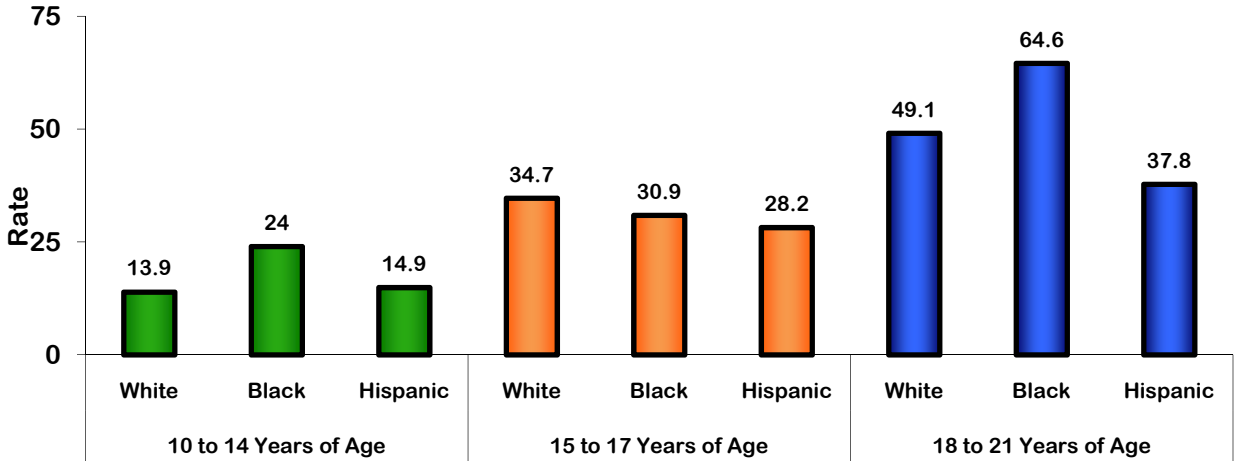
Source: Texas Vital Statistics Mortality File, 1999-2006, Texas Department of State Health Services.

Figure 3-102. Mortality Rate per 100,000 Among Males, by Race/Ethnicity and Age, Texas, 2004-2006



Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

Figure 3-103. Mortality Rate per 100,000
Among Females, by Race/Ethnicity and Age, Texas, 2004-2006



Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

LEADING CAUSES OF DEATH

From 2004 through 2006, there were 6,322 deaths to Texas residents aged 10 to 21 years of age. Of these deaths, 1,034 were to 10 to 14 year olds, 1,506 were to 15 to 17 year olds, and 3,782 were to 18 to 21 year olds. The five leading causes of death for this age group were accidents (24.1 deaths per 100,000 population), assault (6.4 deaths per 100,000 population), intentional self-harm (5.8 deaths per 100,000 population), and malignant neoplasms (3.2 deaths per 100,000 population).

Table 3-9. Texas Resident Deaths to Adolescents 10-21 Years of Age
by Cause of Death, 2004-2006

	Total, 10-21 Years Old		10-14 Years Old		15-17 Years Old		18-21 Years Old	
Cause of Death	Number	Rate	Number	Rate	Number	Rate	Number	Rate
All Causes	6,322	50.2	1,034	19.9	1,506	47.5	3,782	89.4
Accidents	3,038	24.1	409	7.9	706	22.3	1,923	45.5
Assault (homicide)	801	6.4	63	1.2	172	5.4	566	13.4
Intentional self-harm (suicide)	729	5.8	65	1.3	192	6.1	472	11.2
Malignant neoplasms	401	3.2	138	2.7	99	3.1	164	3.9

Rates are per 100,000 population.
Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

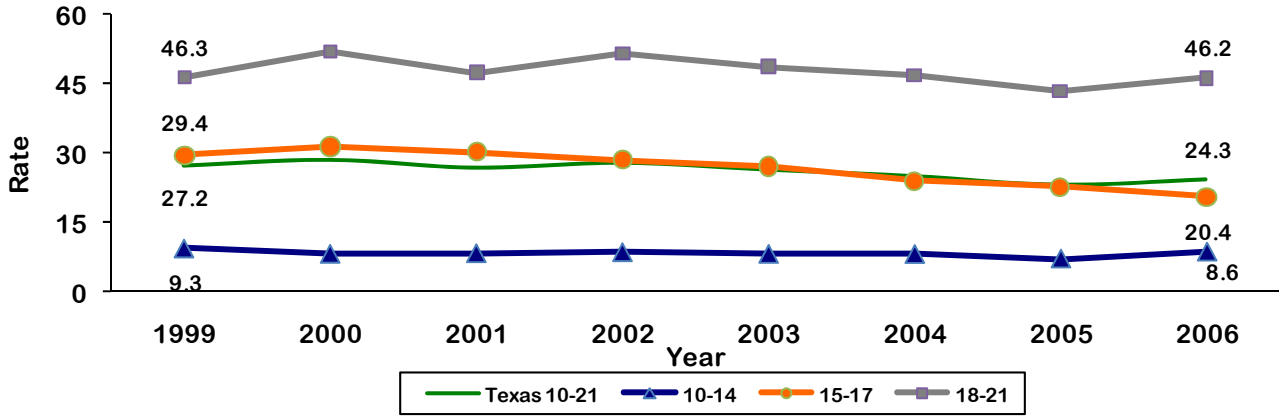
ACCIDENTAL DEATHS (UNINTENTIONAL INJURY)

The unintentional injury mortality rate among Texas children aged 10 to 21 years old ranged from a low of 23.1 per 100,000 population in 2005 to a high of 28.4 per 100,000 population in 2000. The unintentional injury mortality rate decreased by 10.8% from 1999 to 2006 for adolescents aged 10 to 21. The decline among adolescents 15 to 17 years of age (30.7%) was over four times the decline among child 10 to 14 years of age (7.5%).

The unintentional injury mortality rate was greater among males and increased for each age group. White children have the highest unintentional injury mortality rates, regardless of age or gender. Among males, the mortality rate among White children was 1.1 times higher than the mortality rate among Black children in the 10 to 14 year old age group, 2.3 times higher in the 15 to 17 year old age group, and 2.2 times higher in the 18 to 21 year old age group. Among females, the mortality rate among White children was 1.2 times higher than the mortality rate among Black children in the 10 to 14 year old age group, 2.1 times higher in the 15 to 17 year old age group, and 1.3 times higher in the 18 to 21 year old age group.

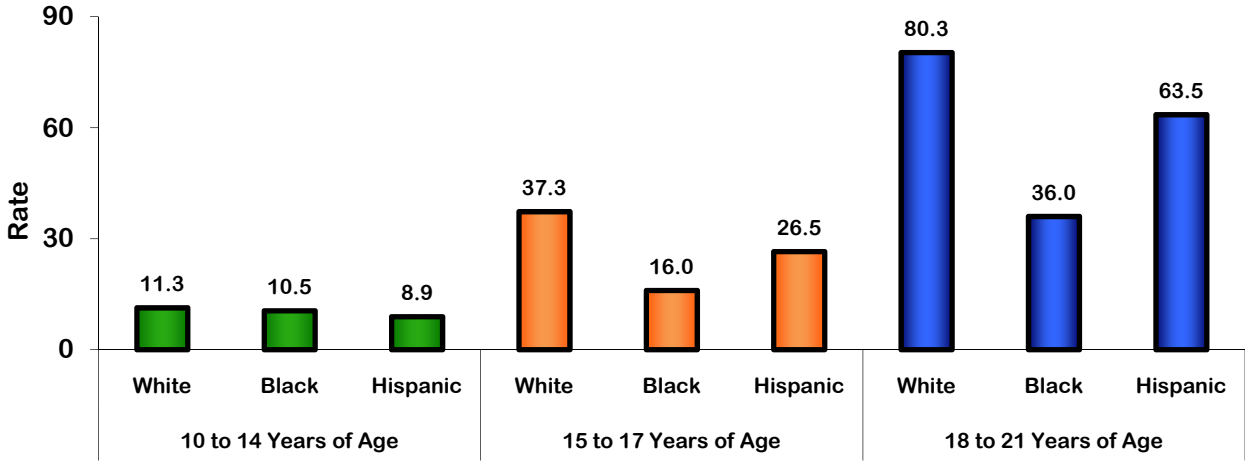
From 2004 to 2006, there were 3,038 accidental deaths to adolescents aged 10 to 21 years old. Of this total, 2,204 (72.5%) were motor vehicle accident deaths. The remaining 27.5% of the accidental deaths were due to a variety of causes of death.

Figure 3-104. Unintentional Injury Death Rate Per 100,000 Population, by Age, by Year, Texas, 1999-2006



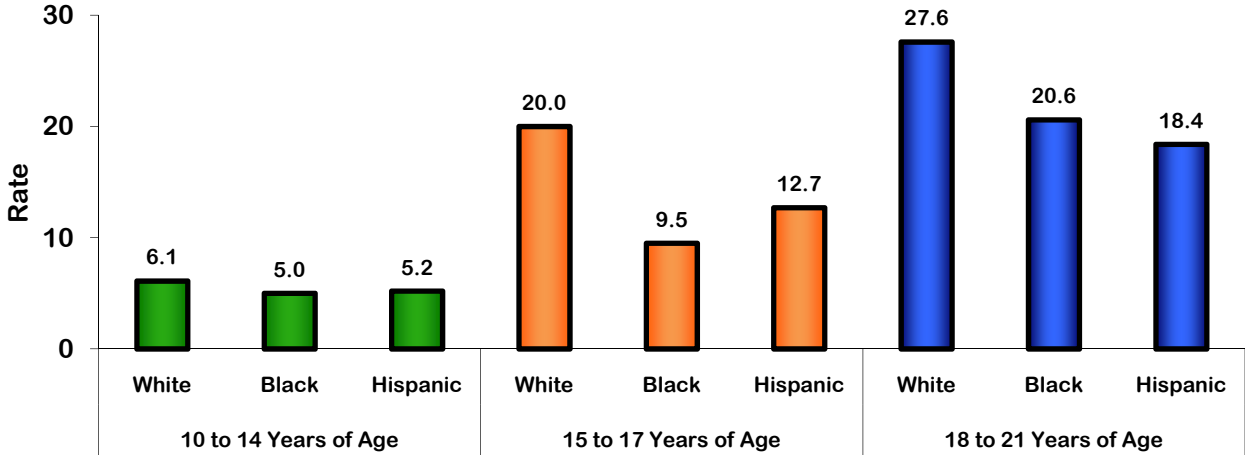
Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

Figure 3-105. Unintentional Injury Death Rate Per 100,000
Among Males by Race/Ethnicity and Age, Texas, 2004-2006



Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

Figure 3-106. Unintentional Injury Death Rate Per 100,000
Among Females by Race/Ethnicity and Age, Texas, 2004-2006



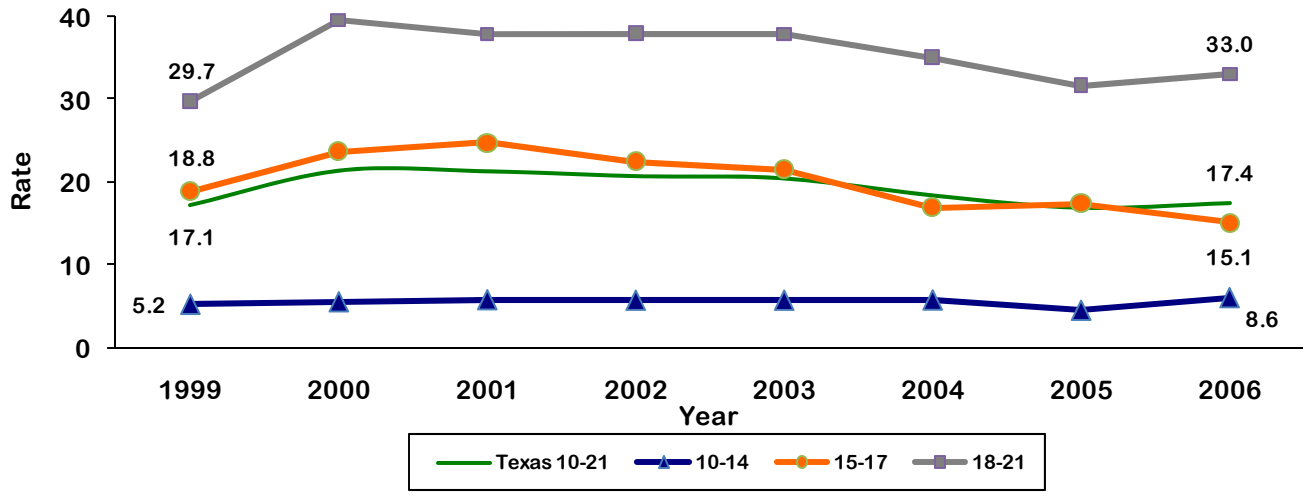
Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

MOTOR VEHICLE CRASH DEATHS

In the 10 to 21 year old age group, there was no change in the rate of motor vehicle crash deaths between 1999 and 2006. In the 10 to 14 year old age group, the rate of motor vehicle crash deaths increased 14.8% between 1999 and 2006. In the 15 to 17 year old age group, the rate of motor vehicle crash deaths decreased 20.1% between 1999 and 2006. In the 18 to 21 year old age group, the rate of motor vehicle crash deaths increased 11.1% between 1999 and 2006.

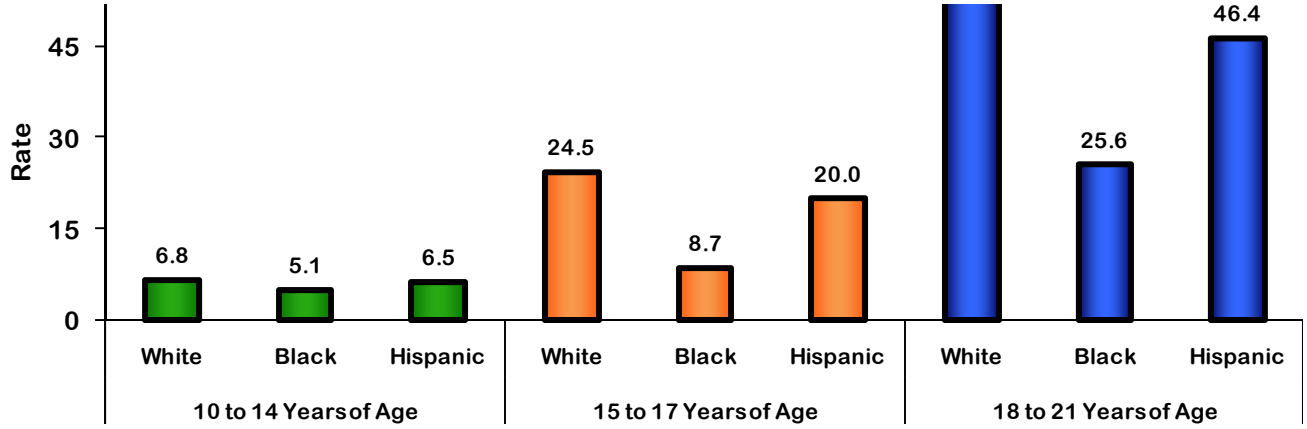
The highest rate of motor vehicle crash deaths was among White children. The rate of motor vehicle crash deaths increased with age. Among males, the mortality rate among White children was 1.3 times higher than the mortality rate among Black children in the 10 to 14 year old age group, 2.8 times higher in the 15 to 17 year old age group, 2.1 times higher in the 18 to 21 year old age group. Among females, the mortality rate among White children was 1.6 times higher than the mortality rate among Black children in the 10 to 14 year old age group, 1.9 times higher in the 15 to 17 year old age group, and 1.6 times higher in the 18 to 21 year old age group.

Figure 3-107. Motor Vehicle Crash Death Rate Per 100,000 Population, by Age, by Year, Texas, 1999-2006



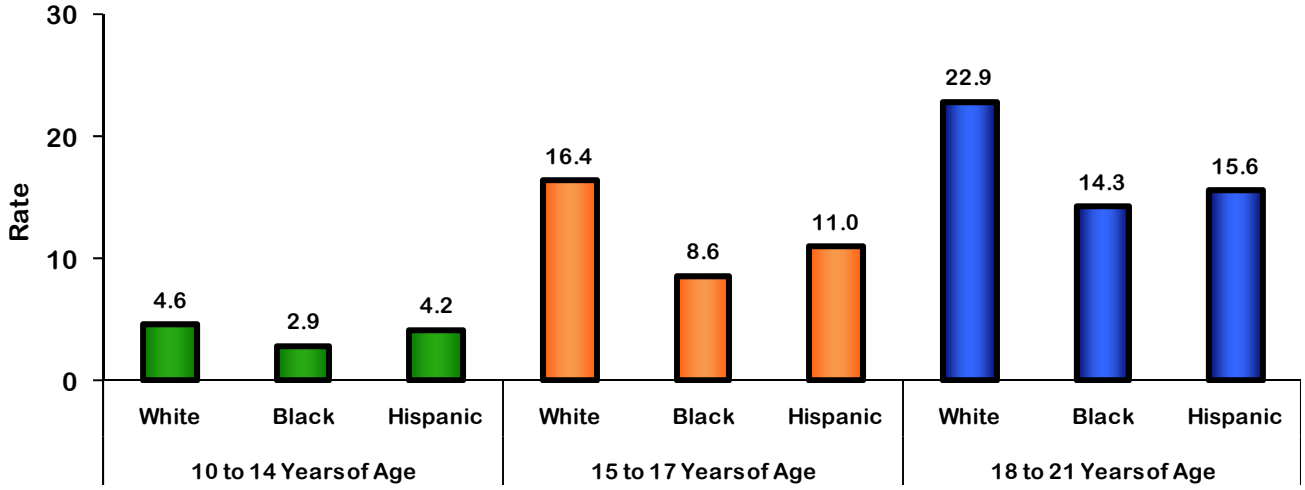
Source: Texas Vital Statistics Mortality File, 1999-2006, Texas Department of State Health Services.

Figure 3-108. Motor Vehicle Crash Death Rate Per 100,000 Among Males by Race/Ethnicity and Age, Texas, 2004-2006



Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

Figure 3-109. Motor Vehicle Crash Death Rate Per 100,000 Among Females by Race/Ethnicity and Age, Texas, 2004-2006



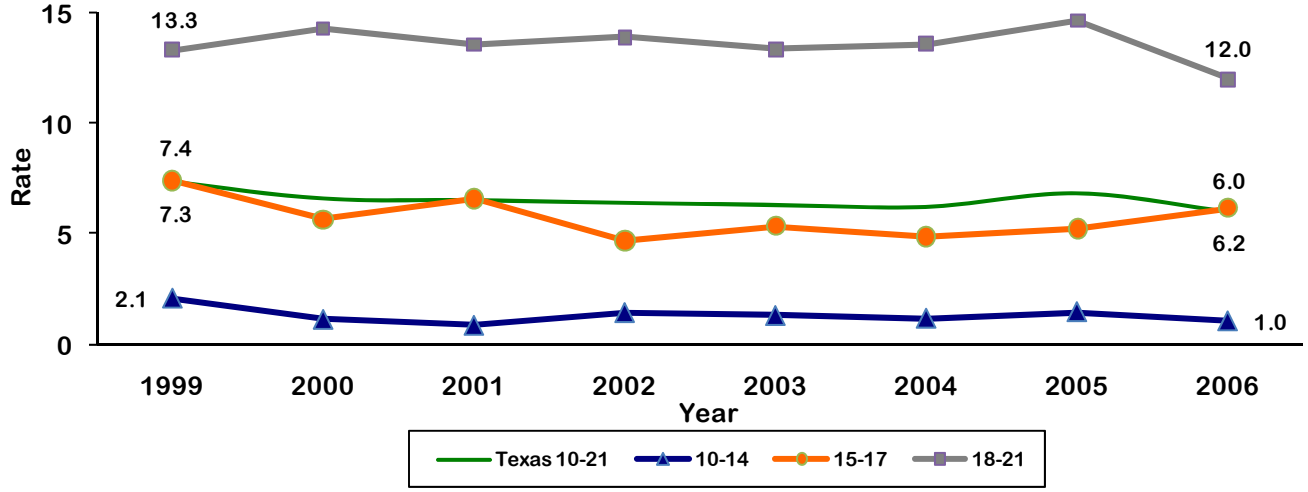
Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

HOMICIDE

In the 10 to 21 year old age group, there was a 17.6% decrease in the homicide rate between 1999 and 2006. In the 10 to 14 year old age group, the rate of homicides decreased 49.5% between 1999 and 2006. In the 15 to 17 year old age group, the rate of homicides decreased 16.9% between 1999 and 2006. In the 18 to 21 year old age group, the rate of homicides decreased 10.0% between 1999 and 2006.

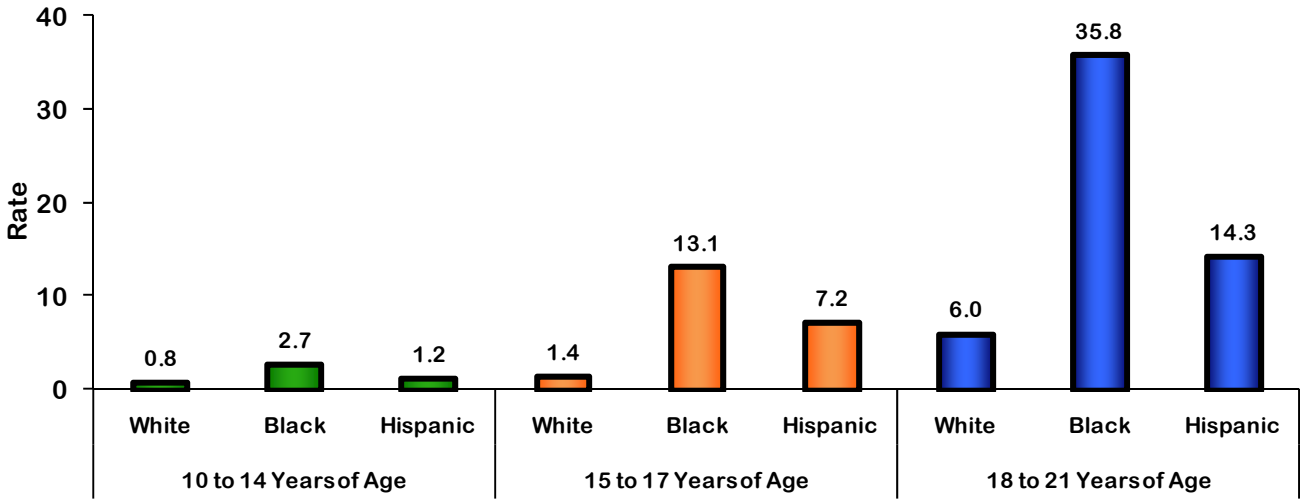
Regardless of gender or age, Black adolescents had significantly higher rates of homicide than children of any other racial/ethnic group. The homicide rate among Black adolescents was 3.4 times greater than among White adolescents in the 10 to 14 year old age group, 9.4 times greater in the 15 to 17 year old age group, and 6.0 times greater in the 18 to 21 year old age group.

Figure 3-110. Homicide Rate Per 100,000 Population, by Age, by Year, Texas, 1999-2006



Source: Texas Vital Statistics Mortality File, 1999-2006, Texas Department of State Health Services.

Figure 3-111. Homicide Rate Per 100,000 Population, by Race/Ethnicity, by Age, Texas, 2004-2006



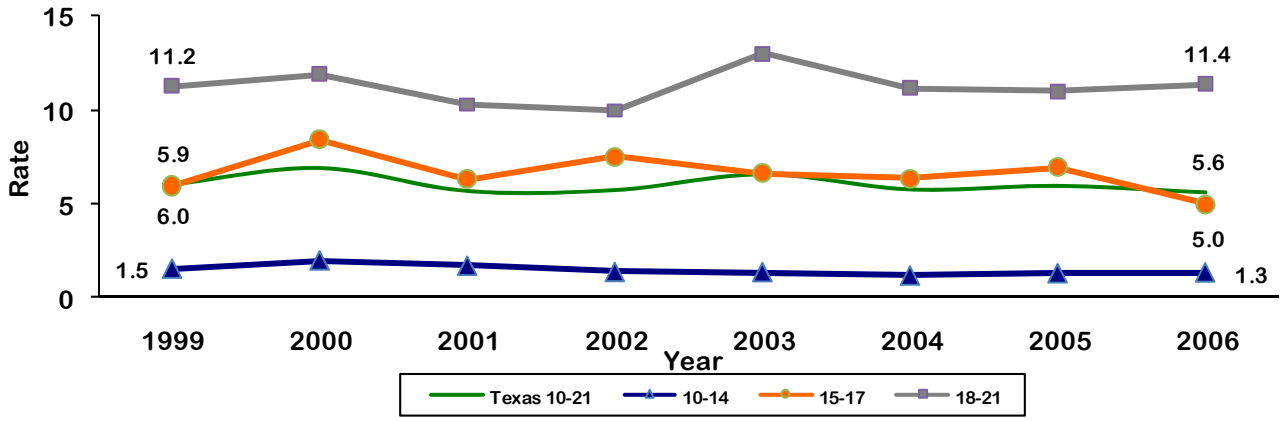
Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

SUICIDE

In the 10 to 21 year old age group, there was a 6.6% decrease in the suicide rate between 1999 and 2006. In the 10 to 14 year old age group, the rate of suicides decreased 13.1% between 1999 and 2006. In the 15 to 17 year old age group, the rate of suicides decreased 16.6% between 1999 and 2006. In the 18 to 21 year old age group, the rate of suicides increased 0.9% between 1999 and 2006.

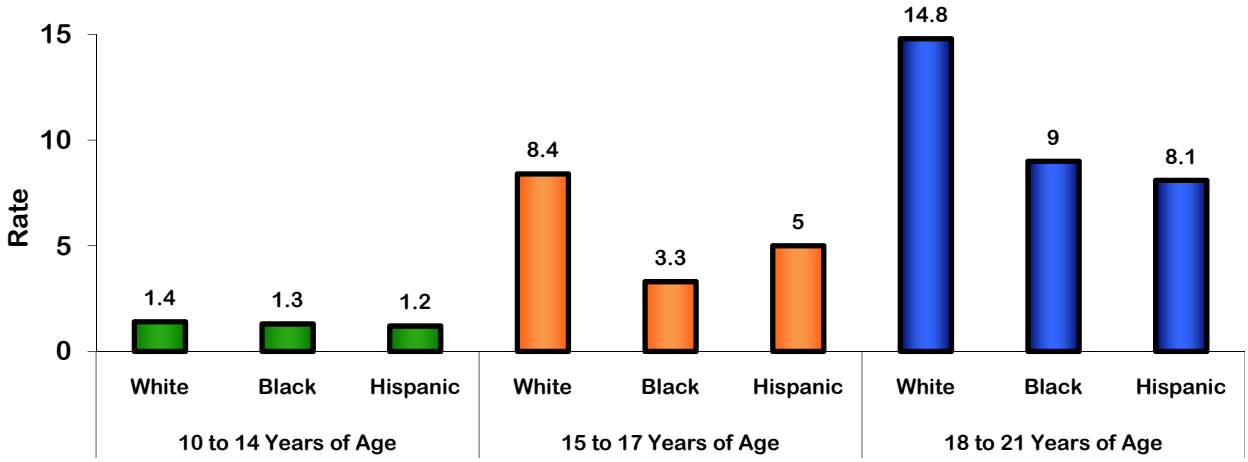
Regardless of gender or age, White adolescents had significantly higher rates of suicide than children of any other racial/ethnic group. The suicide rate among White adolescents was 1.1 times greater than among Black adolescents in the 10 to 14 year old age group, 2.5 times greater in the 15 to 17 year old age group, and 1.6 times greater in the 18 to 21 year old age group.

Figure 3-112. Suicide Rate Per 100,000 Population, by Age, by Year, Texas, 1999-2006



Source: Texas Vital Statistics Mortality File, 1999-2006, Texas Department of State Health Services.

Figure 3-113. Suicide Rate Per 100,000 Population, by Race/Ethnicity and Age, Texas, 2004-2006



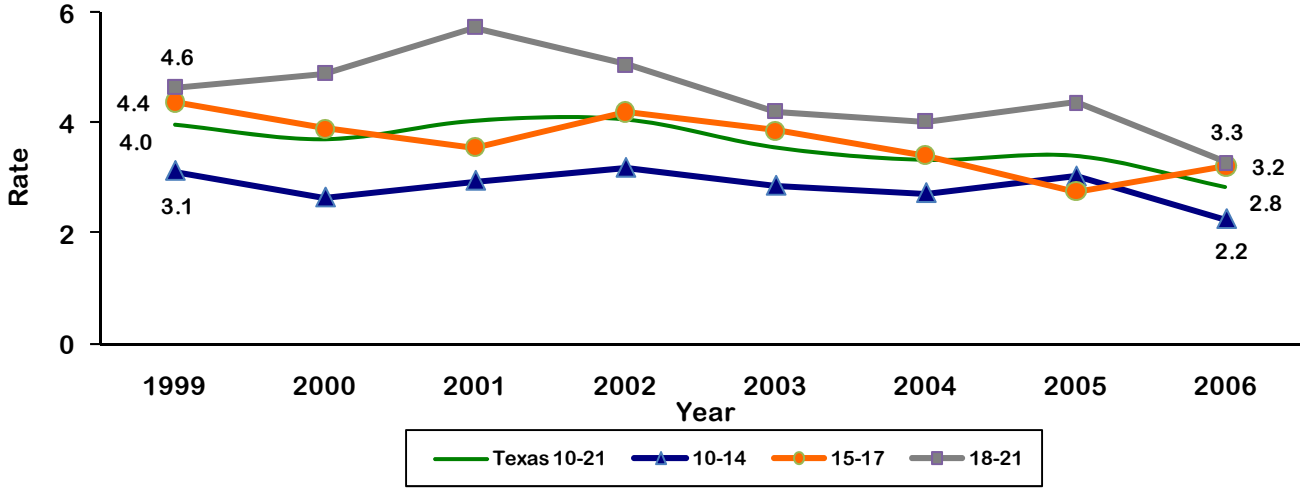
Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

MALIGNANT NEOPLASM (CANCER)

The malignant neoplasm mortality rate among Texas adolescents aged 10 to 21 years old ranged from a low of 2.8 per 100,000 population in 2006 to a high of 4.0 per 100,000 population in 1999 and 2001. The malignant neoplasm mortality rate decreased by 28.2% from 1999 to 2006 for adolescents aged 10 to 21. The malignant neoplasm mortality rate decreased by 27.9% from 1999 to 2006 for adolescents aged 10 to 14, decreased 26.6% in adolescents 15 to 17 years old, and decreased 29.4% in adolescents 18 to 21 years old during this same time period.

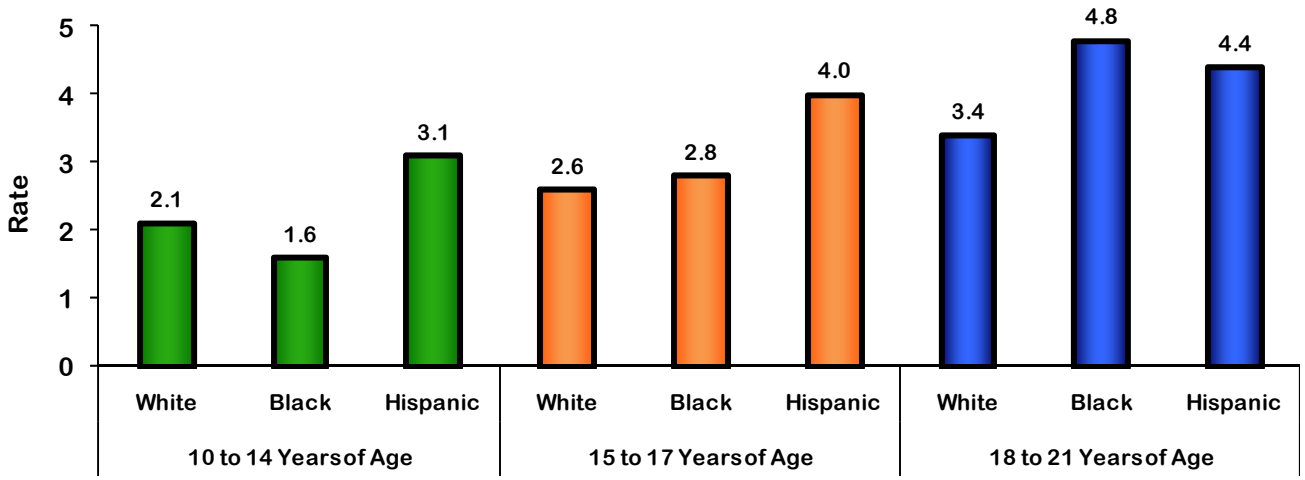
The malignant neoplasm mortality rate increased as age increased, regardless of race/ethnicity. Hispanic adolescents had the highest malignant neoplasm mortality rates in the 10 to 14 year old and 15 to 17 year old age group. Black adolescents had the highest malignant neoplasm mortality rate in the 18 to 21 year old age group. The malignant neoplasm mortality rate among Hispanic adolescents was 1.9 times greater than the rate among Black adolescents in the 10 to 14 year old age group. The malignant neoplasm mortality rate among Hispanic adolescents was 1.4 times greater than the rate among White adolescents in the 15 to 17 year old age group. The malignant neoplasm mortality rate among Black adolescents was 1.4 times greater than the rate among White adolescents in the 18 to 21 year old age group.

Figure 3-114. Malignant Neoplasm Mortality Rate Per 100,000 Population,
Malignant Neoplasm Mortality Rate Per 100,000 Population,



Source: Texas Vital Statistics Mortality File, 1999-2006, Texas Department of State Health Services.

Figure 3-115. Malignant Neoplasm Mortality Rate Per 100,000 Population, by Race/Ethnicity and Age, Texas, 2004-2006



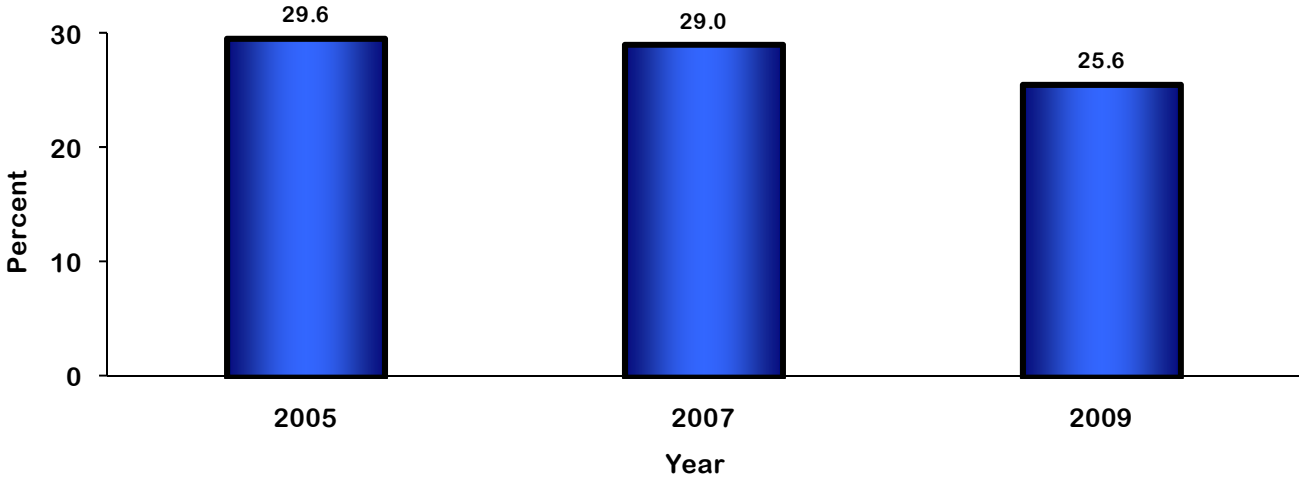
Source: Texas Vital Statistics Mortality File, 2004-2006, Texas Department of State Health Services.

RISK BEHAVIORS

ALCOHOL

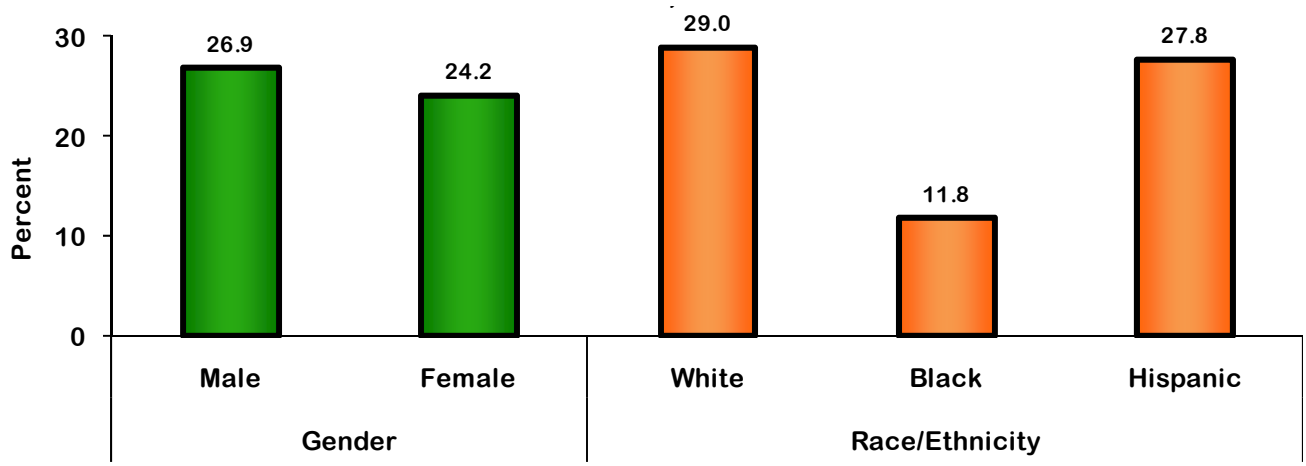
The Youth Risk Behavioral Survey asks students if they have had 5 or more drinks of alcohol in a row, that is, within a couple of hours, on 1 or more of the past 30 days. The percentage of students who reported drinking more than 5 drinks decreased 13.5% from 2005 to 2009. Males (25.9%) were more likely to report drinking than females (24.2%). The percentage of White adolescents who reported they drank was more than 2.5 times as high as the percentage of Black adolescents.

Figure 3-116. Percent of Students Who Had Five or More Drinks of Alcohol Within a Couple of Hours, by Year, Texas, 2005-2009



Source: Youth Risk Behavioral Survey, 2005, 2007, and 2009, Texas Department of State Health Services.

Figure 3-117. Percent of Students Who Had Five or More Drinks of Alcohol Within a Couple of Hours, by Gender and Race/Ethnicity, Texas, 2009

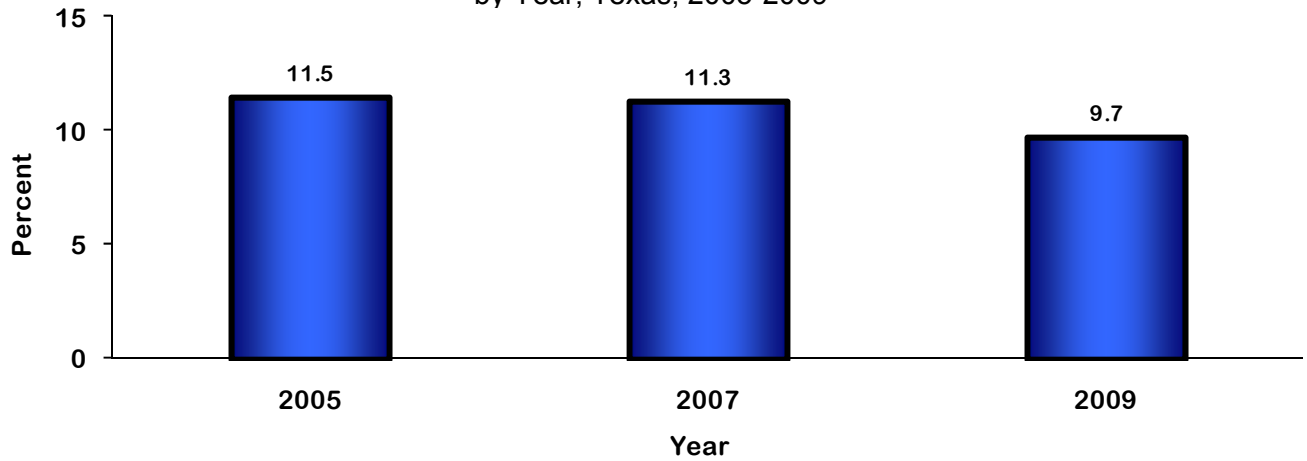


Source: Youth Risk Behavioral Survey, 2009, Texas Department of State Health Services.

CIGARETTES

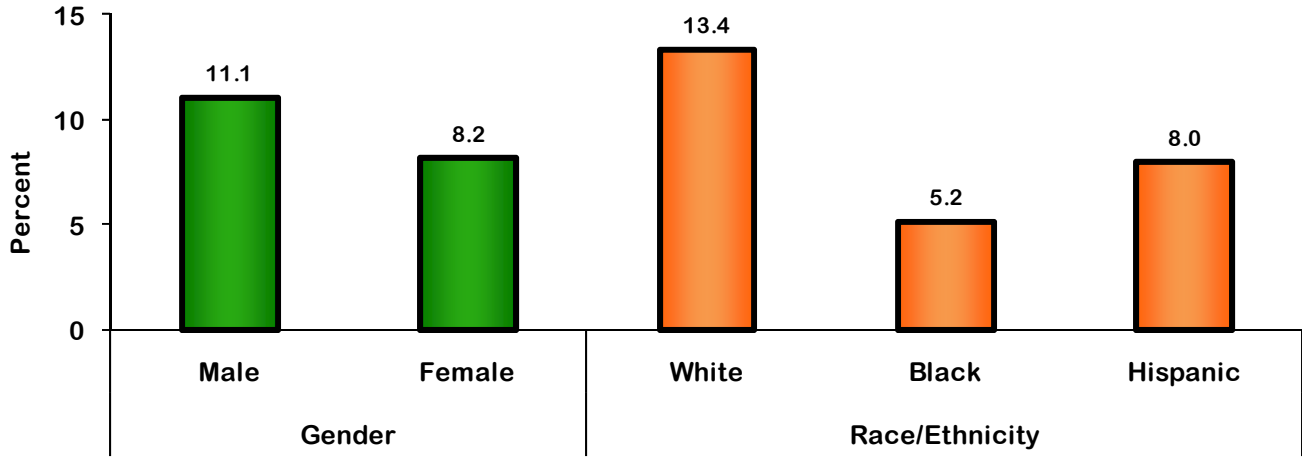
The Youth Risk Behavioral Survey asks students if they have ever smoked cigarettes daily, that is, at least 1 cigarette every day for 30 days. The percentage of students who reported smoking daily decreased 15.7% from 2005 to 2009. Males (11.1%) were more likely to report smoking than females (8.2%). The percentage of White adolescents who reported they smoke was more than 2.6 and 1.7 times as high as the percentage of Black and Hispanic adolescents, respectively.

Figure 3-118. Percent of Students Who Ever Smoked Cigarettes Daily, by Year, Texas, 2005-2009



Source: Youth Risk Behavioral Survey, 2005, 2007, and 2009, Texas Department of State Health Services.

Figure 3-119. Percent of Students Who Ever Smoked Cigarettes Daily, by Gender and Race/Ethnicity, Texas, 2009

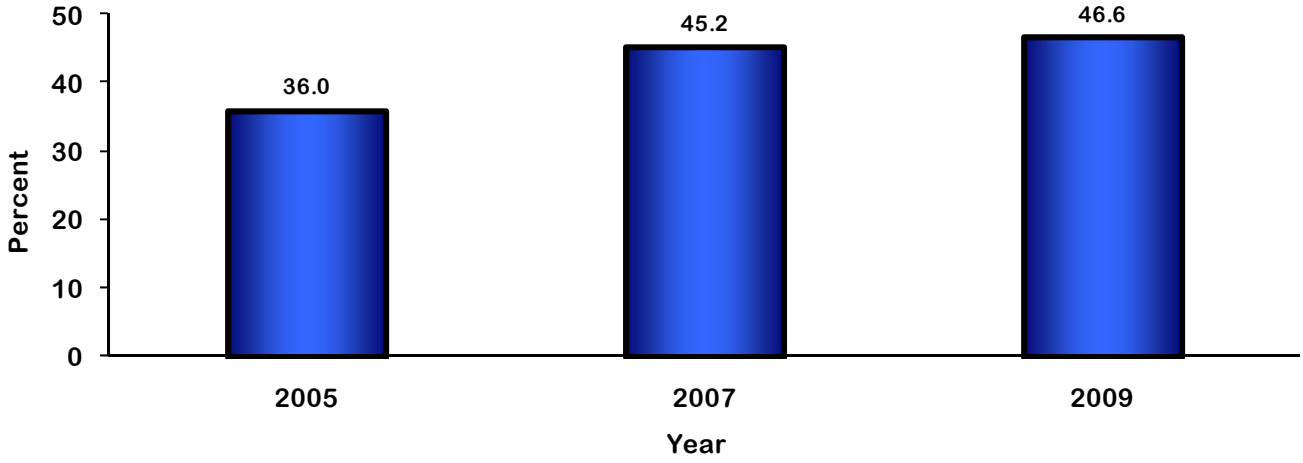


Source: Youth Risk Behavioral Survey, 2009, Texas Department of State Health Services.

PHYSICALLY ACTIVE

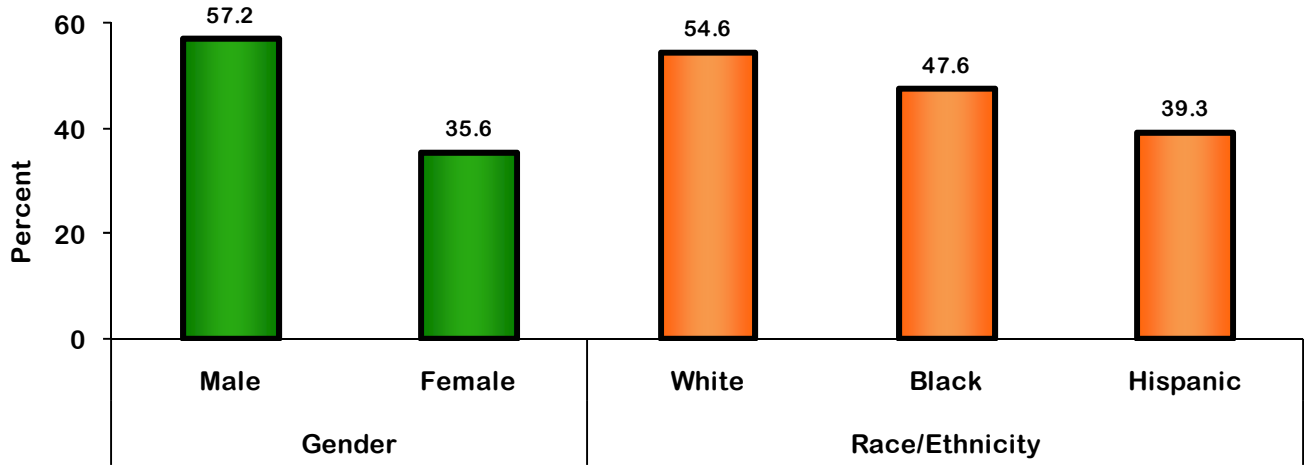
The Youth Risk Behavioral Survey asks students if they were physically active for a total of at least 60 minutes per day on 5 or more of the past 7 days. The percentage of students who reported being physically active increased 29.4% from 2005 to 2009. Males (57.2%) were more likely to report being physically active than females (35.6%). The percentage of White adolescents who reported they were physically active was more than 1.4 times as high as the percentage of Hispanic adolescents.

Figure 3-120. Percent of Students Who Were Physically Active, by Year, Texas, 2005-2009



Source: Youth Risk Behavioral Survey, 2005, 2007, and 2009, Texas Department of State Health Services.

Figure 3-121. Percent of Students Who Were Physically Active, by Gender and Race/Ethnicity, Texas, 2009

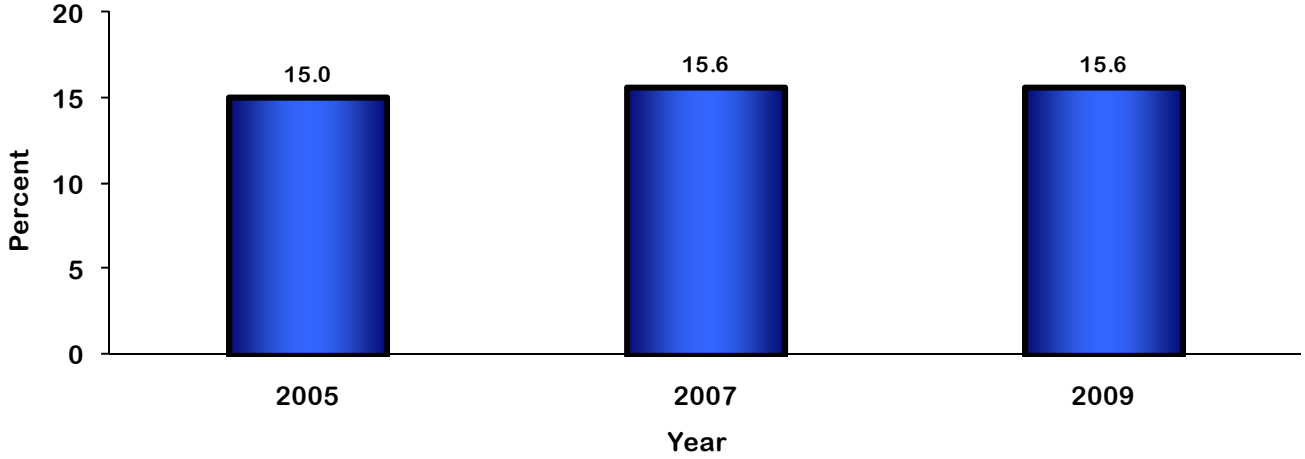


Source: Youth Risk Behavioral Survey, 2009, Texas Department of State Health Services.

OVERWEIGHT

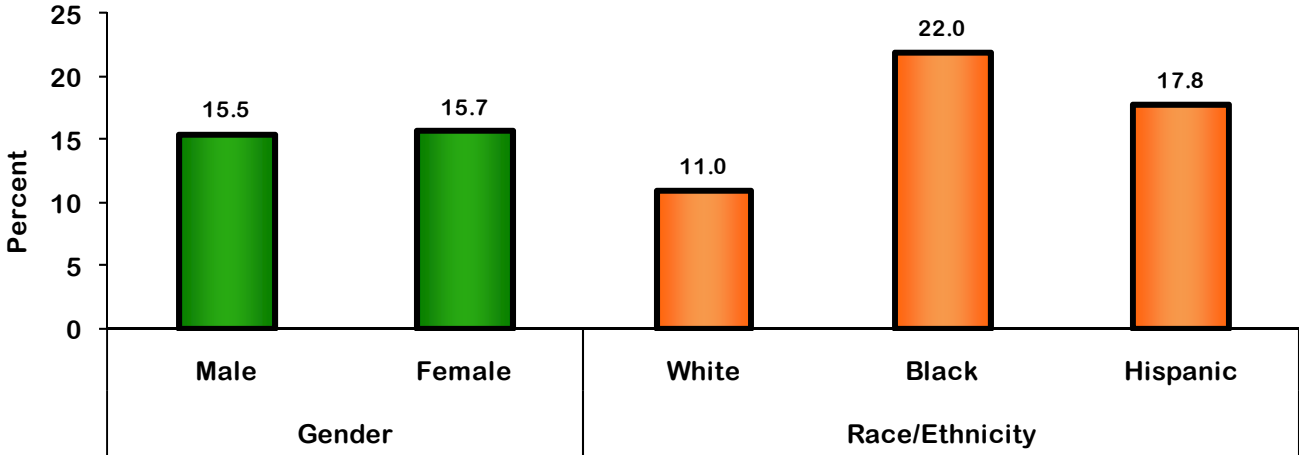
The Youth Risk Behavioral Survey asks students their weight and height to determine their BMI level specific to their age group and gender. The percentage of students who were overweight increased 4.0% from 2005 to 2009. Females (15.7%) were slightly more likely to be overweight than males (15.5%). The percentage of Black adolescents who were overweight was 2.0 times as high as the percentage of White adolescents.

Figure 3-122. Percent of Students Who Were Overweight, by Year, Texas, 2005-2009



Source: Youth Risk Behavioral Survey, 2005, 2007, and 2009, Texas Department of State Health Services.

Figure 3-123. Percent of Students Who Were Overweight, by Gender and Race/Ethnicity, Texas, 2009

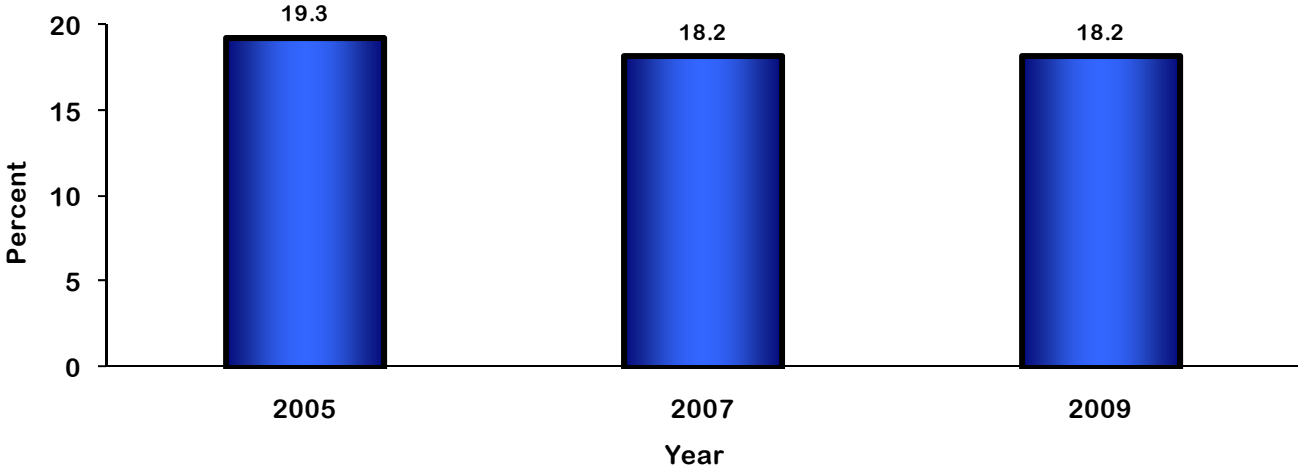


Source: Youth Risk Behavioral Survey, 2009, Texas Department of State Health Services.

WEAPONS

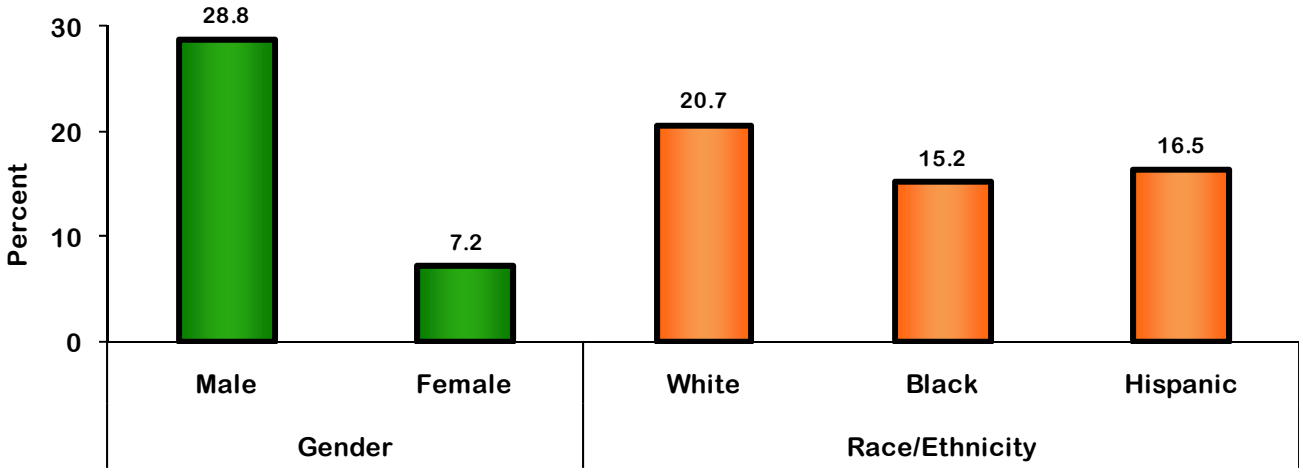
The Youth Risk Behavioral Survey asks students if they carried a weapon such as a gun, knife, or club on 1 or more of the past 30 days. The percentage of students who reported carrying a weapon decreased 5.7% from 2005 to 2009. Males (28.8%) were four times more likely to report carrying a weapon than females (7.2%). The percentage of White adolescents who reported carrying a weapon was 1.4 times as high as the percentage of Black adolescents.

Figure 3-124. Percent of Students Who Carried a Weapon, by Year, Texas, 2005-2009



Source: Youth Risk Behavioral Survey, 2005, 2007, and 2009, Texas Department of State Health Services.

Figure 3-125. Percent of Students Who Carried a Weapon, by Gender and Race/Ethnicity, Texas, 2009

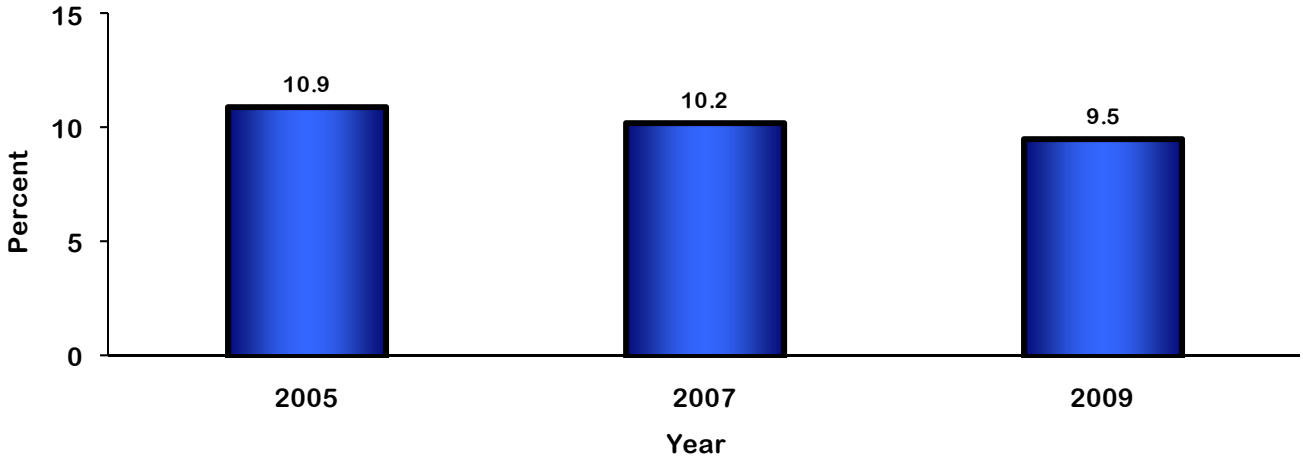


Source: Youth Risk Behavioral Survey, 2009, Texas Department of State Health Services.

DOMESTIC VIOLENCE

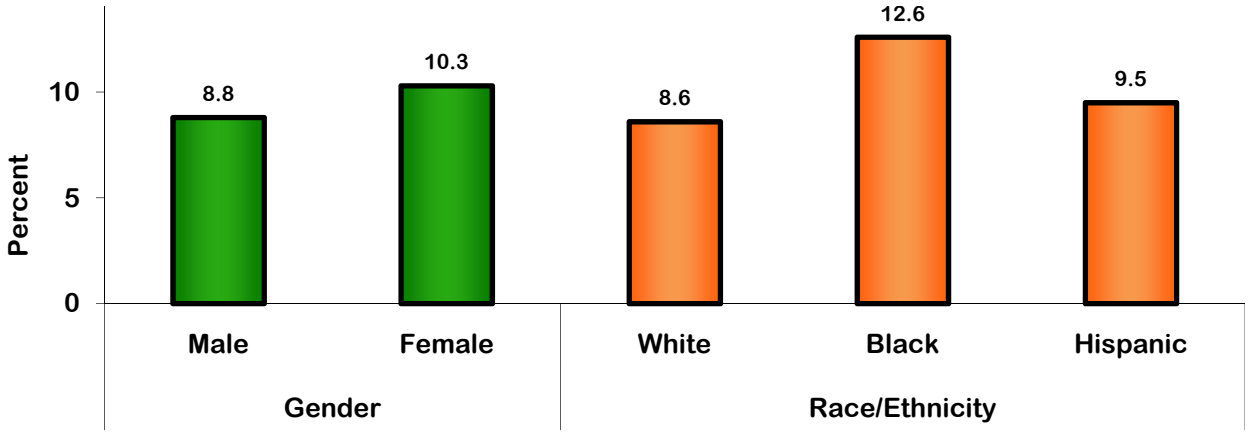
The Youth Risk Behavioral Survey asks students if they were ever hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the past 12 months. The percentage of students who reported domestic violence decreased 12.8% from 2005 to 2009. Females (10.3%) were slightly more likely to report domestic violence than males (8.8%). The percentage of Black adolescents who reported domestic violence was 1.5 times as high as the percentage of White adolescents.

Figure 3-126. Percent of Students Who Were Hit, Slapped, or Physically Hurt by Boyfriend/Girlfriend, by Year, Texas, 2005-2009



Source: Youth Risk Behavioral Survey, 2005, 2007, and 2009, Texas Department of State Health Services.

Figure 3-127. Percent of Students Who Were Hit, Slapped or Physically Hurt by Boyfriend/Girlfriend, by Gender and Race/Ethnicity, Texas, 2009

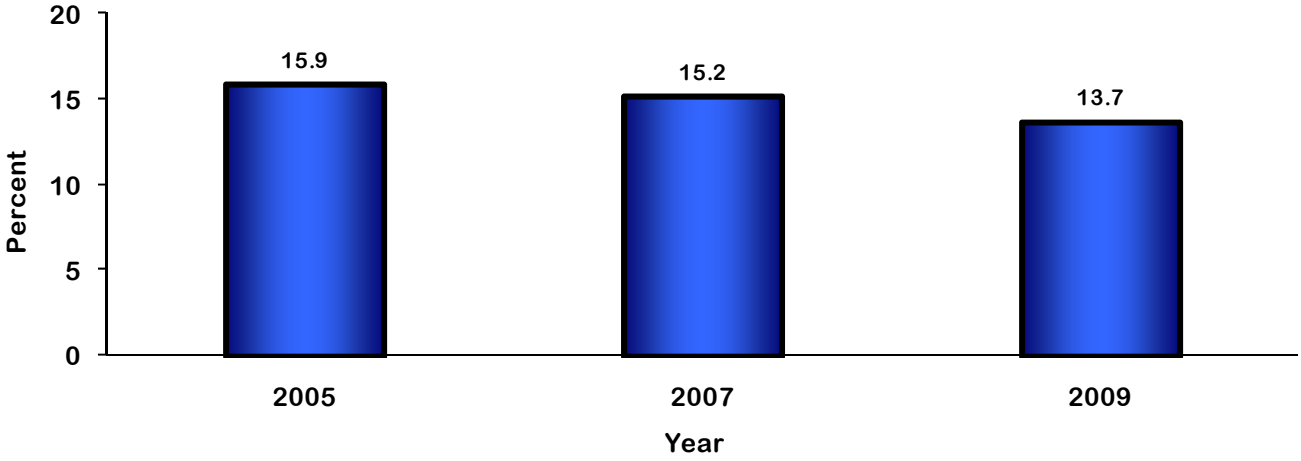


Source: Youth Risk Behavioral Survey, 2009, Texas Department of State Health Services.

SUICIDE

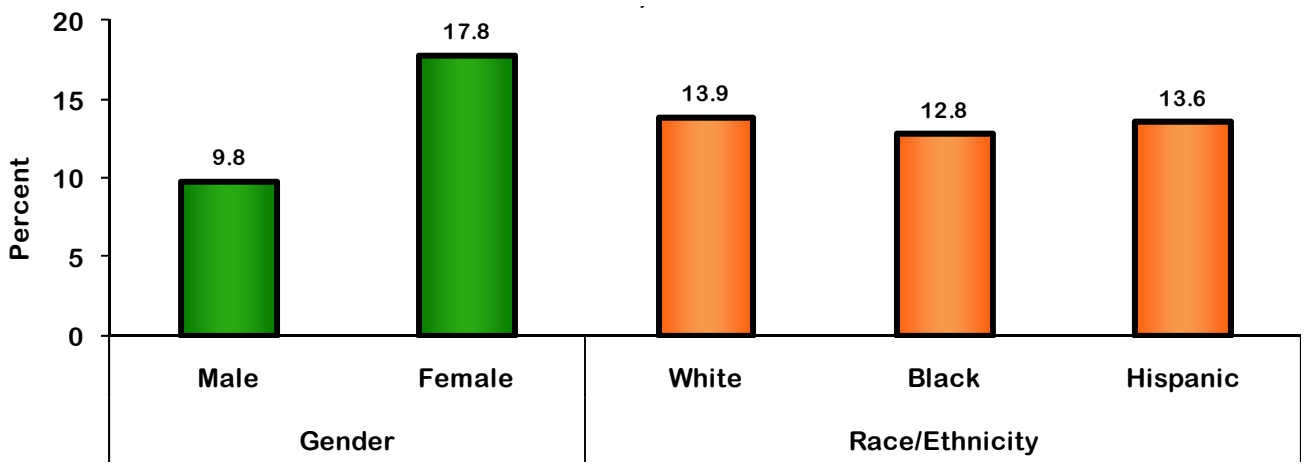
The Youth Risk Behavioral Survey asks students if they had seriously considered attempting suicide during the past 12 months. The percentage of students who reported they considered attempting suicide decreased 13.8% from 2005 to 2009. Females (17.8%) were 1.8 times more likely to report they had considered attempting suicide than males (9.8%). The percentage of adolescents who reported they considered attempting suicide was similar across all races/ethnicities.

Figure 3-128. Percent of Students Who Seriously Considered Attempting Suicide, by Year, Texas, 2005-2009



Source: Youth Risk Behavioral Survey, 2005, 2007, and 2009, Texas Department of State Health Services.

Figure 3-129. Percent of Students Who Seriously Considered Attempting Suicide, by Gender and Race/Ethnicity, Texas, 2009

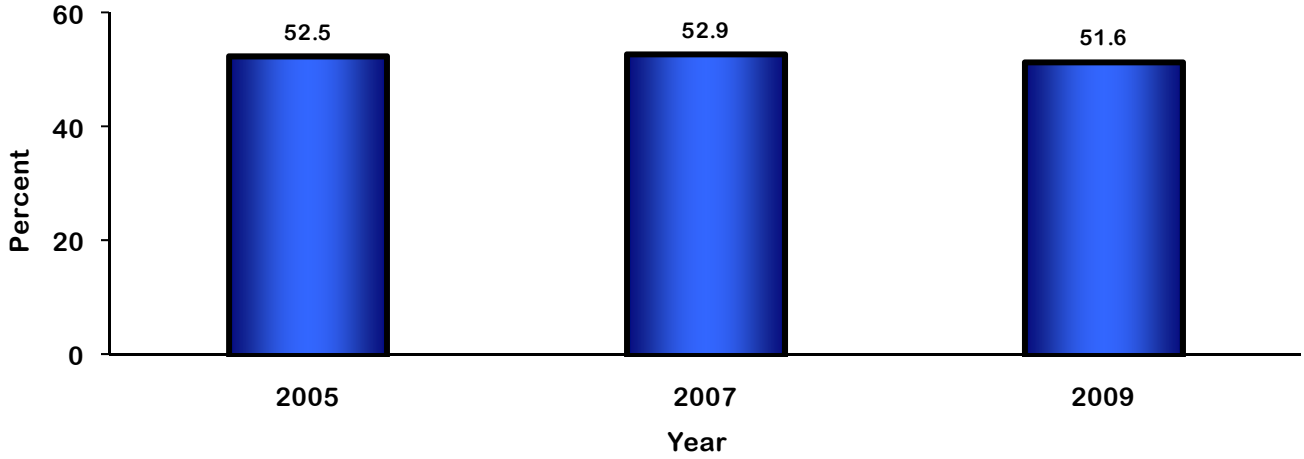


Source: Youth Risk Behavioral Survey, 2009, Texas Department of State Health Services.

SEXUAL INTERCOURSE

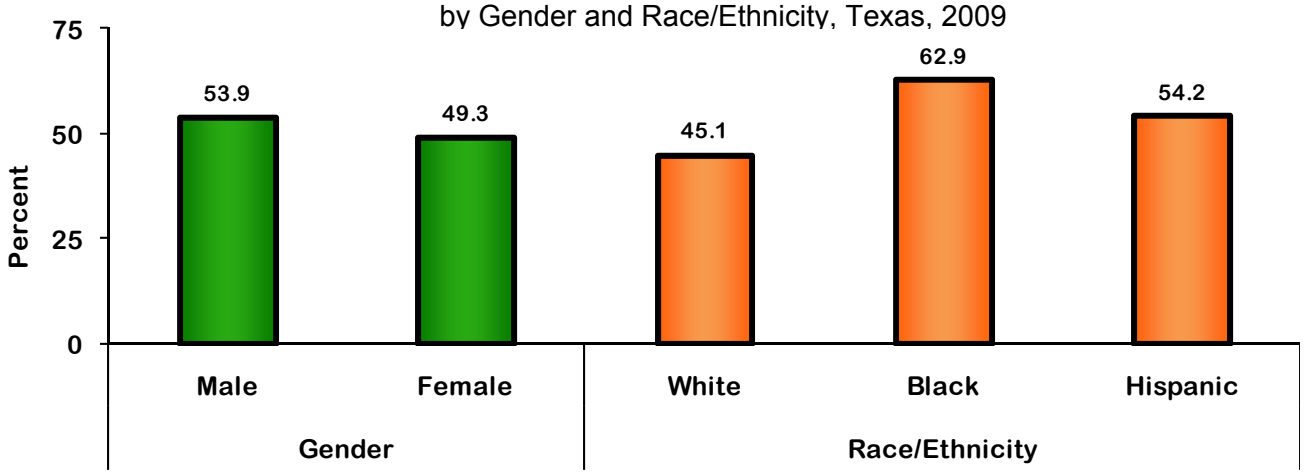
The Youth Risk Behavioral Survey asks students if they had ever had sexual intercourse. The percentage of students who reported they had ever had sexual intercourse decreased 1.7% from 2005 to 2009. Males (53.9%) were slightly more likely to report having had intercourse than females (49.3%). The percentage of Black adolescents who reported ever having sexual intercourse was 1.4 times as high as the percentage of White adolescents.

Figure 3-130. Percent of Students Who Ever Had Sexual Intercourse, by Year, Texas, 2005-2009



Source: Youth Risk Behavioral Survey, 2005, 2007, and 2009, Texas Department of State Health Services.

Figure 3-131. Percent of Students Who Ever Had Sexual Intercourse, by Gender and Race/Ethnicity, Texas, 2009



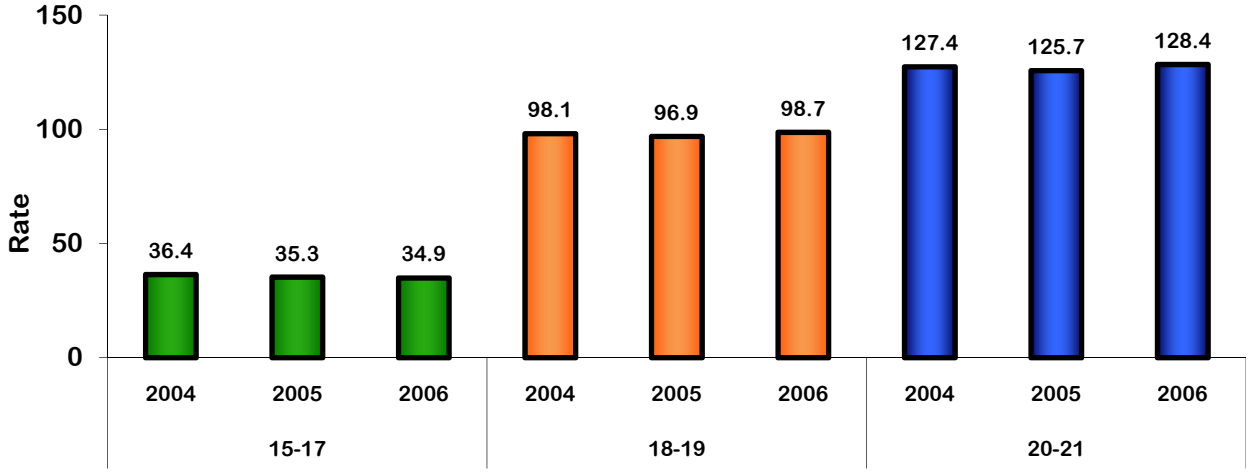
Source: Youth Risk Behavioral Survey, 2009, Texas Department of State Health Services.

BIRTHS TO ADOLESCENTS

The fertility rate for Texas adolescents from 2004 to 2006 was 46.9 live births per 1,000 females 10 to 21 years old. Hispanic women had the highest fertility rates of all races/ethnicities. In 2006, the Hispanic fertility rate was 1.3 and 2.3 times as high as the fertility rate for Blacks and Whites, respectively.

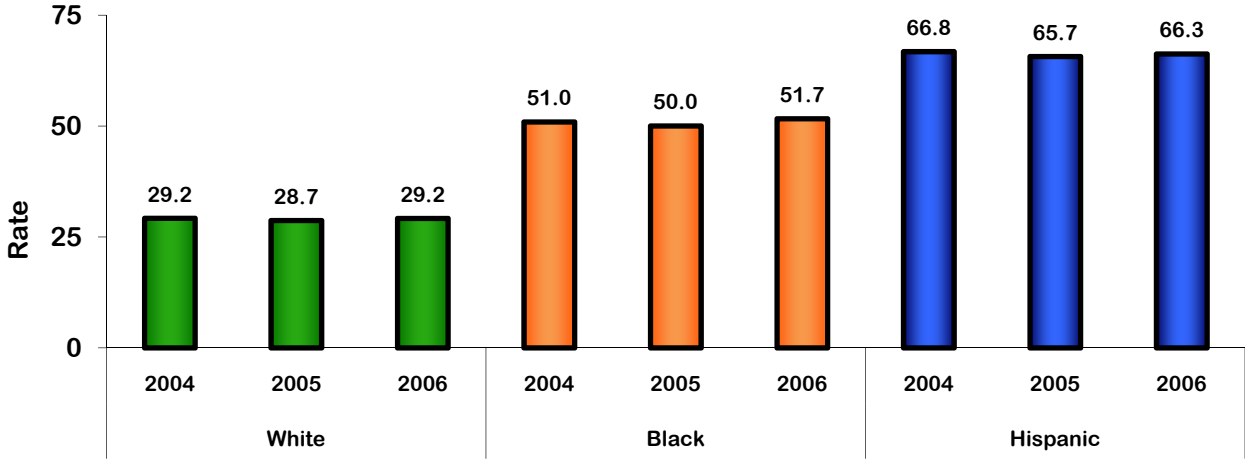
As expected, adolescents 20 to 21 years of age had the highest fertility rates of the different adolescent age groups. The fertility rate remained steady from 2004 to 2006, regardless of race/ethnicity or age group.

Figure 3-132. Fertility Rates by Mother's Age and Year, Texas, 2004-2006



Fertility rates: Number of live births per 1,000 women in specific age group.
Source: Texas Department of State Health Services, Natality Files, 2004-2006.

Figure 3-133. Fertility Rates for Adolescents Aged 10-21 Years Old by Race/Ethnicity and Year, Texas, 2004-2006



Fertility rates: Number of live births per 1,000 women in specific age group.
Source: Texas Department of State Health Services, Natality Files, 2004-2006.

TEXAS PERFORMANCE AND *HEALTHY PEOPLE 2010*

As previously discussed in our review of key measures of the health of women, infants, children, and adolescents, strengths and challenges both exist in meeting the *Healthy People 2010* objectives. However, as noted by the shaded rows in Table 3-10, Texas exceeded the national performance in 12 of 20 of the identified targets below. As DSHS examines future activities in response to *Healthy People 2020*, state objectives will be adjusted to achieve the health outcomes identified.

Table 3-10. *Healthy People 2010* Goal

Healthy People 2010 Goal	Goal	Target	Texas	Objective Met	United States
Reduce the death rate from cancer of the uterine cervix[6]	3-4	2.0[1]	3.1[1]	No	1.3[1]
Increase the proportion of women age 18 years and older who have received a Pap test within the last 3 years[7]	3-11b	90.0%	83.0%	No	82.9%
Increase the proportion of pregnancies that are intended (among females aged 15 to 44)[8]	9-1	70.0%	55.2%	No	49.0%
Reduce pregnancies among adolescent females[8]	9-7	43.0[2]	60.2[2]	No	71.5[2]
Increase the proportion of adolescents who have never engaged in sexual intercourse[7]	9-9	75.0%	51.6%	No	48%
Reduce weapon carrying by adolescents on school property[7]	15-39	4.9%	18.2%	No	5.9%
Reduce fetal and infant deaths[9]	16-1	4.1[3]	6.2[3]	No	6.7[3]
Reduce maternal deaths[6]	16-4	3.3[4]	17.8[4]	No	13.3[4]

Healthy People 2010 Goal	Goal	Target	Texas	Objective Met	United States
Reduce low birth weight and very low birth weight births[10]	16-10				
Low birth weight		5.0%	8.5%	No	6.5%
Very low birth weight		0.9%	1.5%	No	1.1%
Reduce preterm births[10]	16-11	7.60%	13.6%	No	11.1%
Increase abstinence from alcohol, cigarettes and illicit drugs among pregnant women[11]	16-17				
Alcohol		94.0%	91.5%	No	90.0%
Smoking cigarettes		99.0%	91.7%	No	88.3%
Increase the proportion of mothers who breastfeed their babies[12]	16-19				
Early postpartum		75.0%	78.2%	Yes	73.9%
Six months		50.0%	48.7%	No	43.4%
One year		25.0%	25.3%	Yes	22.7%
Reduce the rate of suicide attempts by adolescents[7]	18-2	1.0%	13.7%	No	6.9%
Reduce the proportion of children and adolescents who are overweight or obese[7]	19-3	5.0%	15.6%	No	15.8%
Reduce tobacco use by adolescents[7]	27-2	16.0%	9.7%	Yes	20.0%
Reduce the rate of physical assault by current or former intimate partners[13]	15-34	4.4[5]	21.3[5]	No	44.2[5]

Footnotes:
1. Number of deaths per 100,000 females; 2. Number of pregnancies per 1,000 females aged 15-19 years old; 3. Number of fetal and infant deaths per 1,000 live births and fetal deaths; 4. Number of deaths per 100,000 live births; 5. Number per 1,000 population.

Sources:
6. National Vital Statistics Reports Vol. 57, No. 14, "Deaths: Final Data for 2006" April 17, 2009; 7. U.S. Youth Risk Behavior Survey accessed 5.13.10; 8. Guttmacher Institute data accessed 5.14.10; 9. National Vita Statistics Reports Vol. 58, No. 17 "Births: Final Data for 2006" Jan. 7, 2009, ; 10. National Vital Statistics Reports Vol. 57, No. 7, Jan. 7, 2009; 11. Morbidity and Mortality Weekly Report "Trends in Smoking Before, During, and After Pregnancy - PRAMS, United States" May 29, 2009; 12. National Immunization Survey data accessed 5.13.10; 13. Costs of Intimate Partner Violence Against Women in the U.S." Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Atlanta, GA 2003.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

This needs assessment demonstrates key areas of need for CYSHCN services in Texas as well as certain population sub-groups, geographic areas, or service components that demonstrate some strength. The following discussions focus on the needs, but where they occur, the discussion also highlights signs of strength.

BACKGROUND DATA

According to the 2005-2006 National Survey of Children with Special Health Care Needs (2005-2006 NS-CSHCN), 12.6% of children and youth in Texas under age 18 (806,746 children and youth) have special health care needs. The percentage of CYSHCN in Texas has increased from the 12.0% noted in the 2001 National Survey of Children with Special Health Care Needs (2001 NS-CSHCN) (2001 NS-CSHCN and 2005-2006 NS-CSHCN). Using data from 2007, the Annie E. Casey Foundation estimated the number of children with special health care needs in Texas to be 17.0% or over 1.1 million. According to the Casey Foundation data, Texas is second only to California in the estimated number of CYSHCN (Casey, 2009).

A study using the Child and Adolescent Health Measurement Initiative (CAHMI) Children with Special Health Care Needs (CSHCN) Screener© found that 16% of children and youth ages 0-18 enrolled in the Texas Medicaid STAR Managed Care Organization (MCO) Program were identified as having a special health care need (Institute for Child Health Policy, 2007).

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

According to the 2005-2006 NS-CSHCN, 81.5% of CYSHCN identified in the survey have health conditions lasting twelve months or longer that require prescription medicine. Thirty-five percent of CYSHCN identified in the same survey have an elevated need or use of medical care, mental health, or education services due to health conditions lasting twelve months or longer. Nearly one-quarter (24.6%) of CYSHCN identified in the survey have needs related to emotional, developmental, or behavioral issues, and about 12.9% reported 4 or more conditions from the survey list of conditions (2005-2006 NS-CSHCN).

The NS-CSHCN 2005-2006 indicates that for 22.8% of CYSHCN identified in the survey, daily activities are consistently affected by their conditions. CYSHCN identified

in the survey often missed school due to illness, as 12.9% reported more than 11 school absences due to illness (2005-2006 NS-CSHCN). Further, 20% of Texas households with CYSHCN under age 18 reported having more than one child with special health care needs (2005-2006 NS-CSHCN), which represents an increase over the 18% noted in the 2001 NS-CSHCN (2001 NS-CSHCN).

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

In 2007-2008, Texas had the fourth highest poverty rate for all children under 18 years of age (Kaiser, 2007-2008), and this situation has worsened since 2005, when Texas ranked sixth (Kaiser 2001-2002). According to Annie E. Casey Foundation, the 2008 data showed that 47% of Texas children, or more than 3.1 million, live in households with incomes below 200% FPL, as compared with 40% nationally (Casey Foundation, 2009).

According to the Annie E. Casey Foundation KIDS COUNT Data Center, Texas has the highest percent of all children ages 0-17 without health insurance (20%, 2007 data). This equates to over 1.3 million children, the highest number of uninsured children in any state (Casey Foundation, 2009). Furthermore, in the Texas-Mexico border region, four counties in the Houston vicinity, and in Dallas County, the numbers of uninsured children are much higher. The 2010 projected percents for these areas range from 24.0% to 33.3% (Center for Public Policy Priorities, 2009).

AGENCY, STAKEHOLDER ORGANIZATIONS, AND OTHER SOURCES

CSHCN Services Program staff used three core methods to gather needs assessment information from agencies, stakeholder organizations, and other sources. The first and most extensive method involved the review and analysis of the reports and recommendations of agencies and stakeholder organizations that share an interest in the health care and well being of CYSHCN. The second method was a compilation of information obtained by attending and reporting on a variety of stakeholder meetings that took place during State Fiscal Year (SFY) 2009. The third and final method was a review of several stakeholder electronic mailing list messages that occurred during SFY 2008. The following paragraphs summarize information gleaned from each of these sources.

AGENCIES AND STAKEHOLDER ORGANIZATIONS REPORTS AND RECOMMENDATIONS

2-1-1 Texas is one of the largest information and referral networks in the United States. Information and Referral is available 24 hours a day, 7 days a week throughout the year. Information can be provided in over 90 different languages. Staffed by call specialists who are working towards or endorsed as Certified Information and Referral Specialists by the Alliance of Information and Referral Systems (AIRS), 2-1-1 Texas provides information on health and human services from more than 60,000 state and local programs (Texas Health and Human Services Commission, 2009).

2-1-1 Texas handled over 2.4 million calls in 2009 through 25 call centers, all of which are accredited by AIRS. They also established a temporary 26th call center, staffed by medical professionals, to handle calls in response to the H1N1 pandemic. In addition to having health and human services partners, 2-1-1 Texas maintained interagency relationships with the Texas Workforce Commission for child care and early childhood information, with the Texas Department of Agriculture for summer nutrition program information, and with the Texas Military Families Assistance Program (Texas Health and Human Services Commission, 2009).

In SFY 2009, 130,000 calls to 2-1-1 Texas were categorized, according to the taxonomy guidelines, as related to maternal and child health. Ten of the top thirteen categories receiving more than 3,000 calls each could be related to CYSHCN. These ten categories included more than 63,500 calls and were 48.9% of all MCH calls. The top category was for dental care, with more than 14,000 calls. Other leading categories with importance for CYSHCN included local transportation, prescription medication expense, outpatient mental health care, medical expense assistance, disease/disability specific screening or diagnosis, specialized treatment, case management, hospitals, and psychiatric support services (Texas Health and Human Services Commission, 2009).

The Children's Policy Council (CPC), created by House Bill 1478 of the 77th Texas Legislature (2001), assists health and human services agencies in developing, implementing, and administering family support policies and related long-term care and health programs for children. The Council produces a biennial report with recommendations to the HHSC Executive Commissioner and the Texas Legislature. The Council membership is comprised of a majority of family members of consumers of long-term care and health programs for children, and a variety of members from community, faith, business and other organizations. In its 2008 recommendations to the 81st Texas Legislature (2009), the Council made twenty-one recommendations, all of which related to Texas CSHCN national or state performance measures and needs.

The following are the Council's recommendations:

- Alternatives to institutional care (Related to SPM1)
  1. Prevent the institutionalization of children in state schools and other large institutions.
  2. Continue and expand specific children's riders [Riders 37, 41, and 43 to the Texas Appropriations Act to enable children aging out of foster care, children in nursing homes, and children in small/medium Intermediate Care Facilities for people with mental retardation (ICF/MR) to move out of the institutions].
  3. Implement Medicaid coding procedures for children leaving institutions [to enable provision of necessary specialized services].
  4. Expand Money-Follows-the-Person to include ICF/MRs facilities [in addition to nursing facilities as is provided currently].
- Access to services and supports (Related to NPM3, NPM4, NPM5, NPM6, and SPM1)
  5. Implement a Medicaid Buy-In Program for children with disabilities.
  6. Increase safety net services for children [including crisis intervention, flexible funding for children in foster care moving from inpatient psychiatric settings into the community, and flexible funding to be used by Community Resource Coordination Groups (CRCGs) for children exiting the criminal justice system].
  7. Reduce the community-based services waiting lists.
  8. Educate persons interacting with children with disabilities [such as emergency personnel, health care workers, child care providers and others].
  9. Enhance the 2-1-1 System for services for children with disabilities [involving a stakeholders' group to expand and improve the database of services].
  10. Allow behavioral supports for Home and Community-Based Services Foster/ Companion Care.
  11. Offer equitable, comprehensive waiver services [to meet the needs of all children and young adults with disabilities, regardless of diagnosis].
  12. Increase waiver flexibility [by lifting or increasing service caps and increasing benefits].
  13. Improve the waiver enrollment process [to minimize delays in receiving services after coming off waiting lists].
  14. Review Durable Medical Equipment authorization policies/procedures [to improve consistency, timeliness, quality and accountability across policies for different devices and minimize equipment procurement delays].
- Improve quality and accountability (Related to NPM2, NPM5, and SPM1)
  15. Implement higher standards for mobility aid providers.
  16. Implement quality of care indicators [as recommended by the Forum on Measuring Quality of Health Care for CSHCN in Texas].
  17. Transfer state school monitoring and quality assurance to HHSC.
  18. Ensure family representation on advisory committees.
  19. Support Long-Term Services and Supports Quality Review recommendations [to implement person-directed planning, consistent monitoring of community-based contract performance, and consumer surveys].

- Increase provider capacity (Related to NPM5 and SPM1)
  20. Develop options for equitable provider rates [for direct care workers].
  21. Fund and implement direct service workforce initiative [to address recruitment, retention, and improvements in paraprofessional status] (CPC, 2008).

The CSHCN Services Program staff regularly attended and participated in the CPC meetings and emphasized the importance of the Title V CSHCN performance measures and relevance to the overall CPC recommendations.

The Community Resource Coordination Groups (CRCG) across Texas and the *Texas Integrated Funding Initiative (TIFI) Consortium* receives staff support from the HHSC Office of Program Coordination for Children and Youth (OPCCY). CRCGs work to provide a coordinated approach to service delivery for children, youth, adults, and families with multi-agency needs. The TIFI supports a flexible funding collaboration among agencies, families, and community groups. Furthermore, TIFI serves children/youth with severe emotional disturbance, and their families, by developing systems of care that focus on the families' unique strengths and cultures by assisting children and families to lead healthy lives within their communities. OPCCY compiles reports for these two agency-supported activities that address needs for children and youth in Texas.

The 2008 CRCG Data Report revealed that 59% of all local CRCGs serving children and youth submitted data for 2008 (calendar year). This represented reporting for more than 1,000 individuals. The highest sub-population number served were adolescents between the ages of 13 and 15, representing slightly less than one-half of the total number of children and youth served. Seventy-five percent (75%) of the documented service plans identified needs for skill development around challenging behavior, anger management, impulse control and other similar skills. Fifty-one percent (51%) of the plans identified needs for life skills training, and 50% of the plans identified needs for mental health care services (Texas Health and Human Services Commission, 2009).

The CRCG report also noted that, while the percent of service plans for individuals considered at risk for institutional placement has remained fairly stable over the past three years (approximately 63% to 73% of service plans), recommendations for institutional placement were declining and recommendations for community-based care were increasing. In 2008, recommendations for community-based services surpassed recommendations for institutional placement for the first time since 2003 (Texas Health and Human Services Commission, 2009). However, this encouraging trend is mitigated by other data in the report.

From 2002 through 2008 for CRCGs serving children and youth, as indicated by follow-up service planning data, the report showed a steady decline in the percents of overall

needs met. This means that fewer children and youth were having their overall needs met, even after having specialized coordination of resources through the CRCG. Data for the 1-3 months' follow-up plan reports showed that overall needs met declined from 50% in 2002 to less than 20% in 2008, and for the 4-6 months' follow-up plan reports, overall needs met declined from nearly 80% in 2002 to less than 40% in 2008.

The 2008 TIFI Statewide Expansion Plan identified five objectives to respond to service system delivery needs. These included measures: 1) to increase incentives and funding to support communities interested in addressing the needs of children and youth with severe emotional disturbances and their families using a system of care approach; 2) to develop state-level promising practices around financing strategies that can be replicated; 3) to develop a work plan that outlines benchmarks to achieve statewide coverage of a system of care service delivery approach; 4) to develop a training and technical assistance plan to offer guidance in system of care practices; and 5) to create an evaluation system that provides for continuous quality improvement in system of care practices (Texas Health and Human Services Commission, 2008).

The CHIP (Children's Health Insurance Program) Coalition, the Children's Defense Fund, and Texans Care for Children are loosely-configured collaborations of individuals and organizations that research and advocate for children's public policy issues. Their issues often overlap, and for the 81st Texas Legislature (2009), these groups identified several key children's health care issues related to two broad access-to-care themes: expanding health insurance coverage for all children and increasing public funding for children's mental health. Important needs identified concerning expanding health insurance coverage included:

- Improving the state's public benefits eligibility system (NPM5).
- Providing 12-month continuous eligibility for children's Medicaid (NPM4).
- Creating a CHIP buy-in program for families over 200% FPL (NPM4).
- Increasing reimbursement rates for CHIP and children's Medicaid providers in order to increase children's access to care (NPM4).

Needs identified concerning increasing public funding for children's mental health were:

- Supporting CRCG and TIFI funding (NPM5).
- Improving reimbursement rates for mental health providers (NPM4).
- Addressing an array of access issues for youth with complex needs involved with the juvenile justice system (NPM5).

In addition to these issues identified as priorities for the 81st Texas Legislature, these groups also have been proponents of other performance measures, including especially medical home (NPM3) and transition services (NPM6).

The Disability Policy Consortium (DPC) is a diverse assortment of disability advocacy groups that have joined forces to advance the rights, inclusion and independence of Texans with disabilities. The DPC specifically focuses on public policy and is committed to being an effective player in the system that creates and carries out the laws and policies that advance the rights of Texans with disabilities. The DPC 2009 Policy Priorities Report provided issue briefs in four areas of concern: long-term services, housing, education, and employment/transportation. In the DPC 2009 Policy Priorities, three of ten priorities related directly to needs or performances measures for CYSHCN, and they are:

- Children with disabilities have the right to grow up in a family (SPM1).
- Individuals with disabilities and their families have the right to full participation in the making of policies that affect their lives (NPM2).
- People with disabilities and their families have the right to accessible services and supports customized to their needs, flexible to changing circumstances, and provided in their home community (NPM5).

The issue briefs addressed these priorities with concrete recommendations, and in addition to these priorities, the education issue briefs included one that recommended the following:

- Improve transition planning/services for students with disabilities, including among other provisions, recommendations to provide information about access to Supplemental Security Income and Social Security Disability Insurance; Medicaid and Medicaid waivers and non-Medicaid long-term services and supports; informed consent; rights at the age of majority and guardianship/alternatives to guardianship; and self-advocacy, person-directed planning and self-determination (NPM6) (Disability Policy Consortium, 2009).

The Texas Council for Developmental Disabilities (TCDD) is a 27-member board dedicated to ensuring that all Texans with developmental disabilities have the opportunity to be independent, productive and valued members of their communities. The Council works to ensure that the service delivery system provides comprehensive services and supports that meet people's needs, are easy to access, are cost effective, and improve people's understanding of disability issues. Council members include individuals with developmental disabilities, parents and guardians, as appointed by the governor, representatives from each major state agency that serves people with developmental disabilities, representatives from the state's protection and advocacy system (Advocacy, Inc.) and the two university centers for excellence in developmental disabilities, and local organizations. Stakeholder representatives are the majority of voting members.

In its 2008 Texas Biennial Disability Report, the TCDD characterized the state of services and supports for people with developmental disabilities in Texas and made

recommendations for systems change. Texas ranks 49th out of the 50 states in providing community-based services to individuals with developmental disabilities (Texas Council for Developmental Disabilities, 2008). Among their recommendations are several that addressed needs and paralleled performance measures for CYSHCN, including:

- Reduce the institutional bias and redirect funds to community services for long-term services and supports (SPM1).
- Require health insurance parity for mental and behavioral disorders (NPM4).
- Increase reimbursement for providers to attract and retain quality direct care staff, to recognize a hierarchical structure of reimbursement in order adequately to pay for more complex care, and to provide incentives for innovative quality and cost effectiveness approaches to service delivery (NPM4).
- Enable residents of state schools (now known as state supported living centers) to access community-based alternative living arrangements (SPM1).
- Invest in community respite alternatives (NPM5).
- Enhance the capacity of the community services infrastructure to better support individuals with complex needs, including collecting and analyzing data to identify factors driving admissions to state schools (particularly for children) (NPM5 and SPM1).
- Amend Medicaid waiver eligibility requirements and service arrays to serve individuals with cognitive/emotional-behavioral/psychosocial disabilities with or without accompanying physical disabilities (NPM 4, NPM5, and SPM1).
- Expand services for youth with disabilities in transition (NPM6).
- Ensure that individuals with developmental disabilities, specifically CYSHCN, are not negatively impacted by system changes such as Medicaid reform, managed care expansion, or eligibility infrastructure amendments (NPM5).

The Promoting Independence Advisory Committee (PIAC) is composed of consumer and provider members, appointed by the HHSC Executive Commissioner representing large constituencies of people with disabilities, and members representing state agencies. It is the group that oversees the preparation and revisions to the Texas Promoting Independence Plan, by which Texas complies with the U.S. Supreme Court 1999 decision in *Olmstead v. L.C.*, which said that states must provide community-based services for people with disabilities who would otherwise be entitled to institutional services. The PIAC made two issues their highest priority for the 2008-09 biennium: continued reduction in the interest lists for Medicaid waivers and other community services programs and workforce stabilization. The work of the PIAC impacts children living in congregate care facilities and closely parallels activities for SPM1.

As required by Title 4 of the Texas Government Code, §531.02241(i), the PIAC submits a Stakeholders Report to the HHSC Executive Commissioner each year. The most

recently available 2008 Report identified critical issues that prevent the Texas system from meeting the goals of *Olmstead* and the Plan. These issues included:

- The length of time on an interest list that a person must wait to receive community services.
- A crisis in the direct services workforce for community-based services.
- Inadequate reimbursement for long-term services and supports providers.
- Ongoing fragmentation of the long-term services and supports system between two state agencies and between two payment methods: managed care and fee-for-service.
- Inequities in available services and reimbursement rates and inflexibility among the many Medicaid waiver programs.
- Children continuing to be admitted to institutions (Texas Department of Aging and Disability Services, 2008).

The report indicated that more than 2,000 children have relocated from institutions to families or to a less restrictive setting since 2002; however, the number of children who continue to reside in institutions remains high and new admissions continue. Overall, Texas saw a reduction in the number from 1,363 in 2002, but as of February 2008, 1,020 children remained in institutional settings. In recent years, there have been increases in the numbers of children residing in larger facilities, including Texas Department of Aging and Disability Services (DADS) state-supported living centers and Department of Family and Protect Services (DFPS) facilities. The report stated the following:

> The primary reason for the continued placement of children in facilities is the lack of access to needed family and community-based supports. The major barriers to access include the availability of funding, the availability of providers with the needed expertise, and the ability to access the most appropriate services. Funding flexibility, capacity building, and waiver flexibility should be considered a high priority and addressed as such over the next biennium.
>
> While institutionalization of children with disabilities remains an entitlement under Medicaid policy, family supports and community-based supports and services are dependent upon legislative appropriations. Children and families may wait up to nine years on waiver interest lists to obtain needed community services (Texas Department of Aging and Disability Services, 2008).

Raising Texas is a statewide, collaborative effort to strengthen Texas' system of services for young children and families so that all children enter school healthy and ready to learn. The collaborative partnership includes nine state agencies, 16 community-based agencies and 60 key stakeholders. Its mission is to promote an effective, comprehensive, and seamless system that serves and supports families in the

areas of early care and learning, mental health and social emotional development, parent education and family support and access to medical home. Raising Texas operates with staff support from the Office of Early Childhood Coordination (OECC) within HHSC.

The OECC in partnership with DSHS, received grant funding from the Health Resources and Services Administration, Maternal and Child Health Bureau, to develop a statewide early childhood comprehensive system of services for children under the age of six, and a state plan has been developed.

The state plan took into consideration survey and focus group results from 2002 and 2004 and included four key areas of focus: 1) access to insurance and medical home; 2) social emotional development and mental health; 3) early care and education; and 4) parent education and family support. Within the access to insurance and medical home focus area, the objective was to increase access to and insurance support for medical homes providing comprehensive physical and child development services for all children, including children with special health care needs and assessment, intervention, and referral of children with developmental, behavioral, and psychosocial problems (Raising Texas, 2006).

The Raising Texas efforts resulted in related recent initiatives including a developmental calendar for new mothers of Medicaid-eligible children, an early childhood standards cross-walk to compare child care licensing standards across a variety of accrediting bodies, and a cross-walk of evidence-based practices in parenting education applicable to parents of children ages zero to five (Texas Health and Human Services Commission, 2008).

The Texas Medical Association/Texas Pediatrics Society Forum on Measuring Quality of Health Care for CSHCN in Texas held on October 8, 2008. The co-chairs of the Forum prepared a report that they provided to the HHSC Executive Commissioner, the HHSC Deputy Executive Commissioner for Health Services, and other interested individuals and organizations. The Forum convened interested stakeholders from key organizations and state agency representatives to delineate a core set of high priority health outcome measures for Texas CYSHCN. The Forum made four recommendations:

- Use the core measures in all state health care programs impacting CYSHCN and include identified needed data elements: consistent CYSHCN identification; core demographics; and eight outcome measures for medical home status, family-centered care, health outcomes and functional status, health-related quality of life, access to specialty services, care coordination, transition to adult care, and cost effectiveness.

- To obtain the needed information, use an annual or biannual compilation of data from administrative claims across all payers and providers; a standardized, random sampling family survey of program participants; and a validated child health quality of life instrument, such as the PedsQL™, to obtain needed data.
- Develop a methodology to collect patient-level data from providers, including measures of provider satisfaction and patient's health status global assessments.
- Convene a multi-agency task force to study the recommendations, assist in developing an implementation plan, assist in planning for the process outcome measurement, and evaluate the resulting data analyses (Warren and Adams, 2009).

Contemporaneously with the preparation of this report, a HHSC work group, including staff from the CSHCN Services Program, conducted an Environmental Scan of Agency Service Delivery Programs to identify types of data, existing program measures, and quality measures for all state systems serving CYSHCN (See Appendix H – Environmental Scan of Agency Service Delivery Programs).

In fall 2009, HHSC convened an interagency workgroup to discuss next steps for piloting the core health outcome measures for CYSHCN. As an initial pilot, HHSC will gather standardized satisfaction data from families of CYSHCN who are served in the various health and human agency programs. Data will be gathered through a telephone survey of families randomly sampled from program-supplied databases. HHSC will present the family satisfaction data in a report to the Texas Legislature in June 2010.

The *Texas Statewide Medical Home Workgroup (MHWG)* is a broad-based multi-stakeholder group facilitated by CSHCN Services Program staff. The workgroup includes representatives of state agencies, parents, providers, advocacy organizations, and other interested stakeholders. The group meets quarterly via conference call and face-to-face meetings. The group has generated a definition of the medical home and a strategic plan. The group meets to discuss statewide activities that help Texas make progress toward the goals and objectives of the strategic plan. The group champions the need to improve medical home services in Texas and to ensure that all children in Texas have access to a medical home. There are multiple exciting medical home initiatives currently underway in Texas, including but not limited to the following: the Texas Medicaid Medical Home funding with pilot funding to be initiated in spring 2010; the Texas Medical Home Initiative (TMHI) focused on patient-centered primary care with initial adult-oriented pilots to begin in spring 2010; the DSHS Medical Home Supports seed funding for practices to make medical home improvements; the Texas Parent to Parent Family-to-Family Education and Information Center statewide medical home training; and the Hali Project and family liaisons in primary care medical homes. Data from these initiatives will drive future medical home advancement in Texas.

STAKEHOLDER MEETINGS

CSHCN Services Program central office staff regularly reported concerning their participation in stakeholder meetings. The reports included a description of those in attendance and an outline of important agenda items as well as input concerning individual stakeholder issues as well as system problems and needs. As an example of the approximate volume and content of one year's stakeholder meeting record reports, the following information came from the reports for SFY 2009. Note that in addition to the meetings documented here, regional office staff and community-based services contractors also participated in many stakeholder meetings on the local or regional level.

Central office staff provided reports for 79 meetings of 24 distinct, typically state-level, councils, work groups, or legislative committees, at which more than 1,300 people participated. Both private sector stakeholders and state agency representatives attended the meetings. Of those whose affiliations could be determined and documented, about 260 were people with disabilities or family members of children/people with disabilities and about 240 were individuals representing the provider stakeholder community.

Analysis of the agenda items and stakeholder input revealed that issues were relevant for the Title V needs assessment and frequently concerned national and state performance measures. Grouped according to performance measure, the topics discussed, observations, or needs most frequently identified by stakeholders included the following:

- For NPM02
  - Increase family member staff representation within state agencies. Some health and human services agencies, including the DSHS Mental Health and Substance Abuse Division, DFPS, and the Texas Youth Commission (TYC), include family members in staff positions as designated family liaisons.
  - Continue and increase active family member participation, majority representation, and leadership on health and human services stakeholder councils or work groups. This already is occurring for some groups and should be the norm whenever possible.
  - Health and human services agencies and programs need to universally recognize and adopt principles of self-determination, including freedom, authority, support, responsibility and confirmation.
- For NPM03
  - There are ongoing, system-wide problems concerning various exchanges of medical and health record information among providers, and program eligibility and other documentation within health and human services agencies.
  - Agencies need to seek ways to minimize barriers for providers by simplifying and standardizing documentation for well child exams and screening.

  - There needs to be a means to identify, study, and track quality outcomes measures across all public sector programs.
  - Stakeholders support and are participating with HHSC in developing proposals and new initiatives that promote medical home.
- For NPM04
  - Due to the large numbers of uninsured children in Texas, insure all children through whatever means are most effective, including expansion and promotion of the Children's Health Insurance Program, CHIP Buy-In, federal health insurance reform, 12-month continuous coverage in Medicaid (instead of the current every 6-months' renewal requirement), and improved eligibility determination systems.
  - Both consumer and provider stakeholders agree that provider reimbursement rates in governmental programs are too low.
- For NPM05
  - Stakeholders appreciate being able to use consumer directed services to manage and pay for personal care services.
  - There are inadequate numbers of and inadequate compensation for health care and community-based personal care providers.
  - Medical transportation services are neither efficient nor sufficient.
  - Navigating the array of health and human services programs and systems continues to be difficult.
- For NPM06
  - Stakeholders are disappointed in the agency response to the House Bill 1230 Workgroup recommendations concerning supported employment. Needs remain to increase attendant care wages, improve transportation services, and develop alternatives to sheltered workshops.
  - There are not enough adult-serving providers in Medicaid. Many adult-serving providers feel ill-prepared, are uncomfortable with, or are unwilling to accept youth or young adults with chronic and complex medical needs.
  - Families are not well-prepared to understand or cope with transition from pediatric- to adult-serving providers, and they seek more information as well as improved options for health care.
  - Stakeholders from the rehabilitation and education communities express needs for more collaboration, information and assistance with transition.
  - Transition planning (in schools) should begin before age 16.
- For SPM01
  - Significant numbers of stakeholders advocate against continuing the "entitlement" status of state supported living centers (formerly known as state schools) and other large congregate care settings, whereby funding is presumed for institutions, but not for community-based alternative settings.
  - Discontinue admitting children to state supported living centers and other large congregate care settings.
  - Reduce the number of people on waiting lists for community-based services and provide waiver slots for children in DFPS facilities.
  - Expand consumer directed services options to all community-based programs.

- Improve workforce adequacy, salaries, and employment benefits for community-based personal care attendants.

STAKEHOLDER ELECTRONIC MAILING LISTS

During SFY 2008, staff from the CSHCN Services Program reviewed messages from parent and stakeholder electronic mailing list exchanges. Messages included questions, answers, requests for information or services, and dialogues about shared experiences. These were categorized and summarized to determine the topics discussed most frequently. Staff categorized more than 1,900 messages from six exchanges, including electronic mailing lists for Our Kids, Texas Autism Advocacy, the Texas Disability Network, and three for Texas Parent to Parent. Discussions covered a broad array of topics, but other than announcements about events of interest, the topics occurring most often indicated stakeholder needs for access to or information about the following:

- Parent networks, interpersonal, or interfamily connections, support and advocacy.
- Health care providers, health insurance, and specific diseases or disorders.
- Medicaid waivers, community-based services, and issues/problems with institutional or congregate care settings.
- The Individuals with Disabilities Education Act, Individualized Education Plans and meetings, and related special education issues.
- Specialized durable medical equipment and supplies.

There were several important themes for needs that emerged from the information CSHCN Services Program staff received from agencies, stakeholder organizations and other sources. Key needs were:

- To inform and engage consumers and families concerning programs and service systems.
- To increase the numbers, availability, and reimbursement of health care and other providers serving the population of CYSHCN, especially children eligible for Medicaid and other governmental programs.
- To extend health insurance coverage to all children in Texas.
- To address and assess quality outcomes for health care and other services provided to all CYSHCN in Texas.
- To increase the availability and accessibility of mental health services.
- To increase and improve accessibility for and quality of community-based services that enable children to live with families in communities.
- To address shortcomings for youth and young adults needing transition services, including available and accessible health care services and providers, adequate health care insurance coverage, and meaningful post-secondary employment and education opportunities.
- To limit and avoid institutional placement for children.

PRIMARY AND SECONDARY HEALTH STATUS DATA

The following are summaries derived from several analyses of primary and secondary health status data for children with special health care needs. All of the analyses were developed using the NS-CSHCN data. There were nine separate analyses. Several used approaches that were similar to or complemented work reported recently in the December 2009 Supplement to Pediatrics, entitled "Building Systems of Care: Findings from the National Survey of Children with Special Health Care Needs" (Kogan, Stickland and Newacheck, 2009). Items 1, 4, and 7 used both state and national data, and all other items used the Texas sample.

1. GAP AND QUADRANT ANALYSIS AND COMPARISON OF 2001 AND 2005-2006 STATE AND NATIONAL DATA FOR THREE PERFORMANCE MEASURE OUTCOMES

The analysis compared data from the 2001 and 2005-2006 NS-CSHCN and placed points in quadrants to describe whether performance measure outcomes were better or worse in 2005-2006 than in 2001. The quadrants showed four conditions:

- Texas improving – Nation improving
- Texas improving – Nation declining
- Texas declining – Nation improving
- Texas declining – Nation declining

Clustering of points in a quadrant demonstrated whether Texas was improving or declining as compared with the nation for the performance measure outcomes analyzed. As differences existed across survey years, this analysis used comparative data for only three of the six outcomes.

Table 3-11. Performance Measure Outcomes and Analysis Results

Performance Measure Outcomes	Gap and Quadrant Analysis Results
CSHCN whose families are partners in decision making at all levels, and are satisfied with the services they receive.	Overall, both Texas and the nation improved from 2001 to 2005-2006; however, Texas performed better on 2 out of 3 indicators. Texas did not improve as much as the nation for an indicator concerning whether a doctor makes the family feel like a partner.

Performance Measure Outcomes	Gap and Quadrant Analysis Results
CSHCN who receive coordinated, ongoing, comprehensive care within a medical home.	Texas performed worse than the nation on 15 of 16 indicators for this outcome. Key weaknesses included not having a usual source of care, problems obtaining referrals, getting help to coordinate care, not being satisfied with doctors' communicating with each other, doctors not listening carefully, and doctors not being sensitive to values and customs.
CSHCN whose families have adequate private and/or public insurance to pay for the services they need.	Both Texas and the nation improved from 2001 to 2005-2006, and Texas improved more than the nation on 3 of 6 indicators. The data indicated that, while Texas improved in children having insurance, there remain concerns regarding the adequacy of insurance.

The results of this analyses indicated Texas has continuing needs to maintain activities that support the family partnership in the decision making performance measure and to develop additional activities to target improvement for the medical home and insurance performance measures.

2. EXAMINATION OF FREQUENCIES AND WEIGHTED PERCENTS OF KEY CYSHCN VARIABLES

This was a preliminary analysis of some key CYSHCN descriptive variables in order to discern whether they presented opportunities for further examination or comparison. The results provided limited guidance for future analyses.

- 5% of families reported needing home health care in the past 12 months.
- 54% of families reported their doctor spends enough time with them.
- 65% report they have difficulties getting doctors to listen.
- Only 19% of parents reported they have discussed with their child's doctor how to obtain or keep health insurance when their child becomes an adult.
- 19% reported child's health care has caused family financial problems.

3. CROSS TABULATIONS AND CHI-SQUARE TESTING OF STATISTICAL SIGNIFICANCE FOR FAMILY CENTERED CARE, MEDICAL HOME, AND TRANSITION VARIABLES ACCORDING TO SELECTED DEMOGRAPHIC CHARACTERISTICS FOR CERTAIN HIGHER-PREVALENCE DIAGNOSES

This analysis included first identifying sub-groups for certain higher-prevalence diagnoses. Forty-one percent of parents reported their child has asthma. Twenty percent of parents reported their child has emotional disturbance. Five percent of parents reported their child has autism, and three percent of parents reported their child

has a seizure disorder. Demographic variables included race/ethnicity, parents' education levels, and health insurance status.

Family-centered care

- A majority of all parents with a child who has asthma, emotional disturbance, autism, or epilepsy reported spending 3 to 13 hours a week providing care to their child. Hispanic and African American parents and parents with less than a high school education most frequently reported spending between 3 and 13 hours a week providing care to their child (While differences were demonstrated for both race and parents' education levels, only the findings pertaining to parents' education levels were statistically significant).
- A majority of all parents reported spending less than 1 hour a week coordinating their child's care. Most parents of a child with autism spent 1 hour a week coordinating care, but a majority of parents of a child with epilepsy spent between 3 and 13 hours a week coordinating their care.

Medical home

- Higher educated parents were more likely to report that doctors and other health care providers always listen to them. Regardless of their child's conditions, parents were likely to report that doctors and other health care providers always listen.

Transition

- African American parents, parents with less than a high school education, and parents of children with asthma most often reported that their doctor has encouraged their child to take responsibility for their health care needs.
- Most parents reported that doctors have not talked with them about their child's health care needs as they become an adult. Parents outside a metropolitan service area and parents of a child with autism were more likely to report that their doctor had talked with them about child's health care needs as they become an adult.
- Parents with private insurance reported that a discussion about doctors that treat adults would not have been helpful. Parents with public insurance more often reported that a discussion about doctors that treat adults would have been helpful.

The results of these analyses indicated that, for children who have asthma, emotional distress, autism, or a seizure disorder, adverse disparities existed in family-centered care, medical home, and transition variables, especially for those who are from Hispanic or African American families; have parents with low levels of education; and those that reside in metropolitan areas.

4. CYSHCN QUALIFICATION CRITERIA FOR TEXAS COMPARED WITH NATIONAL DATA AND VALUES FROM SELECTED OTHER STATES (ARIZONA, CALIFORNIA, FLORIDA, ILLINOIS, MINNESOTA, AND NEW YORK)

This analysis described how Texas differs from the nation and from a group of other states, including Arizona, California, Illinois, Minnesota, and New York, based on the CYSHCN qualification criteria. The CYSHCN qualification criteria included needing prescription medication, functional status, and service use. For the nation and all of the comparison states, children qualifying on prescription medication use only was the most frequently cited CYSHCN qualification criterion. Compared to other states, a majority of Texas CYSHCN qualified on this basis.

- Based on the qualification of prescription medication use only, 43.7% of CYSHCN in the U.S. qualified. Among CYSHCN in Texas, 48.1% qualified based on prescription medication use only, and this is the highest percentage when compared with Arizona, California, Florida, Illinois, Minnesota, and New York.
- Based on the qualification of functional status only, 21.5% of CYSHCN in the U.S. qualified. Among Texas CYSHCN, 19.1% qualified on the basis of functional status only, and this was the lowest percentage when compared with Arizona, California, Florida, Illinois, Minnesota, and New York. For the comparison states, Arizona had the highest percentage with 25.0% of CYSHCN in Arizona qualifying based on functional status only.
- Based on service use only, 14% of CYSHCN in the U.S. qualified. Among CYSHCN in Texas, only 11.8% qualified on the basis of service use only, and this was the lowest percentage when compared to the other states selected. The state having the highest percent of CYSHCN qualifying on the basis of service use only was California, with 19.2%.
- Additionally, we compared the group qualifying on both prescription medication use and service use by state and national averages. In the U.S., 20.8% of CYSHCN qualified on prescription medication use and service use. The same percent (20.8%) of Texas CYSHCN qualified based on the combination. Children in Florida demonstrated the highest percent, 22.5%, and children in New York demonstrated the lowest percent, 16.8%.
- As a further point, the analysis identified key diagnoses within those qualifying as CYSHCN based on prescription medication use only. Those diagnoses mentioned most often for Texas CYSHCN were allergies (67.0%), asthma (51.0%), attention deficit hyperactivity disorder (18.0%), headaches (11.0%), depression (6.0%), and epilepsy (5.0%).

The results of this analysis suggest that Texas should consider target populations in developing its performance measure activities. Activities need to target both the broader CYSHCN population as a whole and also the particular needs of those with more complex conditions.

5. CSHCN QUALIFICATION CRITERIA AND ACCESS TO CARE FOR TEXAS CYSHCN

This analysis expanded the scope of the results of the previous analysis concerning CYSHCN qualification criteria. In order to evaluate how qualification criteria might relate

to access to care, this analysis compared the prescription medication use only criterion with all other CYSHCN qualification criteria for certain access to care variables. The access to care variables included having unmet needs, needs for specific family support services, problems getting referrals, a usual source of care, and a personal doctor or nurse. Generally, CYSHCN needing prescription medication use only indicated fewer unmet needs, no need for specific family support services, fewer problems getting referrals, fewer without a usual source of care, and fewer without a personal doctor or nurse.

- In the prescription medication use only group, 89.6% had no unmet needs as compared with CYSHCN qualifying on all other criteria, for which 76% had no unmet need. For CYSHCN qualifying on all other criteria, higher percents had one or two or more unmet needs than did CYSHCN qualifying based on needing prescription medication.
- One hundred percent of CYSHCN qualifying based on prescription medication use only reported either they did not need or had no unmet needs for specific family support services. Among CYSHCN qualifying on all other criteria, 91.2% said they either did not need or had no unmet needs for specific family support services.
- Among CYSHCN needing prescription medication use only, 17.7% reported having problems getting needed referrals as compared with 28.6%% of CSHCN qualifying on all other criteria.
- For CYSHCN needing prescription medication use only, 81.8% reported a doctor's office as their usual source of care, 14.9% reported a clinic, health center or other regular source, and only 3.3% reported relying on emergency rooms or no regular place for care. This contrasted with the group qualifying by all other criteria, which reported 75.9% having a doctor's office, 18.1% having a clinic, and 6.1% having no regular place for care.
- Finally, whether or not CYSHCN qualify based on prescription medication use only showed slightly fewer without having a personal doctor or nurse. The analysis found that 7.6% of the prescription medication group had one or more than one personal doctor or nurse, and for CYSHCN qualifying with all other criteria, 9.3% had one or more than one doctor or nurse.

This analysis showed that the CYSHCN who qualified on the basis of criteria other than prescription medication use only demonstrated greater needs pertaining to access to care. Further, the especially high percentage of these CYSHCN that had problems getting a needed referral pointed to a potential need to increase the specialist provider base for CYSHCN in Texas. For these access to care variables, between 9.3% and 28.6% of the total CYSHCN population experienced increased access to care needs. The following table lists the access to care variables and the percents of CYSHCN qualifying on the basis of criteria other than prescription medication use only.

Table 3-12. Access to Care Based on Criteria Other than Prescription Medication Use

Access to Care Variables	% CYSHCN qualifying based on criteria other than prescription medication use only
Had two or more unmet needs for services or equipment	10.8%
Had one or more unmet needs for specific family support	8.8%
Had problems getting a needed referral	28.6%
Had no regular place of care or relied on emergency room for	6.1%
Did not have a personal doctor or nurse	9.3%

6. CYSHCN QUALIFYING CRITERIA AND DEMOGRAPHIC CHARACTERISTICS WITH DATA CONCERNING SATISFACTION WITH SERVICES, MEDICAL HOME, AND TRANSITION

This analysis further expanded the scope of the previous analyses concerning qualification criteria to compare qualification criteria and demographic characteristics with data concerning satisfaction with services, medical home, and transition. Demographic characteristics included race, metropolitan statistical area, parent's education, income, family structure, and insurance type. The analysis showed statistically significant relationships between qualification criteria and parents' education, income, family structure, and insurance type. The table below summarizes qualification criteria and some of the demographic data.

Table 3-13. Demographic Characteristics of CYSHCN Based on Criteria Other than Prescription Medication Use

Demographic Variables	% CYSHCN qualifying based on criteria other than needing prescription medication only
Non-White Race	49.5%
Location in a metropolitan statistical area	52.3%
Less than a high school education	60.1%*
Income less than 200% FPL	71.0%*
Not a two-parent family structure	45.1%*
Uninsured	63.6%*

* $p < .001$

The analysis also showed significant relationships between demographic characteristics, including race, parents' education, income, family structure, and insurance type, and medical home.

- A significant difference existed between White families and Non-White families in having a medical home. A majority (55.6%) of White families reported having a medical home, while more than three-fifths of Hispanic (64%), African American (61.6%), and all other races (63.3%) reported not having a medical home.
- Findings indicated a significant relationship between parents' education and medical home status. Fifty-five percent of families whose parents had greater than a high school education reported having a medical home, while 84.4% of families whose parents had less than a high school education did not have a medical home. Nearly 70% of parents with only a high school diploma did not have a medical home.
- Significant relationships existed between family income and family structure and medical home status. Majorities of families with higher incomes (≥300% FPL) and those with two-parent family structure had medical homes, while those with lower incomes (≤299% FPL) and other family structures showed a majority did not have a medical home.
- Insurance type also had a statistically significant relationship with medical home status. The majority of families with private and other types of insurance had a medical home, while those with public only, both public and private, and uninsured did not have a medical home. For those who were uninsured, 77.9% did not have a medical home.

Similarly, the analysis showed significant relationships between several of the demographic characteristics, including race, parents' education, income, family structure, and insurance type, and having transition services. These findings for the Texas data closely paralleled those recently reported by Kane and others in a cross-sectional analysis of NS-CSHCN national-level data (Kane, 2009). The families that did not receive needed transition services (for CYSHCN ages 12 to 17 years) more often were non-White, had lower education levels, had low income, had a family structure other than two-parents, or were uninsured.

- A majority of families did not receive services needed for transition to adulthood. Non-white families were more likely to not receive services needed for their special needs child's transition to adulthood.
- Parents' education was significantly related to receiving needed transition services. Similar to the race characteristic, across all parents' education levels, a majority of families did not receive transition services. Higher educated parents received transition services for their special needs child more often than lower educated parents.
- Family income and family structure were significant in receiving needed transition services. For families with incomes ≥400% FPL, a majority (53.6%) stated they received transition services, but for all other income groups, more than two-thirds

did not receive transition services. For families with incomes >200% FPL, 84.4% did not receive transition services. Across all types of family structure, a majority did not receive transition services, but this occurred less often for two-parent families. Stepfamilies showed the highest percent (80.9%) of those that did not receive transition services.

- The findings showed a significant relationship between insurance type and transition services. Only the private insurance only category showed a slight majority (50.5%) that received transition services, and for all other insurance categories, more than three-quarters did not receive transition services. Those who were uninsured had the highest percent (94.8%) that did not receive transition services.

The analysis of the data regarding satisfaction with services revealed similar trends among the demographic characteristics. Statistically significant relationships existed between satisfaction with services and race, income, family structure, and insurance type.

- A significant relationship existed between race and satisfaction with services. White (63.6%) and Hispanic (54.5%) families were more likely to report satisfaction with services, while African American (50.1%) and all other races (53.9%) reported that they were not satisfied with services.
- Satisfaction with services varied by family income. Families having higher incomes (≥300% FPL) more often reported satisfaction with services than families with lower incomes.
- Across all categories of family structure, a majority of families reported being satisfied with services, but those with two parents tended to show higher percents satisfied with services than did the other categories of family structure.
- Those with private insurance only (64.9%), both public and private insurance (52.1%), and other insurance (51.3%) were satisfied with services, while majorities of those with public insurance only (51.8%) and those who were uninsured (57.5%) were not satisfied with the services they received.

Finally, the analysis showed statistically significant relationships between qualification criteria and medical home status, having transition services, and satisfaction with services.

- For CYSHCN who qualified based on prescription medication use only, over one-half (57.6%) had a medical home environment. For all other CYSHCN, over one-half did not have a medical home environment. This was significantly different than for CYSHCN qualifying on the basis of functional status, of which 28.1% had a medical home, and for CYSHCN qualifying on the basis of service use, of which 31.8% had a medical home.
- Regardless of CYSHCN qualification type, a majority of parents reported that their child did not receive services needed for their transition to adulthood. CYSHCN who qualified based on prescription medication use showed the lowest percent

(54.4%) that did not receive transition services, and CYSHCN qualifying on the basis of service use showed the highest percent (82.9%).
- For those qualifying by prescription medication use only, 69.2% indicated satisfaction with services, while majorities of those qualifying by functional status (61.4%) and those qualifying by service use (50.9%) indicated they were not satisfied with services.

Further analysis of this data revealed that significant relationships existed between satisfaction with services and having a medical home and receiving transition services. Among families indicating they had a medical home, 85.1% said they were satisfied with the services they received, but for those without a medical home, 63.2% said they were not satisfied with their services. Similarly, for those families that received transition services, 75.0% said they were satisfied with their services, and for those that did not receive transition services 55.6% said they were not satisfied with their services.

These analyses have helped to quantify the need, identify potentially underserved populations and develop the following general observation concerning possible means to address populations with proportionally greater needs. Medical home, transition, and family satisfaction activities are needed most by CYSHCN that qualify based on criteria other than needing prescription medication use only. Additionally, other population subgroups that have greater need for medical home, transition, and family satisfaction initiatives include: non-White races, living in metropolitan statistical areas, less well-educated parents, lower income, other than two-parent family structures, and uninsured.

7. DEVELOPMENT OF BACKGROUND INFORMATION FOR THE TITLE V STAKEHOLDER SUMMIT

The task for Title V Stakeholder Summit participants was to discuss and prioritize needs for the maternal and child health and CYSHCN populations in Texas. While DSHS selected Summit participants from among those who attended listening sessions and other stakeholders familiar with aspects of Title V services in Texas, few Summit participants were well-versed in the full array of issues to be discussed. In order to provide background information for Summit participants, staff from the CSHCN Services Program and the Office of Program Decision Support (OPDS) conducted research and assembled information concerning the most frequently identified needs and the performance measures for CYSHCN.

Staff used multiple sources to compile a listing of the most frequently identified needs for CYSHCN. Some of the sources included indicators related to the health and well being of CYSHCN in Texas, primary and secondary health status data, accumulated data from the needs assessment stakeholder input process, the DSHS Employee Survey, and the CSHCN Services Program surveys.

The needs assessment sources confirmed that the needs and priorities of CYSHCN and their families continue to be aligned and consistent with the Title V CSHCN national and state performance measures. Therefore, the background document included information about both the most frequently identified needs as well as the national and state performance measures for CYSHCN. The following are some of the highlights taken from the background information provided to Stakeholder Summit participants concerning those needs.

- Improve the availability and quality of mental health services and resources. The 2005-2006 NS-CSHCN shows that in Texas, fewer families of CSHCN need mental health care or counseling services compared to families of CSHCN nationwide. However, of those who need mental health counseling, fewer CSHCN in Texas receive it compared to CSHCN nationwide. The following table summarizes the national and state data concerning those needing mental health care.

Table 3-14. CSHCN Mental Health Services

	CSHCN that needed mental health care or counseling services	Unmet need for mental health care	CSHCN that did not need mental health care or counseling services
Texas	17.3%	3.4%	79.1%
U.S.	21.1%	3.7%	75.2%

- Enhance transportation services for families with limited access to transportation. Access to transportation can be one characteristic that enables community-based systems to be easy to use. While in the 2005-2006 NS-CSHCN, only 2.1% of CYSHCN families in Texas (and 2.2% nationwide), report that they experience difficulties using services because of transportation problems, the availability of nearby services, possibly due in part to limited access to transportation, remains a need.
- Improve transition services for CYSHCN when moving from school to post-school activities (including education, employment, community integration, and adult services). According to the 2005-2006 NS-CSHCN, only 37.1% of Texas youth with special health care needs receive the services necessary to make appropriate transitions to adult health care, work, and independence. This is lower than the national average of 41.2%.

Table 3-15. CYSHCN Transition Services

	Receive services necessary to make appropriate transitions to adult care	Need doctor to communicate with child's school
Texas	37.1%	23.7%
U.S.	41.2%	28.3%

- Provide and promote early intervention and prevention programs for all children under the age of five. According to the 2005-2006 NS-CSHCN, Texas is somewhat ahead of the nation; however, there remains a significant need for early intervention and prevention programs. The 2005-2006 NS-CSHCN shows 27.1% in Texas and 22.6% nationwide of CYSHCN ages 0 to 2 have early intervention programs.
- Promote early intervention and screening for mental health disorders, including autism and Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD).
    - Symptoms of mental disorders such as autism and mental retardation can be detected as early as one year of age (Osterling, 2002). Classroom programs based on behavioral interventions have shown promise, but research on community-based prevention and early intervention has been limited (DuPaul, 2003).
    - The 2005-2006 NS-CSHCN indicates that 4.9% of the CYSHCN population in Texas has autism or autism spectrum disorder, as compared with 5.4% nationally. In its 2007 report, the Centers for Disease Control and Prevention (CDC) estimates that one in every 150 children is diagnosed with autism, making autism more common than childhood cancer, juvenile diabetes and pediatric AIDS combined (Centers for Disease Control and Prevention, 2007). Recently released data from the 2007 National Survey of Child Health (NS-CH) shows that the prevalence of autism in children age 2-17 as reported by parents is closer to one in every 100 children, and among CYSHCN age 2-17, the prevalence is one in every 20 CYSHCN (2007 NS-CH).
    - Based on the 2005-2006 NS-CSHCN, 32.7% of the CYSHCN population in Texas has ADD/ADHD. Among that group, only 60% are screened early and continuously for special health care needs (2005-2006 NS-CSHCN). In the population at large, 2% of elementary school-aged children have ADHD (DuPaul, 2003). Other research that shows 5.7% of 5-year-olds from low-income families have ADHD. Young children with ADHD symptoms have poorer social skills than their non-ADHD counterparts and show elevated levels of verbal and physical aggression in preschool and when interacting with their parents. Preschool-age children with ADD/ADHD are at risk for disruptive behaviors in the school setting, actions which may result in limits to their exposure to academic instruction and socialization (McGoey, 2002).

- Provide parents, including teen parents, with relevant parenting information and skills. While providing relevant parenting information and skills is not exclusively the responsibility of health care providers, those serving CYSHCN should recognize the importance of forming partnerships with families. Both providers and parents need clarity about their roles, mutual contributions, and responsibilities. Partnership includes parents having the information necessary to parent and care for their children with special needs and providers learning about families' cultural norms, beliefs about disabilities, preferences, expectations, and needs (Dale, 1996).
- Provide affordable childcare services, including after-hour childcare and after-school programs. Locating affordable childcare services can be difficult for families of CYSHCN, because CYSHCN may require additional child-care resources. CSHCN may require specialized instruction, classroom equipment, or other personal care. In a study of child-care center directors, those from private child-care centers reported having the ability to include children with disabilities such as asthma, speech or hearing defects, or epilepsy; however, few reported having the resources to manage children who are deaf, use wheelchairs, or have autism. Publically funded child-care centers are mandated to accept all children with special needs; therefore, directors of those programs were much more accepting of CYSHCN (Fewell, 1993).
- Improve accessibility to health care services at clinics by reducing barriers like long wait times, complex eligibility procedures, limited office hours, and difficult medical forms. The 2009 DSHS Provider Survey showed that less than one-third of physicians or nurses, but nearly two-thirds of social workers, said their practices schedule appointments outside normal business hours. While many providers (85%) and CRCG participants (85%) said they accommodate family members' special needs on request, only 52% of providers and 32% of CRCG participants said they ask families how to make their practices or CRCGs more accessible to families (DSHS Provider and CRCG Surveys, 2009).
- Address lack of respite care services for families with CSHCN. Respite care services have long been identified as a need for families of CYSHCN (Cohen, 1985).
    - The 2005-2006 NS-CSHCN showed that respite care was the most requested service of families caring for children with disabilities at home. Families caring for children who are medically fragile also have this same need for respite care, which at times may be critical for the long-term stability of the family and child at home.
    - Availability of respite care services may be an important contributor toward a family's decision concerning placement of a child in an institutional setting. Respite is a key component of community-based family support services. The 2005-2006 NS-CSHCN indicated that in Texas, fewer families with CYSHCN needed respite care; however, of the families that needed respite care, a greater percentage of families in Texas did not receive it as compared to CYSHCN families nationwide.
- Increase accessibility to affordable dental care for Title V families. Within the last 12 months, 79.8% of Texas CYSHCN (ages 0 to17) needed preventative dental

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

- Performance Measure #02 (NPM2): The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive.
    - Family-centered patient care is gaining increasing acceptance as a best practice. The extent to which families of CYSHCN feel that they are partners in decision making is associated with improved family impact outcomes in missed school days, access to specialty care, care satisfaction, and unmet needs for child and family services. The performance measure also is closely aligned with one of the core principles of the Systems of Care philosophy and practice, most closely associated with mental health service systems (DHHS-SAMHSA, 2009).
    - In the 2001 NS-CSHCN, Texas was below the national average in this performance measure, but in 2005-2006, Texas improved its percent and moved slightly ahead of the national average which declined; however, for Texas, this performance measure showed the smallest increase between the two study periods.

The following table compares Texas and the nation for the 2001 NS-CSHCN and the 2005-2006 NS-CSHCN Surveys.

Table 3-16. Percent of CYSHCN Ages 0-18 Whose Families Partner in Decision Making and Are Satisfied with Services

	2001 CSHCN Survey	2005-2006 CSHCN Survey
Texas	57.0%	57.9%
U.S.	57.5%	57.4%

- Performance Measure #03 (NPM3): The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. On the performance measure for medical home in the 2005-2006 NS-CSHCN, 46.3% of Texas CYSHCN families indicated they receive coordinated, ongoing, comprehensive care within a medical home. This is less than the comparable 47.1% nationally, and less than the number reported in the 2001 NS-CSHCN. The percents of CYSHCN in Texas and the U.S. who receive coordinated, ongoing, comprehensive care within a medical home decreased between the 2001 and 2005-2006 CSHCN surveys.

Table 3-17. Percent of CYSHCN Ages 0-18 Who Receive Care in a Medical Home

	2001 CSHCN Survey	2005-2006 CSHCN Survey
Texas	58.3%	46.3%
U.S.	52.6%	47.1%

- Performance Measure #04 (NPM4): The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.
    - Having adequate health insurance is fundamental for families of CSHCN in order to pay for the services they need. It is critical to obtaining and maintaining medical homes and preventive care.
    - According to the Annie E. Casey Foundation KIDS COUNT Data Center, Texas has the highest percent of all children ages 0-17 without health insurance (20%, 2007 data). This equates to over 1.3 million children, the highest number of uninsured children in any state (Casey Foundation, 2009). Furthermore, in the Texas-Mexico border region, four counties in the Houston vicinity, and in Dallas County, the numbers of uninsured children are much higher. The 2010 projected percents for these areas range from 24.0% to 33.3% (Center for Public Policy Priorities, 2009).
    - The NS-CSHCN data show that the percents of CSHCN in Texas and the U.S. whose families have adequate private and/or public insurance to pay for the services they need has risen between 2001 and 2005-2006, but only 58.2% percent of CSHCN families indicate they have adequate private and/or public insurance to pay for the services they need. This is significantly lower than the 62% nationally.

Table 3-18. Percent of CSHCN Ages 0-18 Whose Families Have Adequate Insurance

	2001 CSHCN Survey	2005-2006 CSHCN Survey
Texas	52.9%	58.2%
U.S.	59.6%	62%

    - The CSHCN Services Program manages a health care benefits plan for eligible low income children and youth with special health care needs up to age 21. The plan is a secondary payer after other private and public plans. Its coverage is comprehensive; however, there is a waiting list to receive benefits.

- Performance Measure #05 (NPM5): Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.
    - Having community-based systems that are organized so that families of CSHCN can use them easily involves not only the availability of services, but also their proximity and the means by which they are delivered. It includes such considerations as whether information about health and human services programs is easily understood and readily available; comprehensive case management services are available; programs are streamlined, comprehensive, coordinated and culturally competent; family support services such as respite, and home or vehicle modifications can be obtained easily; and families are satisfied with the services and supports they receive.
    - In both Texas and the U.S., the NS-CSHCN showed that the percent of children with special health care needs whose families report that community-based service systems are organized so they can use them easily rose between 2001 and 2005-2006; however, the Texas 2005-2006 percent is slightly less than the nation. Though the results show changes from one survey to the next, they are not comparable, because the survey questions differed between the two time periods.

Table 3-19. Percent of CSHCN Ages 0-18 Whose Families Report Community-Based Systems of Care are Easy to Use

	2001 CSHCN Survey	2005-2006 CSHCN Survey
Texas	76.8%	88.2%
U.S.	74.3%	89.1%

- Performance Measure #06 (NPM6): The percentage of youth with special health care needs (13 to 17) who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.
    - Successful transition to all aspects of adult life lays a foundation for long-term individual and family physical and mental health and wellness. Federal laws require that transition formally be addressed in both education and vocational rehabilitation. Often times health care transition, which at minimum involves changing from pediatric to adult providers and includes having the knowledge and skills to manage one's own care and adequate resources to pay for care, is overlooked by providers and families alike.
    - From the 2005-2006 NS-CSHCN for Texas, 37.1% of CSHCN (13 to 17 years of age) receive the services necessary to make transitions to all aspects of adult life. This is substantially lower than the 41.2% for the

nation. The data showed a significant increase in 2005-2006 over 2001 for both Texas and the nation; however, the two time periods are not comparable, because many new survey questions were added for the 2005-2006 survey.

- State Performance Measure #01 (SPM1): All children with special health care needs live in families in the community and not in institutional settings.
    - The state performance measure aligns with the Healthy People 2010 objective to reduce the number of children and adults with disabilities living in congregate care facilities (U.S. Department of Health and Human Services, 2000), and it is widely supported by the disability advocacy community, including groups such as the Children's Policy Council at HHSC; the Promoting Independence Advisory Committee and the Permanency Planning Initiative at DADS; the Texas Council for Developmental Disabilities (TCDD); the Disability Policy Consortium (DPC); and many other associations and individuals. Nevertheless, the Promoting Independence Advisory Committee 2008 Stakeholder Report stated that, while there has been a 23% reduction in recent years, as of August 31, 2008, there still were more than 1,000 children residing in institutional settings. In addition, the Texas Council for Developmental Disabilities 2008 Biennial Report says that Texas ranks seventh highest in the nation in its percentage of people with developmental disabilities living in residential facilities with 16 or more beds (Texas Council for Developmental Disabilities, 2008).
    - Furthermore, waiting lists to get the Medicaid 1915(c) waiver services that enable people with disabilities to live outside institutions and in communities have waiting times that are many years in duration (Texas Department of Developmental Disabilities, 2009). The Texas Legislature has appropriated funding to increase the number of waiver slots in recent years; however, tens of thousands of people remain on the interest (waiting) lists.

8. CHI-SQUARE TESTING OF VARIABLES TO EXAMINE CERTAIN ACCESS TO CARE VARIABLES AND PERFORMANCE MEASURE OUTCOMES

In order more closely to examine certain access to care patterns and selected family impact outcomes, OPDS responded to a request from a knowledgeable Title V Stakeholder Summit participant. The access to care variables included the usual place a child goes for care, whether the child has a personal doctor, and whether the family has delayed or gone without care for the child. Family impact outcomes included days of school missed, whether the condition has caused financial problems, and whether family members had stopped working due to their child's condition.

Access to Care. For access to care by days of school missed, a statistically significant relationship existed between days of school missed and both having a personal doctor and delaying or going without care. Among children that did not have a personal doctor

or nurse, 56% missed 1 to 5 days of school within the past 12 months, but among children that did have one personal doctor or nurse, 46% missed 1 to 5 days of school. For families that delay or go without care, 48% of their children missed more than 5 days of school.

For access to care by whether the health condition has caused financial problems, staff tested for the same family impact variables. For whether the health condition has caused financial problems, the only statistically significant impact outcome was whether the family had delayed or gone without care for their child with special health care needs. Among parents who delayed or went without care for their child within the past 12 months, 35% experienced financial problems due to their child's health condition, but among parents that did not delay or go without care, only 17% experienced financial problems.

The analysis also examined access to care by whether family members had stopped working due to their child's condition. For this indicator, there were no statistically significant relationships.

Adverse family impact as measured by increased days of school missed and the CSHCN health condition causing financial problems were both related to the access variable of delaying or going without care in the past 12 months. Increased days of school missed also were related to the child not having a personal doctor or nurse. Whether the child has a place that they go when sick or needing advice about health care appears unrelated to days of school missed or financial problems, and none of these access to care variables are related to whether family members stopped working due to their child's condition.

Performance Measure Outcomes. This analysis examined each of the CSHCN national performance measures by the same family impact outcomes: days of school missed, financial problems, and whether a parent had stopped working.

For the partnership in decision making performance measure, the analysis combined two indicators: whether families are partners in decision making and whether families are satisfied with the services they receive. There was a statistically significant relationship between whether families are partners in decision making and all three family impact outcome variables. Twenty-six percent of children from families who are partners in the decision making and are satisfied with the services they receive missed no days of school compared to 18% of children from families who are not partners in decision making and are not satisfied with the services they receive. Among families in which parents are partners in decision making and are satisfied with the services they receive, only 10% said their child's health caused financial problems. Among families in which parents are not partners in decision making and are not satisfied with services,

30% said they had financial problems due to their child's health. For families in which parents are partners in decision making and are satisfied with services, only 8% had one parent stop working, but for parents who are not partners in decision making and are not satisfied with services, 26% had at least one parent stop working.

For medical home status, there was a statistically significant relationship between medical home status and two family impact outcomes: whether the child's health has caused financial problems, and whether one parent had to stop working. Among families without a medical home, 26% had financial problems due to their child's health and 22% had at least one parent stop working. By contrast, among families with a medical home, only 10% had financial problems due to their child's health, and only 7% had one parent stop working.

For insurance status, there was a statistically significant relationship between insurance status and all three family impact outcomes. Among families with adequate private/public insurance, 26% of children missed no days of school, but for those families without adequate private/public insurance, 18% of children missed no days of school. For families with private/public insurance, 9% experienced financial problems and 21% had at least one parent stop working, while for families without private/public insurance 33% experienced financial problems and 11% had at least one parent stop working.

For services organized so that families can use them easily, there was a statistically significant relationship with all three family impact outcomes. When parents reported that CYSHCN services are organized in ways that families can use them easily, 24% of CYSHCN were never absent from school, 16% experienced financial problems, and 12% had one parent stop working. Comparatively, for parents that report that CYSHCN services were not well organized, fewer (13%) were never absent from school, more (44%) experienced financial problems, and more (35%) had one parent that stopped working.

For the transition performance measure, there was a statistically significant relationship with family financial problems and whether a parent had to stop working. Among families with CYSHCN between 12 and 17 years of age that received needed transition services, 11% experienced financial problems due to their child's health condition and 5% had one parent stop working. Comparatively, among families that did not receive transition services, 24% experienced financial problems and 19% had one parent stop working.

Controlling for CYSHCN qualification criteria, additional analysis examined performance measures and family impact outcomes. Trends seen in earlier analyses remained, and significant findings were the following:

- For families that qualified based on functional status only, those who considered themselves partners in decision making and satisfied with the services they received (34%) reported fewer parents who stopped working as a result of their child's condition than did those were not partners in decision making and not satisfied with services (52%).
- In addition, for families that qualified based on functional status only, those CYSHCN without adequate private/public insurance (56%) missed more days of school than did those with adequate private/public insurance (35%).
- For families with a CYSHCN qualifying on the basis of needing prescription medication and service use, among children that received transition services, 19% missed 5 or more days of school. For those that did not receive transition services, 50% missed 5 or more days of school.
- Families qualifying on the basis of needing prescription medication use only typically more often considered themselves partners in decision making and were satisfied with services, than were families that qualified on a basis other than needing prescription medication use only. For families qualifying on the basis of functional status, a majority was neither partnering in decision making nor satisfied with services. Further, regardless of qualification status, families that were partners in decision making and satisfied with their services experienced fewer financial problems than did those that were not partners and not satisfied with services.

The findings of these analyses reinforce the need for Texas to continue developing activities that improve performance measure outcomes and address needs identified by this assessment, not only as comparative quantitative measures for the state, but also in order to have real impact on quality of life for CYSHCN and their families.

9. CHI-SQUARE ANALYSIS OF SOCIAL/DEMOGRAPHIC DETERMINANTS OF HEALTH COMPARED WITH CSHCN PERFORMANCE MEASURE OUTCOMES AND FAMILY IMPACT OUTCOMES

This analysis expanded upon earlier analyses described in Items 3 and 6 and used five of six demographic variables (race, parents' education, income/poverty level, family structure, and insurance type) as social/demographic determinants of health. The analysis included five national performance measure outcomes (family partnership/satisfaction, medical home, insurance, services easy to use, and transition) and three family impact outcomes (days of school missed, family financial problems, and a family member that had to stop working). The analyses strengthened similar trends as seen in earlier analyses. Significant findings are included in the following three categories.

Social/Demographic Determinants of Health and Performance Measure Outcomes. Several statistically significant relationships existed between social/demographic determinants of health and CSHCN performance measure outcomes:

- Race is associated with parents being partners in decision making, medical home status, and receiving transitional care services.
- Parents' education is associated with medical home status, adequate insurance, and receiving transitional care services.
- Poverty status is associated with all five CSHCN outcomes.
- Family structure is related to medical home status, and receiving transitional services.
- Insurance type is associated with parents being partners in decision making, medical home status, and receiving transitional services.

When examining social/demographic determinants of health in more detail, the review demonstrated some notable patterns. Race/ethnic and income/poverty level differences existed for most CSHCN performance measures. Statistically significant differences occurred for White families and for families with incomes 400% FPL or above versus non-White families and those with lower incomes. White families more frequently reported being partners in decision making (63%), having a medical home (55%), and receiving transition services (46%). Families with incomes 400% FPL or above most often reported being partners in decision making (72%), having a medical home (62%), having adequate insurance (74%), having services easy to use (94%), and receiving transition services (53%).

Similarly, there were differences in CSHCN performance measures according to parents' education levels. Those with more than a high school diploma most often reported being partners in decision making (61%), having a medical home (55%), adequate insurance (63%), and transitional services (43%).

Furthermore, CSHCN performance measures were associated with differences in family structure, although results were mixed. CYSHCN from two-parent families most often had a medical home (52%), while only 36% of CYSHCN from mother-only families had a medical home. CYSHCN from two-parent families most often received transition services (48%), whereas 28% of CYSHCN from mother-only families and only 19% of CYSHCN from stepfamilies received transition services.

Finally, differences in insurance types were statistically associated with all CSHCN performance measures. Those having private insurance most often reported being partners in decision making (64%), having adequate insurance (65%), having services easy to use (91%), and having transition services (50%).

Social/Demographic Determinants of Health and Family Impact Outcomes. Social/demographic determinants of health influenced the family outcomes experienced by CYSHCN and their families:

- Race – African American families were significantly lower than other races in mean days of school missed (3.4). Hispanic families were significantly higher than other races in having at least one parent stop working (23%).
- Parents' education – In families where parents have more than a high school education, children miss fewer days of school (mean = 4 days missed); however, this result was not a significant finding. In families where parents have a high school diploma or less, there were significantly more families with financial problems (30%) and one parent stopping work due to child's condition (39%) as compared to parents with more than a high school education.
- Poverty level – Among families with incomes at 400% FPL or above, children missed fewest days of school (mean = 3.2 days missed), families had fewest financial problems (8%), and the fewest number of parents had to stop working (7%). Similar positive results occurred for families with incomes at 300% to 399% FPL, and they also were significantly better across all three family impact outcomes than families with incomes below 300% FPL.
- Family structure – Children in stepfamilies were more likely to miss more school days (mean = 5.4 days missed) compared to children from other family structures. For example, children in two-parent families missed an average of only 3.9 days of school.
- Insurance status – Having insurance influenced all the identified family outcomes for CYSHCN and their families. Children from families with public insurance missed (on average) 5.1 days of school. This was noticeably higher compared to children from families that have private insurance (mean = 3.7 days missed). Uninsured CYSHCN families were most likely to have financial problems (51%) due to the child's health condition.

Performance Measures and Family Impact Outcomes. Performance measure outcomes also influenced family impact outcomes for CYSHCN and their families. In almost every instance, positive performance measure outcomes demonstrated positive family impact outcomes. The analysis found the following significant relationships:

- Partners in decision making – When CYSHCN parents are partners in decision making and are satisfied with the services they receive, their children missed fewer school days (3.6 versus 5.2 days missed) and were proportionately less likely to experience financial problems (9% versus 30%) and less likely to have one parent stop working (8% versus 25%).
- Medical home – Families that had a medical home were less likely to experience financial problems (10% versus 26%), and less likely to have one parent stop working (6% versus 21%). There were no significant differences in days of school missed for families that had a medical home versus those that did not have a medical home.
- Insurance – CYSHCN with adequate health insurance missed fewer days of school (3.8 versus 4.8 days missed) than CYSHCN without adequate health insurance, and families of CYSHCN with adequate health insurance experienced fewer financial problems (8% versus 32%) and had fewer instances when one parent stopped working (10% versus 21%).

- Services easy to use – Among parents who reported that services are organized for families to use them easily, fewer CYSHCN missed days of school (3.9 versus 6.4 days missed); fewer families experienced financial problems due to their child's condition (15% versus 43%); and fewer had one parent stop working (12% versus 35%).
- Transition – For CYSHCN receiving transition services, fewer families experienced financial problems (10% versus 24%) and fewer had one parent stop working (5% versus 18%). There were no significant differences in days of school missed for CYSHCN that received transition services versus those that did not receive transition services.

Social/demographic determinants of health, including race, parents' education, income level, family structure, and type of insurance, play a large role in the health care experiences of CYSHCN and their families, impacting both performance measure outcomes and family impact outcomes. In addition, evidence in these analyses demonstrated significant influences between positive performance measure outcomes and positive family impact outcomes.

SURVEYS OF KEY STAKEHOLDERS

As described in Section 1: Process for Conducting Needs Assessment, staff with the CSHCN Services Program developed methods and instruments to obtain needs assessment data for three key stakeholder populations, including parents of CYSHCN, health care providers, and participants of Community Resource Coordination Groups (CRCG). The purposes of the Parent Focus Groups and the Parent Survey were to gather information concerning the health care and related services parents received and the needs they had, with content developed around the Title V CSHCN national and state performance measures. The purposes of the Provider and CRCG Surveys were to measure the extent that providers and CRCG participants understood and demonstrated accord with the national and state performances measures for CYSHCN, to query these populations concerning the greatest needs for CYSHCN, and to help guide development of future Title V activities.

The following are summaries of the more important results derived from the focus groups and the three stakeholder surveys. There are several sections to this discussion. They include the results for parent focus groups and for each of the three survey sub-populations, a synopsis of unmet needs identified across all three sub-populations, and a summation of provider and CRCG participant familiarity with Title V CSHCN performance measures.

PARENTS OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS – FOCUS GROUPS AND SURVEY

Focus Groups Observations. Comparatively few family members participated in the focus groups; therefore, staff compiled and categorized the responses but did not conduct any statistical analyses. Generally, staff shared background information concerning Title V CSHCN national and state performance measures and asked parents to talk about services that worked well for them and services that were not working well.

When describing services that worked well, parents typically complimented the providers and individuals that have helped them access care. Parents tended to speak well of those with whom they were most well-acquainted. Parents described good relationships and indicated that providers want to incorporate families in decision making, try to satisfy families, and at least in some ways, seek to give care that embraces many characteristics of a medical or health care home. Comments about services that worked well were less frequent than comments about services that were not working well.

Among the services described as not working well, parents most often identified the following gaps and needs for services, programs, or providers:

- There is too much paperwork, applications are difficult to complete, and an inadequate exchange of information among providers and others.
- There are too many programs; programs are complicated and difficult to understand or access; and families need better information about how to access the programs they need and/or for which they qualify.
- There are not enough therapy or specialist providers; referrals are hard to get; reimbursement is poor; providers don't participate in all types of insurance plans (especially Medicaid); and there are very few adult providers for young adults with disabilities in transition.
- Providers and others need training in caring for or giving services to children with special health care needs.
- Insurance plans have coverage limits and authorization requirements that are not well-suited for CYSHCN, such as no provisions for respite care, 'quality of life' services, some equipment (hearing aids).
- There are too many case managers; each program has its own approach to case management with no one to coordinate across programs; and some program's case managers are not readily available (heavy caseloads and/or distance to offices).
- Mental health and substance abuse programs are unavailable or too limited in scope.
- Waiting lists for Medicaid Waiver (community-based) services are too long.

These results were reflective of and consistent with the results of other needs assessment activities.

Parent Survey General Information. The following points summarize the general results of the Parent Survey.

- Nearly 80% of parents responding (n=395) reported that their doctor listens to them.
- Almost 90% of respondents (n=430) reported they can ask their doctor questions, and more than 8% (n=41) reported they can sometimes ask their child's doctor questions.
- More than 86% of parents (n=429) reported that their child sees the same doctor for regular care at most visits.
- In addition, 76% of parents (n=377) felt they can work with their doctor and make choices together about their child's care.
- One-third of respondents (33.2%, n=165) reported it is hard and additional 20.1% (n=100) reported that it is sometimes hard to find specialists for their child.
- Less than two-thirds (62.4% n=307) indicated that their child's doctor helps to find specialists or other services for their child.
- Of those responding Yes or No to whether their child's doctor had asked the child (if 14 years of age or older) to talk about his/her own health care, the majority said No (52.4%, n=76).
- Overall, a majority of those responding (58.6%, n=275) have not thought about changing to a doctor who treats adults when their child is age 18 or older; however, a majority of respondents had children 10 years old or younger (56.2%, n=259). Among those with children 14 years of age and older (n=160), 42.5% (n=68) responded Yes, 49.4% (n=79) responded No, and 8.1% (n=13) did not answer the question.
- Forty-two percent of respondents (n=199) reported that they got help finding health care, including equipment for their child. An additional 16.6% (n=79) indicated they sometimes got help. This complemented the 50.6% (n=250) who indicated they do not need help to get health care and equipment for their child.
- Less than one-third (28.7%, n=142) indicated that they need help, and 15.7% (n=78) indicated they sometimes need help to get health care and equipment for their child. Of these, 65 (29.5%) said that they did not get or were not sure whether they had gotten help to find that care.
- Nearly one-third (29.0%, n=144) indicated that they need help and another 8.4% (n=42) indicated that they sometimes need help to get family support services, such as respite, van lifts, ramps, or changes to their homes, for their child.
- For those that indicated they needed help of any kind, only about one-third (33.8%, n=113) responded that they know how to get that help. An additional 12.2% (n=41) said they sometimes know how to get that help.
- When asked to indicate what services or products they or their child most needed, respondents most frequently indicated respite (25.6%, n=33), home modifications (21.7%, n=28), equipment (17.8%, n=23), and

insurance/funding/Medicaid (10.1%, n=13). In addition, nearly 10% of those providing a response (9.3%, n=12) also indicated the need for providers.

- A majority of respondents (58%, n=288) reported that they planned that their child would live with them when the child becomes an adult, but of the 85 (17.1%) respondents who reported that their child will not live with them once the child becomes an adult, 48 (56.4%) reported their child will live independently, 7 (8.2%) reported in a group home, and 30 (35.3%) were unsure.

Parent Survey Significant Differences Based on Respondents' Languages and HSRs. Staff also analyzed the Parent Survey to determine whether significant differences in response occurred, either according to parents' language or according to DSHS Health Service Region (HSR). More than 20% of parents (n=105) completed the survey in Spanish. Statistically significant differences occurred for 6 of 15 questions analyzed according to respondents' languages.

- More English respondents (70.3%, n=277) reported that their doctor spends enough time with them or their child compared to Spanish respondents (58.8%, n=60).
- English respondents (88.7%, n=347) were more likely to report that their child sees the same doctor for regular care at most visits compared to Spanish respondents (79.6%, n=82).
- Spanish respondents (43%.2%, n=45) were more likely to report that it is hard to find specialists for their child compared to English respondents (30.6%, n=120).
- Fewer Spanish respondents (12.6%, n=12) reported that their child's doctor asks their child age 14 or older to talk about his/her own health care compared to English respondents (15.3%, n=57).
- Fifty-five percent of Spanish respondents (n=57), as compared with 38% (n=142) of English respondents reported getting help to find health care and equipment.
- A significantly larger share of Spanish respondents (78.8%, n=82) than English respondents (52.5%, n=206) plan on their adult child living with them in adulthood.

As discussed in Section 1: Process for Conducting Needs Assessment, the largest number of parents (n=117) who responded to the survey lived in HSR 10, and there were no respondents from HSR 11. While the data indicates statistically significant differences between regions for most of the questions, findings should be interpreted cautiously in several instances, due to small cell sizes.

- Parents from HSR 2 (90%, n=18) and HSR 4 (80.5%, n=33) were most likely to report that their doctor spends enough time with them and their child. These regions both were significantly different from the responses for HSR 1 (61%, n=36) and HSR 6 (51.7%, n=15), in which respondents were least likely to report their doctor spends enough time with them.
- Ninety-five percent (n=19) of parents from HSR 2 reported that their doctor listens to them. The lowest regional percents of parents reporting this were in

HSR 5 (71.4%, n=5), HSR 6 (72.4%, n=21), HSR 7 (75.9%, n=63), and HSR 9 (75%, n=18). HSR 6 and HSR 7 were statistically significant from HSR 2.

- The highest percent of parents who reported they can ask their doctor questions was from HSR 1 (98%, n=56). This was statistically different than the lowest percents of parents in HSR 3 (79.2%, n=38), HSR 4 (84.6%, n=33), and HSR 8 (86%, n=37).
- The lowest percent of parents who reported they feel they can work with their doctor and make choices together about their child's care was in HSR 6 (55.2%, n=16). This region was statistically different from the regions having the five highest percents of parents responding affirmatively to the question, which were HSR 1 (78%, n=46), HSR 2 (84.2%, n=16), HSR 7 (79.7%, n=67), HSR 8 (79.1%, n=34), and HSR 10 (81.2%, n=95).
- Parents in HSR 2 had the highest percent (90%, n=18) who reported that their child's doctor helps to find specialists or other services for their child. Five regions having the lowest percents responding Yes to the question were HSR 3 (50%, n=24), HSR 4 (58.5%, n=24), HSR 6 (37%, n=10), HSR 7 (58.5%, n=48), and HSR 9 (63.5%, n=14), and these all were significantly different than HSR 2 (50%, n=3).
- Parents in HSR 8 (59.5%, n=25) were most likely and statistically different than parents in five other regions who were least likely to report that they have thought about changing to a doctor who treats adults when their child is 18. The five regions having the lowest percents of Yes responses were HSR 2 (30%, n=6), HSR 3 (38.3%, n=18), HSR 5 (16.7%, n=1), HSR 7 (40.9%, n=29), and HSR 10 (33.6%, n=38).
- Over one-half of parents in HSR 10 (50.4%, n=58) reported getting help to find health care, including equipment for their child. This contrasted with and was significantly different that in HSR 6 (7.4%, n=2) and HSR 7 (32.5%, n=25). The HSR having the lowest percent of parents responding that they received help was HSR 6, and this result was significantly lower than for all other HSRs.
- There was significant variation among regions in responses to the question asking whether respondents needed help to get health care and equipment or to care for their child. The highest rate of parents reporting the need for help occurred in HSR 8, where 40% (n=17) reported this need. This was significantly different than in HSR 2 (21%, n=4), HSR 7 (23%, n=19), and HSR 9 (4%, n=1). Recalling that HSR 6 had the lowest proportion of respondents who said they got help, the proportion of affirmative responses in HSR 6 was in the mid-range for this question (31.0%, n=9).
- The results of the question concerning parents' needs for help to get family support services, such as respite, van lifts, ramps, or changes to their houses, did not indicate any significant differences, but HSR 6 (58.6%, n=17) had the highest proportion of parents responding that they had a need for family support services, such as respite van lifts, ramps, or changes to their house. All other regions had less than 40% affirmative response for this need.
- Only slightly more than one-half (53.2%, n=25) of respondents in HSR 1 reported that they knew how to get the help needed to get healthcare, equipment, or family support services. This differed significantly from respondents in HSR 6

(15%, n=3), HSR 7 (23.5%, n=12), HSR 9 (18.2%, n=2), and HSR 10 (28.2%, n=24), and across all regions, a mean of less than 35% indicated they knew how to get the help they said they needed.

- Concerning whether parents plan on their children living with them in adulthood, 68% (n=80) of parents in HSR 10 reported that they plan for their child to live with them as an adult, while only 29.2% in HSR 9 (n=80) reported the same. The proportion of respondents in HSR 10 is significantly larger than in 4 other regions, and the proportion of respondents in HSR 9 is significantly smaller than in six other regions.

Parent Survey Concluding Observations. In general, the responses to the survey indicated mixed results for the Title V CSHCN national and state performance measures. Examining the findings in detail suggests opportunities to develop activities which could further advance progress toward meeting the performance measures. The following are some summary observations:

- The responses to the CSHCN Services Program parent survey indicated a potentially higher level of families partnering in decision making than did the national data; however, the parent survey respondents typically were connected with the Program or other Texas health and human service systems, and as such may differ measurably from the general population of children and youth with special health care needs queried in the NS-CSHCN.
- Overall, 87% (n=429) of parents reported that their child sees the same doctor for regular care at most visits, and on a region-by-region basis, three-quarters or more parents from all HSRs reported that their child sees the same doctor for most regular care visits. There were statistically significant findings based on respondents' language, but no statistically significant findings based on geographic region for this question. For the population measured by this survey, the responses indicated a possibly greater presence of medical home than the 2005-2006 NS-CSHCN showed.
- Regarding insurance coverage, only 7.7% (n=37) of respondents to this survey indicated they had no coverage at all; however, there were 22 missing responses. According to the NS-CSHCN and other sources, these results may have been atypical for the general population of CYSHCN. Among those with Private insurance, many more were English respondents than Spanish respondents. Ninety-five percent of those with private insurance were English respondents. Conversely, there were proportionately larger numbers of Spanish respondents without insurance.
- Concerning the needs for transition services, the larger proportions of negative responses on this survey, while not directly comparable, were in agreement with the NS-CSHCN findings. The needs for health care transition awareness and services shown by this survey were extensive.
- These results suggested an important need to improve access to community-based services, especially respite services. Even among those families closely affiliated with the CSHCN Services Program, this survey showed that the needs to help families use community-based service systems were substantial.

- The results of this survey considered against data available regarding institutionalization of children in Texas suggested that for those responding to this survey, the demand for institutional care will be minimal.
- There was wide variation between regions on many of the questions. Identifying the HSRs with highest and lowest percents for each question may enable development of regionally targeted activities that would more efficiently enhance improvement of the performance measures (See Appendix I – CSHCN Parent Survey Report).

HEALTH CARE PROVIDERS – SURVEY

Provider Survey General Information. The following is a general summary of the health care provider survey.

- One-quarter of respondents (25%, n=64) are CSHCN Services Program providers, but nearly three times as many (72%, n=186) were providers for Texas Vaccines for Children (TVFC). About seventeen percent (n=43) were providers for both the CSHCN Services Program and TVFC. While many CSHCN Services Program providers are TVFC providers, there are many more TVFC providers that are not currently enrolled as providers in the CSHCN Services Program. This suggests a potentially fertile population to target for increased CSHCN Services Program provider enrollment.
- Among the nearly one-third (32%, n=82) of respondents who were unsure whether their practice or clinic was enrolled in the CSHCN Services Program, 22 were physicians (31% of physicians), 30 were nurses (39% of nurses), 3 were social workers (8% of social workers), and 27 were all other professions (36% of all other professions). This distribution suggests the CSHCN Services Program may need to improve its visibility among physicians, nurses, and other professionals.
- Overall, about 80% (n=205) indicated their practices encourage and facilitate family involvement during office visits; however, fewer practices have characteristics that more intentionally engage families and consumers.
    - Less than one-half (43%,n=109) indicated their practices schedule office visits at times other than weekdays from 8:00 a.m. to 5:00 p.m.
    - About 40% (n=104) indicated they have a patient, family, or consumer advisory group.
    - Forty-three percent (n=107) said their practices have mission statements, by-laws, or operating guidelines which show that their practices encourage family input/participation.
    - Only 11% (n=26) indicated that family members helped write or approve their mission statements, by-laws, or operating guidelines.
    - More than two-thirds (67%, n=172) indicted that their practices orient or train staff about the value of family input, but only 7% (n=18) indicated that family members participate in orienting or training staff.
- Two-thirds of respondents (66%, n=168) indicated their staff members were familiar with the basic characteristics of a medical home, but only 46% (n=117)

reported that they consider their practices to be a medical home. About one-quarter of respondents (25%, n=64) indicated they were CSHCN Services Program providers, and significantly higher numbers of these providers considered their practices to be a medical home as compared with those that were not CSHCN Services Program providers.

- Among 69 physicians that responded to questions concerning medical home, more than three-quarters (77%, n=53) indicated their staff members were familiar with the basic characteristics of a medical home, and a like number (75%, n=52) indicated they consider their practices to be a medical home for their patients who are children, youth, or young adults with special health care needs.
- Overall, more than two-thirds (68%, n=172) reported they assist families in finding health care insurance when needed, and this was especially true for nurses (75% of nurses responding, n=57) and social workers (89% of social workers responding, n=37). Further, significantly more CSHCN Services Program providers reported assisting families in finding health care insurance than those that were not CSHCN Services Program providers.
- More than two-thirds (69%, n=175) of all respondents indicated their staff members were knowledgeable concerning health insurance resources in Texas. This was the case for 63% of physicians (n=44), 90% of social workers (n=32) and 86% of nurses (n=56). Even though considering themselves knowledgeable, nearly one-half (49%, n=123) of those responding reported experiencing difficulty finding health insurance resources.
- Many indicated their practices have ways to address cultural (77%, n=196) and transportation (58%, n=148) issues, but only 38% (n=98) indicated they have ways to address child care issues, if these issues are barriers to family involvement.
- About 85 % (n=217) indicated they accommodate family members' special needs upon request, and slightly more than one-half (52%, n=132) indicated they ask families how to make practices more accessible.
- Twenty-one percent (n=55) reported that they have employees that are people with disabilities or family members of children or youth with special health care needs.
- Nearly three quarters (73%, n=184) indicated they help families in finding community-based services and supports, but more than one-half (56%, n=142) said they experience difficulty doing so.
- Overall, one-third (33%, n=84) of practices indicated they ask families to evaluate services and supports available in their communities.
- More than three-quarters of all respondents (76%, n=196) indicated they encourage youth and young adults to take responsibility for their own care, but fewer (58%, n=146) indicated they discuss with youth, young adults, or their families planning for transition to providers serving adults. Among physician respondents alone, 87% (n=60) indicated they encourage young adults to take responsibility for their own care, and 67% (n=45) said they discuss planning for transition to adult providers.
- Overall, about two-thirds (66%, n=169) reported they assist young adult consumers to find health care providers serving adults or other health care

transition services. Among those responding yes or no, 58% (n=105) reported experiencing difficulty finding those providers. About one-third of respondents (29%, n=75) indicated either don't know or not applicable to the question concerning whether their practice experienced difficulty finding providers serving adults.

- Forty percent (n=101) indicated their practices are familiar with transition services provided through area school districts; 35% (n=88) indicated they are familiar with transition services available through the Department of Assistive and Rehabilitative Services (DARS); and 24% (n=62) said they are familiar with DARS transition vocational rehabilitation specialists located in are high schools.
- More than one-half (54%, n=138) of all respondents indicated their practices are familiar with Medicaid and non-Medicaid community-based long-term care programs (e.g., Medicaid Waiver Programs, Personal Care Services, In-Home and Family Supports, etc.) and a like number (56%, n=143) indicated their practices help link families to these programs.
- When asked whether their practices have ways to identify or determine the least restrictive environment in which patients can reside and receive services, only 37% (n=95) responded Yes. Twenty-one percent (n=53) said they have ways to follow up on patients who are placed in long-term institutional settings, and 22% (n=55) indicated they help interested families to return home their children that live in long-term institutional settings. Nineteen percent (n=13) of physicians, 18% (n=14) of nurses, and 47% (n=17) of social workers, indicated they help families in this way; however, CSHCN Services Program providers were more likely to report that their practices assist in bringing home children that live in long-term institutional settings.

Provider Survey Significant Differences Based on Provider Type. The following is a summary of all statistically significant differences among the questions according to respondents' provider types.

Physicians

Significant differences for physicians seemed to cluster around survey items related to medical home. Physician respondents were *most* likely to say that their practices:

- Routinely encourage and facilitate family involvement during an office visit.
- Have staff members that are familiar with the basic characteristics of a medical home, as compared with social workers and the all other professions categories.
- Provide medical homes for their patients who are children, youth, or young adults with special health care needs.
- Encourage youth and young adults to take responsibility for their own care, as compared with the all other professions categories.
- Experience difficulty finding health care providers serving adults or offering other health care transition services, as compared with nurses and the all other professions categories.

Physicians were *least* likely to say that their practices:

- Schedule office visits at times other than weekdays from 8 to 5 that are convenient for families.
- If considered to be a medical home, assist families and consumers when needed in finding a health care provider to be a primary medical home.
- If not considered to be a medical home, experience difficulty finding health care providers to be a medical home, as compared with social workers and the all other professions categories.
- Have ways to address specific cultural issues, if they are barriers to family involvement.
- Ask families how to make their practices more accessible to families, as compared with nurses and social workers.

Nurses

- Nurses were *most* likely to indicate that their office documents show that their practices encourage family input/participation in document development or review.

Social Workers

Social workers were *most* likely to indicate that their practices:

- Ask families if they are satisfied with services received at this practice.
- Assist families and consumers in finding health care insurance when needed, as compared with physicians and the all other professions categories.
- Are knowledgeable about health insurance resources in Texas, as compared with physicians and the all other professions categories.
- Experience difficulty finding health care insurance resources, as compared with the all other professions category.
- Have ways to address specific cultural, transportation, and child care issues, if they are barriers to family involvement.
- Accommodate family members' special needs upon request, as compared with the all other professions category.
- Hire patients with disabilities or family members of children or youth with special needs on staff, as compared with the physician and all other professions categories.
- Help families find community-based services and supports, e.g., respite, vehicle or home modifications, social services.
- Ask families to evaluate services and supports available in their communities.
- Discuss with youth and young adults (and/or their families) planning for transition to providers serving adults.
- Help families and young adult consumers when needed in finding health care providers serving adults or other health care transition services.

- Experience difficulty finding health care providers serving adults or offering other health care transition services, as compared with nurses and the all other professions categories.
- Are familiar with transition services available through area school districts and through the Department of Assistive and Rehabilitative Services (DARS).
- Are acquainted with DARS transition vocational rehabilitation specialists located in high schools in the area.
- Are familiar with Medicaid and non-Medicaid community-based long-term care programs.
- Help link families to services through Medicaid and non-Medicaid community-based long-term care programs.
- Have ways to identify or determine the least restrictive environment in which patients can reside and receive services.
- Help interested families to return home their children that live in long-term institutional settings.

Social workers were *least* likely to say they consider their practices to be a medical home for their patients who are children, youth, or young adults with special health care needs.

All Other Professions

Respondents from all other professions were *least* likely to say that their practices:

- Ask families if they are satisfied with services received at their practice.
- Have documents which show that the practice encourages family input/participation in document development or review.
- Orient or train staff about the value or importance of family input.
- Have ways to address child care issues, if they are barriers to family involvement, as compared with Nurses and Social Workers.
- Discuss with youth and young adults planning for transition to providers serving adults.

Provider Survey Significant Differences Based on CSHCN Services Program Provider Enrollment. Practices enrolled in the CSHCN Services Program were *more* likely than those that were not enrolled in the program to say that their practices:

- Ask families if they are satisfied with services received at this practice.
- Orient or train staff about the value or importance of family input.
- Consider their practices to be a medical home for its patients who are children, youth, or young adults with special health care needs.
- Assist families and consumers in finding health care insurance when needed.
- Have ways to address transportation issues, if they are barriers to family involvement.
- Ask families to evaluate services and supports available in their communities.
- Encourage youth and young adults to take responsibility for their own care.

- Discuss with youth and young adults (and/or their families) planning for transition to providers serving adults.
- Are familiar with transition services available through the Department of Assistive and Rehabilitative Services (DARS).
- Are acquainted with DARS transition vocational rehabilitation specialists located in high schools in the area.
- Are familiar with Medicaid and non-Medicaid community-based long-term care programs (i.e., Medicaid Waiver Programs, Personal Care Services, In-Home and Family Supports, etc.).
- Help link families to services through Medicaid and non-Medicaid community-based long-term care programs.
- Have ways to identify or determine the least restrictive environment in which patients can reside and receive services.
- Have ways to follow up on patients who are placed in long-term institutional settings.
- Help interested families to return home their children that live in long-term institutional settings.

Provider Survey Concluding Observations. In general, the responses to the survey indicated that providers understand and demonstrate accord with the Title V CSHCN national and state performance measures. Examining the findings in more detail suggested there may be activities which, if undertaken by the CSHCN Services Program in conjunction with providers across Texas, could advance progress toward meeting the performance measures. The following observations summarize potential areas for collaboration, information dissemination, and outreach.

- There are many more TVFC providers that are not currently enrolled as providers in the CSHCN Services Program. This suggests a potentially fertile population to target for increased program provider enrollment.
- The distribution of providers who were unsure whether their practices were enrolled in the CSHCN Services Program suggests the program may need to improve its visibility among physicians, nurses, and other professionals.
- The results of this survey suggest that a possible future activity for the CSHCN Services Program is to develop targeted strategies and tools that assist health care providers with increasing family member involvement, generally, and specifically for program providers, to receive encouragement and technical assistance about including family members in staff training opportunities.
- Providers have widespread, but not universal, understanding of and support for medical home principles. CSHCN Services Program policies and activities, including statewide collaboration with professional and/or multi-agency groups, must continue to facilitate strategies that improve provider understanding of and commitment to full implementation of the medical home as a practice standard.
- The numbers of children in Texas that are uninsured and consequentially have reduced access to routine health care services is an important problem. It is a problem not only for the families impacted by the statistic, but also for health care

providers and the citizens of Texas. Lack of insurance results in social and economic costs of illness versus wellness, including lost productive school and/or work time, reduced preventive intervention, inappropriately expended urgent or emergency care resources, and increased inpatient care.

- Health care providers are among the most knowledgeable professionals concerning health care insurance resources, but nearly one-half of respondents reported experiencing difficulty finding health insurance resources.
- Among the health care professionals responding to this survey, physicians were the least inclined to indicate that their practices assist families with finding health insurance resources. This suggests an opportunity for targeted information sharing and technical assistance in order to optimize insurance coverage for children who are eligible.
    - In order to maximize resources that are available, the Texas-Mexico border region, four counties in the Houston vicinity, and Dallas County, where the numbers of uninsured children are much higher, are geographic areas that must be considered prime locations for targeted outreach concerning available health insurance resources.
    - Information sharing and technical assistance concerning health insurance eligibility for governmental programs might best be targeted toward providers outside the CSHCN Services Program.
- All of the survey questions concerning possible barriers to family involvement consistently showed that CSHCN Services Program providers responded yes more often than not-CSHCN Services Program providers. This suggests that CSHCN Services Program providers may tend toward organizing their practices so families can use them more easily. Therefore, not-CSHCN Services Program providers should be targeted for increased outreach concerning how their practices and community-based service systems can be easier for families to use.
- Regardless of provider program enrollment, there appears to be only limited employment of patients with disabilities or family members of children or youth with special needs. Encouraging providers to employ patients with disabilities or family members of children or youth with special needs is an activity that might advance the performance measure to make community-based services easy to use.
- About one-half of providers asked families how to make their services more accessible, but only about one-third of providers indicated that they asked families to evaluate community based services. A majority of providers reported difficulty finding community-based services and supports. Sometimes families are the best sources of information to access and improve services. Providers likely need tools to help them evaluate their practices and community-based services and better identify available and needed resources in their communities.
- With the exception of social workers, providers lack certain skills and knowledge needed to best serve transitioning youth and their families.
- Larger numbers of health care providers need to be made familiar with transition services provided through area school districts and through the Department of Assistive and Rehabilitative Services (DARS).

- Three-quarters of providers said that they encouraged youth and young adults to take responsibility for their own care, and CSHCN Services Program providers were significantly more likely than were not-CSHCN Services Program providers to do this. However, less than one-half typically used health care transition strategies including transition planning, helping find adult providers, and having familiarity with other local transition services. Health care providers continue to need additional assistance concerning tools and resources available to provide transition services for youth and young adults with special health care needs.
- While about one-half of providers are familiar with Medicaid and non-Medicaid community-based long-term care programs, less than one-quarter indicated they help interested families to return home their children that live in long-term institutional settings. Providers may need additional encouragement or resources to be more proactive in identifying and assisting families to move home their children living in institutional care settings.
- High proportions of social workers and CSHCN Services Program providers indicated they were engaged in activities that support keeping children with special health care needs with families in communities and not in institutional settings. Nevertheless, there are some providers that could be more engaged in activities that support this performance measure.
- There were 142 surveys that provided information in response to the question asking "What is the single greatest unmet need of child or young adult consumers (ages 0-21) served by your practice?" The five needs mentioned most often were:
    - Access to care, services, and transportation;
    - Availability of providers, including specialists, and dentists;
    - Education and outreach to the public about services for children with special health care needs;
    - Inadequate distribution of community-based social services and resources; and
    - Availability of family support and respite services
- Thirty-two percent (n=84) of respondents reported that prior to receiving this survey, their knowledge and understanding of the six performance measures was good/average or excellent/complete. Sixty-six percent (n=171) reported that it was limited/incomplete or poor/inadequate. Among social workers and CSHCN Services Program providers, the numbers of respondents that reported good/average or excellent/complete knowledge and understanding were slightly higher, but the results of this survey indicated that all health care professionals need additional training and orientation to improve their knowledge and understanding of the Title V CSHCN performance measures (See Appendix J – CSHCN Provider Survey Report).

COMMUNITY RESOURCE COORDINATION GROUPS (CRCG) – SURVEY

CRCG Survey General Information. The following is a general summary of the results from the CRCG survey.

- Overall, respondents reported that their CRCGs facilitate cooperation with the families of children with special health care needs at all levels. Ninety-four percent (n=201) of respondents reported that their CRCGs routinely encourage and facilitate family involvement at the family's own service planning meetings, 86% (n=183) indicated they schedule service planning meetings at times appropriate for families and consumers, and 56% (n=120) reported that their CRCGs orient or train their members about the value or importance of family input.
- Only 50% (n=107) of respondents reported that their CRCGs have knowledge about the basic characteristics of a primary care medical home, and 40% (n=48) said they experience difficulty finding health care providers to be a medical home.
- Many respondents (78%, n=165) reported that their CRCGs are knowledgeable about and 68% (n=145) reported that they assist their clients in finding health insurance, yet 48% (n=102) reported that they experience difficulty in finding health insurance.
- Findings showed that CRCGs have ways to address transportation issues (71%, n=153), cultural issues (73%, n=155), and child care issues (54%, n=116), if they are barriers to family involvement.
- Over 85% (n=183) indicated they accommodate family members' special needs upon request.
- Thirty-two percent (n=68) of those surveyed reported that family members are eligible to serve in leadership positions.
- In contrast with an apparently high level of support for family involvement, only 17% (n=37) of respondents said that their CRCGs regularly ask families to evaluate services and supports available in their communities; only 18% (n=39) survey consumers or their families to determine if they are satisfied with the services they receive from the CRCG; and only 32% (n=68) said their CRCGs regularly ask consumers or families how to make CRCGs more accessible to consumers or families.
- Sixty-three percent (n=134) said that their CRCGs assist families and young adult consumers in finding health care providers serving adults or other health care transition services; however, 51% (n=108) reported that they experience difficulty in finding these providers or services.
- More than 80% (n=176) of respondents reported they help link families with Medicaid waiver and non-Medicaid community-based services programs; 75% (n=159) said they have ways to identify least-restrictive environments; 66% (n=139) said they can follow up on clients placed in institutional settings; and 47% (n=100) indicated they help return home children living in institutionalized settings.

CRCG Survey Statistically Significant Differences Based on Affiliation Category. Below is a summary of all statistically significant differences among the questions according to respondents' grouped affiliations. The professional or personal affiliation was an optional item in the survey and included a large array of state and local agencies, as well as family member, consumer, caregiver, advocacy organization, faith-based organization, and community action organization. For the purpose of comparing responses by affiliation, the data analyses used six key categories: DSHS Staff Serving CYSHCN, MH/MR Centers represented by DSHS and by DADS, Public Education represented by school districts, education services centers, and the Texas Education Agency, Local Juvenile Probation Departments, Private Sector individuals or entities, and Affiliation Not Listed. The diversity of expertise across affiliations and the significant differences reported in these findings suggested that there may be opportunities for targeted information dissemination or technical assistance based on agency affiliation.

DSHS Staff Serving CYSHCN

Significant differences for DSHS Staff Serving CYSHCN seemed to cluster around survey items related to medical home and transition. Respondents from DSHS Staff Serving CYSHCN were *most* likely to:

- Report that members of their CRCGs are familiar with the basic characteristics of a medical home, as compared with respondents from Local Juvenile Probation.
- Report that their CRCGs assist families and consumers when needed in finding a health care provider to be a primary care medical home, as compared with all respondents except those from the Private Sector and Affiliation Not Listed.
- Report that their CRCGs experience difficulty finding health care providers to be a medical home, as compared with respondents from Local Juvenile Probation and Affiliation Not Listed.
- Report that their CRCGs experience difficulty finding health care providers serving adults or offering other health care transition services, as compared with respondents from Local Juvenile Probation and Affiliation Not Listed.

DSHS Staff Serving CYSHCN respondents were *least* likely to report that their CRCGs encourage and facilitate family members to be at service planning meetings for other consumers, and they were statistically different from Private Sector respondents on this measure.

DSHS Staff Serving CYSHCN respondents also were *least* likely and significantly different from Mental Health/Mental Retardation (MH/MR) Centers and Local Juvenile Probation respondents, to ask families to evaluate services and supports available in their communities; however, there were only 37 individuals (17%) that responded affirmatively to this question.

MH/MR Centers (DSHS and DADS)

Significant differences for CRCG participants affiliated with MH/MR Centers seemed to cluster around family input, linkages, and evaluations of community services and supports; experiencing difficulty finding health insurance and community-based services and supports; and in ways to follow up on consumers who are placed in institutional settings. Respondents from MH/MR Centers were *most* likely to:

- Report that their CRCGs experience difficulty finding health care insurance resources for CYSHCN, as compared with respondents from the Private Sector and Affiliation Not Listed.
- Report that their CRCGs help link families to services through Medicaid and non-Medicaid community-based long-term care programs, as compared with respondents from all other affiliations, except those from Public Education and Affiliation Not Listed.
- Report that their CRCGs experience difficulty finding community-based services and supports, as compared with respondents from Affiliation Not Listed. The data showed that this difference also occurred, but to a lesser degree, for respondents affiliated with Public Education and Local Juvenile Probation as compared with respondents from Affiliation Not Listed on this question.
- Report that their CRCGs have ways to follow up on consumers who are placed in institutional settings, which was significantly different from DSHS Staff Serving CYSHCN respondents.

Public Education

Significant differences for CRCG participants affiliated with Public Education were more often related to having difficulty finding community-based services and supports and having expertise with school district transition services. Respondents from public education were *most* likely to:

- Report that their CRCGs experience difficulty finding community-based services and supports, as compared with respondents from Affiliation Not Listed.
- Report that their CRCG members are familiar with transition services available through area school districts, as compared with respondents from all other affiliations, except those from the Private Sector.

However, compared to all others except the Private Sector and Affiliation Not Listed, respondents from Public Education were *least* likely to say that their CRCGs schedule service planning meetings at a time when families can attend.

Also, as compared with respondents from MH/MR Centers and Affiliation Not Listed, respondents from Public Education were *least* likely to say their CRCGs orient or train their members about the value or importance of family input.

Further, respondents from Public Education, as compared with those from Affiliation Not Listed, were *least* likely to indicate their CRCGs help interested families to return home their children that live in institutional settings.

Local Juvenile Probation

CRCG participants affiliated with Local Juvenile Probation showed significant differences that clustered around health insurance resources, asking families about making CRCGs more accessible, and being less familiar and involved with families and consumers needing a medical home than other respondents. Respondents from Local Juvenile Probation were *most* likely to:

- Report that their CRCGs assist families and consumers in finding health care insurance when needed, as compared with those from Affiliation Not Listed.
- Report that members of their CRCGs are knowledgeable about health insurance resources in Texas, as compared with those from Public Education.
- Report that their CRCGs regularly ask families how to make the CRCG more accessible to families, as compared with those from DSHS Staff Serving CYSHCN, Public Education, and the Private Sector. Respondents from Affiliated Not Listed also were significantly different those affiliated with DSHS Staff Serving CYSHCN and Public Education on this measure.

As compared with DSHS Staff Serving CYSHCN, those from Local Juvenile Probation were *least* likely to say that members of their CRCGs were familiar with the basic characteristics of a medical home.

Further, respondents from Local Juvenile Probation, as compared to respondents from DSHS Staff Serving CYSHCN, the Private Sector, and Affiliation Not Listed, were *least* likely to indicate that their CRCGs assisted family members and consumers in finding a health care provider to be a primary care medical home.

Private Sector

Respondents from the private sector were *most* likely to:

- State that their CRCGs routinely encourage and facilitate family members to be at service planning meetings for other consumers, and this finding was statistically significant when compared with respondents from DSHS Staff Serving CYSHCN.

Private Sector respondents were *least* likely to report their CRCGs have mission statements, by-laws, or operating guidelines and this finding was significant when compared with respondents from Affiliation Not Listed.

CRCG Survey Concluding Observations. In general, the responses to the survey indicated that CRCG participants understand and demonstrate accord with the Title V

CSHCN national and state performance measures. Examining the findings in more detail suggested there may be activities which, if undertaken by the CSHCN Services Program in conjunction with members of CRCGs across Texas, could further advance progress toward meeting the performance measures. The following observations summarize potential areas for collaboration, information dissemination, and outreach.

- Since one-third of all respondents did not know whether their CRCGs had mission statements, by-laws, or operating guidelines, and since large numbers of respondents did not know whether their CRCG's documents encourage family input/participation or whether family members helped write the documents, a potential area for collaboration between CRCGs and the CSHCN Services Program would be to develop specific activities that assist the CRCGs with targeted strategies to increase family member involvement.
- Nearly one-third (32%) of respondents did not know whether the members of their CRCGs were familiar with the basic characteristics of a medical home, and those affiliated with Local Juvenile Probation showed they were least familiar with the characteristics of a medical home. This identifies a potential area for collaboration between CRCGs, Local Juvenile Probation personnel, and the CSHCN Services Program to share information about the health care and medical home needs of children and youth involved with the juvenile justice system and enhance their knowledge concerning medical home principles and criteria.
- The national- and state-level data and the findings of this survey all suggested a need to continue working to make easily finding and readily obtaining health insurance for CYSHCN an essential activity. Targeted outreach concerning available health insurance resources might first be aimed at the Texas-Mexico border, the Houston vicinity, and Dallas County. Also, the CSHCN Services Program can work toward being sure that CRCG participants are well-informed concerning the availability of program health insurance benefits and services in order to address insurance gaps that occur for some CYSHCN in Texas.
- The data showed only limited CRCG evaluation of services, accessibility, and community resources. The CSHCN Services Program could provide expertise and assist to develop and distribute evaluation tools and encourage more easily-used community-based services.
- Many respondents indicated familiarity with transition services available through school districts and DARS, but the responses to this survey and the 2005-2006 NS-CSHCN suggested a need for continued efforts to increase awareness about adolescent to adult health care transition and to expand the availability of adult-serving providers.
- Members of CRCGs appeared to need additional information regarding the roles they could have with permanency planning and to help families return home children that live in institutional settings.
- There were 158 responses to an open-ended question asking, "What is the single greatest unmet need of child or young adult consumers (ages 0-21) served by your CRCG?" Responses revealed that the single greatest unmet need was for mental health or behavioral health services, facilities, and programs. Other

important unmet needs included funding or resources for long-term residential treatment or placement; having services available within nearby or local communities, and aspects of CRCG operations.

- The findings concerning how respondents rated their knowledge and understanding of the six Texas performance measures are consistent with other findings in this survey. Less than one-half of respondents indicated their knowledge and understanding as Good/Average or Excellent/Complete. This suggests that the CSHCN Services Program should target participants of CRCGs as important partners and an audience for information concerning not only the CSHCN Services Program health benefits plan and other services, but also the facts of and fundamental principles promoted by the Title V performance measures (See Appendix K – CSHCN CRCG Survey Report).

SUMMARY OF UNMET NEEDS FOR FAMILY, PROVIDER, AND CRCG SURVEYS

All of the DSHS surveys included open-ended questions asking respondents to identify unmet needs. Twenty-eight percent of parents (n=143), 55% of providers (n=142), and 75% of CRCG participants (n=159) responding to the DSHS surveys provided additional information concerning unmet needs. These survey questions cannot be compared directly, but the information received suggests comparable themes. The following table captures and summarizes in no particular rank the top categories of needs mentioned most often for each group surveyed.

Table 3-20. Unmet Needs Reported in Family, Provider, and CRCG Surveys

Parents* n=143	Providers n=142	CRCG Participants** n=159
Comparable or Related Needs		
Providers	Availability of providers, including specialists and dentists	Providers
Insurance, funding, or Medicaid	Access to care, services, and transportation	Funding, health care or insurance
Respite care	Availability of family support and respite services	Respite or family support services
	Inadequate distribution of community-based social services and resources	Lack of services nearby or in local communities
Differing or Unrelated Needs		
Home modifications	Education and outreach to the public about services for CYSHCN	Availability of mental health services, facilities or programs***
Various types of specialized equipment		Funding or resources for long-term treatment or placement

*The Parent survey responses primarily focused on needs for health care, equipment, and family support services, such as respite, van lifts, ramps, or home modifications.

**CRCG participants often serve children and youth with complex physical and behavioral health problems, many of whom are in crisis.

*** In data recently released by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, the National Survey of Children's Health 2007 showed that nationally 40% of all children in need of mental health services for emotional development or behavioral problems did not receive them. Among uninsured children, more than one-half did not. In Texas, 58.3% did not receive needed mental health services. (USDHHS, HRSA, MCHB, 2009).

FAMILIARITY WITH TITLE V CSHCN PERFORMANCE MEASURES

Both the Provider and the CRCG Surveys asked respondents to assess their familiarity with the Title V CSHCN performance measures before having completed the survey. The results indicated that the CSHCN performance measures were not well-known among those professionals most closely associated with CYSHCN.

- For providers – Only thirty-two percent of all respondents (n=84) and 45% of respondents indicating they were CSHCN Services Program providers (n=30) reported that prior to receiving the information provided in the survey, they would rate their knowledge and understanding of the Texas performance measures as excellent/complete or good/average. A larger number of social workers indicated their knowledge was good/average or excellent/complete as compared with other professions; however, cell sizes were too small for statistical comparison among professions.
- For CRCG participants – Less than one-half of respondents indicated their knowledge and understanding as Good/Average or Excellent/Complete.

These results suggested that the CSHCN Services Program should continue targeting providers and CRCG participants for increased technical assistance concerning not only the CSHCN Services Program health benefits plan and other services, but also the facts of and fundamental principles promoted by the Title V performance measures.

GUIDANCE AND SUBJECT MATTER EXPERTISE FOR THE STATEWIDE NEEDS ASSESSMENT PLANNING GROUP

As CSHCN Services Program staff participated in the Needs Assessment Planning Group, staff was involved at all stages of the process that resulted in determining the most frequently identified needs for the CYSHCN population. Most important to that process were the identification of geographic locations for the listening sessions; validating full accessibility and cultural sensitivity on behalf of those representing the CYSHCN population; developing contact information for distributing announcements about the Community Listening Sessions, the Title V Stakeholder Summit, and Public

Forums; and encouraging participation in these events by sufficient numbers of people who have personal, familial, or professional experience with CYSHCN.

In addition, CSHCN Services Program staff reviewed the data obtained through the processes overseen by the Needs Assessment Planning Group to assist in distilling the data from the Community Listening Sessions into the listings of needs that PPRI used in developing the web-based surveys and the Stakeholder Summit activities, as well as those that DSHS used with the Employee Survey. For the Stakeholder Summit, staff provided background information to inform stakeholders concerning the 10 most important needs plus the 5 national and one state-level performance measures, as discussed earlier in the Primary and Secondary Health Status Data section of this report. For the DSHS Employee Survey, the Needs Assessment Planning Group agreed to include all of the needs statements identified through the listening sessions plus the national and state performance measures. Additional details about the Planning Group activities, the PPRI needs assessment process, and the outcomes of the Employee Survey are reported in Section 1: Process for Conducting Needs Assessment.

CONCLUSIONS

The outcome of the needs assessment processes enabled DSHS to develop 10 proposed Title V priority statements for FY 2011 through FY 2015 that encompassed all of the identified needs statements and performance measures. Typically, each priority related to many needs statements and more than one state or national performance measure. Nine of ten proposed Title V priority statements related to one or more of the CSHCN national or state performance measures and at least one priority statement addressed every CSHCN performance measure.

In developing the 10 priority statements for FY 2011 through FY 2015, DSHS staff having expertise for the CYSHCN population considered strengths and needs for CYSHCN identified through four additional needs assessment sources and strategies, including:

- Agency, Stakeholder Organizations, and Other Sources,
- Primary and Secondary Health Status Data,
- Independent Surveys of Key Stakeholders, and
- Guidance and Subject Matter Expertise for the Needs Assessment Planning Group.

The information gathered through these methods further substantiated the 10 priorities and provided additional detailed information to shape the strategies future state activities for CYSHCN in Texas. For CYSHCN in Texas, the most important needs continue to be reflective of and aligned with the Title V CSHCN national and state

performance measures. Needs assessment themes that emerged to influence the focus of specific Title V CSHCN Annual Plan activities included needs for:

- Family participation,
- Increased community-based services and reduction of congregate care,
- Core quality of care outcome measures for CYSHCN across state health and human services programs,
- Advancement of medical home services,
- Increased providers and provider access and provider reimbursement,
- Increased and improved mental health services and access to mental health services,
- Improved transition services,
- Improved service system coordination,
- Enhanced promotion of the Title V performance measures to increase knowledge of CRCG staff, providers, and parents/consumers, and
- Targeting services based on data analysis of social, demographic, and condition-specific determinants of health and quality of life outcomes of CYSHCN.

In addition to identifying ongoing needs, the needs assessment highlighted several key strengths. There are additional recent encouraging developments that will impact Texas services for CYSHCN over the next five years and influence the context of Title V planning and activities.

The 81st Texas Legislature (2009) passed three measures that hold promise for future activities and improvement in outcomes for CYSHCN. These included creation of a Task Force for Children with Special Needs (Senate Bill 1824), Medicaid Buy-In for disabled children whose family incomes do not exceed 300% FPL (SB187), and the Council on Children and Families (SB1646). Activities on these measures are in their initial stages, with little action expected before SFY 2011; however, DSHS executive leadership and other staff have been participating in early developments and planning.

Texas is 1 of 17 states engaging in the Patient-Centered Medical Home Demonstration Projects sponsored through the Patient-Centered Primary Care Collaborative. The project is entitled the “Texas Medical Home Initiative.” Participating Texas stakeholders include the Texas Chapter of the American College of Physicians, Texas Academy of Family Physicians, Texas Medical Association, Texas Medical Foundation Health Quality Institute, Texas Pediatric Society, DSHS, Aetna, Blue Cross Blue Shield of Texas, CIGNA, Humana, United HealthCare, HHSC Medicaid-CHIP Division Office of the Medical Director, IBM, and Health Dialog.

The project will begin with a small scale implementation. Based upon “lessons learned” during the first 12-18 months of this implementation, the project will be expanded. During Stage One, the focus will be primarily on adults; however, the project will also

include patients younger than 18 with severe asthma. In addition, there will be a focus on young adults with special health care needs aged 14-24 if transferring from pediatric practices. Stage One will be limited to practices that treat adult patients or both child and adult patients in which the medical home team leader is a primary care physician within one of three practice types: 1 large primary care practice, 2 small to medium (2 to 7 practitioners) primary care practices or one multi-specialty and/or integrated practice. Selected practices will have a 6 month "ramp up" period to achieve the qualifications required to initiate payment:

- National Committee for Quality Assurance Level 1 recognition.
- 24 hour/7 day access.
- Establishment of a patient registry.
- Implementation of evidence-based protocols.
- Establishment of service agreements with defined specialty practices and at least one frequently referred-to hospital.
- Agreement to assist in providing relevant patient claims and defined additional clinical information to the TMHI project.
- Participation in the special needs transition program (Patient Centered Primary Care Collaborative, 2009).

As mentioned in the introductory information, CSHCN Services Program staff has been participating in planning and development for the project.

EveryChild, Inc. was formed in July 2000 as the result of activities of a coalition formed of individuals and organizations dedicated to the development of a system of support for families to provide alternatives to institutional placement of children with disabilities. It is a non-profit corporation, and its mission is to create a system that ensures children with disabilities grow up in families instead of institutions. In 2009, through Title V grant funding, DSHS contracted with EveryChild, Inc. to conduct a study to better understand the use of congregate care for children with disabilities in Texas. Two of the grant deliverables are a comprehensive literature review and an analysis of Permanency Planning Instruments of children residing in nursing homes; small, medium, and large Intermediate Care Facilities; DADS Mental Retardation facilities; and DFPS General Residential Operations facilities.

In February 2010, EveryChild, Inc. released "Precarious Pathways: Use of Residential Congregate Care by Children with Developmental Disabilities," authored by Nancy Rosenau, Ph.D, Executive Director. More than 40 pages in length and incorporating over 190 references, the document is a comprehensive literature review of the subject. The work identifies a common thread in the literature: that there is a "need for guiding principles that centralize the role of supporting the parent-child relationship." In its conclusion it says, "Congregate care offers too little benefit at too great a developmental risk to children when family-based alternatives are possible." The literature suggests

that family-based alternatives may fulfill the functions of congregate care more effectively and would result in better developmental outcomes for children (Rosenau, 2010). Further, the review demonstrates that the other analytical work being conducted through this grant is unique beyond anything currently in the literature. We anticipate that this initiative will provide important insights regarding the supports needed to enable children and youth with disabilities to live in families, not only in Texas, but beyond.

In ongoing activities as the result of a lawsuit, *Frew v. Suehs,* HHSC agreed to implement strategic initiatives to improve access to medical and dental care, including preventive care, for Medicaid beneficiaries (children) enrolled in Texas Health Steps. In 2007, $150 million was appropriated and is part of an ultimate $1.8 billion plan to address the issues identified in the law suit. This has immediate importance for CYSHCN who are eligible for Medicaid, but likely will have “ripple” effects throughout the service system in Texas. An advisory committee composed of consumer, provider, and academic stakeholders advises HHSC concerning the distribution of funds. Some recent proposals with specific implications for CYSHCN include Physician Directed Care Coordination, Medical Home for Children with Special Health Care Needs, Pediatric Specialty Access Improvement Consultation and Referral Network, Pediatric Subspecialty Access Improvement, Integrated Pediatric and Mental Health Program, and Medicaid Curriculum and On-Site Training for Dental Students and Medical and Dental Residents.

SECTION 4: MCH PROGRAM CAPACITY BY PYRAMID LEVEL

DIRECT HEALTH CARE AND ENABLING SERVICES

Safety net direct health care and enabling services are provided to women and children in Texas through multiple delivery systems funded by and administered from all levels of government: federal, state, and local.

TEXAS MEDICAID PROGRAM

Medicaid is a jointly-funded state-federal program, administered in Texas by the Health and Human Services Commission (HHSC). Serving primarily low-income families, children, pregnant women, the elderly, and people of all ages with disabilities, the Texas Medicaid Program provides acute health care (physician, inpatient, outpatient, pharmacy, lab, and X-ray services) and long-term services and supports for aged and disabled clients. In addition, Texas has elected to cover a limited number of optional groups such as pregnant women and infants who are between 134% and 185% of the Federal Poverty Level (FPL) and "medically needy" groups. Medically needy groups consist of pregnant women and children who exceed traditional income eligibility limits, but do not have the resources to pay for their medical expenses. If the medical expenses for these groups exceed a "spend down" amount calculated on their income, they are determined Medicaid eligible.

According to *Texas Medicaid and CHIP in Perspective 2009*, one in eight Texans relied on Medicaid for health insurance or long-term care services as of December 2007. For State Fiscal Year (SFY) 2007, there were 4,146,902 unduplicated full- and partial-benefit Medicaid recipients. Of these recipients, 71% were under age 21 and 59% were age 14 and younger. Children make up the largest share, 70%, of full-benefit Medicaid clients. Medicaid funds more than half of all births in Texas. In SFY 2005, Medicaid paid for approximately 56% of all births in Texas and in SFY 2007, 61% of the pregnant women in the Medicaid program were age 24 and younger (Texas Health and Human Services Commission, 2009).

Depending on where the participant resides and the type of health care services that are needed, there are several Medicaid delivery options available in Texas including traditional fee-for-service, Primary Care Case Management (PCCM), State of Texas Access Reform (STAR), STAR+PLUS, NorthSTAR, and STAR Health.

PCCM is a non-capitated, managed care model made up of a network of primary care providers and hospitals that is provided in 202 counties consisting of mostly non-urban areas. Participants with PCCM coverage are assigned a primary care provider and obtain referrals for specialty care. In return, participating primary care providers are paid traditional Medicaid fee-for-service rates plus an additional case management fee per participant, per month for serving as a participant's primary care provider. Non-disabled children, low-income families, pregnant women, and Supplemental Security

Income (SSI) adults without Medicare are required to participate in PCCM, while children eligible for SSI may choose to participate.

Some PCCM participants who are blind, disabled, or elderly may be identified to receive PCCM+PLUS services based on a predictive likelihood their care will be more costly and complex. In an effort to reduce medically unnecessary emergency room visits, participants receive education on PCCM services, assistance with hospital discharge and care coordination plans, and case management services among other specialized services through the network.

PCCM participants who are not identified for PCCM+PLUS can still access care coordination and case management services through referral from their primary care provider to Community Health Services coordinators located throughout the PCCM counties.

STAR is also a managed care model which provides primary care and referrals for specialty care; however it is a fully-capitated, Health Maintenance Organization (HMO) model operating under the authority of a 1915(b) Medicaid waiver. Residing in nine largely urban areas of Texas, STAR participants are primarily non-disabled children, low-income families, and pregnant women. They receive additional benefits not available in the traditional and PCCM programs such as unlimited medically necessary prescriptions for adults, annual adult well-exam, value-added services voluntarily provided by the contracted HMOs.

STAR+PLUS is a partially-capitated HMO model that integrates both acute and long-term services for clients eligible for SSI. This model operates under approved 1915(b) and 1915(c) Medicaid waivers. STAR+PLUS carves out inpatient hospital services from the capitated rate and pays them using traditional Medicaid fee-for-service rates. In addition to an established primary care provider, the program provides coordinated acute and long-term services and supports through a single system. STAR+PLUS utilizes strategies such as community-based alternatives and individualized care plans to minimize the use of traditional long-term care facilities.

Operating solely in the Dallas area, NorthSTAR integrates publicly-funded mental health and substance abuse treatment services under one program. Most Medicaid participants residing in the service area are automatically enrolled. Eligibility for NorthSTAR must be determined for non-Medicaid eligible individuals based on certain clinical and financial criteria.

STAR Health is a collaborative between HHSC and the Department of Family and Protective Services (DFPS) to provide coordinated medical, dental, and behavioral health services to children in foster care and kinship care. STAR Health participants have an established medical home and take part in a web-based electronic medical record, called the Health Passport.

WOMEN'S HEALTH AND FAMILY PLANNING WAIVER

In January 2007, HHSC implemented a Medicaid waiver to expand eligibility for comprehensive women's health and family planning services known as the Women's Health Program (WHP). WHP provides screening for diabetes, sexually transmitted infections, high blood pressure, cholesterol, tuberculosis, breast and cervical cancers, and other health issues, in addition to access to counseling and family planning methods, to women ages 18-44 whose household incomes are below 185% FPL and who are U.S. citizens or qualified residents. This expansion of services allowed for Title V funds, once utilized for DSHS family planning services to this population, to be dedicated to other MCH initiatives.

An unduplicated total of 151,989 women were enrolled in WHP at some point during 2009. Since WHP was implemented on January 1, 2007, an unduplicated total of 217,377 women have been enrolled in the program at some point (Texas Health and Human Services Commission, 2009).

HOME AND COMMUNITY-BASED WAIVERS

Table 4-1 details some of the home and community-based 1915(c) waiver programs that HHSC administers. These programs serve people using cost-effective resources available within the home and/or community setting rather than in an institutional setting. Many of these programs have an interest list of people wanting to enroll as demand for these services exceeds available capacity. Services provided under these waiver programs include nursing and personal attendant services, minor home modifications, dental services, respite, therapy, adaptive aids and supplies, and emergency response services.

Table 4-1. Home and Community-Based Medicaid Waiver Programs in Texas

Waiver Program	Population Served	Services Provided
Medically Dependent Children Program (MDCP)	Children and young adults under age 21 who are at risk of nursing facility placement because of complex medical needs and qualify for nursing facility services.	• Adjunct support services • Adaptive aids • Financial management services • Minor home modification • Respite • Transition assistance
Home and Community-Based Services (HCS)	People of all ages who have a determination of mental retardation made in accordance with state law or have been diagnosed by a physician as having a related condition and who are living with their family, in their own home or in other community settings.	• Adaptive aids • Case management • Day habilitation • Dental treatment • Minor home modification • Nursing services • Residential assistance • Respite • Supported employment
Community Living Assistance and Support Services (CLASS)	People of all ages who have a qualifying disability, other than mental retardation, which originated before age 22 and which affects their ability to function in daily life.	• Adaptive aids and medical supplies • Case management • Consumer directed services • Habilitation • Minor home modification • Nursing services • Physical and Occupational therapy • Psychological and behavioral support services • Respite • Speech pathology
Deaf-Blind Multiple Disabilities (DBMD)	People age 18 and older who are deaf, blind, and have a third disability that meets intermediate care facility for persons with mental retardation or a related condition care criteria.	• Adaptive aids and medical supplies • Assisted living (licensed up to six beds) • Behavior support services • Case management • Consumer Directed Services • Employment assistance • Habilitation • Minor home modifications • Nursing services • Physical/occupational therapy • Prescription drugs, if not covered through Medicare • Respite • Specialized nursing services • Speech, hearing and language therapy • Supported employment • Transition assistance services

Waiver Program	Population Served	Services Provided
Community Based Alternatives (CBA)	Adults (age 21 and older) who qualify for nursing facility services.	• Adaptive aids and medical supplies • Adult foster care • Assisted living/residential care services • Dental services • Emergency response services • Home delivered meals • Minor home modifications • Nursing services • Occupational therapy • Personal assistance services • Prescription drugs, if not covered through Medicare • Respite • Speech and /or language pathology services • Transition assistance services
Texas Home Living (TxHmL)	People of all ages with mental retardation who live with their families or in their own homes and meet the SSI income limit.	• Adaptive aids • Behavioral support • Community support • Day habilitation • Dental treatment • Employment assistance • Minor home modifications • Nursing services • Respite • Specialized therapies (audiology, speech/language pathology, occupational therapy, physical therapy, and dietary services) • Supported employment

Sources: Texas Health and Human Services Commission (2009), Department of Aging and Disability Services (2010).

MONEY FOLLOWS THE PERSON

Money Follows the Person is a program under Texas' Promoting Independence Initiative and is one of several ways Texas has responded to *Olmstead v. L.C.,* the 1999 U.S. Supreme Court decision. In that case, the Court decided that states cannot discriminate against people with disabilities by offering them only institution-based long-term care services when they could be served in a community-based setting. Historically, state nursing facility appropriations could not be used to fund community-based services, however legislative actions in recent years established policy permitting the amount of state funds used for institutional care to "follow" a person to a community-based setting. Money Follows the Person allows individuals to choose how and where they will receive long-term services without being placed on an interest list.

Texas was one of 17 states that successfully competed for a Deficit Reduction Act of 2005, Money Follows the Person Demonstration award. The state is receiving approximately $18 million in enhanced funding through calendar year 2011 to provide additional community options and/or supports for individuals who want to relocate from institutional settings (Texas Health and Human Services Commission, 2009).

TEXAS CHILDREN'S HEALTH INSURANCE PROGRAM

The Texas Children's Health Insurance Program (CHIP) is a joint federal state partnership and is administered by HHSC. The annual allocation of federal funds allotted to each state for the program is capped. The program serves children from birth through 19 years of age with household incomes at or below 200% FPL and who are not otherwise eligible for Medicaid. CHIP services are delivered by 16 HMOs and one exclusive provider benefit plan that serves clients residing in rural areas.

According to *Texas Medicaid and CHIP in Perspective 2009*, CHIP participation has fluctuated over recent years due, in part, to legislatively-directed policy changes. The average monthly caseload of CHIP participants was slightly over one-half million children before it declined to a little more than 300,000 in 2006 due to policy changes enacted by the 78th Texas Legislature (2003). Some of those policy changes were reversed by the 80th Texas Legislature (2007), and the average monthly caseload rebounded to 476,636 as of August 2008. The revisions to the CHIP policy instituted in 2007 that most likely led to the increase in caseload included:

- Ninety-day waiting period was no longer required for most new enrollees,
- Enrollment fees were eliminated for families with incomes less than or equal to 150% FPL,
- Deduction for child care expenses was again allowed when determining income eligibility,
- Limit on assets was increased, and
- The enrollment period was extended from 6 months to 12 months (with an income review after 6 months of service for clients over 185% FPL).

In SFY 2008, over 80% of CHIP clients were between the ages of 6 and 18. The trend towards older age groups may be a result of the tiered income eligibility requirements based on age for children in Medicaid. Medicaid serves infants younger than 1 year of age with household incomes up to 185 % FPL, children ages 1 through 5 up to 133% FPL, and children ages 6 through 18 up to 100% FPL. In contrast, income eligibility requirements for CHIP remain consistent at up to 200% FPL through age 19 (Texas Health and Human Services Commission, 2009).

CHIP PERINATAL

Beginning January 2007, CHIP benefits were expanded to provide 12 months of continuous coverage for prenatal and postpartum care to unborn children of women who are ineligible for Medicaid and whose incomes are under 200% FPL. CHIP Perinatal clients are exempt from the 90-day waiting period, the assets test, and all cost-sharing, including enrollment fees and co-pays, for the duration of their coverage period.

Similar to WHP, this expansion program allowed for Title V funds once utilized for direct care services to be dedicated to other MCH initiatives. However, in this case, a portion of Title V funds are utilized to reimburse up to two visits during the CHIP Perinatal eligibility determination process to ensure pregnant women receive immediate prenatal care.

The total CHIP Perinatal caseload for SFY 2009 was 63,001. All clients were under 1 year of age since a pregnant woman can only enroll her child prior to delivery and the period of coverage is limited to 12 months. Approximately 98% of clients have family incomes at or below 185% FPL (Texas Health and Human Services Commission, 2009).

OTHER SAFETY NET DIRECT AND ENABLING HEALTH CARE SERVICES IN TEXAS

FEDERALLY QUALIFIED HEALTH CENTERS

Federally Qualified Health Centers (FQHCs) are community-based, non-profit or public entity health care clinics charged with providing comprehensive primary health care services to individuals who are underserved, underinsured, and/or uninsured. FQHCs provide services to individuals regardless of ability to pay, and charge for services based on a sliding-fee scale. There are currently 64 FQHCs and 3 FQHC Look Alikes in Texas operating over 300 clinic sites across the state. A directory of Texas FQHCs can be found through the DSHS website at: http://www.dshs.state.tx.us/chpr/FQHCmain.shtm.

COUNTY INDIGENT HEALTH CARE

In addition to state administered safety net programs, county governments also play a role in the health care delivery system in Texas. All counties are mandated to ensure the availability of health care services to uninsured individuals with household incomes below 21% FPL. To comply with this mandate, counties that are not fully served by a public facility, such as a hospital district or a public hospital, are responsible for

administering a County Indigent Health Care Program (CIHCP) for eligible residents of all or any portion of the county not served by a public facility. Depending on the availability of local resources and partnerships established with other entities, access to health care safety net services may differ greatly from one county to the next across all 254 Texas counties. There are currently 144 CIHCPs, 140 hospital districts, and 19 public hospitals in Texas.

Required services depend on the type of governmental entity. Counties are required to provide basic health care services such as preventive and primary care, prescription medications, laboratory and X-ray services, inpatient and outpatient hospital services, and care at skilled nursing facilities. Counties have the option of providing services such as dental and vision services, emergency medical care, durable medical supplies and equipment, and care provided at an FQHC or by an Advanced Practice Nurse or Physician Assistant. The law is less prescriptive in the case of services that are provided by hospital districts and public hospitals. It states that these entities shall "endeavor to provide the basic health care services" counties are required to provide (Texas Health and Safety Code §61.054 and 61.055).

2-1-1 TEXAS

HHSC administers 2-1-1 Texas, a toll-free, one-stop telephone resource to receive information and referrals for existing resources throughout Texas. Calls are routed to one of 25 local agencies contracted to answer calls for a certain geographic area where trained resource specialists ascertain the caller's need and assist them utilizing a comprehensive database listing of health and social services for the local area. In addition, individuals can call 2-1-1 to begin the eligibility determination process for services such as Medicaid, CHIP, and the Supplemental Nutrition Assistance Program (SNAP). A searchable database of services is available to the public at https://www.211texas.org/211/search.do. 2-1-1 has also become an important component in Texas' disaster response. During Hurricane Ike and the recent H1N1 flu outbreak, 2-1-1 Texas quickly and efficiently shared emergency response information to assist people affected. In Texas, calls to the 1-800-311-BABY line for information on maternal and child and health are answered by 2-1-1 resource specialists.

HOME VISITING PROGRAMS

HHSC provides support for 11 Nurse-Family Partnership (NFP) sites in 7 Texas cities (Austin, Dallas, Fort Worth, Houston, Lubbock, Port Arthur, and San Antonio) that pairs Bachelor's prepared, registered nurses with Medicaid eligible, first-time mothers. The purpose of this program is to improve pregnancy outcomes, self-sufficiency, and child health and development. During regular visits that take place in the family's home

beginning in the second trimester of pregnancy and concluding when the child is 2 years old, the nurses provide support; education; and counseling on health, parenting, developmental issues, and life skills. Approximately 1,800 clients were served by the Texas NFP sites during SFY 2009 (Texas Health and Human Services Commission, 2009).

The Department of Family and Protective Services (DFPS), a sister agency of DSHS, houses the Division of Prevention and Early Intervention (PEI). PEI administers a variety of prevention programs through contracts with community-based agencies to prevent the abuse, neglect, delinquency, and truancy of Texas children. Home visiting programs such as Parents as Teachers© and Healthy Families America® are examples of the evidence-based curriculum utilized by contractors to support parenting and healthy child development for families at risk of abuse and neglect.

TEXAS MEDICAL TRANSPORTATION PROGRAM

To assist in accessing non-emergency health care services, the Texas Medical Transportation Program (MTP) arranges transportation to clients enrolled in programs such as Medicaid and the CSHCN Services Program who do not have other means of transportation. Transport is provided through public transportation, demand-response transportation, and mileage reimbursement. In addition, MTP cover the costs of in-state and out-of-state travel, lodging, and meals if needed. An HHSC report of the program indicates that approximately 99.5% of MTP expenditures are attributed to Medicaid enrolled clients. Of these clients, approximately 43% of expenditures are for Medicaid clients under 21 years of age. CSHCN Services Program expenditures only accounted for 0.4% of the total amount expended in SFY 2008 (Public Consulting Group, 2009).

TITLE V-FUNDED DIRECT AND ENABLING HEALTH CARE SERVICES

In Texas, Title V funds the provision of direct and enabling health care services for women seeking family planning and prenatal care; for infants, children, and adolescents needing well-child check-ups and dental care; children and youth with special health care needs and their families seeking coordinated health care services tailored to their individual needs; and for families interested in genetic screening and counseling services. The majority of these services are provided through contracts with local providers including city/county health departments, hospital districts, school districts, Federally Qualified Health Centers (FQHCs), non-profit agencies, and individual providers. Contracts are awarded through a competitive request for proposal process that typically includes a three- to five-year renewal period after the first year of implementation. In the case of health care benefits provided through the Children with Special Health Care Needs (CSHCN) Services Program, a fee-for-service claims payment system is used to reimburse providers for services rendered.

Direct and enabling health care services are provided to individuals and families who are not eligible for the same services through other programs such as Medicaid and CHIP and who are at or below 200% FPL for CSHCN-related services and at or below 185% FPL for all other services. Title V-funded providers are required to screen for Medicaid/CHIP eligibility and to assist those individuals who are potentially eligible with the Medicaid/CHIP application forms. To ensure continuity of care during and after the eligibility determination process, Title V-funded providers must also be enrolled as Medicaid providers. Typically, Title V reimburses contractors for services provided using Medicaid reimbursement rates. If a client that received services paid with Title V funds is later found to be Medicaid/CHIP eligible through the eligibility determination process, contracted providers are able to recoup payment from Medicaid/CHIP for those services and restore funding to Title V.

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

The array of Title V-funded direct and enabling services for reimbursement is summarized in Table 4-2

Table 4-2. Home and Community-Based Medicaid Waiver Programs in Texas

Type of Service	Description of Direct and Enabling Services Provided
Prenatal Services	• Initial, follow-up, and postpartum visits • Ultrasound • Laboratory testing • Nutrition counseling • High-risk case management
Family Planning Services	• Comprehensive health history and physical exam • Laboratory testing such as screenings for cervical cancer, sexually transmitted infections, cholesterol, blood glucose, and pregnancy • Provision of contraceptive methods, counseling, and education • Treatment of sexually transmitted infections
Dysplasia Services	• Initial and follow-up visits • Diagnostic and therapeutic procedures such as colposcopy, biopsy, cryotherapy, and loop electrosurgical excision procedure
Child/Adolescent Services	• Periodic well-child exams • Limited sick-child exam and follow-up • Immunizations • Periodic oral evaluation, fluoride treatments, sealants, and extractions • High-risk case management • Nutritional counseling

Type of Service	Description of Direct and Enabling Services Provided
Children with Special Health Care Needs Services Program	• Comprehensive array of physical, mental, and dental health services • Evaluation and diagnosis • Inpatient and outpatient hospital services • Prescription medications • Case Management • Family Support Services such as respite, home/vehicle modifications, and special equipment • Limited transportation assistance
Genetics Services	• Detailed family genetic health history • Physical examination • Laboratory testing • Counseling and case management

DIRECT AND ENABLING SERVICES ADMINISTERED BY DSHS THROUGH OTHER FUNDING SOURCES

Table 4-3 details a sample of the safety net direct and enabling services that are administered by DSHS through other state and federal funding sources and the criteria required to qualify for services.

Table 4-3. Direct and Enabling Services Administered by DSHS through Other Funding Sources

Program	Description	Eligibility Criteria
Breast and Cervical Cancer Services	• Clinical breast and cervical cancer screenings • Diagnostic services for women with abnormal breast or cervical cancer results • Cervical dysplasia treatment • Case Management	• Household income at or below 200% FPL • No other source of payment • Texas resident*
Family Planning Services (Title X and Title XX)	• Comprehensive health history and physical exam • Laboratory testing such as screenings for cervical cancer, sexually transmitted diseases, cholesterol, blood glucose, and pregnancy • Provision of contraceptive methods, counseling, and education • Treatment of sexually transmitted infections	• Household income at or below 250% FPL (Title X); at or below 185% FPL (Title XX) • No other source of payment • No residency requirement (Title X); Texas resident (Title XX)
County Indigent Health Care Program	• Counties not fully served by a public hospital or a hospital district may request state assistance fund reimbursement from DSHS once they have expended eight percent of their General Revenue Tax Levy on indigent health care	• Household income at or below 21% FPL (Counties have the option of serving clients at higher incomes not to exceed 50% FPL) • No other source of payment • County resident

Program	Description	Eligibility Criteria
		• Resource limits
Primary Health Care Services	• Preventive health care including immunizations, screenings, and wellness exams • Diagnosis and treatment • Family planning • Health education • Emergency Medical Services • Optional services include dental and podiatry care, prescription medication, medical devices and durable supplies, nutrition services, and home health care	• Household income at or below 150% FPL • No other source of payment • Texas resident
Epilepsy Services	• Outpatient care including diagnostic, treatment, education and support services for people with epilepsy or seizure-like symptoms	• Household income at or below 200% FPL • No other source of payment (unless on waiting list for CSHCN Services Program)
Texas HIV Medication Program	• Provides medications for the treatment of illnesses caused by HIV and other opportunistic infections in HIV-infected individuals as prescribed by their doctor • Financial assistance with out-of-pocket costs associated with Medicare Part D prescription drug plans, including co-payments, deductibles, coinsurance, and during the coverage gap (the "donut hole")	• Diagnosis of HIV disease and under the care of a Texas-licensed physician who prescribes the medication(s) • Household income at or below 200% FPL • No other source of payment, or has utilized the Medicaid pharmacy benefit for the month • Texas resident
Adult Mental Health Services	• Treatment services for adults who have severe and persistent mental illnesses such as schizophrenia, major depression, or bipolar disorder • Treatment services for adults who have co-occurring psychiatric and substance abuse disorders • Medication-related services including medication clinics and education • Rehabilitation services such as vocational training and supported employment and housing • Family support and education related to mental illnesses • Referral • Assertive Community Treatment (time-limited mobile clinical and rehabilitation service coordination provided in community or home setting) • Case management/service coordination to meet ongoing or long-	• Adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders that require crisis resolution or ongoing and long-term support and treatment

Program	Description	Eligibility Criteria
	term support and treatment • Crisis response through crisis hotlines and mobile crisis outreach teams • Community-based short-term psychiatric hospitalization, residential treatment, and respite care	
Children's Mental Health Services	• Screening and assessment • Psychiatric diagnostic interview • Skills training and development • counseling • Pharmacological management • Medication training and support • Case/service coordination • Engagement activity • Family training • Family partner services • Wrap-around treatment model for intensive service packages • Parent support group • Family case management • Flexible funds • Crisis services may include: o Crisis hotline o Crisis intervention services o Psychiatric diagnostic interview o Pharmacological management o Safety monitoring o Crisis transportation o Crisis flexible benefits o Respite services o Extended observation o Crisis residential services o Crisis stabilization unit o Family partner o Engagement activity o Inpatient hospitalization o Crisis follow-up and relapse prevention	• Children must be between the ages of 3 through 17 with a diagnosis of mental illness and exhibit serious emotional, behavioral or mental disorders and: o Have a serious functional impairment; o Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or o Are enrolled in a school system's special education program because of a serious emotional disturbance
Substance Abuse Outreach, Screening, Assessment, and Referral	• Identify individuals in need of substance abuse services • Gather information to assess needs • Referral to appropriate services	• All Texas residents
Substance Abuse Treatment Services	• Full continuum of services designed to treat substance abuse and dependence • Specialized services for pregnant and parenting women • Detoxification, residential and outpatient services, services for co-occurring substance use and mental	• Clinically appropriate • Texas Residents • Household income at or below 200% FPL (sliding scale for those above) • No other source of payment

Program	Description	Eligibility Criteria
	health disorders, services for adults and youth	
Pregnant Post Partum Intervention	• Community-based outreach and interventions • Motivational counseling • Case management • Treatment referral and support	• All pregnant and post partum teens and adults at-risk of substance abuse or who have family members with substance abuse issues

*Residency does not necessarily require citizenship.

TEXAS HEALTH STEPS

The Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT), known in Texas as Texas Health Steps, offers comprehensive medical and dental prevention and treatment and case management services for low-income, Medicaid-eligible children from birth through age 20. Texas Health Steps promotes periodic screenings to assure age-appropriate physical, behavioral, developmental, and nutritional status. Outreach staff increases family awareness of available services, increases use of preventive services, and helps families obtain comprehensive services available through a network of private and public providers. Texas Health Steps helps to assure access to comprehensive services through efforts focused on recruitment and retention of qualified providers.

Related to the *Frew v. Suehs* lawsuit concerning utilization of preventive services in children's Medicaid, DSHS MCH staff provides support for the strategic initiatives that have been developed to improve direct care for children with Texas Health Steps/Medicaid coverage. Examples include:

- Increased reimbursement rates for medical and dental providers.
- Development of a Promotor(a)/Community Health Worker (CHW) curriculum to help reduce unnecessary use of hospital emergency rooms (ER). Patients receiving Medicaid that present in the ER for non-emergent care are linked with a CHW to increase understanding and knowledge of their Medicaid benefits and to help identify any barriers that may exist in accessing their medical home. In addition, a resource guide including some of the most frequent reasons for non-acute admission to the ER was developed to help parents determine when they should call their primary care doctor and when they should call 9-1-1.
- Provision of specialized training to Medicaid dentists on the needs of children under the age of 3 and the addition of a new billing code for dental exams for children under 3 years of age to encourage more comprehensive care, including fluoride varnish for children and counseling and education for parents. As of January 2010, DSHS trained 1,515 dentists on the First Dental Home initiative, and 209,958 children under the age of 3 received dental services through this project.
- Training and reimbursement for Medicaid pediatricians to perform limited oral evaluations and apply fluoride varnish to children as young as 6 months old

within the medical home. The training encourages pediatricians to refer young patients to a Medicaid dentist for ongoing dental care. As of January 2010, 1,015 medical providers received training through this project, and 50,295 children received an oral evaluation in their pediatrician's office.

- Integration of pediatric and mental health services into pediatric offices that see large numbers of children with Medicaid coverage. HHSC worked with the University of Texas Health Science Center at San Antonio to set up 11 pilot sites in the Dallas/Fort Worth area, San Antonio, Lubbock, El Paso, and the Rio Grande Valley. The sites hired mental health professionals to perform mental health assessments and brief interventions for a variety of behavioral and emotional problems. The mental health professionals reported more than 1,700 face-to-face contacts with children eligible for Medicaid in the project's first four months of operation in 2008 (Texas Health and Human Services Commission, 2009).

SCHOOL-BASED HEALTH CENTERS

Another way to help ensure the delivery of preventive and primary health care services to medically underserved children and adolescents is through School-Based Health Centers (SBHCs). In 2009, there were nearly 90 SBHCs serving Texas children. SBHCs use a comprehensive, multi-disciplinary approach to provide services such as:

- Well-child exams and immunizations,
- Acute care for minor illness and injury,
- Management of chronic illness,
- Dental screenings, treatment, and referral,
- Mental health services, and
- Basic health education.

SBHCs are usually located on school campuses, although some are located in easily accessible sites off campus or through mobile clinics. Some SBHCs only serve students from one school, while others serve students from multiple schools. Before receiving services, students must present a signed parental consent form indicating all services that may be provided to the student. In many instances, family members, such as siblings or children of parenting teens, also are eligible to use SBHC services.

DSHS provides start-up funding for SBHCs in medically-underserved areas. The program currently allows a maximum three years of funding per funded school district. Funding ranges from $125,000 in year one to $62,500 in year three. Since SFY 1994, 45 SBHCs have been funded and of those, 30 SBHCs were still in operation in SFY 2009.

ISSUES INFLUENCING CAPACITY FOR DIRECT AND ENABLING SERVICES

Title V provides a variety of services to women, infants, children, and CYSHCN. Table 4-4 contains a list of services that were provided to Title V clients in SFY 2009.

Table 4-4. Title V Funded Services by Service Type and SFY09 Number of Clients Served

Title V Funded Services	Number of Clients Served
Child Health & Dental	15,370
CSHCN Services Program Clients	2,291
CSHCN Services Program Clients Removed from Waiting List	655
Dysplasia – Adolescents	188
Dysplasia – Women	749
Family Planning	44,897
Genetics	2,419
Prenatal Care	32,899

UNEMPLOYMENT, INCOME, AND POVERTY

Information on unemployment, income, and poverty can be found in the Introduction section.

UNCOMPENSATED CARE

According to a report released by the DSHS Hospital Survey Unit entitled, *Charity Care Charges and Selected Financial Data for Acute Care Texas Hospitals, 2008*, there was over $13 billion dollars of uncompensated care in Texas in 2008. This accounted for 9.2% of the total gross patient revenue. Of this $13 billion, 44.9% was from bad debt and the remaining 55.1% was for charity care. Between 1999 and 2008, uncompensated care increased by nearly 179% in Texas. In 2008, 33.9% of the uncompensated care was provided by public hospitals, 44.5% was provided by nonprofit hospitals and 21.6% was provided by for-profit hospitals (Texas Department of State Health Services, 2010).

LACK OF HEALTH INSURANCE AMONG CHILDREN

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

RURAL HEALTH

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

Hospital emergency rooms often become clinics, a costly way to provide basic care. Without available primary care, rural residents lack an appropriate entry into the health care systems. No financing, managed care or other access scheme can operate effectively without this groundwork. The barriers to access to care described above contribute to women not accessing prenatal care in a timely manner, not remaining in care for the duration of the pregnancy, or missed appointments due to reluctance to travel long distances or pay for services.

Postpartum and inter-conception visits may also be delayed or skipped. After infants are born, well-baby checks and immunization visits may be missed or delayed, as may preventive and therapeutic dental health visits for women and children. When these visits are missed, there are fewer opportunities to observe developmental delays or health concerns that can ultimately lead to long-term problems. Mental health issues might also not be identified. Women who are experiencing problems might avoid addressing them, and providers have fewer opportunities to observe warning signs. Even if a provider does observe symptoms, there is often a lack of mental health providers to serve the population.

BORDER HEALTH

The DSHS Office of Border Health (OBH) "was created in 1993 to enhance agency efforts to promote and protect the health of border residents by reducing community and environmental health hazards along the Texas-Mexico border, in collaboration with communities and U.S. and Mexican local, state, and federal entities" (Texas Department of State Health Services, 2009). Seven border communities (Del Rio, Eagle Pass, El Paso, Harlingen, Laredo, Presidio, and Uvalde) have OBH field staff who are experts in the following fields: sanitation, environmental health, toxicology, epidemiology, food safety, and policy analysis and development. These crucial staff help ensure that the border area's public health concerns are coordinated appropriately.

While the border region is a dynamic part of this state and nation both in population and economic growth, it is characterized by high poverty and disease rates. Approximately, 2.5 million Texans live on the Texas-Mexico border, accounting for 10.2% of the state's total population. In 2008, the median household income for the 32 border counties was

$31,253, compared to the non-border median household income of $41,775. On average, families that live in a border county make approximately 25.2% less than families residing in a non-border county.

DIRECT PATIENT CARE PHYSICIANS

In 2009, there were 39,374 direct patient care physicians in Texas. This number excluded federal and military physicians, residents, and fellows. There were approximately 158.3 direct patient care physicians per 100,000 people in 2009. Texas continues to see an increase in the number of direct patient care physicians in the state. Ten years ago, there were approximately 151.8 direct patient care physicians per 100,000 people. Despite these improvements, as of September 2009, 25 of the state's 254 counties had no direct patient care physicians, and 18 counties had only one practitioner.

In 2009, there were 16,830 primary care physicians in Texas. In 2008, the estimated population for Texas was 24.3 million. Eight percent of this population was located in 156 rural counties and 92% was located in the remaining 98 urban counties. In comparison, 5.9% of practicing primary care physicians were located in rural areas of the state, and 94.1% practiced in urban counties. Similarly, the 2008 estimated population in the border area accounted for 10.2% of the total population; however, only 7.5% of practicing primary care physicians resided in a border county.

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

CYSHCN-SPECIFIC PROVIDER ISSUES

The CSHCN Services Program relies on specialists, as well as primary care physicians. In 2009, there were 16,830 primary care physicians, and 26 counties did not have a primary care physician. In the area of pediatrics, there were 3,028 licensed pediatricians in Texas in 2009, and 137 counties without a pediatrician (Texas Department of State Health Services, 2010). This picture is complicated by the fact that, due to a variety of reasons, many physicians outside major medical centers are reluctant to provide ongoing care for children and youth with complex health care needs.

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

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

HEALTH PROFESSIONAL SHORTAGE AREAS

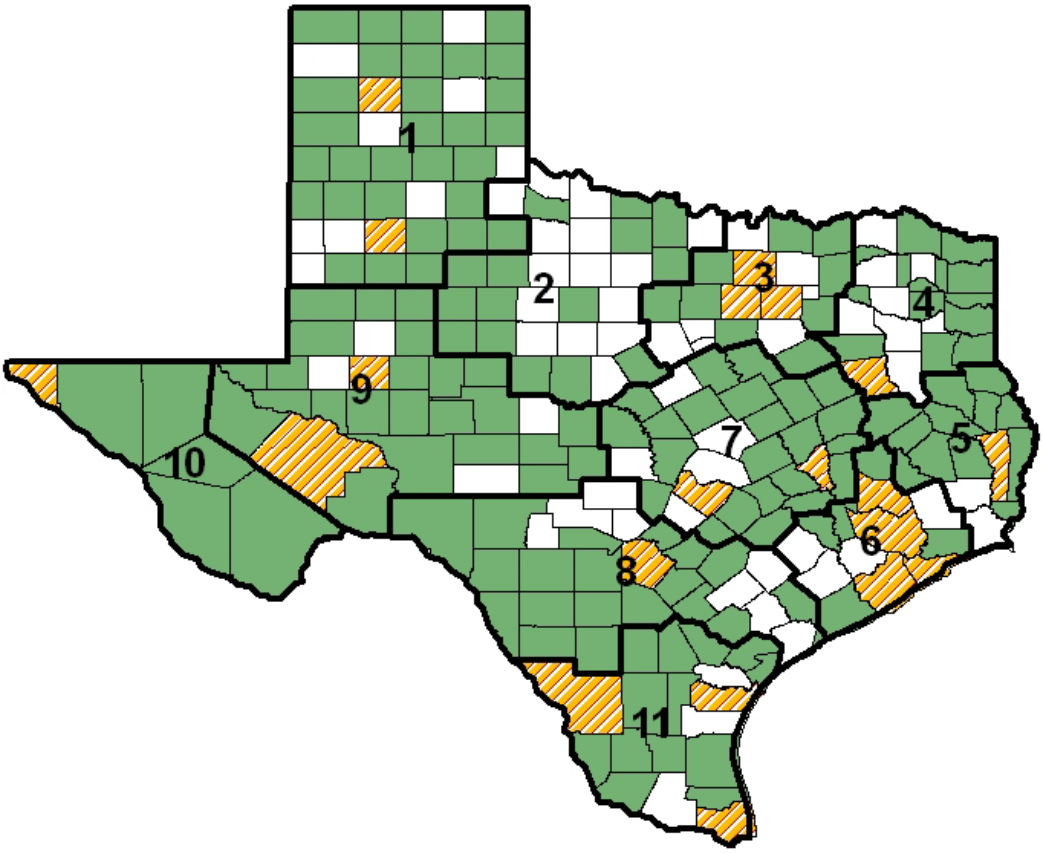
The Texas Primary Care Office (TPCO), located within the Office of Title V and Family Health, administers the HPSA program in Texas. Since HPSA designations are federal designations, the final determination of eligibility is determined by the Shortage Designation Branch located in the federal Health Resources and Services Administration (HRSA).

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

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

In 2010, 189 (74.4%) of the 254 counties were recognized as having too few primary care physicians including family practitioners, general practitioners, pediatricians, internists, or obstetrician/gynecologists. Twenty counties (7.9%) were determined to be partial primary medical care HPSAs and 169 counties (66.5%) were whole primary medical care HPSAs. More than 19 million, or 78.4%, Texans reside in counties with a whole or partial HPSA that are designated as physician shortage areas. Of the total population living in the 189 county area, 39.3% of residents are Hispanic, with the largest concentrations along the Texas-Mexico border and in South Texas.

Map 4-1. Primary Care Health Professional Shortage Areas

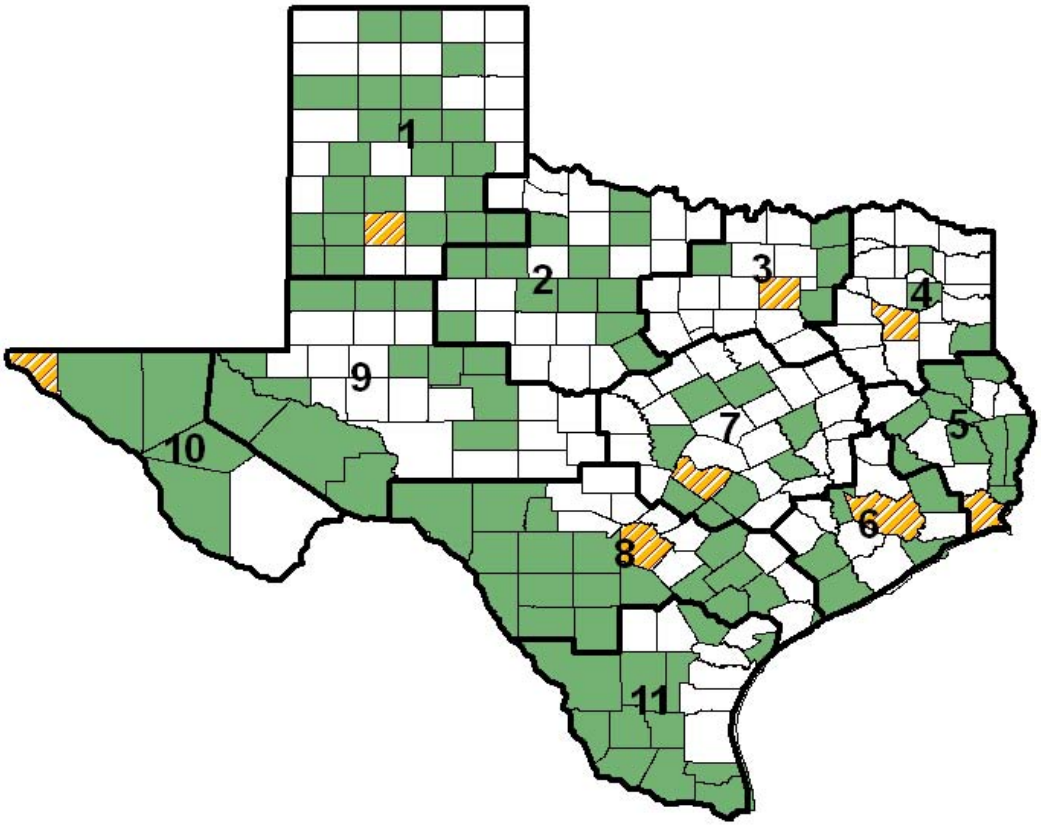


Health Service Regions
Not Designated
Whole County Health Professional Shortage Area Geographic or Low Income Designation
Partial County Health Professional Shortage Area Geographic or Low Income Designation

Map created by Office of Program Decision Support, April 2010
Source: Health Resources and Services Administration, Shortage Designation Branch, April 29, 2010

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

Map 4-2. Dental Health Professional Shortage Areas

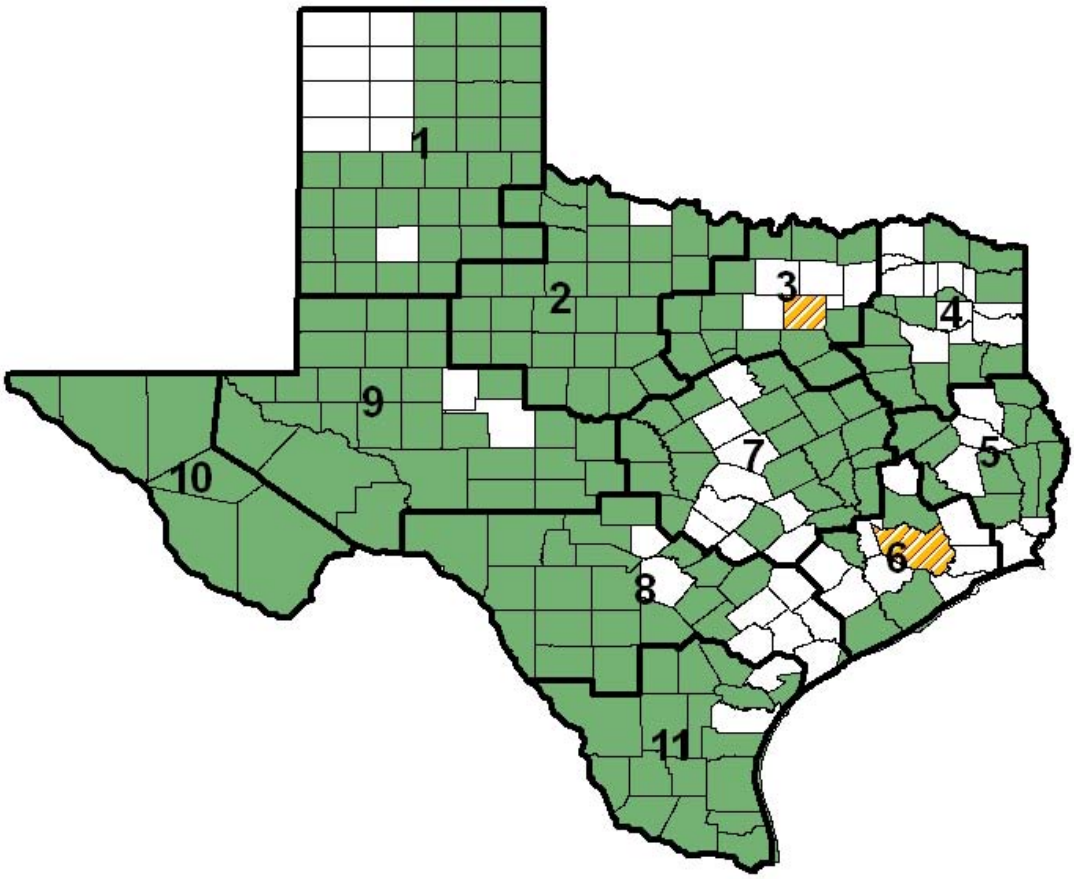


Health Service Regions
Not Designated
Whole County Dental Shortage Area Geographic or Low Income Designation
Partial County Dental Shortage Area Geographic or Low Income Designation

Map created by Office of Program Decision Support, April 2010
Source: Health Resources and Services Administration, Shortage Designation Branch, April 29, 2010

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

Map 4-3. Mental Health Professional Shortage Areas



Health Service Regions
Not Designated
Whole County Mental Health Shortage Area Geographic or Low Income Designation
Partial County Mental Health Shortage Area Geographic or Low Income Designation

Map created by Office of Program Decision Support, April 2010
Source: Health Resources and Services Administration, Shortage Designation Branch, April 29, 2010

OTHER SHORTAGE AREAS

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

DSHS EFFORTS TO IMPROVE ACCESS TO PREVENTIVE AND PRIMARY HEALTH CARE SERVICES

DSHS administers initiatives that build capacity in Texas to improve access to preventive and primary health care services.

FQHC INCUBATOR PROGRAM

In 2003, the 78th Texas Legislature (2003) approved state funding to implement the Federally Qualified Health Center (FQHC) Incubator Program. Through an open enrollment process, this program provides financial support to local organizations and existing FQHCs to establish new or expand existing clinic sites eligible for FQHC funding. Each funded organization enters into a contract with DSHS that specifies a schedule of payments and the benchmarks they must achieve for reimbursement. TPCO, under the supervision of the Title V Director, provides technical assistance and contract administration for this initiative. The first contracts were awarded in late 2003. Since its inception, approximately 90 non-profit or public entity organizations have received funding through the program and approximately 30 new FQHCs were established statewide.

CONRAD 30 J-1 VISA WAIVER

In addition, TPCO administers the Conrad 30 J-1 Visa Waiver Program. Under this program, DSHS requests waiver of the foreign country residence for a qualified physician to practice in a HRSA-designated medically underserved or health professional shortage area. Since 2002, the program has recommended 30 waivers each year, which is the limit per state. Each waiver has a three-year obligation, resulting in a total of 90 physicians serving HRSA-designated physician shortage areas at any one time (Berry, 2010).

LOAN REPAYMENT PROGRAMS

Another strategy to help improve access to health care services statewide is the implementation of state- and federally-funded loan repayment programs. In Texas, these programs include Children's Medicaid Loan Repayment, Physician Education Loan Repayment, Dental Education Loan Repayment, and National Health Service Corps. Table 4-5 provides details on the various programs (Berry, 2010).

Table 4-5. DSHS Administered Loan Repayment Programs

Program Name	Program Description	Approved Specialties	Utilization Data
Children's Medicaid Loan Repayment Program	Provides student loan repayment assistance to physicians and dentists who provide services to children receiving Medicaid	• Allopathic or Osteopathic Physician with any medical specialty or sub-specialty that provides services to children receiving Medicaid • General and Pediatric Dentist	• 300 physicians and dentists are participating in the first cohort. • Applications are being accepted for the second cohort and will be selected in August 2010.
Physician Education Loan Repayment Program	Provides loan repayment funds to physicians who agree to practice in a HPSA, and provide health care services to clients enrolled in Medicaid and CHIP	Priority Specialties: • Family Practice • Osteopathic Family Practice • Obstetrics/ Gynecology • Internal Medicine • Pediatrics • Psychiatry • Geriatrics	• The first cohort was selected in June 2010 consisting of a maximum of 225 physicians.
Dental Education Loan Repayment Program	Provides loan repayment funds to dentists who agree to practice in a Dental HPSA	• General Dentistry • Pediatric Dentistry	• Dentists are awarded funding on a first come, first served basis.

Program Name	Program Description	Approved Specialties	Utilization Data
National Health Service Corps (NHSC)	Provides tax-free loan repayment assistance to primary care medical, dental, and mental health clinicians in exchange for service in a HPSA	• Allopathic or Osteopathic Physician: o Family Medicine o Pediatrics o Internal Medicine o Obstetrics/ Gynecology • Nurse Practitioner • Certified Nurse-Midwife • Physician Assistant • General Dentist • Registered Clinical Dental Hygienist • Mental or Behavioral Health Professional: • Psychiatrist (MD/DO) • Clinical/Counseling Psychologist • Clinical Social Worker • Psychiatric Nurse Specialist • Marriage & Family Therapist • Licensed Professional Counselor	• 173 NHSC participants are serving in Texas. • 165 are loan repayment recipients and 8 are scholars. • NHSC providers work in 99 of the 1007 HPSAs in Texas.

POPULATION-BASED SERVICES

Current Title V population-based initiatives can be categorized into two major groups:

- Those which are implemented through competitive procurement to contractors targeting local areas or a group of individuals, and
- Those that are delivered by DSHS central and regional office staff, with a statewide impact.

In general, all population-based projects are aligned with essential public health services and are specifically targeted at activities around the Title V national and state performance measures. Moreover, there has been increasing focus on incorporating evidence-based strategies and promising practices within the design of these efforts.

The following is a high-level summary of population-based programs supported in total or in-part by Title V funding and staff resources:

HEALTH SCREENING PROGRAMS

DSHS-administered health screening programs include hearing loss and congenital and heritable disorders screening for newborns. Additionally, older children attending day

care and school are screened for vision, hearing, and spinal conditions. DSHS staff develops rules, standards, and training, and provides oversight and monitoring of the various health screening programs.

The health screening programs work closely with Health Service Region (HSR) case management staff to locate and assist children with abnormal screens to facilitate confirmatory testing and provide additional supportive and follow-up services. HSR case managers work at the local level with partnering agencies to coordinate services and share resources. Additionally, regional case management staff regularly participates in coalitions, community resource coordination groups, and child mental health teams.

NEWBORN SCREENING

Nationally, the American College of Medical Genetics (ACMG), with the support of HRSA, recommended that all states screen for a specific set of disorders. The 79th Texas Legislature (2005) mandated that DSHS expand to the ACMG-recommended panel of disorders as funding allowed. As a result, Texas began screening for 27 disorders in late 2006. Texas added cystic fibrosis to the newborn screening panel in January 2010. The overwhelming majority of U.S. states screen for these same 28 disorders. The DSHS laboratory and newborn screening programs work closely together to coordinate services such as identifying and locating children with abnormal screens, educating providers, and ensuring that appropriate follow-up occurs. This infrastructure was also recently expanded to account for the increase in the number of newborns who will require confirmatory testing and follow-up care. DSHS provides financial assistance to uninsured children identified with an abnormal screen to ensure access to confirmatory testing and/or treatment.

There were 413,983 babies born in Texas in SFY 2008. Of these, approximately 98% were screened for 27 disorders and 637 babies received a confirmatory test for one of the abnormal screens.

NEWBORN HEARING SCREENING

The 76th Texas Legislature (1999) passed House Bill 714 providing for the implementation of the state's newborn hearing screening, tracking, and intervention program which became effective May 11, 2000. DSHS implemented the Texas Early Hearing Detection and Intervention (TEHDI) Program to establish screening, monitoring, and outreach standards for the care of children with hearing loss.

TEHDI is designed to oversee the newborn hearing screening, diagnostic, and referral to early intervention process. The program ensures all children who have hearing loss

as newborn infants or young children are identified early and provided appropriate intervention services needed to prevent delays in communication and cognitive skill development. The overall TEHDI goals are to:

- Provide the earliest possible assessment, referral, and intervention for newborns.
- Screen all newborns for hearing loss before 1 month of age, preferably before hospital discharge.
- Provide all infants who screen positive to have a diagnostic audiologic evaluation before 3 months of age.
- Provide all infants identified with a hearing loss to receive appropriate early intervention services before 6 months of age.

DSHS certified 220 birthing facilities in SFY 2009 to conduct newborn hearing screening. Among these facilities, 98.4 percent of newborns (380,706) were screened for hearing loss prior to hospital discharge, with 96.1 percent (371,607) passing the screening. A total of 13,373 newborns (3.5%) required follow-up upon discharge, which includes 4,274 newborns (1.1%) who missed the screening for various circumstances along with 9,099 newborns (2.4%) who received an abnormal result.

In June 2009, DSHS started developing an educational curriculum for outreach and training of stakeholders throughout the spectrum of care for infants with potential and/or confirmed hearing loss. Stakeholders include prenatal care providers, birthing facilities, midwives, audiologists, medical home providers, early childhood intervention services, and ear, nose, and throat practices.

VISION/HEARING SCREENING

The DSHS Vision and Hearing Screening Program's mission is that preschoolers and school children with hearing and vision problems are identified early and linked to appropriate remedial services and that school children will learn about preventive vision and hearing care. Texas law requires that all children enrolled for the first time in any public, private, parochial, or denominational school or in a DFPS licensed child care center or licensed child care home in Texas, or who meet certain grade criteria, must be screened or have a professional examination for possible vision and hearing problems. There are approximately 2.7 million children screened annually for vision and approximately 2.6 million children screened annually for hearing.

SPINAL SCREENING

The 69th Texas Legislature (1985) passed House Bill 832 which required screening for abnormal spinal curves for students in grades six and nine attending public and private

schools. Screening should be done during the growth spurt years, ages 10-14 years, to detect spinal deformities early. For children showing any signs of a possible curvature, schools are required to notify the parents. The screening requirement may be met if the child has been screened for spinal deformities by a physician and a record has been provided. During the 2007-2008 school year, the Spinal Screening Program screened approximately 715,560 children and referred 23,614 children for follow up.

LEAD SCREENING

To eliminate childhood lead poisoning in Texas, the DSHS Texas Childhood Lead Poisoning Prevention Program (TX CLPPP) engages in activities to reduce and monitor lead exposure in Texas children. TX CLPPP identifies at-risk populations, sources of lead exposure, and methods to control or eliminate lead hazards. Texas Health and Safety Code, Chapter 88, requires the reporting of elevated blood lead levels for children younger than 15 years of age. Since 1996, TX CLPPP has been responsible for this monitoring and reporting activity. In addition, TX CLPPP conducts child lead poisoning prevention activities and environmental lead investigations of households and day care facilities. In 2008, 324,810 children were tested for lead resulting in 2,893 (0.9%) of these children with an elevated blood lead level.

SCHOOL HEALTH

The DSHS School Health Program supports the development of comprehensive school health education and school-related health care services statewide through two major program areas: school health network and school-based health centers. The program provides start up grant funding for communities to establish school-based health centers to provide preventive and primary health care services on school campuses to a target population of medically underserved school age children and adolescents. In addition, the program funds the Texas School Health Network, which consists of a School Health Specialist in each of the state's 20 Regional Education Service Centers. The specialists serve as coordinating points and collaborative catalysts that promote healthy school environments and healthy behaviors of all students and personnel. Many other programs within DSHS utilize the skills of the specialists to promote their special initiatives, but each specialist tailors his or her program to concentrate on those needs/issues identified by the local school districts and the community.

WOMEN'S AND PERINATAL HEALTH

HEALTHY START COLLABORATION

Texas has six Healthy Start sites that are organized into a single Texas Healthy Start Alliance. The six sites in Texas are in Brownsville, Houston, Fort Worth, Dallas, Laredo and San Antonio. The mission of Healthy Start is to collaborate with others to promote healthy families and communities in the state through education, advocacy, capacity-building, and research. DSHS staff works collaboratively with the Texas Healthy Start Alliance to strengthen the efforts targeting the high risk populations that Healthy Start serves.

The Healthy Start sites are working on a variety of population-based activities, including breastfeeding, immunization compliance, diabetes and risk factors of overweight/ obesity, folic acid promotion, STI prevention courses, early prenatal care social marketing campaigns, and car seat safety.

INTEGRATED APPROACH TO WOMEN'S SERVICES

In collaboration with HHSC's Texas Office for Prevention of Developmental Disabilities, a work group has been established within DSHS to explore ways to integrate efforts to screen, assess, and refer women for domestic violence, mental health, and substance use/abuse services. Current activities are focused on the development of resource guides that provide information on best practices in working with women around these topics.

Additionally, efforts are underway to partner with the Texas Council on Family Violence, which was one of 10 sites that received Project Connect funding from the national Family Violence Prevention Fund in 2010. Project Connect is an initiative of the Office on Women's Health, U.S. Department of Health and Human Services to create comprehensive models of public health prevention and intervention that can lead to improved health and safety. Each funded site will work with family planning, adolescent health, home visitation, and other maternal child health and perinatal programs to develop policy and public health responses to domestic and sexual violence.

TOBACCO PREVENTION AND CESSATION

The DSHS Tobacco Prevention and Control program coordinates six statewide Tobacco Prevention and Control Coalitions (TPCCs) and 11 Prevention Resource Centers (PRCs) throughout the state. The TPCCs and PRCs are responsible for distributing information and raising public awareness about tobacco prevention and cessation, which includes targeting the perinatal population. One resource that is commonly

distributed to health care providers is the *Yes You Can Clinical Toolkit.* MCH staff helped promote the use of this toolkit as a best practice with perinatal health providers.

In addition, the Tobacco Prevention and Control program utilized Title V funding in SFY 2009 and SFY 2010 to implement a targeted media campaign focusing on women, particularly pregnant women, who smoke. Television spots promoting cessation ran in six media markets during the weeks surrounding Mother's Day. The spots have a call to action for smokers to call the state-funded telephone Quitline for free cessation counseling and nicotine replacement therapy.

INFANT FEEDING

BABY CAFÉ

Baby Café, located in El Paso, Texas, is a mother-to-mother drop-in center that provides support to women who are breastfeeding or are interested in doing so. It is open two to three times per week and is free to all who attend with no appointment needed. Mothers support other mothers, and a lactation professional is always available for consultation. The idea is predicated on evidence showing that children who were breastfed as babies have a significantly lower risks of becoming obese later in life. Title V funding currently supports planning and development activities moving toward a future expansion of Baby Café to the San Antonio area.

BETTER BY BREASTFEEDING

Better by Breastfeeding, a collaborative project at DSHS, uses infant feeding data from the Newborn Screening Card to examine the prevalence of in-hospital breastfeeding rates. Data from the newborn screening card were linked to the live birth certificate to support a media campaign to improve hospital policies and practices related to breastfeeding. An informational document includes regional and state breastfeeding data as well as a resource list, self-assessment, and fact sheet. Individual hospital reports include hospital, regional, and state data for any and exclusive breastfeeding as well as data for breastfed infants who also receive formula supplementations. The reports are provided to hospital decision makers to help promote the key messages of the project: 1) exclusive breastfeeding is an important obesity prevention and community health strategy; 2) breastfeeding policies impact breastfeeding outcomes; and 3) DSHS has tools and resources to help hospitals adopt best practices.

MOTHER FRIENDLY WORKSITE

Texas law directs DSHS to designate Texas businesses as Mother-Friendly Worksites, if they voluntarily have a written policy to support employed mothers by doing the following:

- Have flexible work schedules to provide time for expression of milk;
- Provide an accessible location allowing privacy;
- Provide access to a nearby clean and safe water source and a sink for washing hands and rinsing out any breast-pump equipment; and
- Provide access to hygienic storage alternatives for the mother to store her breastmilk.

Many companies offer additional benefits. The practical aspect of becoming a Mother-Friendly Worksite is that a business can customize benefits to meet the company's and employed mothers' needs. Texas Businesses can apply to be designated as Mother-Friendly by completing an application.

TEXAS TEN STEPS FACILITY PROGRAM

The Texas Hospital Association and DSHS together have developed the Texas Ten Step Facility Program in an effort to improve the health of Texas mothers and infants by promoting breastfeeding. The objectives of the Texas Ten Step Facility Program are to:

- Encourage facilities to reach the goal of having 75% of their mothers breastfeeding at discharge;
- Help facilities support breastfeeding mothers before, during, and after delivery; and
- Encourage facilities to identify breastfeeding resources for mothers after they are discharged.

Currently, there are 74 certified Texas Ten Steps Facilities in Texas. As of January 1, 2006 there were 48 certified Texas Ten Step Facilities in Texas. In 2006, 109,704 babies were born at one of these facilities, accounting for 27.5% of the total births.

BEST PRACTICES DISSEMINATION

DSHS was recently awarded funding through the American Recovery and Reinvestment Act, Communities Putting Prevention to Work, for DSHS MCH staff to work with other state agencies, the Texas Worksite Wellness Advisory Board, WIC local agencies, and Texas Ten Step hospitals to develop worksite lactation support programs and to gather and disseminate best practices. This initiative is currently in the initial start-up phase.

CHILD HEALTH

ON-LINE TRAINING MODULES

In collaboration with the Texas A&M University Agrilife Extension office, 10 online modules were developed for child care providers on various child health issues. These modules included information on the following topics:

- Safe sleep
- Infection control
- Supporting children´s social and emotional development
- Childhood immunizations
- Oral health
- Caring for CYSHCN
- Injury prevention and child safety
- Linking to health care resources
- Supporting breastfeeding
- Encouraging healthy eating and physical activity in young children

The modules can be completed at no-cost to the providers (unless a certificate of completion is needed for the purposes of continuing education credit), and efforts are currently underway to have the modules translated into Spanish. The modules can be viewed at: http://extensiononline.tamu.edu/courses/child_care.php.

IMMUNIZATIONS

In March 2009, the Centers for Disease Control and Prevention (CDC) named Texas the most improved state in childhood immunizations. Moreover, San Antonio/Bexar County was named the most improved city/county. Texas increased 13.5 percentage points in childhood immunizations coverage rates from 2004 to 2008, based on National Immunization Survey data of children 19 through 35 months of age. San Antonio/Bexar County improved 11.3 percentage points. Coverage is for the 4:3:1:3:3:1 immunization series: four doses of diphtheria/ tetanus/pertussis vaccine, three doses of polio vaccine, one dose of measles vaccine, three doses of Haemophilus influenzae type b (Hib) vaccine, three doses of hepatitis B vaccine, and one dose of varicella vaccine.

Since its inception in 1994, Texas has participated in the Federal Vaccines for Children Program. This program guarantees vaccines will be available at no cost to providers, in order to immunize children who meet the eligibility requirements. Today, there are more than 6,000 Texas providers enrolled. The Texas Vaccines for Children (TVFC) program automatically covers all vaccines recommended by the Advisory Committee on Immunization Practices and approved by CDC.

Under TVFC, the following groups of children receive their vaccines for free:

- Uninsured or underinsured children.
- Children who are covered by CHIP.
- Children who are of Native American or Native Alaskan heritage.
- Children on Medicaid.

ImmTrac, the Texas immunization registry developed by DSHS, is a free, confidential registry designed to consolidate immunization records from multiple providers and store a child's immunization information electronically in one secure central system. ImmTrac offers health care providers and authorized users easy online access to a child's immunization history. The registry is part of a DSHS initiative to increase vaccination coverage for children across Texas.

CHILDHOOD OBESITY

The DSHS Nutrition, Physical Activity & Obesity Prevention Program (NPAOP) works to reduce the burden of death and disease related to overweight and obesity in Texas. NPAOP partners with state and local organizations and communities across the state to promote science-based nutrition and physical activity interventions, policies, and environmental changes. Recently, a request for proposals was developed in response to special funding allocated by the Texas Legislature to support communities in making policy and environmental changes around nutrition and physical activity at the community level, and address the CDC's *Recommended Community Strategies and Measurements to Prevent Obesity in the United States.* Funding from Title V and the Office of Border Health was added to the original funding amount to focus obesity prevention strategies in children and adolescents and in the Texas-Mexico border population, respectively. Three contracts address border health issues, four contracts address physical activity strategies, and five contracts address nutritional strategies. Title V funds support four of the projects throughout the state. Examples include implementing a school gardening initiative in 15 school sites and supporting 56 Head Start centers by incorporating the CDC recommended obesity prevention strategies.

Another example of a collaborative project across DSHS programs addressing obesity prevention is the "Get Fit Kit," a toolkit for school nurses to use with adolescents who are identified as overweight or obese through the state's physical assessment test. This toolkit was developed in response to school nurses that voiced the need for a resource tailored for them about nutrition and physical activity specifically for adolescents. The toolkit includes lessons for students on MyPyramid, portion control, physical activity and Body Mass Index, fast food and snacking, reading nutrition labels, and diabetes. There is also an interactive website www.getfitkit.org to complement the toolkit that provides

access to the lesson information for both students and nurses. There are interactive games and quizzes, including a pretest and posttest to help evaluate whether students are learning key messages from the toolkit.

ORAL HEALTH AND COMMUNITY WATER FLUORIDATION

ORAL HEALTH PROGRAM

The DSHS Oral Health Program (OHP) encourages Texas residents to improve and maintain good oral health. OHP works with various partners to identify the oral health needs of Texans and the resources required to meet those needs. Assessment of need is accomplished through the use of the Association of State and Territorial Dental Directors Basic Screening Survey (BSS). Statewide-targeted populations for the BSS are third graders in public schools and children enrolled in Early Head Start and Head Start programs. Policy development activities are directed primarily towards clinical dental policies associated with the Texas Health Steps Dental Services, the EPSDT program in Texas.

In addition to central office staff, OHP has five regional dental teams, headquartered throughout the state, comprised of a dentist and dental hygienist. These teams provide direct dental preventive services to the targeted populations and gather surveillance data.

TEXAS FLUORIDATION PROGRAM

The Texas Fluoridation Program continues to increase the percentage of the population that receives the lifelong oral health benefits provided by the consumption of optimally fluoridated water through site inspections of community water systems, operator training, fluoridation quality monitoring, and system design. To date, the Texas Fluoridation Program has assisted in the initiation and upgrading of community water fluoridation for 75% of the population in Texas. Trainings are provided to water works operators and include information on the oral health benefits of fluoridation, chemical calculations, metering pump calibration, chemical handling safety, and fluoride testing.

INJURY/VIOLENCE PREVENTION

STATE CHILD FATALITY REVIEW TEAM COMMITTEE

The State Child Fatality Review Team (SCFRT) Committee is a statutorily-defined multidisciplinary group of professionals who serve to:

- Develop an understanding of the causes and incidences of child deaths in Texas;
- Identify procedures within the agencies represented on the committee to reduce the number of preventable child deaths; and
- Promote public awareness and make recommendations to the Governor and the Texas Legislature for changes in law, policy, and practice to reduce the number of preventable child deaths.

The SCFRT Committee meets quarterly to discuss issues related to child safety, to suggest strategies to improve child death data collection and analysis, and to determine recommendations to make Texas safer for children. The SCFRT Committee works closely with local child fatality review teams (CFRTs) from across the state. These local CFRTs conduct the actual reviews, provide data on all reviews, and identify local child safety issues.

CFRTs are multi-disciplinary and multi-agency groups of professionals who volunteer to regularly review child (under 18 years of age) deaths in a specified geographic area to understand safety risks for children and reduce the number of preventable child deaths. Typically, teams correspond to a given county, although multi-county teams may be formed in areas with a population of less than 50,000 people. Local CFRTs are responsible for:

- Providing assistance, direction, and coordination to investigations of child deaths;
- Promoting cooperation, communication, and coordination among agencies involved in responding to child fatalities;
- Developing an understanding of the causes and incidence of child death in the county or counties in which the review team is located; and
- Advising the SCFRT Committee on changes to law, policy, or practice that will assist the team and the agencies represented on local teams in fulfilling their duties.

The primary role of the local CFRTs and the SCFRT Committee is to prevent future child deaths. Local teams collect data, identify local child safety issues, and address them through education and prevention initiatives. In submitting local data, local teams together create a detailed picture of child death as a public health issue in Texas. The SCFRT Committee reviews the data collected statewide to develop position statements and make recommendations to the Texas Legislature. Texas currently has 63 CFR teams that serve 187 counties. There were 506,526 children residing in counties that did not have a CFRT team in 2008 (7.80% of the total population). The remaining 5,988,698 children (92.2%) live in a county that has CFRT coverage.

SAFE RIDERS

The Safe Riders Traffic Safety Program (Safe Riders) is a Texas-wide child passenger safety program that is dedicated to preventing deaths and reducing injuries to children due to motor vehicle crashes. DSHS, sponsor of Safe Riders in cooperation with the Texas Department of Transportation, has been providing leadership for child passenger safety since the passage of Texas's first seat belt law in 1985. A statewide Child Passenger Safety Advisory Committee composed of DSHS staff, traffic safety specialists, Safe Kids Coalitions, and community information distribution partners advise the program through conference calls and an annual meeting.

Safe Riders manages about 80 local community agencies that offer classes and seats to low-income families. From 10,000 to 15,000 seats are distributed annually in conjunction with educational programs.

Safe Riders conducts traffic-safety workshops and provides traffic-safety educational materials to hospitals, health clinics, schools, social service agencies, as well as on-line via the DSHS website. Safe Riders organizes and teaches child passenger safety technician certification training and refresher courses for child passenger safety technicians who offer child seat checkups to parents and caregivers.

DEVELOPMENTAL DISABILITIES PREVENTION

The Texas Office for Prevention of Developmental Disabilities (TOPDD) is the designated state program to coordinate developmental disabilities prevention activities among the Health and Human Services Enterprise agencies. One of the focal activities of TOPDD is the prevention of traumatic brain injuries of children on bicycles. DSHS MCH staff are working with TOPDD to disseminate information on bicycle safety, as well as distributing helmets through the local CFRTs. TOPDD staff also conducts a train-the-trainer workshop on organizing and running a bicycle rodeo and on bicycle helmet distribution.

SAFE SLEEP TRAINING

In collaboration with DFPS, two trainings were developed to increase knowledge and awareness about safe sleep practices for infants. The community-based training, *Safe Sleep for Babies*, targets anyone who works with parents, including professionals, paraprofessionals, and lay workers. The training will be piloted in three counties, with a goal of 30 people attending each training, during summer 2010. *Safe Sleep for Babies* will also be available via the DSHS website and web downloads will be tracked to evaluate additional utilization. The second training targets Child Protective Services (CPS) investigators to help them recognize unsafe infant sleeping habits and to provide

guidance on educating parents on safe sleep practices. This training will be required for all 5,000 CPS caseworkers in Texas.

MEDICAL CHILD ABUSE RESOURCES AND EDUCATION SYSTEM

The Medical Child Abuse Resources and Education System (MEDCARES) was established by the 81st Texas Legislative Session (2008) to improve services related to child abuse and neglect in hospital or academic health care settings through funding, collaboration, and outcome reporting. Grant funding is provided to develop and support regional programs to improve the assessment, diagnosis, and treatment of child abuse and neglect. The funds are intended for hospitals or academic health centers with expertise in pediatric health care and a demonstrated commitment to developing basic programs in the same field for the assessment, diagnosis, and treatment of child abuse and neglect. A nine member Advisory Committee guides DSHS and HHSC in establishing priorities and rules regarding MEDCARES funding awards.

RAPE PREVENTION AND EDUCATION GRANT

DSHS receives funding through the Rape Prevention and Education (RPE) grant administered by CDC. DSHS contracts with the Texas Office of the Attorney General's Sexual Assault Prevention and Crisis Services Program to implement this grant. In SFY 2009, there were 1,071 professional trainings conducted and 23,667 professionals received training on rape prevention and education. In addition, there were 8,121 educational sessions conducted, including education and training programs for students and campus personnel designed to reduce the incidence of sexual assault. There were 215,079 participants who received training at these educational sessions.

The purpose of this contract is to support the primary prevention of sexual assault and/or violence. The following activities are used to achieve the goals of the project:

- Educational seminars.
- Training programs for professionals.
- Preparation of information material.
- Education and training programs for students and campus personnel designed to reduce the incidence of sexual assault.

Currently, the RPE Planning Team is in the process of implementing the CDC-approved State Plan for the Primary Prevention of Sexual Violence in Texas. This includes exploring ways to expand the prevention efforts beyond education and training to policy and environmental change.

ADOLESCENT HEALTH

TEXAS HEALTHY ADOLESCENT INITIATIVE

DSHS has implemented the Texas Healthy Adolescent Initiative (THAI) to improve the overall health and well-being of Texas adolescents, age 10-18 years. THAI provides funding for Local Community Leadership Groups (LCLG) to conduct a needs assessment and develop a strategic plan for their community to address adolescent health through a comprehensive youth development approach. To help ensure a comprehensive approach, LCLG members have a variety of expertise including adolescent health and mental health, school advisory councils, community resource coordinating groups, juvenile justice, faith-based services, sports and recreation, and parents of adolescents.

THAI strives to incorporate evidence-based youth development principles throughout all levels of interaction with youth in each community. THAI grant recipients incorporate strategies such as involving families, strengthening academic skills and opportunities for youth and family members and school-to-work programs. Strategies may also include mentoring programs, referrals to health and mental health services, and activities that enhance self-esteem. By putting these strategies into place, local communities should improve protective factors such as future orientation and reduce risk taking behaviors among youth.

Six communities in Texas were selected to participate in this initiative beginning September 2009 in Longview, San Antonio, Fort Worth/Dallas, Austin, Houston, and Lubbock.

TEXAS TEEN OPPORTUNITY PROJECT

DSHS is working collaboratively with the University of Texas at Austin on a research project to identify the knowledge, attitudes, and beliefs of adolescents and young adults, both parenting and non-parenting males and females, and parents of adolescents to help inform the development of interventions to prevent adolescent pregnancy. Forty-nine focus groups were conducted across Texas.

DSHS TITLE V POPULATION-BASED REGIONAL STAFF

The DSHS Title V Population-Based Regional Staff have identified four priority areas on which to focus their regional-based activities. These areas include obesity, access to

care, injury prevention, and teen pregnancy prevention. Table 4-6 describes the variety of population-based activities being conducted to address these priority areas.

Table 4-6. DSHS Regional Priority Areas and Population-Based Activities

Priority Area	Examples of Population-Based Activities
Injury Prevention	Sexual/Domestic violence prevention Suicide prevention Drug/Alcohol abuse prevention Poison prevention GASP (Games Adolescents Shouldn't Play) Parenting classes
Teen Pregnancy Prevention	Local coalition participation Prevention programming/curricula Parent education Working with schools/school health advisory committees Working with Education Service Centers Capacity building of local community efforts
Obesity Prevention	Local coalition participation Prevention programming/curricula Parent education Working with schools/school health advisory committees Worksite wellness
Access to Care	Local coalition/taskforce participation Community Health Worker training Promotion of health literacy Conducting community needs assessments Participation in community events (i.e. screenings, presentations)

In addition, DSHS regional MCH staff focuses on developing, nurturing, and participating on CFRTs throughout the state. Since the involvement of the regional MCH staff in CFR two years ago, the number of active CFRTs has nearly doubled. Regional staff identifies potential committee members in their communities, convenes informational meetings about CFR, and assists communities with their interagency agreements so they can be recognized formally as CFRTs. Regional staff members often serves as the lead on injury prevention efforts and keeps DSHS MCH staff informed about the progress and any issues that may arise on their local teams. DSHS regional MCH staff, central office MCH staff, and members of local CFRTs partnered in the planning and execution of the CFRT Workshops held in summer 2009.

EDUCATIONAL RESOURCES

DSHS produces a variety of educational resources for health care providers and the public. The following list is a portion of those supported all or in part by Title V:

- *A Woman's Right to Know:* In 2003, the Texas Legislature mandated that women have the right to review information in advance of an abortion procedure.

The booklet and resource guide provides information in accordance with the legislation (http://www.dshs.state.tx.us/wrtk/default.shtm).

- *Information on Umbilical Cord Blood Banking and Donation:* Texas law mandates that a physician or other person permitted by law to attend to a pregnant woman during gestation or at delivery shall provide the woman with this information before the third trimester of pregnancy (http://www.dshs.state.tx.us/mch/pdf/umbilical%20brochure%20(2).pdf).
- *Information for Parents of Newborns:* This booklets meets the requirements set forth in the legislation (SB 316) enacted September 1, 2005 that requires hospitals, birthing centers, physicians, nurse-midwives, and midwives who provide prenatal care to pregnant women during gestation or at delivery to provide the woman and the father of the infant or other adult caregiver for the infant with a resource pamphlet that includes information on postpartum depression, shaken baby syndrome, immunizations, newborn screening and SIDS. DSHS was directed to develop the booklet that meets these requirements. The booklet includes additional information that is useful to parents, such as car seat safety and how to choose a child care facility (http://www.dshs.state.tx.us/mch/pdf/info_for_parents.pdf).
- *Safer Sleep for Babies: Precautions for All Parents and Infants* - Creating a safe sleep environment by placing infants on their backs to sleep reduces the chance of SIDS. This fact sheet was developed in collaboration with DFPS to increase awareness and educate caregivers on Safe Sleep (http://www.dshs.state.tx.us/mch/pdf/Safer_Sleep_for_Babies-Precautions_for_All_Parents_and_Infants.pdf).
- *Healthy and Safe Child Care:* A safe child care environment is crucial to reducing the risk of unintentional injuries to infants and children. This new poster has been developed for child care providers to address the top injury risks to children in child care facilities (http://www.dshs.state.tx.us/mch/pdf/healthy_safe_poster_english.pdf).
- *Lead Information Fact Sheets for Parents:* TX CLPPP partners with local and regional health departments; city, state, and federal agencies; and other community organizations to protect Texas children from lead poisoning. Funds from the CDC enable TX CLPPP to conduct child lead poisoning surveillance as well as primary and secondary prevention activities focusing on children younger than 6 years (72 months) of age. Part of these funds were used to develop informational fact sheets for parents of young children to educate about lead, where it can be found and the potential health risks associated with elevated levels of lead in the blood (http://www.dshs.state.tx.us/lead/parents.shtm).

INFRASTRUCTURE-BUILDING SERVICES

The successful implementation of the DSHS services and activities described in the preceding levels of the MCH pyramid is predicated by a solid foundation of infrastructure-building activities supported by Title V resources. Key components of this foundation include:

- Established, on-going communication efforts between all levels and organizations involved in service delivery;
- Consistent quality monitoring and improvement of service delivery;
- Provision of training, technical assistance, and administrative support to promote service delivery;
- Coordinated efforts to integrate service delivery; and
- Sustained data collection, surveillance, and evaluation systems to provide information on progress towards performance objectives

MULTI-DIRECTIONAL COMMUNICATION

TIER ONE INITIATIVE

Within DSHS, cross-cutting projects that are dependent upon multiple levels of the agency's operations and that are critical to the agency's mission may be deemed Tier One Initiatives. This designation for the Five-Year Needs Assessment has allowed the Title V Director to provide regular updates to the Commissioner's direct reports concerning the process. In addition, Commissioner Lakey provided direct guidance on the priority needs and the resulting activity plans for the coming year.

TITLE V DSHS PARTNERS MEETINGS

On a quarterly basis, DSHS MCH staff brings together representatives from a variety of DSHS programs that influence maternal and child health such as WIC, Safe Riders, Tobacco Prevention and Control, Newborn Screening, CSHCN Services Program, Mental Health, Substance Abuse, and Oral Health. These meetings provide an opportunity to provide program updates, obtain feedback from on proposed activities, and identify opportunities for collaboration across agency programs.

CONTRACTOR CONFERENCE CALLS

Programmatic staff hosts regular conference calls with contracted providers to share programmatic updates, administer professional development and technical assistance, obtain feedback on proposed activities, and provide networking opportunities among contractors.

Additional information on communication efforts can be found in Section 2: Partnership Building and Collaboration Efforts.

ADMINISTRATIVE SUPPORT

Since Title V-funded services are primarily provided through contracts with local providers, it is critical that the agency has the capacity to administratively support the

provision of these services and ensure the contracted providers execute the services competently. Several areas of the agency provide the staffing, policy and procedure development, training and technical assistance, and quality assurance needed to support contractors.

- The Preventive and Primary Care Unit (PPCU) oversees the development of clinical policies and operational processes to guide contractors in determining eligibility, delivering high-quality clinical services, and submitting accurate billing for reimbursement. PPCU clinical staff review contractors' clinical standards and protocols and provide support to required advisory committees such as the locally implemented Family Planning Informational and Educational Committees and the state-level Breast and Cervical Cancer Clinical Workgroup. PPCU also develops and conducts professional education opportunities for clinical and administrative contractor staff to help support a highly-skilled workforce.
- The Purchased Health Services Unit develops and administers health care benefits and services under the CSHCN Services Program as well as provides medical expertise and consultation to providers of services for CYSHCN. More information on infrastructure building activities is provided in the CSHCN – Constructs of a Service System portion of this section.
- The Performance Management Unit (PMU) has primary responsibility for coordinating the contract procurement process, tracking contractor expenditures and performance measures, and quality assurance and quality improvement activities for contracted providers. Quality assurance staff survey contractor compliance with program rules, policies, and procedures for clinical services and administrative functions based on pre-developed review tools. Quality assurance site visits are based on risk assessments, and contractors are required to submit corrective action plans for areas found to be out of compliance during the review. Quality improvement activities focus on a comprehensive analysis of quality assurance results and outcomes. Systemic performance issues are tracked and quality improvement activities are developed and implemented to assist contractors in correcting areas of concern.
- DSHS operates within a structure defined geographically by 8 HSRs responsible for the provision of essential public health services to all Texans. Title V funds positions based in these regional offices to provide services, especially in areas with no local health department (156 out of 254 Texas counties have no local public health presence) and to assist in providing technical assistance, contract management, and quality assurance activities to Title V-funded contractors.

INTEGRATED EFFORTS FOR PROGRAM PLANNING AND IMPLEMENTATION

Among state and local MCH programs, the following projects are working to improve direct care and enabling service delivery utilizing collaborative efforts:

- An inter-agency workgroup has been established that includes representation from programs such as Family Planning, Title V Prenatal Services, WIC, Mental Health and Substance Abuse (MHSA), DSHS MCH staff, and HHSC's Texas Office for Prevention of Developmental Disabilities. This workgroup is exploring ways to integrate efforts to screen, assess, and refer women for domestic violence, mental health, and substance use/abuse services. Current activities are focused on the development of resource guides that provide information on best practices in working with women around these topics that can be used by family planning, prenatal, WIC, and MHSA contractors across the state.
- DSHS MCH staff is collaborating with Family Planning staff to examine the issue of health literacy and to possibly develop a toolkit for family planning contractors to use in working with their clients.
- DSHS MCH staff are partnering with the Community Health Worker Training and Certification Program to develop training on tobacco cessation during pregnancy for use by agencies that train and certify promotores.
- DSHS MCH staff is currently participating on an internal work group to explore the use of group models in the provision of prenatal care.

COORDINATION EFFORTS WITH OTHER GROUPS AND ORGANIZATIONS

Coordination efforts with other groups and organizations are detailed in Section 2: Partnership Building and Collaboration Efforts.

WORKFORCE DEVELOPMENT EFFORTS

DSHS understands that developing and maintaining a health workforce appropriate in skills and numbers is critical for the agency to accomplish its mission: To promote health and well-being in Texas. Therefore, the department is involved in a number of efforts to examine, evaluate, and enhance the supply of health professionals practicing in Texas.

LEADERSHIP EDUCATION IN ADOLESCENT HEALTH

Leadership Education in Adolescent Health (LEAH) is a program funded by HRSA's Maternal and Child Health Bureau that provides interdisciplinary leadership training, faculty development, continuing education, scholarship, technical assistance, and collaboration with state Title V programs, State Adolescent Health Coordinators, policymakers, and organizations concerned with the health of adolescents. LEAH projects are committed to honoring diversity among youth and training health care leaders who have the capacity to develop programs, services, and interventions within the cultural context and social environments relevant to those being served.

DSHS staff partners with Baylor College of Medicine, the LEAH grantee for Texas, to explore new initiatives that further the MCH professional knowledge base in Texas. One such initiative involves an internal medicine rotation for physician residents to provide experience working in a transition clinic for older teens and young adults with chronic diseases and disabilities.

TEXAS STATEWIDE HEALTH COORDINATING COUNCIL

The Texas Statewide Health Coordinating Council (SHCC) is a 17-member council, with 13 members appointed by the governor and 4 ex-officio members representing specified state agencies. The broad purpose of the SHCC is to ensure health care services and facilities are available to all Texans through:

- Conducting health planning activities.
- Guiding the development and submission of the Texas State Health Plan. This plan makes recommendations to the governor and the legislature to ensure a quality health care workforce for Texas. The plan is due to the governor for adoption by November 1 of each even-numbered year.

Staff in the Center for Health Statistics, with assistance from other DSHS program areas, supports the SHCC's activities. The 75th Regular Texas Legislative Session (1997) and the 79th Regular Texas Legislative Session (2005) amended Texas statute to expand the SHCC's focus to include health workforce and health information technology respectively. The SHCC has statutory oversight of the Health Professions Resource Center and the Texas Center for Nursing Workforce Studies.

- *The Health Professions Resource Center (HPRC)* was established in 1989 as the primary resource for health workforce data in the state. Located within the DSHS Center for Health Statistics, activities of HPRC include:
    - Collect, analyze, and disseminate data concerning the supply trends, geographic distribution, and demographics of health care professionals;
    - Study health care workforce issues and prepare reports on the findings;
    - Designate health care delivery sites where mid-level providers can practice limited prescriptive authority;
    - Compile and provide information related to the Health Professional Shortage Areas and Medically Underserved Areas/Populations programs in collaboration with the U.S. Department of Health and Human Services and the Texas Primary Care Office; and
    - Provide resources for primary care providers seeking collaborative practice opportunities through a clearinghouse program.
- *The Texas Center for Nursing Workforce Studies (TCNWS)* was created by the 78th Texas Legislature (2003) in response to mounting concern about Texas' nurse shortage. Also located within the Center for Health Statistics, TCNWS

serves as a resource for data and research on the nursing workforce in Texas. This includes collecting and analyzing data on nurses in Texas regarding:

- Educational and employment trends,
- Supply and demand trends,
- Nursing workforce demographics, and
- Migration of nurses.

Additionally, TCNWS collaborates and coordinates with other organizations such as the Board of Nursing, the Texas Higher Education Coordinating Board, and the Texas Nursing Association that gather and use nursing workforce data. This coordination establishes better sources of data for legislators, policy makers, and stakeholders.

DSHS OFFICE OF ACADEMIC LINKAGES

The Office of Academic Linkages (OAL) works to identify and support partnerships between DSHS and academic institutions. Within this purview, OAL helps to develop the statewide workforce need to improve the health and well-being of Texans through the following initiatives:

- *The Continuing Education (CE) Service* coordinates the provision of continuing education contact hours throughout the state for DSHS public events. The CE Service ensures continuing education events meet the national standards or guidelines for disciplines including Medical, Nursing, Health Education Specialist, Social Worker, and Sanitarian.
- *DSHS Grand Rounds* provides employees the opportunity to expand their knowledge of the science and practice of behavioral and population-based health. The series of scholarly presentations support workforce development by encouraging a culture of learning and the integration of evidence into practice. All employees are encouraged to participate and free continuing education credit is available for many professions. Community partners from local health departments and community mental health centers as well as Health and Human Services Enterprise employees are also invited.
- *Office of the State Director of Nursing* provides leadership and coordination regarding nursing practice among all service arenas of DSHS to include:
    - Provides a nursing perspective on agency-wide governance groups and planning committees as well as with external customer groups;
    - Professional development planning for nurses, including agency-required training, ongoing continuing education, and leadership and management opportunities;
    - Technical oversight and assistance through the development and deployment of core nursing policies and procedures to guide nursing practice within the agency;
    - Assistance with nursing recruitment and retention through the use of needs assessments data and development of strategies to promote the attractiveness of public sector nursing; and

  - Chairs the DSHS Nursing Leadership Council, an organization of nursing representatives from DSHS divisions, practice partner organizations, and academia, appointed by the DSHS Commissioner to provide leadership for the provision of public health and psychiatric mental health nursing in Texas.
- *The Preventive Medicine/Public Health Residency Training Program* prepares physicians who possess the prerequisite training, dedication, and value systems for a preventive medicine practice and career. The residency program is a one-year practicum which constitutes the third year of a three-year residency. The entering physician must have satisfied all requirements for a clinical year rotation and hold a Masters of Public Health or comparable master's degree which meets the requirements of the American Board of Preventive Medicine's eligibility criteria for its National Board examination. To promote a rounded experience in preventive medicine and public health, the residency program provides exposure to periodic special learning opportunities under the auspices of other institutions or agencies. Residents may be based in the central office in Austin or in one of the HSR offices across the state depending on the establishment of appropriate supervision, support, and opportunities for the experiences required by the program.

STRATEGY FOR PROMOTION OF HEALTH PARAPROFESSIONALS (TIER ONE INITIATIVE)

An internal workgroup has been formed within DSHS to develop recommendations for increasing the number of certified paraprofessional health workers (PHWs) and for promoting the use of PHWs within and outside the agency. Additionally, the workgroup will identify ways in which non-certified PHWs can provide health-related support in communities throughout Texas. For the purposes of this initiative, a PHW is defined as:

> *A person, who with or without compensation, may provide one or more of the following tasks: cultural mediation between communities and health and human services systems; informal counseling and social support; culturally and linguistically appropriate health education; advocates for individual and community health needs; assures people receive the health services they need; builds individual and community capacity; or provides referral and follow-up services.*

This definition is inclusive, but not limited to the following position titles, which may be considered "paraprofessionals" in certain fields of practice: Peer Support Specialist, Family or Parent Liaison, Promotora, Community Health Worker, Consumer Advocate, Consumer Liaison and/or Youth Liaison.

TRAININGFINDER REAL-TIME AFFILIATE INTEGRATED NETWORK

TrainingFinder Real-Time Affiliate Integrated Network (TRAIN) is a project of the Public Health Foundation Learning Management System funded through The Robert Wood Johnson Foundation, CDC, and participating states. The most comprehensive clearinghouse of public health and preparedness training on the web, TRAIN is comprised of the national www.train.org site and participating TRAIN affiliate sites. Because all TRAIN sites are connected, TRAIN users can access information about state, local, national, or international training available to them through any participating TRAIN site. Over 3,000 courses are provided through TRAIN with 250,000 registered users nationwide. When completed, TRAIN will serve the majority of the U.S. public health workforce. Texas is one of approximately 20 states that use TRAIN as the centralized database for sharing public health training opportunities. There are over 90,000 registered users in Texas alone. Of this total, 44,000 are Health and Human Services Enterprise staff.

DSHS DATA COLLECTION, RESEARCH, AND EVALUATION EFFORTS

The DSHS Office of Program Decision Support (OPDS) provides the majority of data collection, research, and evaluation support for MCH activities. OPDS is primarily responsible for analysis and reporting of progress toward the Title V national and state performance measures. OPDS also provides the department with information on the effectiveness of interventions as well as the “state of health” for the MCH population. A sample of methods used to serve these functions is described below.

PREGNANCY RISK ASSESSMENT MONITORING SYSTEM

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a surveillance project designed to monitor maternal attitudes and behaviors before, during and after pregnancy. A partnership between CDC and DSHS, this project is a population-based assessment that monitors the health and behaviors of new mothers in the State of Texas. It provides up-to-date information regarding birth and pregnancy trends, covering topics such as prenatal care and substance use. A sample of about 300 mothers is drawn every month from the birth records provided by the Vital Statistics Unit at DSHS. PRAMS uses mixed mail and telephone modes to conduct interviews with biological mothers of infants aged 60-180 days old. Texas initiated PRAMS data collection in May 2002, and is currently one of 37 states (plus New York City and the Yankton Sioux Tribe of South Dakota) participating.

TEXAS INFANT SLEEP STUDY

The objective of the Texas Infant Sleep Study is to determine the prevalence of risk factors, specifically infant sleep position and sleep surface, for Sudden Infant Death Syndrome (SIDS). Currently, no population level data on infant care practices associated with SIDS risk exists in Texas. The Texas Infant Sleep Practices Survey is a statewide, stratified random sample survey of infant care practices. The sampling frame was formed from Texas residents who had a live birth in Texas from September 1, 2008-March 31, 2009, as documented by a Texas vital records' birth certificate. The study sample of approximately 4,000 women is randomly representative of all mothers who had a live birth during this period. Data were collected via a telephone survey in the summer of 2009 for three strata: White, Black and Hispanic. In order to make inferences about prevalence rates of maternal behaviors at the state level and within the three race/ethnicity strata, sample size calculations were performed separately for each stratum. All interviews were conducted by trained, bi-lingual interviewers at the Public Policy Research Institute at Texas A&M University. DSHS is currently analyzing the data to examine the prevalence of, and relations between, risk factors for SIDS by socio-demographic characteristics.

WIC INFANT FEEDING PRACTICES SURVEY

DSHS staff designed and implemented an enhanced infant feeding practices survey in 2009. The infant feeding practices survey is a biennial survey administered through WIC Local Agencies to collect information regarding beliefs, attitudes, practices, and experiences (including experiences related to hospital policies, breastfeeding and working, social support, and breastfeeding in public) surrounding infant feeding among women receiving WIC services. The purpose of the survey is to provide data to local WIC agencies to assist in modification of existing activities and the planning and development of new activities. Therefore, the survey results are important in shaping current WIC policy. There were approximately 6,800 surveys completed by mothers entering a WIC clinic for certification of their one-year-old child anytime from April 15-July 31, 2009.

SCHOOL PHYSICAL ACTIVITY AND NUTRITION SURVEY

OPDS staff collaborated with the Dell Center for Healthy Living at the University of Texas School of Public Health on the recent iteration of the School Physical Activity and Nutrition (SPAN) survey. SPAN assesses the behaviors and perceptions of 4th, 8th, and 11th graders about nutrition and physical activity, including body image and other social-emotional indicators associated with childhood obesity. The latest SPAN survey also

administers a questionnaire to the parents of the fourth graders to examine the relationship between parental perceptions and behaviors and those of their children.

STATE SYSTEMS DEVELOPMENT INITIATIVE

Texas has participated in the State Systems Development Initiative (SSDI) for 18 years. SSDI's vision in Texas is promoting data integration that can advance performance measurement and research and improve the health of the women and children of Texas. It is only through understanding more about the populations we serve that we can hope to provide government services that move us in the direction of improving the quality of life and health outcomes and fostering the independence of those who rely on the safety net. The data available to Texas policy makers is significant. DSHS has identified six primary projects to work on during our current five-year grant. These projects involve linking the live birth and/or death datasets to other datasets throughout Texas, including CPS datasets maintained by DFPS. One of these primary projects involves linking live birth certificate data to CPS data to answer the following question: Are the rates of adolescent pregnancy higher for adolescent girls who had involvement with child protective services compared to those who had no involvement with child protective services?

In addition to the data collection, research, and evaluation efforts provided by OPDS, DSHS has a number of programs that also address these areas regarding the MCH population.

CENTER FOR HEALTH STATISTICS

The DSHS Center for Health Statistics was established to provide a convenient access point for health-related data for Texas. The objective of the Center is to be a source of information for assessment of community health and for public health planning. Data provided by the Center are used to support research, grant applications, and policy development and to provide rapid needs response to health emergencies. Technical assistance is also provided in the appropriate use of the data provided, and in the development of innovative techniques for data dissemination. The following is a sample of the activities conducted by the Center:

- Manage and administer statewide survey tools such as the Behavioral Risk Factor Surveillance System.
- Provide technical expertise on research design, geographic information system (GIS), and analytical methods.
- Collect and report hospital facility data, hospital charity care, and community benefits data.

- Collect and report hospital discharge data and data from HMOs to help consumers make informed health care decisions.
- Collect, analyze, and publish employment, demographic, and educational trends for health care professionals as well as research workforce data needed to address the current and future health-related workforce shortages in Texas.

BIRTH DEFECTS MONITORING

The DSHS Birth Defects Epidemiology and Surveillance Branch (BDES) encompasses two major components: the Texas Birth Defects Registry and the Texas Center for Birth Defects Research and Prevention. In 1994, the Texas Birth Defects Registry was established to identify and describe the patterns of birth defects in Texas. Through multiple sources of information, the Registry actively monitors all births in Texas and identifies cases of birth defects. Once identified, information is abstracted from medical records regarding birth defect diagnosis, medical tests and procedures, gestational age, delivery information, illnesses, complications, maternal exposures, and demographic information.

In 1996, the Texas Center for Birth Defects Research and Prevention was established as part of BDES. The mission of the Texas Center is to conduct research studies to understand the causes of specific birth defects, including participation in the National Birth Defects Prevention Study. The Texas Center is in a unique position to contribute to the understanding of what causes birth defects, especially due to the 1,200-mile border shared with Mexico. Health disparities between Texans living along the border with Mexico and those in non-border communities have long been a concern for public health officials. The national study area for Texas is currently the Lower Rio Grande Valley, which encompasses Gulf Coast industrial cities such as Corpus Christi, as well as Cameron and Webb Counties. These two counties on the border with Mexico have experienced some of the country's highest neural tube defect rates.

In addition to participating in the National Birth Defects Prevention Study, the Texas Center is funding local research projects, including studies that examine:

- The interaction of metabolic, genetic, and environmental risk factors for certain birth defects of the brain and spinal cord.
- The link between neural tube defects and maternal risk factors, such as maternal diabetes, obesity, smoking, and dieting behaviors.
- The link between birth defects and certain environmental factors, such as hazardous waste sites and air pollution.
- Patterns and risk factors associated with oral clefts and clubfoot in Texas (Texas Department of State Health Services, 2009).

VITAL STATISTICS

The DSHS Vital Statistics Unit is responsible for all original birth and death records, applications for marriage licenses, and reports of divorces and annulments in Texas. In addition, a paternity registry and a voluntary adoption registry are maintained, and information provided by courts of law is processed, recorded, and disseminated on all lawsuits affecting the parent-child relationship. Information from the documents this Unit processes is used for a variety of research and evaluation purposes. Natality files consist of all births that occurred in Texas during a given year and are a resource for tracking patterns in preterm births, low birth weight births, newborn screenings completed, utilization of prenatal care, and teen pregnancy in Texas. Mortality files consist of all deaths that occurred in Texas during a given year and are a resource for tracking patterns in suicides, deaths caused by intentional or unintentional injuries, or deaths caused by chronic disease. These files allow for birth and death rates to be calculated at the county or city level and they can be linked in order to investigate issues such as infant mortality or deaths of young children. To date, these files are current as of 2006.

CANCER REGISTRY

The Texas Cancer Registry (TCR) is a statewide population-based registry that serves as the foundation for measuring the Texas cancer burden, comprehensive cancer control efforts, health disparities, progress in prevention, diagnosis, treatment, and survivorship, as well as supports a wide variety of cancer-related research. These priorities cannot be adequately addressed in public health, academic institutions, or the private sector without timely, complete, and accurate cancer data.

TCR is the fourth largest cancer registry in the U.S., and currently meets the National Program of Central Cancer Registries, CDC high quality data standards, and is Gold Certified by the North American Association of Central Cancer Registries. Over 248,000 reports of cancer were received in 2009 from over 500 hospitals, cancer treatment centers, ambulatory surgery centers, and pathology laboratories located throughout the state. Of these reports, over 20,000 were for out-of-state residents, largely due to the internationally recognized cancer care available in Texas. These reports are distributed throughout the U.S. to other state cancer registries, and make a significant contribution to the overall national cancer surveillance system.

TCR collects information, such as the types of cancers that occur and their locations within the body, the extent of cancer at the time of diagnosis (disease stage), the kinds of first course treatment that patients receive, length of survival, and patient characteristics. These data are reported from various sources, including hospitals,

cancer treatment centers, ambulatory surgery centers, pathology laboratories, and physician's offices, as well as supplemented through various data sharing efforts with other government data collection systems, such as vital statistics (Texas Department of State Health Services, 2010).

CSHCN - CONSTRUCTS OF A SERVICE SYSTEM

STATE PROGRAM COLLABORATION WITH OTHER STATE AGENCIES AND PRIVATE ORGANIZATIONS

A unique and unprecedented opportunity now exists in Texas for intra- and inter-agency and stakeholder collaboration regarding services for CYSHCN and their families. Senate Bill 1824, 81st Legislature, Regular Session, 2009, established a Task Force for Children with Special Needs to improve the coordination, availability, and quality of services for children and young people with developmental or intellectual disabilities, serious mental illness and/or chronic illness. It is comprised of leaders from key child-serving state agencies, legislators, and public members. By September 1, 2011, the Task Force must create a five-year statewide strategic plan with goals and objectives to improve services for its target population. To help inform the plan, the Task Force includes eight subcommittees, each responsible for studying key issues and making related recommendations. The subcommittees include health, mental health, education, transitioning youth, juvenile justice, long-term care, early childhood intervention, and crisis prevention.

The Task Force will be informed and guided by the work of numerous existing stakeholder groups. The DSHS Assistant Commissioner for Family and Community Health Services serves as the chair of the Health Subcommittee. The CSHCN Services Program staff members are actively involved in providing information and expertise for the Task Force. The Title V CSHCN Director has already presented information about the Title V CSHCN national and state performance measures to the Task Force and has been selected as a member of the Health Subcommittee. Another CSHCN Services Program staff member has been selected to serve on the Transition Subcommittee. The Task Force will integrate and coordinate policy and quality measures for CYSHCN and their families across state agencies. The Title V Five-Year CSHCN Needs Assessment will contribute extensive baseline data for the Task Force.

The Task Force is facilitated by HHSC and members of the Texas Legislature and the Governor's Office are involved. Due to the high-level visibility, leadership, charge, and accountability of the Task Force, there will be a tremendous opportunity to coordinate, improve, and advance services for CYSHCN in Texas.

As a preface and as ongoing support to the new Task Force, the CSHCN Services Program has long valued the importance of partnership building and collaboration among its stakeholders. As is evident in the details provided in the CSHCN Needs Assessment sections concerning Process and Partnership Building, the Texas Title V Five-Year Needs Assessment for CYSHCN involved multiple state agencies, advocacy organizations and other sources, and extensive stakeholder involvement and partnerships.

This level of involvement and collaboration is made possible, in part, because CSHCN Services Program staff actively participate in and report on the meetings and activities of key state-level stakeholder groups, including the Children's Policy Council, Promoting Independence Advisory Committee, Children's Health Insurance Plan Coalition, Texas Parent to Parent Advisory Committee, Texas Council on Developmental Disabilities, Early Childhood Intervention Advisory Council, Texas Integrated Funding Initiative, CRCG State Work Group, Texas Pediatric Society, Medical Home Workgroup, Traumatic Brain Injury Advisory Council, Leadership and Education in Adolescent Health Advisory Committee, Raising Texas, and other groups whose members convene to improve the service systems impacting CYSHCN in Texas. Many of these groups include members from state agencies as well as consumers and providers. For almost all of them, consumers or providers lead the groups, and their membership constitutes a majority. Staff work to increase awareness of the Title V CSHCN performance measures among these and other key stakeholder groups as they identify and consider the needs of CYSHCN in Texas and formulate recommendations for service system improvement. Many of these groups issue formal reports and some regularly submit recommendations each biennium to the Texas Legislature.

The reports and recommendations of key agency, advocacy, and stakeholder groups constituted an important share of the information obtained concerning sources and indicators related to the health and well being of CYSHCN in Texas. Most important among these were the reports of the Children's Policy Council, the Center for Public Policy Priorities, the Children's Defense Fund, Texans Care for Children, the Texas Council for Developmental Disabilities, the CRCG State Work Group, Raising Texas, and the Promoting Independence Advisory Committee. In addition, program staff drew specific data for the needs assessment Stakeholder Summit background documents from the CHIP Coalition and the KIDS COUNT Data Center, the Texas Promoting Independence Plan, and the Texas Council for Developmental Disabilities 2008 Texas Biennial Report.

Staff provided stakeholders with health status data from national and state surveys and received stakeholder direction concerning health status indicators during the needs assessment process. As with the reports of key stakeholder groups mentioned above, health status data constituted an important part of the Title V Stakeholder Summit resource material ("homework") and served to inform participants regarding applicable indicators for CYSHCN. Staff received guidance from key stakeholders in the development of important primary and secondary health status data, most especially in the crafting of data pertaining to relevant social determinants of health and health outcomes for CYSHCN.

As part of the needs assessment, CSHCN Services Program staff conducted parent focus groups and distributed Parent Surveys. Focus groups were conducted in June at the 2008 Texas Parent to Parent Annual Conference in Austin; in October 2008 at the Coalition of Health Services/Uniting Parents in Amarillo; in January 2009 at the West Texas Rehabilitation Center in San Angelo; and in February 2009 at the African American Family Support Conference in Austin. Key partners in the Parent Survey piloting and distribution included Texas Parent to Parent, the Central Texas Children with Special Needs Network, and the CSHCN Services Program community-based services contractors. CSHCN Services Program staff and contractors administered the surveys, typically distributing paper copies during conferences, meetings of family support groups, or following individual case management appointments. By partnering with these organizations to involve parents, program staff obtained more direct contact with and enhanced response from many more parents than had been achieved historically through less personal survey distribution methods. Staff broadly distributed provider surveys through email notices, remittance report banner messages, and various provider bulletins. However, provider organizations, e.g. the Texas Pediatric Society, also assisted with distribution. While the exact number is not certain, it is estimated that many thousands of providers received such notices and had opportunities to participate in the Provider Survey.

Similarly, staff sought guidance from the CRCG State Work Group in the development of the CRCG Survey for the Title V CSHCN needs assessment. The Work Group is comprised of state-level agency representatives, meets approximately quarterly and provides inter-agency linkages and consultation for CRCG activities and reporting. In Texas, CRCGs are local interagency groups comprised of public and private agency representatives. Together, participants develop service plans for individuals and families whose needs often highlight gaps in the regular service delivery system and require more intensive interagency service coordination and cooperation. CRCGs originated when the Texas Legislature passed Senate Bill 298 into law in 1987. This bill directed state agencies serving children to develop a community-based approach to better

coordinate services for children and youth who have multi-agency needs and require interagency coordination. More recently, communities have begun using this approach to serve adults with complex needs. CRCGs are organized and established on a county-by-county basis. CRCG members are from public and private sector agencies and organizations. Many CRCGs also include parents, consumers, or caregivers as members.

The purpose of the CRCG Survey was to measure the extent that CRCG participants understood and demonstrated accord with the Title V CSHCN national and state performances measures for children with special health care needs and to help guide development of future Title V activities. After vetting the CRCG Survey instrument through the CRCG State Work Group, the CSHCN Services Program conducted an online survey of CRCG participants in March and April 2009. The CRCG Survey was distributed to CRCG members throughout Texas by the HHSC's Office of Program Coordination for Children and Youth (OPCCY), which provides staff support and technical assistance for CRCGs and coordinates statewide CRCG activities and reporting. The OPCCY distributed initial and reminder announcements about the survey via email. By partnering with these entities in development and distribution of the CRCG Survey, the CSHCN Services Program was able to enhance the response to the survey.

The combined total of individuals completing all three CYSHCN surveys approached 1,000 individuals.

To facilitate the needs assessment community listening sessions and needs assessment communications and engagement of stakeholders, CSHCN Services Program staff compiled contact information for and assisted in distributing announcements to about 140 key leaders within CYSHCN stakeholder groups and 23 community-based services contractors across Texas. These contacts formed the basis for mass distributions of information seeking participation and input of CYSHCN stakeholders throughout the needs assessment process. Personal interaction with CSHCN Services Program staff facilitated engagement of stakeholders in the needs assessment process and made the contacts more productive.

Both state-level partners and community-based stakeholders contributed to the needs assessment and will continue to inform and monitor progress in meeting the prioritized areas of need. Stakeholders have indicated their willingness to work with the CSHCN Services Program on specific activities to address needs of CYSHCN and their families.

The needs assessment activities are built upon a solid foundation of stakeholder collaboration that is ongoing. The CSHCN Services Program staff complete "Stakeholder Meeting Records" after attending stakeholder group meetings in order to capture key stakeholder feedback, identify emerging issues/needs and identify opportunities for further collaboration. These records are reviewed periodically and themes identified, enabling an ongoing needs assessment and stakeholder feedback to inform the program and Title V planning process.

The CSHCN Services Program staff actively collaborates with HHSC, other health and human services agencies, the Texas Education Agency, and others to provide subject matter expertise regarding CYSHCN. Staff also serves on multiple interagency group, committees, and initiatives, e.g. the HHSC "Raising Texas" workgroups (the Texas Early Childhood Comprehensive Systems plan). The Title V CSHCN Director and the Texas Medical Director for Medicaid and CHIP collaborate on the Texas team for the National Academy for State Health Policy's Collaborative to Advance Medical Homes in Medicaid and CHIP.

Related to CYSHCN, key Texas government partners include, but are not limited to, the following:

- Texas Health and Human Services Commission (HHSC)
- Department of Aging and Disability Services (DADS)
- Department of Assistive and Rehabilitative Services (DARS)
- Department of Family and Protective Services (DFPS)
- Texas A&M University Center on Disability and Development
- Texas A&M University Center for Housing and Urban Development
- Texas Council on Autism
- Texas Council on Developmental Disabilities (TCDD)
- Texas Department of Insurance
- Texas Education Agency (TEA)
- Texas Governor's Committee on People with Disabilities
- Texas Legislative Budget Board
- Texas State Data Center
- The University of Texas Center for Disability Studies

Related to CYSHCN, key Texas stakeholder and advocacy organization partners, include, but are not limited to, the following:

- Advocacy, Inc.
- Center for Public Policy Priorities
- Children's Defense Fund – Texas
- Disability Policy Consortium
- Hogg Foundation for Mental Health

- Raising Texas
- Texans Care for Children
- Texas Academy of Family Physicians
- Texas Association of Community Health Centers
- Texas Autism Advocacy
- Texas Children's Mental Health Forum
- Texas Dental Association
- Texas Mental Health America
- Texas Medical Association
- Texas Nurses Association
- Texas Pediatric Society
- Texas Parent to Parent
- The CHIP Coalition
- The Primary Care Coalition
- The ARC of Texas
- United Cerebral Palsy

STATE SUPPORT FOR COMMUNITIES

DSHS and other health and human services agencies provide a broad range of supports for CYSHCN and their families in communities. An environmental scan of agency programs was generated in October 2006 to identify and describe the CYSHCN populations served (See Appendix H – Environmental Scan of Agency Service Delivery Programs). The newly created Task Force for Children with Special Needs will further define this data and the available community services and supports in order to develop a strategic plan to improve care for CYSHCN and their families.

Despite this unprecedented opportunity to address improvement in services for CYSHCN and their families, state funding limitations and dilemmas remain with potential impact on supports to communities for this purpose. As an example, a recently released letter regarding the DARS Early Childhood Intervention (ECI) eligibility criteria to all stakeholders noted some possible changes. The letter stated that in the 2012-13 biennium, there is a possibility that ECI services cannot continue to be delivered at current funding levels, and, should that occur, a narrowing of eligibility for the program remains one of several options being considered. DARS conducted eight statewide meetings in January 2010 to allow stakeholders, especially families who have received ECI services, to share their ideas on how best to use limited dollars to provide the services most important to children and families. The information gathered will help DARS provide valuable information to legislators as they consider the agency's ECI funding request for the 2012-13 biennium. DARS anticipates a significant funding request, and coupled with the economic challenges facing the State, says that the

agency must be prepared to offer alternative service levels in ECI consistent with available resources.

Title V federal and state funds support the efforts of the CSHCN Services Program. To maximize these resources on an ongoing basis, the CSHCN Services Program seeks opportunities to collaborate and coordinate community supports with the various health and human service agencies as well as local/community-based service organizations. As previously described, the CRCGs provide opportunities for local service coordination and collaboration to fill service gaps. Regional DSHS case management staff who are funded by the CSHCN Services Program participate in, and many times lead the CRCGs across the state. In SFY 2010, the CSHCN Services Program also is providing approximately $2.9 million to fund 25 community-based services contracts that provide community supports to CYSHCN and their families. Contractors are selected through a competitive bid process. Contractors provide case management services, family supports and community resources, and clinical support services. CSHCN Services Program regional and central office staff provides technical assistance and quality monitoring for the community-based services contractors. Funding for community-based services contractors has remained at the same level over the past decade due to the continuing need for direct health care benefits funding for CYSHCN, as demonstrated by the program's waiting list.
In SFY 2010, the CSHCN Services Program funded several special Title V initiatives. Funding of the Leadership Education in Adolescent Health (LEAH) project at Baylor College of Medicine (BCM) in Houston enabled 50 additional family members from communities throughout the state (parents and youth/young adults with special needs) to attend the annual LEAH transition conference; supported implementation and evaluation of a transition module in the electronic medical records of the Texas Children's Hospital's specialty clinics (serving children from various communities in Texas); and supported a rotation for 12 internal medicine residents in the BCM Transition Clinic to educate them on the needs of youth and young adults with special needs and their roles as collaborative partners in the transition process with pediatricians, youth/young adults, and family members. Additionally, funding was provided for as many as 10 medical home support contracts with seed money grants up to $20,000/year to help medical home practices make improvements in their medical home services. Funding also was available to help support the Texas Medical Home Initiative (TMHI) to incorporate transition best practice modeling, implementation, and reporting into the TMHI initial adult medical home pilot in spring 2010. The pilot focused on a group of practices in North Texas. Also, funding was allocated to EveryChild, Inc. to analyze the Permanency Plans of children in congregate care throughout the state and determine reasons for children remaining in institutions. This analysis will highlight family support needs in communities throughout Texas.

In addition, the CSHCN Services Program's health care benefits help numerous CYSHCN from communities throughout Texas to access needed health care. Although the program has a waiting list for health care benefits, the program was able to serve 2,294 CYSHCN in SFY 2009. The program's health care benefits include family support services, such as respite and home and vehicle modifications. The program depends on enrollment of providers from communities throughout Texas and reimburses providers on a fee-for-service basis. The program provides case management services to clients, including those on the waiting list, through DSHS regional staff and community-based services contractors.

COORDINATION OF HEALTH COMPONENTS OF COMMUNITY-BASED SYSTEMS

As described above, the Texas CRCGs serve a role in coordinating health services at the community/county level and regional staff and contractors funded by the CSHCN Services Program participate in the CRCGs. Case management services provided through regional staff and contractors also funded by the CSHCN Services Program, help CYSHCN and their families to access and coordinate health care services through community-based, state, and federally operated programs. Community-based services contractors (for case management, family supports and community resources, and clinical supports) are required in their contracts to identify and network with mental health service providers, federally qualified and rural health centers, and emergency preparedness planning efforts in their communities and report quarterly on their networking activities. Case management contractors as well as regional staff also report quarterly on the number of CYSHCN assisted with establishing a medical home and with transition services. The LEAH projects funded by the CSHCN Services Program in SFY 2010 (described above) focus on enhancing transition services from pediatric to adult care for CYSHCN and their families. Also, LEAH grant activities at Baylor College of Medicine in Houston, Texas, have engaged and provided education and training to multiple professionals and family members from diverse communities throughout Texas regarding transition best practices. The medical home supports seed money grant funding provided in SFY 2009 and SFY 2010 assists practices in various communities throughout Texas to make medical home improvements (including improvements in transition services).

The CSHCN Services Program coordinates the statewide Medical Home Workgroup (MHWG). The MHWG has generated opportunities for inter-agency and community organization collaborations. The MHWG strategic plan sparked Texas' participation in the National Initiative for Children's Healthcare Quality's Medical Home Learning

Collaborative II (of 10 states) in 2005. As part of the Collaborative, two medical home practices in Texas partnered with the Texas state-level team to explore the concept of the medical home, make improvements, collect data, and evaluate progress. The Baylor College of Medicine (BCM) Transition Clinic in Houston, Texas and Su Clinica Familiar (a federally qualified health center) in Harlingen, Texas were the two medical home practice settings. The partnerships established with these practices during the Collaborative have had a ripple effect over time. The BCM Transition Clinic continues to operate and influence transition services for youth and young adults with special health care needs in Houston and the surrounding communities, as well as statewide. Su Clinica Familiar also has continued their medical home improvement activities and received a medical home supports seed money grant from the CSHCN Services Program in SFY 2009. The model of the medical home in the Su Clinica Familiar federally qualified health center has opened up discussions with the Texas Association of Community Health Centers (TACHC). It is clear that the infrastructures of the federally qualified health centers and rural health centers are designed to support and implement the medical home concept. The CSHCN Services Program has worked with TACHC as part of the MHWG, and TACHC has assisted in disseminating medical home information broadly across the state to community health centers.

At the January 2010 MHWG meeting, information was shared concerning a National Institutes of Health-funded health information exchange system pilot to assist medical home practices in coordinating the various components of the care of complex patients. The discussion of electronic medical records and the evolution of such systems in Texas will be coordinated by HHSC. It will be important for the CSHCN Services Program to contribute to such discussions and monitor how such systems will impact the coordination of health care for CYSHCN and their families.

If federal health care reform results in increased funding of community health centers, home-visiting, and preventive health care initiatives, such funding will impact coordination of health care at the community-based level for CYSHCN and their families. The above described capacity will help ensure that the needs of CYSHCN and their families are considered as funding is allocated.

COORDINATION OF HEALTH SERVICES WITH OTHER SERVICES AT THE COMMUNITY LEVEL

Much of the coordination of health services with other services at the community level is supported through the infrastructure of the CRCGs and DSHS regional case management staff and contractors. However, community-based services organizations are the true core infrastructure operating in the state. State staff partner with some of

these organizations through formal contractual arrangements and with others through electronic mailing list communications, participation in organizational meetings, and participation/presentations at conferences, etc.

Texas Parent to Parent, based in Austin, is the federally funded Family-to-Family Health Care Education and Information Center. The CSHCN Services Program contracts with Texas Parent to Parent to provide family support and community services in the Harlingen and Dallas areas. Also, staff participates in the Texas Parent to Parent annual parent conference as speakers, planners, and exhibitors. One CSHCN Services Program staff member has initiated and coordinated the Teen Transition Expo during these parent conferences for the last three years, serving and engaging teens in the conference planning and activities. Texas Parent to Parent participates in the MHWG and provides medical home trainings to professionals and parents throughout the state. Their electronic mailing list communications enable information to be shared with families across Texas. Texas Parent to Parent and the other community-based services contractors were instrumental in generating parent input for the Title V Five-Year Needs Assessment process.

The CSHCN Services Program staff has collaborated with TEA, the Regional Education Service Centers, DARS, and Independent Living Centers to promote and improve transition services for CYSHCN in Texas. Staff has taught health transition curricula in the Independent Living Center classroom settings. New partnerships in the areas of education, employment, and adult living are emerging through the creativity and perseverance of CSHCN Services Program staff, and the collaboration of other state agency and local organization staff.

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

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

SECTION 5: SELECTION OF STATE PRIORITY NEEDS

As described in Section 1: Process for Conducting Needs Assessment, the stakeholder input process gathered public input that resulted in recommended needs statements for maternal and child health in Texas. The Needs Assessment Planning Group reviewed the needs statements included in Table 1-2 of Section 1 and sorted them into groups based on similarities of populations, services, or functions, leading to a proposed list of 10 priority needs. The order of the 10 items is not a ranking by importance, as all are considered of equal value. The thematic grouping of statements is in Table 5-1.

Table 5-1. Proposed Title V Priorities and Sample Recommendations

Proposed Title V Priorities SFY 2011 – SFY 2015	Sample Recommendations for Priorities/ Identified Needs Statements
Support and develop health care infrastructure that provides coordinated access to services in a culturally competent manner, addressing health issues across the life course.	Improve and simplify the public health application and renewal process, such as Medicaid, CHIP, and Title V programs.
	Implement the holistic approach for health care and social services using a care navigator and flexible funding support.
	Define, promote, and support (including reimbursement rates) a comprehensive coordinated approach for health and dental care and occupational services for women and children.
	Address the problem of individuals going to the emergency room for non-emergency care.
	Promote awareness and public knowledge about health services and providers available in the community.
	Increase and support community clinics serving women, infants and children in rural areas, including subsidized clinics for low-income populations.
	Promote a healthcare approach that involves a single primary care provider to coordinate routine and preventative healthcare for women and children throughout their lifetime.

Proposed Title V Priorities SFY 2011 – SFY 2015	Sample Recommendations for Priorities/ Identified Needs Statements
	Expand the numbers and types of primary care services available for Title V families (e.g., fee-for-service).
	Availability of child health insurance.
	Provide more affordable health insurance coverage for Title V eligible populations.
	Improve social supports (e.g., support groups, counseling groups and mentors) and clinic facilities to provide medical services for pregnant teens.
	Improve accessibility to health care services at clinics by reducing barriers like long wait times, complex eligibility procedures, limited office hours, and difficult medical forms.
	Provide more low-cost, preventive health screenings for women including PAP smears, mammograms and other routine care.
	Increase and support community clinics serving women, infants and children in rural areas, including subsidized clinics for low income populations.
	Increase percent of children with special health care needs whose families have adequate private and/or public insurance for the services they need.
	Provide more therapy services, including occupational therapy, alternative therapy, and physical therapy.
Increase the availability of quality mental health and substance abuse services.	Improve the availability and quality of mental health services and resources.
	Promote early intervention and screening for mental health disorders, including autism and ADD/ADHD.

Proposed Title V Priorities SFY 2011 – SFY 2015	Sample Recommendations for Priorities/ Identified Needs Statements
	Improve substance abuse rehabilitation treatment capacity for youth and adults.
	Improve substance abuse rehabilitation and treatment facilities and services in the community.
	Promote suicide prevention efforts.
Increase the number of youth with special health care needs who receive necessary services to transition to all aspects of adult life.	Improve transition services for CSHCN when moving from school to post-school activities (including education, employment, community integration, and adult services).
	Promote local vocational programs and vocational therapy for children and adults with disabilities.
Increase access to dental care.	Increase accessibility to affordable dental care for Title V families.
Support community-based programs that strengthen parenting skills and promote healthy child and adolescent development.	Provide parents, including teen parents, with relevant parenting information and skills.
	Create or promote support programs and social networking opportunities for adult and teen parents, including CSHCN.
	Provide affordable childcare services, including after-hour childcare and after-school programs.
	Provide quality foster care and child protection services.
	Promote prevention efforts to address substance abuse.
Support the development of community-based systems that provide essential	Enhance transportation services for families with limited access.

Proposed Title V Priorities SFY 2011 – SFY 2015	Sample Recommendations for Priorities/ Identified Needs Statements
enabling services needed to improve health status.	Provide better access to meal or food bank programs in the community, including programs for children while not in school.
	Increase access to low-cost prescriptions and medications.
	Promote awareness and public knowledge about health services and providers available in the community.
Improve the organization of community-based systems of care for children with special health care needs.	Provide affordable childcare services, including after-hour childcare and after-school programs, for CSHCN.
	Need for least restrictive lifetime services for CSHCN, including respite and transition care.
	Increase the percent of children with special health care needs whose families report their community-based service systems are easy to use.
	Create or promote social support programs (e.g. recreation, counseling, family support services) for CSHCN.
Use population-based services including health promotion and disease prevention interventions to improve health outcomes of the MCH population.	Enhance education and financial support of breastfeeding initiatives, including promotion of primary care that treats mothers and infants as a breastfeeding unit.
	Address the issue of environmental contaminants that interfere with health and child development.
	Provide violence prevention services and teen dating violence services such as counseling, shelter, prevention education, etc.
	Decrease teen pregnancy rates.

Proposed Title V Priorities SFY 2011 – SFY 2015	Sample Recommendations for Priorities/ Identified Needs Statements
	Reduce childhood obesity.
	Develop more prevention-based programs for all target populations.
	Promote nutrition, physical activity, and obesity prevention for teens.
	Promote immunization and wellness programs for children.
Ensure all children, including children with special health care needs, have access to a medical home and other health care providers through increased training, recruitment, and retention strategies.	Recruit and train dental and health care practitioners to care for CSHCN, including financial incentives for the practice.
	Increase the number of affordable public and private pediatric providers.
	Increase the number of specialists providing affordable care.
	Increase training for health care providers and organizations that provide services for CSHCN.
	Improve school health programs through coordination with local health care agencies and organizations.
	Address the shortage of nurses, especially in non-urban areas.
Promote the expansion of new or existing evidence-based interventions to address maternal and child health needs.	Promote healthier lifestyles by expanding evidence-based prevention programs.
	Use outcomes-based indicators and evidence-based interventions to achieve improved outcomes.

Proposed Title V Priorities SFY 2011 – SFY 2015	Sample Recommendations for Priorities/ Identified Needs Statements
	Assess and evaluate the needs and barriers for local health care programs.
	Focus on systems of care and prevention and environmental changes to improve MCH health outcomes.

Following presentations of the proposed priorities to the DSHS Executive Leadership team, Regional Medical Directors, and Deputy Regional Directors from all Health Service Regions, the Title V Director shared the proposed priorities through public forums held in each of the eight regional headquarters in early 2010. Feedback received throughout the process indicated that all of the proposed priorities were considered valid and within the potential scope of the department and Title V-funded activities.

As shown in Table 5-2, all but 1 of the 10 priorities can be linked with national performance measures (NPMs) and state performance measures (SPMs) from the previous 5-Year Needs Assessment (See Appendix L – Title V National and State Performance Measures for a list of NPMs and SPMs). Internal and external stakeholders agreed that the priority to "Promote the expansion of new or existing evidence-based interventions to address maternal and child health needs" was an overarching priority that was essential in response to limited resources and the agency's fiscal responsibilities. With that recognition, DSHS established a new state performance measure to gauge success in addressing the priority. There has been a shift in the department's priorities since 2005, when the department submitted the SFY 2006 Five-Year Needs Assessment. Tables 5-2 and 5-3 highlight both sets of priorities for further discussion.

Table 5-2. Title V Priorities Crosswalk

Title V Priorities SFY 2011 – SFY 2015	Similar to SFY 2006 – 2010 Priority?	Current NPM Or Existing SPM?	MCH Pyramid Level
Support and develop health care infrastructure that provides coordinated access to services in a culturally competent manner, addressing health issues across the life course.	Yes	NPM 3,4,5,13,18	Direct Infrastructure Building
Increase the availability of quality mental health and substance abuse services.		NPM 3,4,5,15,16 SPM 4	Direct Infrastructure Building
Increase the number of youth with special health care needs who receive necessary services to transition to all aspects of adult life.	Yes	NPM 6	Enabling
Increase access to dental care.	Yes	NPM 3,4,5,9 SPM 6	Direct Infrastructure Building
Support community-based programs that strengthen parenting skills and promote healthy child and adolescent development.	Yes	NPM 2,5 SPM 1,3	Enabling Population-Based
Support the development of community-based systems that provide essential enabling services needed to improve health status.		NPM 5 SPM 1	Enabling Population-Based

Title V Priorities SFY 2011 – SFY 2015	Similar to SFY 2006 – 2010 Priority?	Current NPM Or Existing SPM?	MCH Pyramid Level
Improve the organization of community-based systems of care for children with special health care needs.	Yes	NPM 5 SPM 1	Enabling Infrastructure Building
Use population based services including health promotion and disease prevention interventions to improve health outcomes of the MCH population.		NPM 5,7,8,10,11,12,14,18 SPM 2,5,7	Population-Based
Ensure all children, including children with special health care needs, have access to a medical home and other health care providers through increased training, recruitment, and retention strategies.	Yes	NPM 3	Infrastructure Building
Promote the expansion of new or existing evidence-based interventions to address maternal and child health needs.			Infrastructure Building

Table 5-3. Priorities from SFY 2006 Five-Year Needs Assessment

Priorities from SFY 2006 Five-Year Needs Assessment
1. Increase partnerships with families of CSHCN in decision-making at all levels and family satisfaction with the services they receive.
2. Increase the number of CSHCN who receive coordinated, ongoing, comprehensive care within a medical home.
3. Reduction of institutionalized CSHCN.
4. Decrease adult obesity.

Priorities from SFY 2006 Five-Year Needs Assessment
5. Improve and expand healthcare infrastructure.
6. Decrease the number of women of childbearing age who smoke.
7. Decrease childhood obesity.
8. Increase access to dental care.
9. Reduce domestic violence.
10. Increase the number of youth with special health care needs who receive the services necessary to make transition to all aspects of adult life.
Additional priority need as noted in Form 14:
Improve the organization and coordination of community-based service systems for CSHCN and their families so that an increased number of families of CSHCN report that these systems are easy to use.

Generally, the SFY 2006 priority statements were too specific or did not represent the full scope of needs identified in the current assessment. While there may be criticism that the new priorities are either too broad or cannot be solely addressed through the efforts of Title V funding alone, they are meant to serve as a framework that can be used as a consistent guide for the future. The department's ability to respond to the rapidly-changing health care environment requires broad vision and flexibility. In an effort to reduce redundancy, some priorities were discontinued because they are already addressed as NPMs (e.g., NPMs 2, 3, 4, 5, and 6). The priority to increase access to dental care remains as the only priority from SFY 2006 to remain in the current list, primarily because of the consistent stakeholder feedback related to unmet needs in this area.

The 10 state priorities easily can be linked to the four service levels of the Title V Pyramid: Direct, Enabling, Population-Based, and Infrastructure Building. Some actually cover more than one level, as indicated in the last column of Table 5-2. All three MCH populations are included in the new priorities and aspects of prevention, primary care, and services for CYSHCN have been woven throughout the set.

In developing the following SPMs, the Needs Assessment Planning Group and Title V DSHS Partners worked together to create activity plans that would reflect the priorities and provide opportunities to focus on the use of existing resources:

- CYSHCN Congregate Care: Change in percentage of CSHCN living in congregate care settings as a percent of base year 2003.
- Childhood Obesity: Prevalence of obesity and overweight among school-aged children.
- Infant Mortality: Rate of excess feto-infant mortality in Texas.
- Tobacco Use: Proportion of women between the ages of 18 and 44 who are current cigarette smokers.
- Injury/Violence Prevention: Rate of preventable child death.
- Evidence-Based Programs: The extent to which research findings and evidence-based practices are used to develop and improve MCH programs, including social determinants of health.
- Mental Health/Substance Abuse: The extent to which programs enhance statewide capacity for public health approaches to mental and behavioral health for MCH populations.

Five of the seven are new or revised SPMs which will be combined with the existing NPMs to provide an ongoing assessment of progress in addressing the priorities.

As noted in Section 4: MCH Program Capacity by Pyramid Level, the capacity to address the priorities and needs of the MCH population in Texas includes challenges in available and sustainable funding, information technology, and untapped public/private/academic partnerships. These challenges will be explored further, and specific activities within the NPMs and SPMs will be developed to strengthen those areas within the context of the department's responsibilities as the public health agency, the potential changes in health care systems, and the state budget over the next five-year period.

SECTION 6: OUTCOME MEASURES – FEDERAL AND STATE

In SFY 2009, Texas met three of the six national outcomes measures concerning fetal, infant, and child mortality. Those met included the postneonatal mortality rate per 1,000 live births, the perinatal mortality rate per 1,000 live births plus fetal deaths, and the child death rate per 100,000 children aged 1-14. The remaining three outcome measures were not met, although there was improvement in two. The two unmet outcomes having improvement were the infant mortality rate per 1,000 live births and the neonatal mortality rate per 1,000 births. From 2005 to 2009, there was no change in the ratio of the Black infant mortality rate to the White infant mortality rate and a slight worsening in the ratio of the Black perinatal mortality rate to the White perinatal mortality rate. Table 6-1 compares the annual performance objectives and the annual indicators for Texas in 2009 for these measures.

Table 6-1. National and State Outcome Measures

Outcome Measure	Annual Performance Objective	Annual Indicator 2009
NOM 01: Infant mortality rate per 1,000 live births	5.5	5.8
NOM 02: Ratio of the Black infant mortality rate to the White infant mortality rate	1.7	2.6
NOM 03: Neonatal mortality rate per 1,000 live births	3.5	3.8
NOM 04: Postneonatal mortality rate per 1,000 live births	2.4	2.0
NOM 05: Perinatal mortality rate per 1,000 live births plus fetal deaths	8.9	5.2
NOM 06: Child death rate per 100,000 children aged 1-14	23.0	19.5
SOM 01: Ratio of the Black perinatal mortality rate to the White perinatal mortality rate	1.0	3.0

A review of the outcome measures that were met indicates that Texas has shown consistent improvement in mortality outcomes, once an infant moves out of the perinatal and neonatal states. Mortality decreased in children who are older than 28 days and those past infancy (>12 months). For the past five years, Texas has either met or exceeded the annual performance objective for postneonatal mortality rate. This may be attributed to a decrease in deaths due to Sudden Infant Death Syndrome (SIDS), improvements in the care of premature and low birth weight infants, and efforts to reduce preventable birth defects such as some neural tube defects. Additionally, for the

past five years, Texas either has met or exceeded the annual performance objective for child death rates. This improvement may be attributed to efforts, such as newborn screening, which through state mandated requirements assure that newborns are screened for several genetic disorders that can result in severe or fatal consequences if not detected and treated; Texas Health Steps, which provides early and periodic screening resulting in fewer adverse health outcomes; and the DSHS Safe Riders program that distributes child car safety seats, provides car seat safety checks, and education to parents and other community partners.

Improvements in infant mortality, neonatal mortality, and perinatal mortality may also be attributed to the same factors that led to improvement in the outcome measure for postneonatality rate; however, Texas needs to focus on factors that reduce the mortality of fetuses and very young infants (under 28 days). Activities planned to address national performance measures for breastfeeding, very low birth weight, and access to prenatal care all are expected to positively impact these outcome measures.

Very little change has occurred around outcome measures 2 and 7. The ratio of the Black infant mortality rate to the White infant mortality rate was exceptionally high in 2005, but stayed at constant levels across the remaining years. This spike may be due to limitations in small data sizes. Similarly, for the state outcome measure, there has been little change. Although it is not immediately clear why there has been no improvement for these outcomes, the Texas experience mirrors the national data. Prematurity, low birth weight, SIDS, and consequently, perinatal and infant mortality, continue to be disparately high in the Black population compared to the White and Hispanic populations. Current research into this disparity focuses on the Life Course Perspective, which considers a woman's health and well-being throughout her lifetime, with special emphasis on inflammation, infection, and stress as critical factors. While increasing the number of women who access adequate and early prenatal care is often considered to be the primary approach to reducing this disparity, this method will only work if the prenatal care incorporates an approachable format and meets the specific needs of the at-risk population.

Studies show that pregnant women suffer high rates of physical and/or emotional abuse with profound consequences, including miscarriage. Consequently, these activities also directly are linked to fetal and perinatal mortality and may be linked indirectly to the other outcome measures. The activities to address the percent of female clients suspected of being victims of relationship violence include increasing screening and referral for domestic violence, increasing the number of collaborations around domestic violence, and developing a webpage to educate and inform health care providers.

Some data indicate a link between obesity during pregnancy and the incidence of neural tube defects, some of which can be fatal or severely compromise the child. Also, some

data indicate that when the mother is obese, there is higher risk of prematurity, delivery complications and Cesarean delivery, all of which can potentially lead to increased perinatal, infant, neonatal, postneonatal, and child mortality. Furthermore, since the incidence is high among Black women, obesity can play a role in infant health disparity.

The activity plan to address the rate of obesity among women aged 18 and over includes collaborating with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to assess the effectiveness of the improved nutrition changes in food packages available to WIC clients as of October 1, 2009. Changes in the WIC food package may have a significant impact on this measure as they promote improved nutrition and breastfeeding. Increased attention to preconception care and a growing focus on policy and environmental change also will continue to improve in this measure.

Research shows a link between fetal exposure to alcohol, tobacco, and controlled substances and birth defects, mental retardation, prematurity, and low birth weight. All of these conditions can lead to increased perinatal, infant, neonatal, postneonatal, and child mortality. An increased focus on changing norms in the local community may have an impact on smoking prevalence in the third trimester. Through collaboration, DSHS implemented new distribution routes for existing smoking cessation tools, including developing and distributing health promotion messages and materials targeted to pregnant and parenting women and their families. These efforts are expected to positively impact these measures.

Infants who are breastfed from the time of hospital discharge through the first year of life experience less respiratory and gastrointestinal disease, leading to fewer life threatening illnesses. They are also less likely to die from SIDS. Research has shown that premature infants thrive best on breast milk, and often are released from the hospital sooner than their formula-fed counterparts. Breastfed premature babies are less likely to develop necrotizing enterocolitis (NEC), an often fatal gastrointestinal condition that destroys the intestinal tissue and which affects approximately 10% of VLBW babies. Data indicate that Black women have the lowest rate of breastfeeding, and increased breastfeeding by this population could be a factor in reducing the Black infant mortality disparity as well as improving these outcome measures. Activities such as working with hospitals to help them become Texas Ten Step hospitals that promote breastfeeding from birth, designing materials to promote breastfeeding specifically to Black families, and using peer counselors for outreach to promote breastfeeding may improve these outcome measures.

Very low birth weight (VLBW) babies face many challenges to survival throughout their first weeks of life, their first year, and into childhood. Some of these challenges include neurological and respiratory problems, NEC, cerebral palsy, and failure to thrive. VLBW

is almost always linked to prematurity, and while current practices have led to a reduction in the incidence of prematurity, Texas must address the clear disparities that exist for Blacks. Ultimately, reducing prematurity and consequently VLBW will most likely require broad societal changes that reduce poverty, assure a medical home for each person, and minimize stress factors resulting from societal issues such as poverty and racism. The activity plan for reducing the number of VLBW births in Texas focuses on understanding why these births occur, the populations that are at greater risk, and the contributing socioeconomic risk factors.

Women and teens with unintended pregnancies may delay prenatal care, which may affect the health of both infants and mothers. Women of all ages may have unintended pregnancies, but some groups, such as teens, are at a higher risk. Teen mothers are more likely than mothers over age 20 to give birth prematurely. In 2006, the 914 adolescents between 10 and 14 years old who gave birth in Texas were nearly twice as likely to deliver prematurely as women ages 30 to 34 (20.0% and 13.1%, respectively). Activities to reduce births for teens aged 15-17 include a collaborative research project to identify the knowledge, attitudes, and beliefs of adolescents and young adults, both parenting and non-parenting males and females, and parents of adolescents to help inform the development of interventions to prevent adolescent pregnancy. These activities are intended to impact the outcome measures of infant mortality, perinatal mortality, neonatal mortality, the ratio of Black infant mortality to White infant mortality, and the child death rate for ages 1-14.

Another factor that can improve outcome measures is if VLBW infants are born in specialized facilities that have the experience, expertise, and equipment necessary to effectively care for them. Identifying women at higher risk for delivering VLBW babies and ensuring delivery in specialized facilities reduces the risks incurred by delays in transport or by the mode of transport. The activity plan for increasing the number of VLBW infants born at appropriate facilities is developing a process to facilitate the appropriate referral of at-risk women to facilities involved a study linking maternal and fetal/infant demographic information from fetal death and infant birth certificates with delivery hospital information. This study found that while greater proportions of Black women accessed sub-specialty care, Black women were transferred to higher levels of care in the smallest proportions. Texas must develop perinatal regionalization strategies, building upon further research into the racial/ethnic differences in access and utilization of high-level obstetrical care to make improvements to these measures.

Improving access to prenatal care and ensuring that the care is high quality, culturally competent, and meaningful may also play a role in improving outcome measures. Part of the activity plan for increasing the number of infants born to pregnant women receiving prenatal care beginning in the first trimester proposes to promote perinatal benefits through the Children's Health Insurance Program (CHIP). In January 2007,

Texas became the ninth state to extend CHIP benefits to the unborn children of pregnant women who are ineligible for Medicaid. Numerous barriers exist in Texas to accessing prenatal care in a timely manner, including lack of easy access to care, lack of providers, transportation issues, and cultural norms. Minimization or reduction of barriers to access for prenatal care is the intent of these activities.

NEEDS ASSESSMENT SUMMARY

In conducting the SFY 2011 Title V Five-Year Needs Assessment, DSHS made considerable efforts to ensure that stakeholder input was direct and inclusive of as many partners, providers, consumers, and other stakeholders interested and impacted by MCH issues as possible. The process incorporated a wide variety of methods and venues to gather input from and establish ongoing communication with stakeholders: community meetings, state-level meetings, group presentations, web-based surveys, facilitated exercises, email communication, newsletter articles, and website information.

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

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

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

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

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

Due in part to the changes in methodology for conducting the SFY 2011Five-Year Needs Assessment, the priority needs have changed from those identified in SFY 2006. While there appear to be differences in the two lists, the majority of priorities identified in SFY 2006 are embodied under the new priority statements, even if they are not spelled out specifically. The new priorities are meant to serve as a framework that can be used as a guide for the future. This flexibility will allow DSHS to adapt Title V activities to meet new requirements resulting from actions such as possible state budget reductions and/or federal health care reform.

Note that the basic format and structure of the Title V Five-Year Needs Assessment document is defined by the Health Resources and Services Administration of the U.S. Department of Health and Human Services in federal guidance. The guidance document is available for review at ftp://ftp.hrsa.gov/mchb/blockgrant/bgguideforms.pdf.

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