Maternal and Child Health Services Title V Block Grant

Texas

FY 2022 Application/ FY 2020 Annual Report

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Table of Contents

I. General Requirements

I.A. Letter of Transmittal

Texas Department of State Health Services

John Hellerstedt, M.D.
Commissioner

September 1, 2021

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

To Whom It May Concern:

As Associate Commissioner of the Community Health Improvement Division at the Texas Department of State Health Services, I hereby submit this letter to apply for the Maternal and Child Health Services Title V Block Grant funds for federal fiscal year 2022. The online application has been completed in accordance with this year's grant guidance.

Should you have questions or need additional information, please contact Jeremy Triplett, Title V Maternal and Child Health Director, at 512-776-2567, or me at 512-776-7321. Thank you for your consideration and review of the Texas Maternal and Child Health Services Title V Block Grant Application for FY 2022 and Annual Report for FY 2020.

Sincerely,

Manda Hall, MD

Manda Hall, MD, Associate Commissioner
Community Health Improvement Division
Texas Department of State Health Services

Attachment

P.O. Box 149347 • Austin, Texas 78714-9347 • Phone: 888-963-7111 • TTY: 800-735-2889 • *www.dshs.texas.gov*

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Through the implementation of data-driven, evidence-based/informed initiatives, Texas remains committed to the Title V vision of improving the health and well-being of the nation's mothers, infants, children and youth, including children and youth with special health care needs (CYSHCN) and their families. Texas continues to emphasize ongoing surveillance, needs assessment, evaluation, and research for programming throughout the lifecourse. Texas focuses on enhancing family partnerships, addressing community-level drivers, and reducing health disparities in all population domains. State priorities to support this vision reflect the specific needs identified through a comprehensive five-year needs assessment (NA). The Texas Department of State Health Services (DSHS) recently completed this NA, which informed the State Priority Needs (SPNs), National Performance Measures (NPMs), and State Performance Measures (SPMs).

The Texas Title V MCH NA consisted of a four-pronged approach for data collection and analysis and included surveys, key informant interviews, focus groups, and analysis of existing data and surveillance data. Through collaboration and engagement with Maternal and Child Health (MCH) stakeholders and families, Texas DSHS worked to ensure that there was broad representation of the diverse experiences, populations, regions, and needs that reflect the diversity of Texas. The State Priority Needs that were identified through analysis of the Needs Assessment findings and through partner feedback are:

1. Implement health equity strategies across all maternal and child health populations.
2. Improve nutrition across the life course.
3. Improve the cognitive, behavioral, physical, and mental health and development of all MCH populations.
4. Increase family support and ensure integration of family engagement across all MCH programming.
5. Support health education and resources for families and providers.
6. Promote safe, stable, nurturing environments to reduce violence and the risk of injury.
7. Improve transition planning and support services for children, adolescents, and young adults, including those with special health care needs.
8. Support comprehensive, family-centered, coordinated care within a medical home model for all MCH populations.
9. Improve maternal and infant health outcomes through enhanced health and safety efforts.

Based on the Needs Assessment findings, Texas selected the following NPMs and developed the following SPMs for the FY21-FY25 Title V MCH Block Grant cycle:

Through National Performance Measures (NPMs), Texas is focusing on breastfeeding, safe sleep, developmental screening, injury prevention, medical home and transition for children with special health care needs, and maternal and household smoking. State Performance Measures (SPMs) include community inclusion for CYSHCN, child obesity, infant mortality disparities, maternal morbidity disparities, and maternal health and safety. Though many of the performance measures remain the same from the previous five-year cycle, the strategies, activities, and programming have evolved and will continue to see enhancements throughout the coming years due to ongoing evaluation and needs assessments. Family Partnerships, Community-Level Drivers, and Health Disparities and Inequities remain a focus of all areas of Title V programming and serve as the foundation of efforts to move the needle for all MCH populations in Texas.

Texas MCH provides education, awareness, support and resources to improve the health of women, infants, children, adolescents, and children and youth with special healthcare needs (CYSHCN) throughout Texas. For regional population-based activities, critical partnerships inform the development and implementation of precision public health activities in local areas by focusing on data, state and national priorities, and community needs to prioritize and determine local initiatives.

As COVID-19 continues to affect the lives of Texans, Texas Title V has played a critical role in supporting families, assisting with state public health follow-up efforts, and providing essential data and epidemiology supports to agency and state leadership.

Maternal and Women's Health

There continues to be a focus on severe maternal morbidity and maternal mortality. DSHS has made progress in building infrastructure and capacity to promote prenatal care, health, and wellness among women of child bearing age (WCBA) through the efforts of women's health programming and other statewide initiatives, such as the Maternal Mortality and Morbidity Review Committee (MMMRC) and Healthy Texas Mothers and Babies (HTMB). The MMMRC is a 17-member group that is legislatively mandated to study maternal mortality and morbidity in Texas. Through HTMB, Texas aims to improve maternal and infant health by advancing quality and evidence-based prevention for all Texas mothers and babies. HTMB engages community partners to strengthen networks for collaboration, innovation, and collective impact through local community coalitions and workgroups. The HTMB Perinatal Quality Improvement Network drives system changes to support adoption and diffusion of quality improvements for maternal and infant health and safety. This is accomplished through the MMMRC, the Texas Collaborative for Healthy Mothers and Babies (TCHMB), and the Texas Ten Step Star Achiever Initiative to improve maternity care practices in birthing facilities.

DSHS was designated as the lead coordinating agency to implement Alliance for Innovation on Maternal Health (AIM) bundles. The TexasAIM initiative was launched in June 2018. Nearly all of Texas' hospitals with obstetric lines of service are enrolled in TexasAIM and participate in the Obstetric Hemorrhage Bundle. These hospitals represent approximately 98% of all the birthing hospitals in Texas and provide care for approximately 99% of the births in Texas and approximately 9.9% of the births in the nation. As of August 2021 there are 208 hospitals enrolled TexasAIM Hypertension bundle representing 94% of Texas birthing hospitals in Texas.

DSHS continues outreach efforts through collaboration with partners to educate the public on risks of tobacco exposure among pregnant women and children. DSHS incorporates tobacco prevention messaging into clinical policy, provider and Community Health Worker training, and other platforms.

Perinatal/Infant Health

Texas continues to develop, implement, and evaluate comprehensive programs to address known barriers to and increase support for breastfeeding. DSHS implements a robust slate of activities to leverage and build upon previous successes and to address known barriers to breastfeeding. The number of Texas Mother-Friendly Worksites, Texas Ten Step Hospitals, and Baby-Friendly Hospitals continues to grow as DSHS reaches across employment and health care systems to provide information, education, communication, and technical assistance to facilitate system improvement as well as recognition for uptake of recommended practices. More than 85% of Texas births now occur in facilities working to improve utilization of the Ten Steps to Successful Breastfeeding, an evidence-based bundle of practices to improve infant feeding and infant health outcomes.

Texas NA data shows disparities in sleep-related infant deaths. DSHS and the Texas Department of Family and Protective Services (DFPS) continue to work together to address preventable child deaths through development of an interagency strategic communications plan. DSHS drafted a strategic communication plan informed by the American Academy of Pediatrics, the national Safe to Sleep campaign, and the National Action Partnership to Promote Safe Sleep.

Although Texas has made progress in reducing infant mortality, data continues to show disparities between Black and White birth outcomes. Texas developed a SPM to reduce the ratio of White and Black infant mortality by addressing safe sleep, breastfeeding, timely prenatal care, and access to and awareness of other public health interventions among Black women in Texas.

Child Health

Child Health initiatives focus on developmental screening, injury prevention, secondhand smoke reduction, and obesity prevention. Developmental screening is a priority in Texas, as 63% of report that they did not complete a developmental screening with their doctor for their child. MCH will lead Help Me Grow Texas (HMGTX), a statewide network of partners working together to build strong, connected communities and healthy, resilient families. HMGTX promotes early identification of developmental concerns, then links children and families to community-based services.

Injury prevention is a large component of both the Child and Adolescent Health Domains. Child injury continues to be one of the leading causes of death for children aged 1 to 14 years of age, and non-natural child deaths frequently involve motor vehicle crashes, drowning, and child abuse and neglect. Title V administers programs including Child Fatality Review (CFR) to understand child deaths through multidisciplinary review on the local level.

Obesity is at the heart of many health issues in Texas across the lifespan. Obesity prevention interventions have the potential to greatly reduce disease burden and improve the overall health of Texans. Expansion and increased use of School Physical Activity Nutrition (SPAN) data to inform population-based and targeted prevention/intervention for obesity reduction will be critical for success.

Reducing secondhand smoke exposure is important throughout the life course. Through collaborative partnerships with the DSHS Tobacco Prevention and Control Program, MCH populations are educated on the health effects of secondhand smoke exposure, especially in pregnant women and children.

Adolescent Health

By utilizing Positive Youth Development (PYD) as a foundation for activities, DSHS will continue to focus on injury prevention. DSHS sponsors a Youth Engagement Specialist to support youth interested in becoming leaders within their community, region or state through participation in councils, workgroups and committees. DSHS supports suicide and self-injury prevention initiatives. Through injury prevention efforts, conferences, and Child Fatality Review Team trainings, DSHS works to promote collaboration and best practice sharing among injury prevention professionals to reduce injuries and hospitalizations. DSHS leads statewide initiatives and partners with clinic-based contractors to address these priorities by supporting youth-friendly improvement activities and incorporating best practice as it pertains to obesity, screening and referral of high risk issues.

Children with Special Health Care Needs (CSHCN)

The CSHCN Systems Development Group (SDG) works to strengthen community-based services to improve systems of care for CSHCN, including clients receiving health care benefits through the State's CSHCN Health Care Benefits Program. The SDG focuses on meeting federal expectations regarding overarching health care systems components for CSHCN, including establishing medical homes, promoting community inclusion, and planning for the transition to adulthood, including transitioning to adult health care. The Family Delegate for Texas and Texas Parent to Parent are included in program activities to ensure the family voice is included in the development and implementation of CSHCN programming.

Texas leads the Medical Home Learning Collaborative (MHLC), which meets quarterly to exchange best practice resources on implementation of medical home. The MHLC also develops community-based initiatives and collaborates with DSHS regional staff to assist with connecting CSHCN and their families to a medical home. The

Children with Medical Complexity CoIIN is a multistate collaborative focused on the population of CSHCN with the greatest medical needs. DSHS formed a state team to engage in quality improvement focused on a cohort of children with medical complexity in Texas.

The SDG develops community-based initiatives to ensure that communities are welcoming, inclusive, and supportive to minimize the sense of isolation experienced by many CSHCN and their families. The SDG developed a transition toolkit and educational resources for families and providers to ensure that all CSHCN are transitioning to adulthood with appropriate supports in place. Community-based initiatives include transition workshops, conferences, and collaboration with DSHS regional staff to prepare families for transition and connect youth with special health care needs to adult services.

To promulgate progress and improve outcomes related to these initiatives, Texas strives to maintain the MCH infrastructure, capacity, and subject matter expertise across all population health domains. For more information on MCH efforts in Texas, please visit http://www.dshs.texas.gov/mch/.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

Texas continues to strategically use Title V funds to ensure statewide maternal and child health (MCH) needs are being addressed. The Department of State Health Services (DSHS) is Texas' public health agency and improving the lives of women and children, including children with special needs, is a priority. The work of Title V is driven by State and National Performance Measures, and guided by the State Priority Needs that were identified during the statewide needs assessment. Ongoing evaluation allows for flexibility in programming and responsiveness to emerging issues, such as COVID-19. As COVID-19 continues to affect the lives of Texans, Title V works to identify MCH needs, support families, and adapt programming and operations as needed. Title V values stakeholder and community engagement, and strives to strengthen partnerships to advance MCH programming throughout Texas, and improve MCH health outcomes. Title V is situated organizationally within DSHS to align with other sections that focus on MCH, such as Health Promotion and Chronic Disease Prevention, Environmental Epidemiology and Disease Registries, and Vital Statistics. Title V also staffs over 90 personnel throughout the Texas Public Health Regions to identify local community needs and develop solutions for improvement. Finally, Title V ensures that a continual and comprehensive review of finances and programming is in place so that utilization of Title V MCH Block Grant funds is methodical and reflects the needs of Texas.

III.A.3. MCH Success Story

The COVID-19 pandemic continues to bring global challenges and disruptions which affect the lives of all Texans. From the beginning, Texas Title V has played a critical role in supporting families and providing essential expertise and epidemiology (EPI) supports to agency and state leadership. Flexibility is at the core the Texas Title V COVID-19 response success. Texas Title V team members have demonstrated a fervent commitment to supporting Texans through the pandemic as well as continuing to provide needed services to MCH populations throughout the state. MCH has pivoted many programs to address specific needs for families related to COVID-19. This includes providing Texas regions with additional Title V funds to increase staff that help with isolation supports in communities across the state, and allowing provisions in its contracts to provide additional support and resources for families, including one-time payments for families in crisis to help pay for food, clothing, transportation, home and medical supplies, and other basic needs.

Texas Title V also continues to support the state's overall COVID-19 response effort in multiple ways, including the provision of EPI support, communications, subject matter expertise, and resources. MCH EPI expertise has been used to track cases through public health follow-up, as well as provide research and statistical analysis for the agency. The MCH EPI team has also begun to assess the effects of COVID-19 in families through surveys as part of our on-going needs assessment. MCH staff continues to work with DSHS Communications and other partners to ensure relevant, reliable information and resources to help inform the general public on many aspects of COVID-19. Teams have collaborated with stakeholders and partners to create and disseminate targeted information to families.

Texas Title V continues to support families and provide education, awareness, support and resources to improve the health of women, infants, children, adolescents, and children and youth with special healthcare needs (CYSHCN) throughout Texas. MCH participates in multi-disciplinary workgroups and continues to strategically prioritizes efforts. MCH continues to provide resources and guidance to its Community Based Contractors, who provide case management to families who have children with special healthcare needs. This includes emergency planning, counseling and coordination of healthcare treatment plans.

Texas Title V will continue to monitor the health and wellbeing of all MCH populations and will retain the flexibility and expertise to address new challenges with COVID-19, as well as other emerging issues that arise.

III.B. Overview of the State

Overview of the State

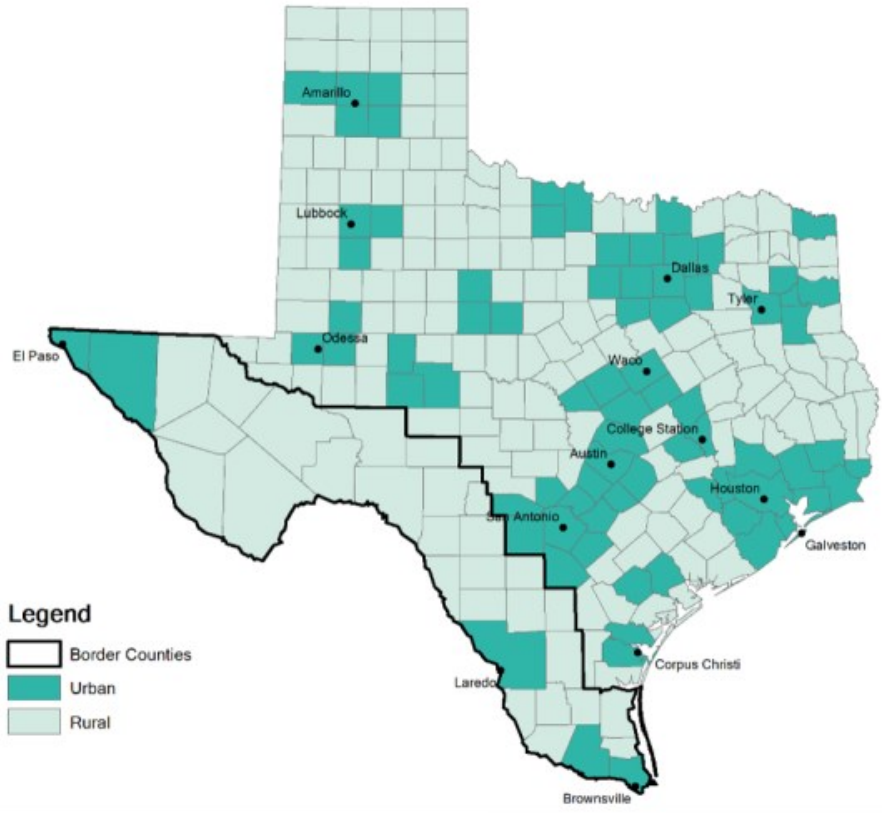
Texas is a vast state, with regional differences in geography, population size, and demographic and socioeconomic characteristics. This section provides an overview of these variations and the existing challenges related to health care availability and access, as well as cultural literacy and effectiveness in meeting the health needs of Texas mothers, children, and their families.

Geography

Texas is the second largest state in the United States (behind Alaska) in terms of land. The Lone Star State encompasses approximately 262,000 square miles, and accounts for 7.4 percent of the total United States land area. The land area of Texas is equal to that of all six New England states and Ohio, New York, Pennsylvania, and North Carolina combined [[1]]. Texas has a larger land area than any single country completely contained in Europe including France and the Ukraine. Texas is slightly longer than it is wide, with the greatest straight-line distance from the northwest edge of the Panhandle to the southern tip of Texas below Brownsville on the Rio Grande spanning 801 miles [[2]]. The broadest expanse from east to west is 773 miles from the Sabine River in Newton County to the western bulge of the Rio Grande just above El Paso [2].

The geography of Texas is as varied as it is large. Texas includes 254 counties that are classified as either rural or urban (Figure 1), with 88.4 percent of the population residing in urban counties. The five largest metropolitan areas in Texas are located around the cities of Houston, San Antonio, Dallas, Austin, and Fort Worth, and these areas encompass multiple counties. Given the immense size of Texas, the distance that some individuals must travel to receive health care services can be a significant challenge to accessing and receiving those services, especially for those living in rural counties (Figure 1).

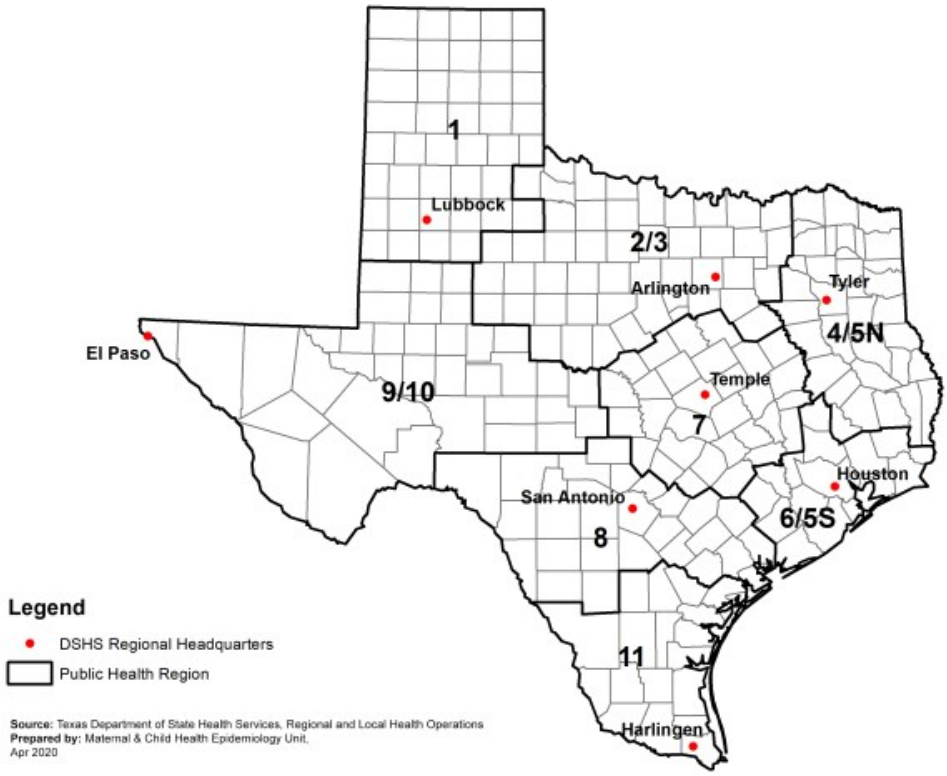
Figure 1. Rural and Urban County Designations in Texas, 2020.



Source: United States Census Delineation Files, March 2020
Prepared by: Maternal and Child Health Epidemiology Unit
March 2021

For administrative purposes, each of the 254 Texas counties is assigned to one of 8 public health regions. Figure 2 outlines the eight public health regions and the city where each regional office is located. Regions 8, 9/10, and 11 contain border counties.

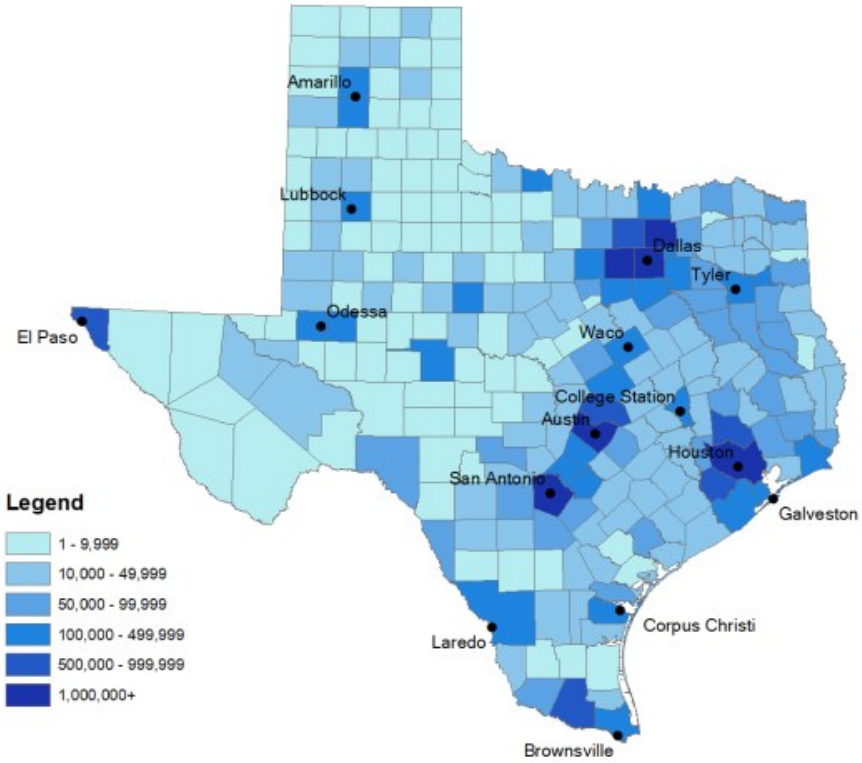
Figure 2. Texas Public Health Regions.



Population

Just as the Texas geography is varied, so is the distribution of its population (Figure 3). Differences in race/ethnic composition, along with the high percentage of foreign-born residents, present cultural literacy and effectiveness challenges when it comes to meeting maternal and child health (MCH) needs.

Figure 3. Texas Total Population by County, 2019.

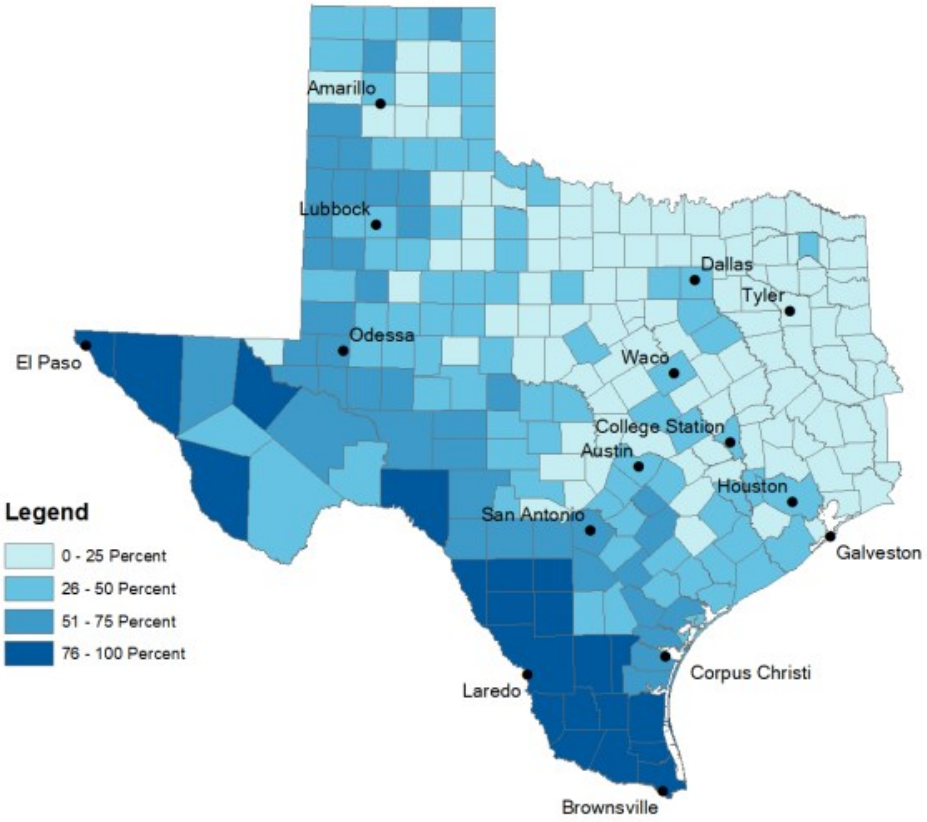


Texas also has the second-largest population size in the United States (behind California), with an estimated population of over 29 million in 2019. According to United States Census annual estimates, Texas has been one of the fastest-growing states in the nation since 2010, with a 14.9 percent increase in the Texas population from 2010 to 2019. The Texas Demographic Center predicts that by 2050, the population in Texas will exceed 47 million people [[3]]. The majority of Texans live in the northeast, east, central, south, and gulf coast regions of the state (Figure 3).

Race/Ethnicity

The population of Texas is racially/ethnically diverse with 41.8 percent non-Hispanic White (hereafter referred to as White in the text and graphs), 39.3 percent is Hispanic, 11.8 percent is non-Hispanic Black (hereafter referred to as Black), 4.8 percent is non-Hispanic Asian (hereafter referred to as Asian), and 2.2 percent is non-Hispanic Other in 2019 (data not shown) [3]. Counties with the highest proportions of Hispanic populations are primarily located in the southern and western regions of Texas along the Texas-Mexico border. In 2019, three major cities in Texas (Brownsville, Laredo, and El Paso) were located in counties where over 75 percent of the population was Hispanic, and another three cities (San Antonio, Corpus Christi, and Odessa) were located in counties where over 50 percent of the population was Hispanic (Figure 4).

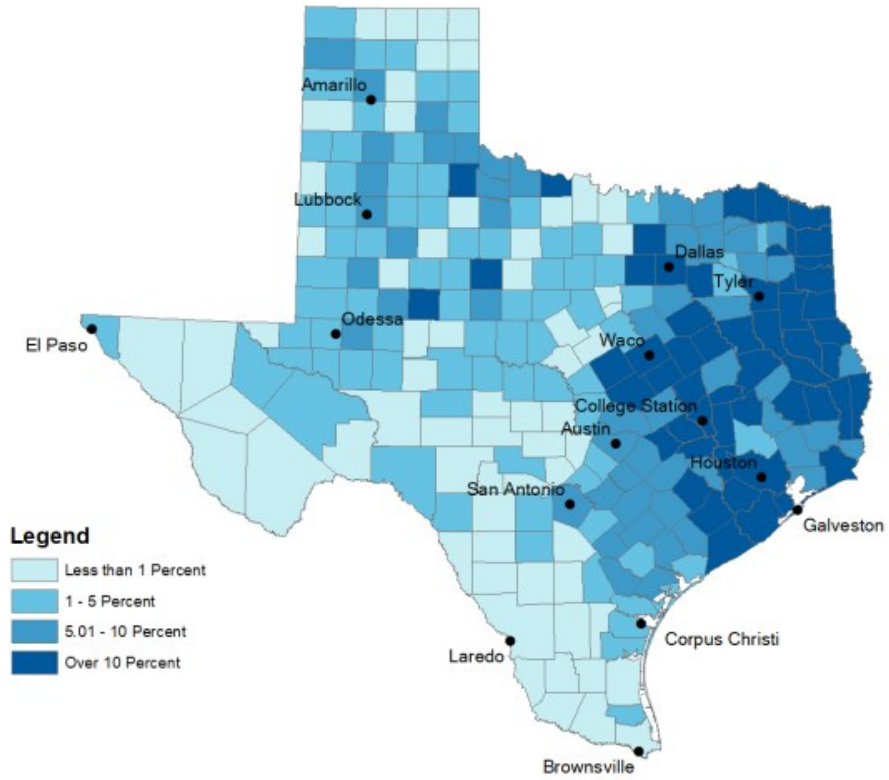
Figure 4. Percent of the Texas Population who are Hispanic or Latino by County, 2019.



Source: 2019 Texas Population Estimates Program, Texas Demographic Center
Prepared by: Maternal and Child Health Epidemiology Unit
Mar 2021

The distribution of the Black population in Texas (Figure 5) differed from that of the Hispanic population. Based on 2019 Texas Demographic Center data, counties with the highest proportions of Black populations were largely concentrated in the northeastern, eastern, and north gulf-coast regions of the state. In contrast to the Hispanic population, the Black population along the Texas-Mexico border was low and estimated to be slightly above 38,000 in 2019.

Figure 5. Percent of the Texas Population who are Black by County, 2019.

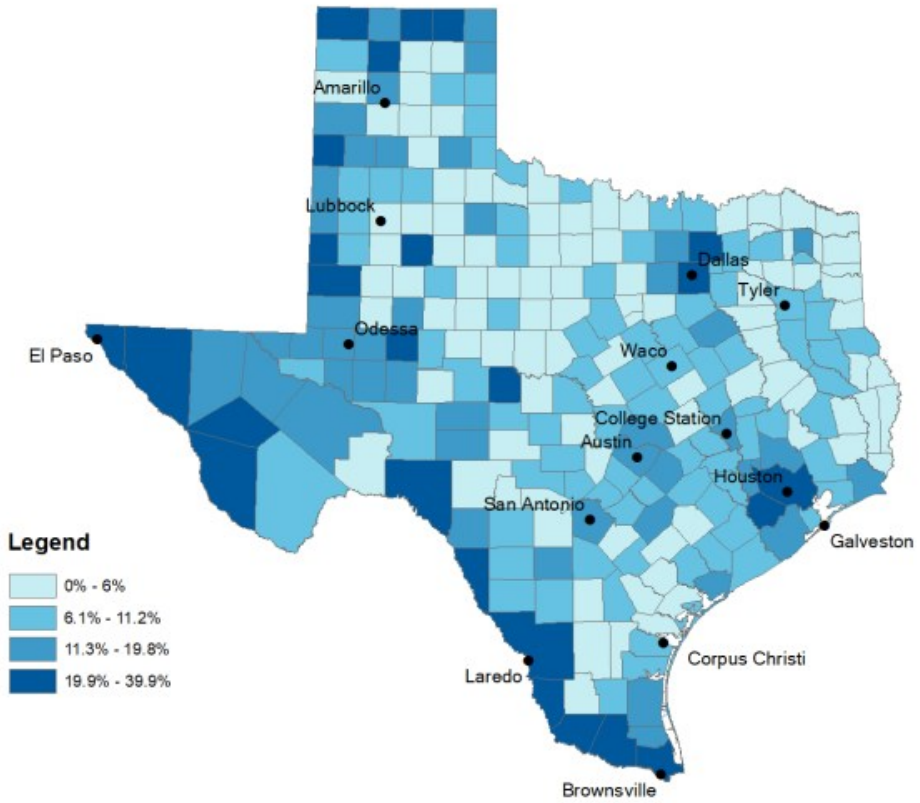


Source: 2019 Texas Population Estimates Program, Texas Demographic Center
Prepared by: Maternal and Child Health Epidemiology Unit
Mar 2021

Foreign-Born

Texas had a higher percentage of foreign-born residents (17.1 percent) compared to the nationwide average (13.7 percent) in 2019. In total, 60.4 percent of foreign-born residents in Texas were not United States citizens. Over 67.4 percent of foreign-born Texas residents were born in Latin American countries – more than 16 percentage points over the national average [[4], [5]]. Approximately 35.6 percent of Texans spoke a language other than English at home in 2019. Almost 30 percent of Texans spoke Spanish at home, compared with 13.5 percent of United States residents [[6]]. Texas border counties had high percentages of foreign-born residents in 2015-2019, as did several other counties in west and northwest Texas (Figure 6). Counties containing the non-border cities of Houston, Dallas, and Austin also had high concentrations of foreign-born residents. Given these demographic and social variations, the Texas Department of State Health Services' (DSHS) Community Health Worker (CHW) program has increased the number of certified CHWs to address the need for cultural literacy and effectiveness [[7]].

Figure 6. Percent of the Texas Population who are Foreign Born by County, 2015-2019.



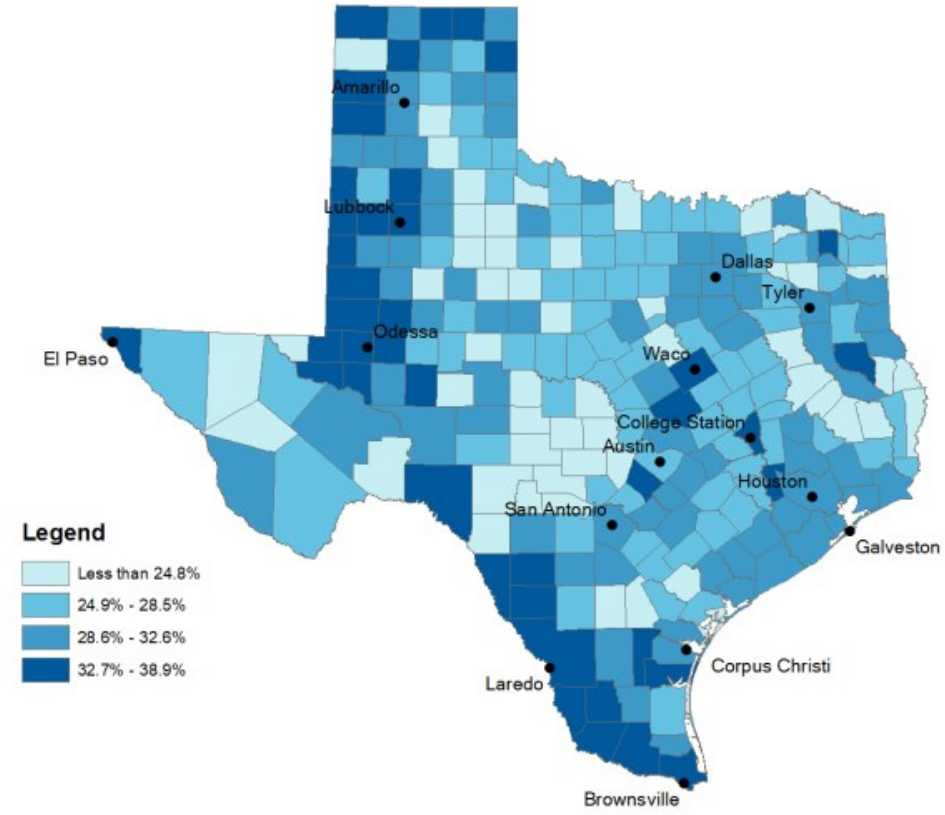
Source: U.S. Census Bureau, American Community Survey, 2015-2019
Prepared by: Maternal and Child Health Epidemiology Unit
Mar 2021

Age

According to 2019 American Community Survey 1-year estimates, Texas is the second youngest population in the United States, with a median age of 35.1 years, behind Utah (median age 31.2 years) [[8]].

In 2019, Texas had the second largest proportion of the population comprised of children younger than 18 years old (25.5 percent) in the nation [[9]]. About 6.8 percent of the Texas population were younger than five years old, 14.4 percent were five to 14 years old, and 4.3 percent were 15 to 17 years old. Texans younger than 22 years of age accounted for 31.2 percent of the total population in 2019. Border counties in South Texas had high percentages of individuals younger than 22 years old, as did several counties in the Texas Panhandle (Figure 7) [[10]].

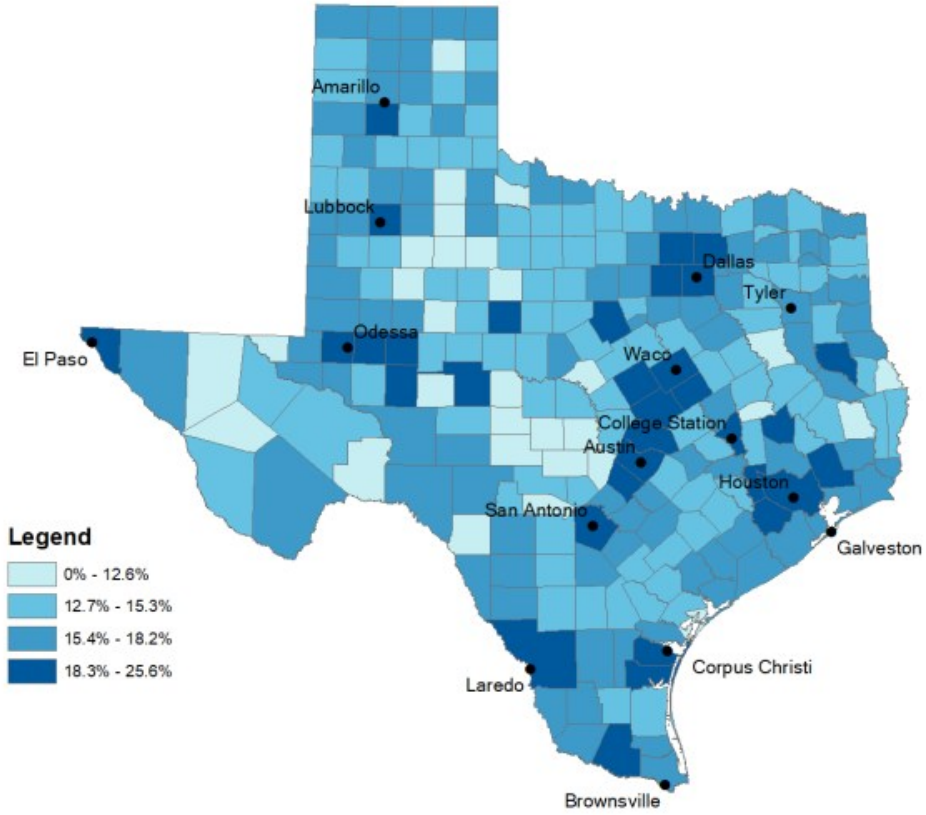
Figure 7. Percent of the Texas Population Under 22 Years Old by County, 2019.



Source: 2019 Texas Population Estimates Program, Texas Demographic Center
Prepared by: Maternal and Child Health Epidemiology Unit
Mar 2021

Women comprised half of the total population in Texas in 2019, and women of childbearing age comprise an important part of the population. Women between 18 and 44 years of age accounted for 18.7 percent of the total population of Texas [10]. For the most part, urban counties with large metropolitan areas (including counties containing the cities of Dallas-Fort Worth, Houston, San Antonio, Austin, and El Paso) had the highest proportions of women in their childbearing years (Figure 8).

Figure 8. Percent of the Texas Population Who Are 18-44 Years Old and Female by County, 2019.



Source: 2019 Texas Population Estimates Program, Texas Demographic Center
Prepared by: Maternal and Child Health Epidemiology Unit
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Children with Special Health Care Needs

The 2019 National Survey of Children's Health (NSCH) estimated that 15.8 percent of Texas children ages 0-17 had a special health care need. Of those Texas children identified as Children with Special Health Care Needs (CSHCN), 47.0 percent were White, 37.9 percent were Hispanic, and 8.7 percent were Black [[11]].

Socioeconomic Characteristics

Socioeconomic characteristics such as income and poverty, food security, education, unemployment, and crime rates are added challenges for meeting the health needs of mothers, children, and families in Texas. The presence of an increased number of risk factors of this nature in a community pose a danger to the health of the individuals within that community throughout the entire life course.

Income and Poverty

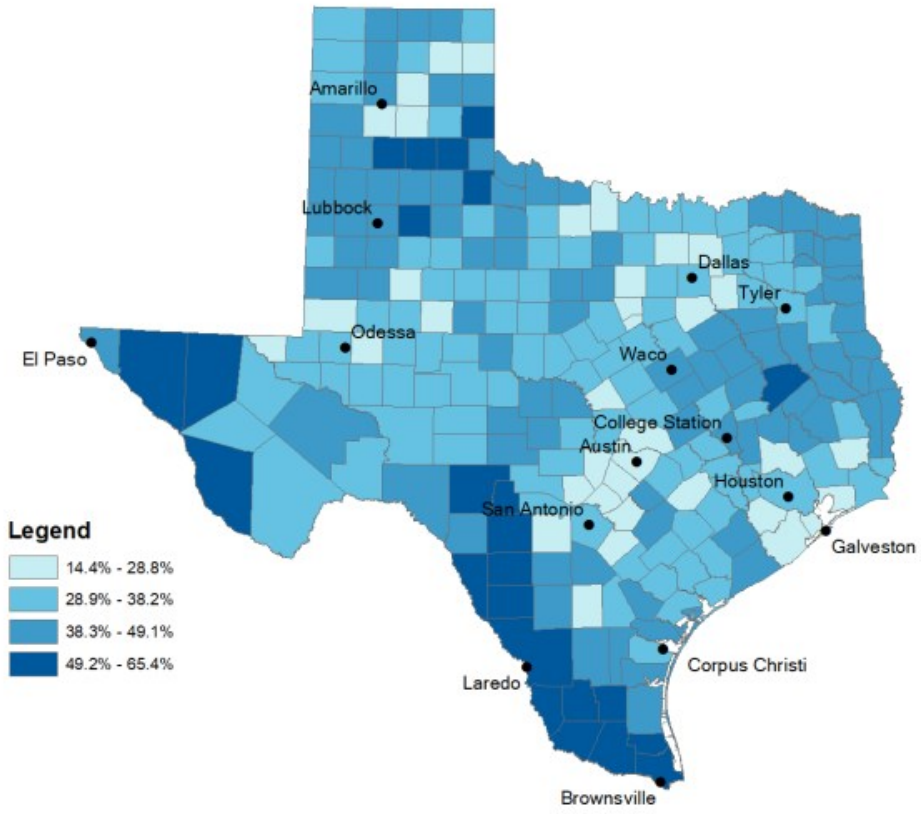
Income inequalities exist within different areas in Texas and largely reflect gender and race/ethnic differences. In 2019, the median household income in Texas was $61,874, which was slightly lower than the national median household income of $62,843 [8].

The Federal Poverty Level (FPL) is set by the United States Census Bureau based on income thresholds that vary by family size and composition. If a family's total income is less than their determined income threshold, then that family and every individual in it is considered to be in poverty. These poverty thresholds are used throughout the mainland United States and do not vary geographically; however, they are updated each year to account for inflation. According to 2019 American

Community Survey estimates, Texas had a higher proportion (13.6 percent) of people living below the FPL than the national average of 12.3 percent [8].

The proportion of adults living below the FPL varies geographically and by sex. Among the adult population aged 18 and older in Texas, counties with a large proportion of adults living below the FPL in 2015-2019 were concentrated in the Texas-Mexico border region. Several counties in east Texas, north central Texas, and the Texas Panhandle also had high rates of adults living below 200 percent FPL (Figure 9).

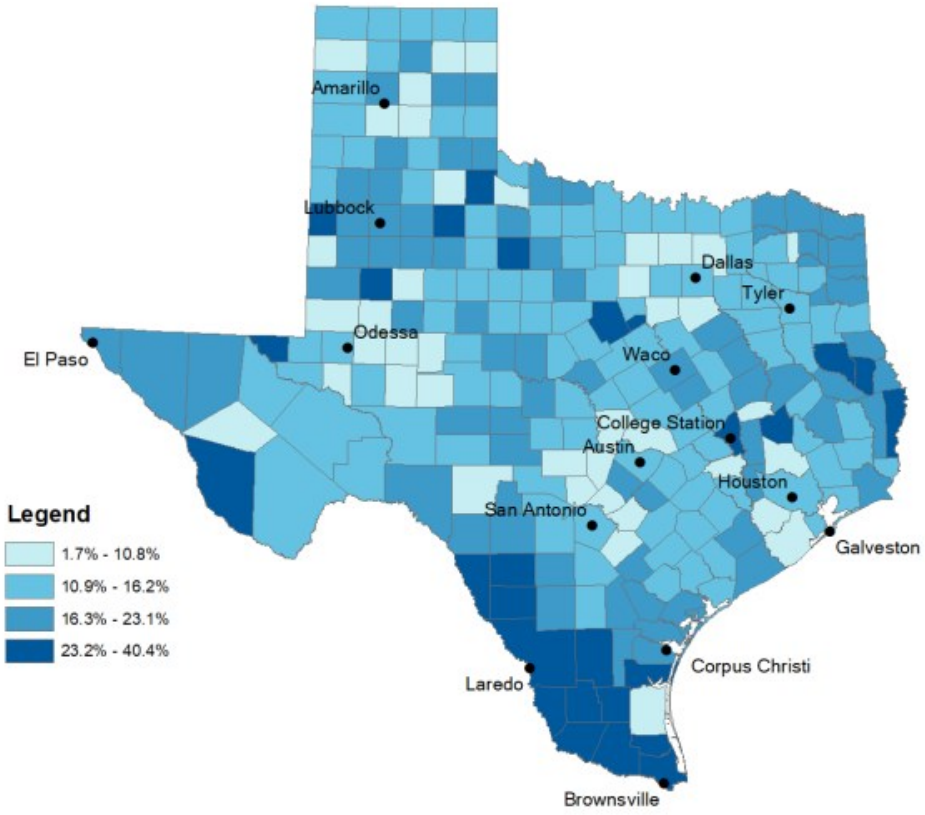
Figure 9. Percent of the Texas Adult Population Below 200 Percent Federal Poverty Level by County, 2015-2019.



Source: U.S. Census Bureau, American Community Survey, 2015-2019
Prepared by: Maternal and Child Health Epidemiology Unit
Mar 2021

It was estimated that about 15.0 percent of the female population lived below the FPL in Texas in 2019 [[12]]. Counties in the Texas-Mexico border region had high rates of women living below the FPL, as did several counties in rural East Texas, west of Fort Worth. The fastest growing major metropolitan areas – Austin, Houston, and San Antonio – had a relatively low proportion of women living below the FPL (Figure 10).

Figure 10. Estimated Percent of the Texas Adult Female Population Below 100 Percent Federal Poverty Level by County, 2015-2019.



Source: U.S. Census Bureau, American Community Survey, 2015-2019
Prepared by: Maternal and Child Health Epidemiology Unit
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Food Security

Food security refers to a household's ability to provide enough food to keep each member of the family active and healthy. Along with negative health outcomes, food insecurity can make it difficult for children to learn and grow [[13]]. Overall, the food insecurity rate in the United States is an estimated 12.5 percent of the total population and 17.0 percent of children. As of 2018, 22.5 percent, nearly one in four children in Texas live in a food insecure household. There are eight counties in Texas where 30 percent or more children experience food insecurity (data not shown) [[14]].

Education

As higher educational attainment has been associated with positive health outcomes, it is crucial to understand education within the context of Texas [[15]]. Among those 25 years and older, a greater percentage of both men (15.9 percent) and women (14.8 percent) in Texas had less than a high school education in 2019, compared with men (12.1 percent) and women (10.8 percent) nationwide. About 25 percent of Texas residents aged 25 and older had a high school diploma or equivalent as their highest level of educational attainment, and 20 percent had a bachelor's degree or higher [9].

Educational attainment levels are not evenly distributed throughout the state. There were four counties where the educational attainment of a bachelor's degree or higher was greater than 45 percent among individuals 25 years of age and older: Denton and Collin counties outside of Dallas, Fort Bend county outside of Houston, and Travis county in central Texas (part of the Austin-Round Rock metropolitan area). Counties where less than 10 percent of the people aged 25 years and older had a bachelor's degree or higher were largely clustered in south Texas, west Texas, and east Texas [8].

Unemployment

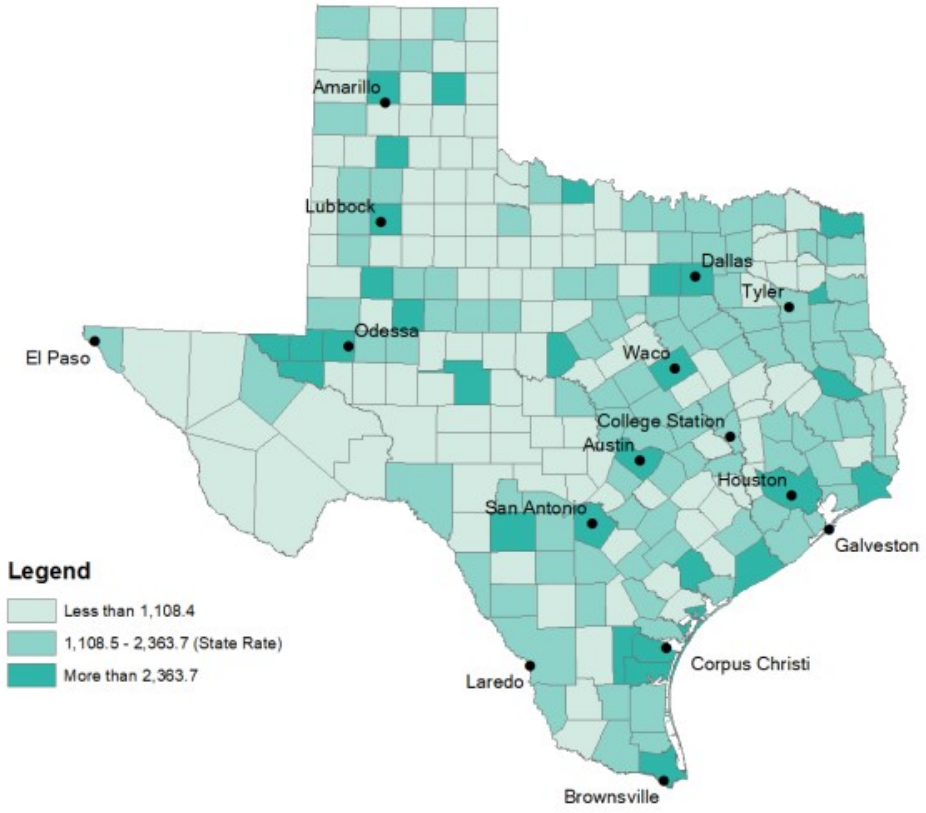
While Texas had a higher percentage of adults without a high school diploma compared to the nation, it had about the same rate of unemployment (4.4 percent) as seen nationwide (4.5 percent) in 2019 [8]. Even among persons aged 25-64 without a high school diploma, Texas had a lower rate of unemployment (4.4 percent) compared to the national average for this educational attainment group (6.7 percent). Consistent with nationwide trends, the Texas unemployment rate increased as education level decreased. The unemployment rate in Texas was as low as 2.5 percent among those with a bachelor's degree or higher in 2019 [8].

Crime

Crime impacts the physical and behavioral health and wellbeing of mothers, children, and their families. Neighborhood crime can be detrimental to the safety of children by creating unstable living environments. By assessing communities where crimes occur more frequently, it is possible to identify areas where high risk populations reside and help prevent adverse consequences. In 2019, Texas' Crime Rate was 2,779.3 crimes per 100,000 persons [[16]].

Texas index crime statistics include two major categories of crime: property crimes and violent crimes. Property crimes consist of burglary, larceny-theft, and motor vehicle theft. The 2019 property crime rate was 2,363.7 crimes per 100,000 Texans. The highest property crime rates in 2019 were primarily localized within larger Texas cities and their surrounding areas (Figure 11) [16].

Figure 11. Texas Property Crime Rate per 100,000 Residents by County, 2019.

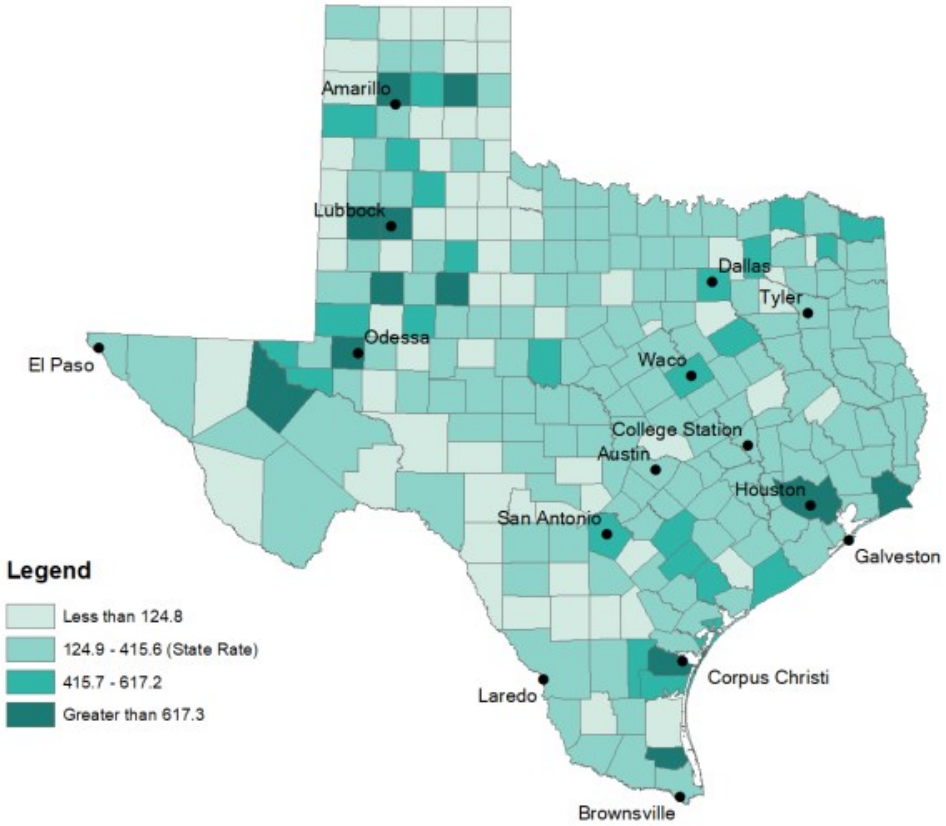


Source: Texas Department of Public Safety, Texas Crime Report 2019.
Prepared by: Maternal and Child Health Epidemiology Unit
Mar 2021

Violent crimes recorded in the Uniform Crime Report index include murder, rape, robbery, and aggravated assault. The violent crime rate was 415.6 crimes per 100,000 Texans. The highest violent crime rates in 2019 were primarily concentrated near the

larger cities of the panhandle: Odessa, Lubbock, and Amarillo (Figure 12). Houston, Dallas, San Antonio, Corpus Christi and surrounding areas also had a high concentration of violent crimes [16].

Figure 12. Texas Violent Crime Rate per 100,000 Residents by County, 2019.



Source: Texas Department of Public Safety, Texas Crime Report 2019.
Prepared by: Maternal and Child Health Epidemiology Unit
Mar 2021

Violence within Texas families has also been recognized as a growing threat to the safety of Texans. The Uniform Crime Report indicated 196,902 family violence incidents in Texas in 2019. Although the largest percentage of family violence was between other family members (56.5 percent), family violence also occurred among spouses/couples (27.3 percent) and within parent-child relationships (16.1 percent). Females were more likely to be victims in family violence. Of the victims whose gender was known, 28.7 percent were male, and 71.3 percent were female. The 25-29 age group had the highest number of victims in family violence [16].

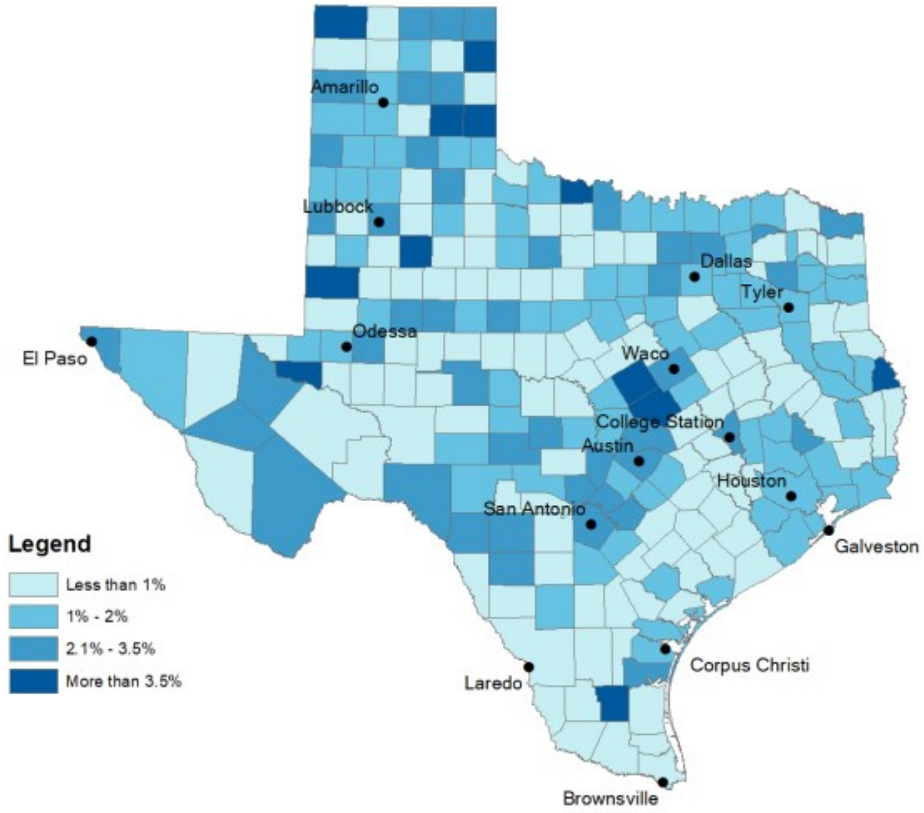
Mobility/Migration

Moving or relocating is one of life's most stressful events and can impact individual health and well-being. For example, results from the Texas School Survey of Substance Use show that this may influence risk behaviors in youth, as students in grades seven to 12 living in their current school district for three years or less are more likely to use illicit drugs than those living there more than three years [[17]]. Texas demographic data illustrates patterns of migration that include moving into the state from other states and countries and moving within the state between counties.

Out-of-State Mobility/Migration

Four Texas metropolitan areas (Houston, Dallas, Austin, and San Antonio) together added more people than any state in the country (except for Texas as a whole) between 2016 and 2017. The population in these four metropolitan areas increased by more than 350,000 people in a year. Among these four fastest-growing areas in Texas, between 2016 and 2017, two to three percent of the population consists of people who moved to the area from out of state (out-of-state migration). Some rural counties also had high levels of out-of-state migration in 2015-2019, particularly in the parts of the state bordering Oklahoma and the Panhandle, as well as in west Texas (Figure 13) [8]. The majority of Texas counties had little to no new residents from other states.

Figure 13. Percent of Resident Population that Moved from Another State to Texas by County, 2015-2019.



Source: U.S. Census Bureau, American Community Survey, 2015-2019.
Prepared by: Maternal and Child Health Epidemiology Unit
Mar 2021

The oil and gas industry is concentrated in three areas of the state, west near Odessa, south between San Antonio and Corpus Christi, and west near Fort Worth (data not shown). In previous years, migration of people into these areas could be attributed to the jobs created by the oil and gas industry, but in recent years drilling permits have fallen from 10,533 approved drilling permits in 2018 to 9,616 in 2019 [[18],[19]]. Additionally, Texas is home to 13 United States military installations. A number of counties that saw a high level of out-of-state migration also have a United States military base nearby. In 2019, the military contributed to 226,555 direct jobs to the Texas economy [[20]].

In-State Mobility/Migration

Another aspect of mobility is the number of people who move within or between counties in Texas. While out-of-state migration may reflect job growth, mobility of populations within a county and between counties is more complicated.

Counties with universities and colleges in Texas were among the highest rates of within-county relocations over a one-year period [8]. College Station, Austin, Lubbock, and San Antonio are home to four of the ten largest universities in Texas, which can partially explain the high rates of within-county relocations in these areas. College students tend to move often within the same county to take advantage of lower rents.

Health Care Coverage and Access

Health insurance and access to health care are fundamental to the health of Texans. With 18.4 percent of the state's

population uninsured, Texas has the highest uninsured rate in the country [[21]]. Percent of the population that is uninsured is shown in Table 1. Region 11 has the highest uninsured rate and Region 7 has the lowest rate.

Table 1. Percent of Population that is Uninsured by State and Public Health Region

Region	Percent Uninsured
Texas	18.4%
Region 1	19.3%
Region 2/3	19.1%
Region 4/5N	20.6%
Region 6/5S	20.4%
Region 7	16.0%
Region 8	18.1%
Region 9/10	22.0%
Region 11	28.2%

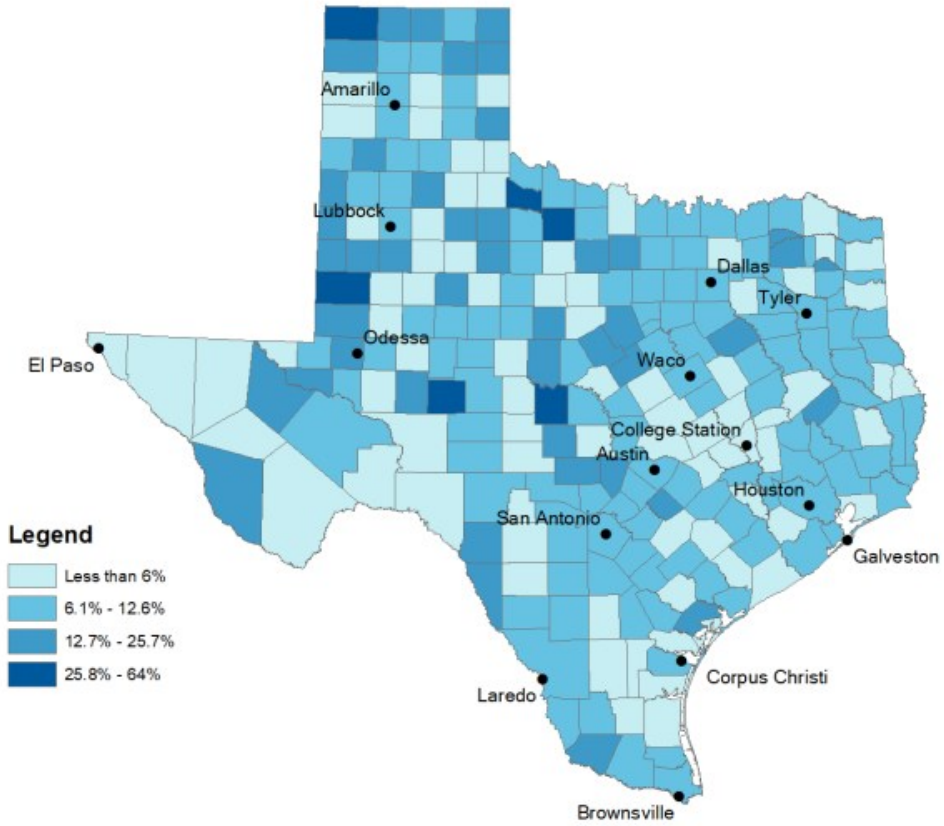
Source: Small Area Health Insurance Estimates, 2018. Current Population Reports, United States Census Bureau, 2019.
Prepared by: Maternal and Child Health Epidemiology Unit
Apr 2020

Health Insurance

Texas had the highest proportion of the population without health care coverage of any state in 2019, with 18.4 percent uninsured. The national average was 9.2 percent. Texas had higher proportions of uninsured children, uninsured women of childbearing age, and uninsured individuals living below 200 percent FPL than the corresponding uninsured percentages for these groups nationwide. In Texas, 10 percent of children younger than six years old were uninsured, and 28.2 percent of Texas women aged 19 to 44 were uninsured. Furthermore, 30.6 percent of Texans living below 100 percent FPL were uninsured [[22]]. In addition, 2018-2019 NSCH data showed that 10.6 percent of CSHCN ages 0-17 in Texas had no health insurance or had periods of no coverage during the year prior to the survey, higher than the nationwide average of 6.9 percent [[23]].

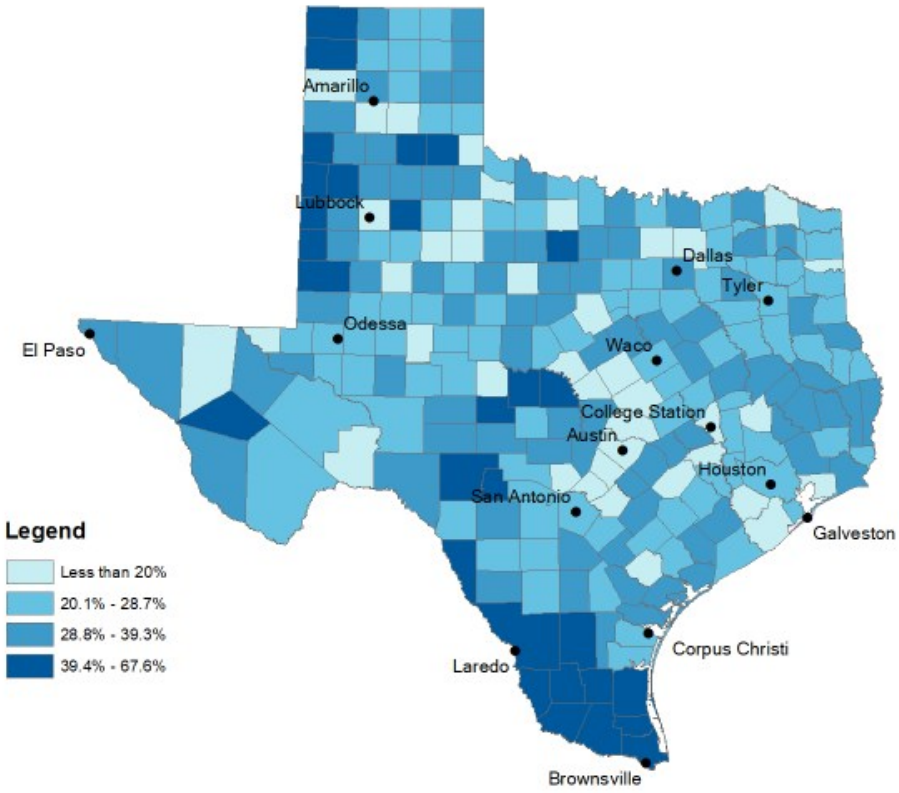
Counties with high proportions of uninsured children younger than six years of age were concentrated in west Texas between Odessa and San Antonio, and in the Panhandle (Figure 14). The Texas-Mexico border regions and several counties outside Lubbock and Waco had high proportions of women aged 19 to 44 without health insurance (Figure 15).

Figure 14. Percent of Texas Children Younger than Six Years Old Without Health Insurance by County, 2014-2018.



Source: U.S. Census Bureau, American Community Survey, 2015-2019.
Prepared by: Maternal and Child Health Epidemiology Unit
Mar 2021

Figure 15. Percent of Texas Women (19-44 Years) Without Health Insurance by County, 2015-2019.

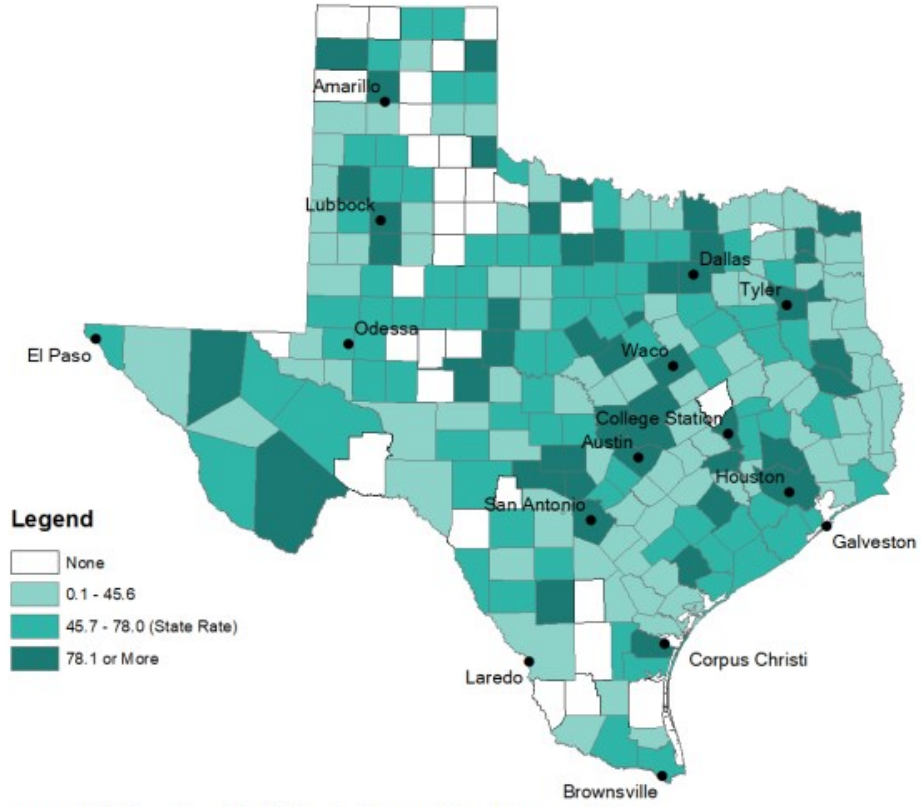


Source: U.S. Census Bureau, American Community Survey, 2015-2019.
Prepared by: Maternal and Child Health Epidemiology Unit
Mar 2021

Access to Health Care

Given the large size of the state and the vast distances between points of care for health services in rural areas, access to care in the state of Texas can be a challenge. There was an increase in the number of primary care physicians in Texas from 18,834 (70.6 per 100,000 population) in 2013 to 22,610 (78 per 100,000 population) in 2019. However, 32 counties still had no primary care physicians in 2020 (Figure 16).

Figure 16. Number of 2020 Primary Health Care Physicians per 100,000 Texas Residents by County, 2019.

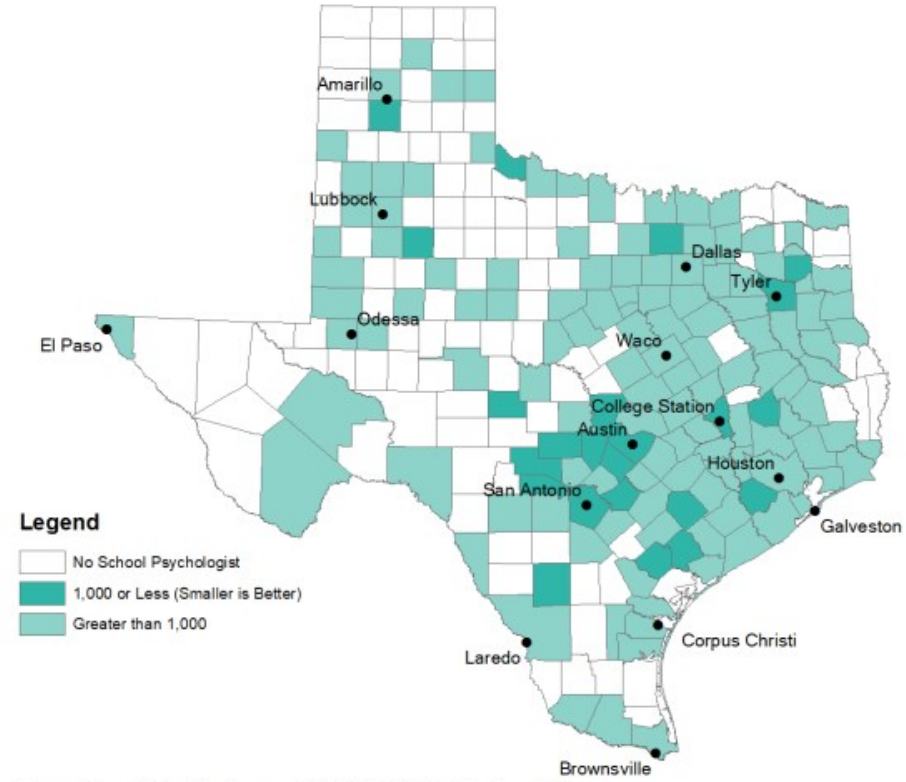


Source: 2019 Texas Population Estimates Program, Texas Demographic Center.
Texas Health Professions Resource Center, 2020
Prepared by: Maternal and Child Health Epidemiology Unit
Mar 2021

The total number of obstetricians (OB) and/or gynecologists (GYN) increased from 2,483 in 2013 to 2,678 in 2018. The density of OB/GYNs in Texas increased slightly from 18.5 OB/GYNs per 100,000 females in 2013 to 18.6 per 100,000 females in 2018. A total of 155 counties had no OB/GYN in 2017 [[24]].

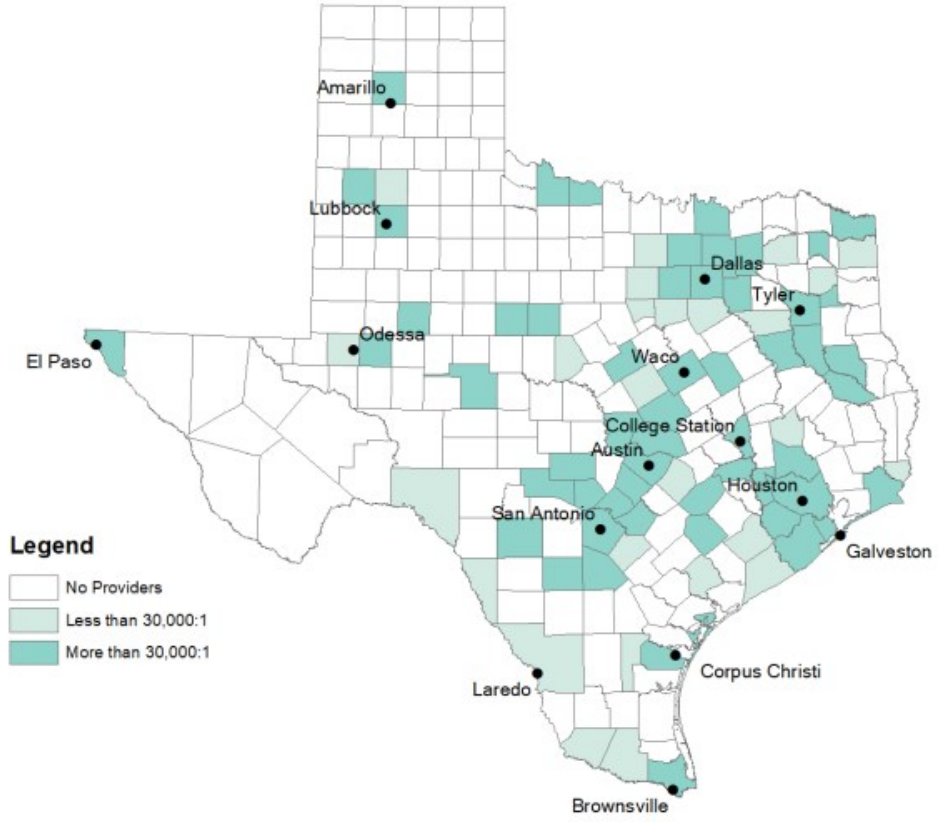
The National Association for School Psychologists recommends a student-to-provider ratio of 1,000:1 [[25]]. In Texas, only 23 counties met this recommendation in 2019, including Travis and Bexar counties which respectively contain the cities of Austin and San Antonio (Figure 17).

Figure 17. Ratio of Texas Students to School Psychologists by County, 2020.



Psychiatrist shortage is also a concern. The HPSA cut-offs for designating an area with a mental health shortage is 30,000 people or residents to one psychiatrist, and 20,000 people/residents to one psychiatrist in areas with high needs [[26]]. One hundred and seventy-three counties do not have a psychiatrist, and many that do have at least one psychiatrist meet the HPSA criteria for the mental health shortage designation [[27]]. Several counties surrounding major cities, however, met one of the two HPSA cut-offs (Figure 18).

Figure 18. Ratio of 2020 Psychiatrists to Texas Residents by County, 2020



Source: 2019 Texas Population Estimates Program, Texas Demographic Center.
Texas Health Professions Resource Center, 2020
Prepared by: Maternal and Child Health Epidemiology Unit
Mar 2021

Additional challenges exist in identifying psychiatrists who specialize in child psychiatry. It is estimated that there are only about 8,300 practicing child and adolescent psychiatrists in the country [[28]]. There are almost no child and adolescent psychiatrists in the state practicing outside of major cities in Texas.

Emerging Issues

The 87th Texas Legislature, Regular Session convened on January 12, 2021 and adjourned May 31, 2021. DSHS tracked approximately 700 bills during that time, and of the 36 bills that were assigned to MCH, 7 of those bills passed and will impact MCHS. House Bill (HB) 4 relating to the provision and delivery of health care services under Medicaid and other public benefits programs using telecommunications or information technology and to reimbursement for some of those services; HB 1164 relates to patient safety practices regarding placenta accreta spectrum disorder; HB 1967 relates to a database of information about women with uterine fibroids and to uterine fibroid education and research; HB 2831 relates to the confinement in county jail of persons with intellectual or developmental disabilities; Senate Bill (SB) 970 relates to the repeal of certain provisions related to health and human services; SB 1578 relates to the use of opinions from medical professionals in making certain determinations relating to the abuse or neglect of a child; and SB 1941 relates to the creation of a hyperemesis strategic plan. Lastly, per an exceptional item submitted by the DSHS, the appropriations bill, Senate Bill 1, now includes a rider that allows for greater flexibility with funding for maternal mortality programming.

The positioning of DSHS' Maternal and Child Health Section (MCHS) program staff at both the state and regional levels allows a broad and local approach in addressing current and emerging issues, including novel coronavirus (COVID-19), lung injuries associated with vaping, and maternal mortality and severe morbidity in Texas.

Addressing COVID-19

In 2019, a novel coronavirus emerged causing a respiratory disease known as COVID-19 and leading to a pandemic which is ongoing as of August 2021. The disease was first reported in the United States in late January 2020 [[29]]. Texas reported its first case in early March 2020. As of March 16, 2021, Texas had over 2,351,382 confirmed cases and 45,700 fatalities, with 4,279 new cases and 69 fatalities on March 16, 2021. All 254 Texas counties have reported cases, indicating widespread community transmission [[30]].

As of August 2021, the Food and Drug Administration issued Emergency Use Authorization to Moderna, Pfizer-BioNTech, and Janssen (Johnson and Johnson) for their COVID-19 vaccines. Distribution of COVID-19 vaccinations have been underway in Texas since December 2020. As of March 20, 2021, a total of 9,204,921 doses of the COVID-19 vaccination have been administered in Texas, with 3,148,130 individuals being fully vaccinated [[31]]. In May, 2021, vaccine eligibility opened up to all individuals in Texas over the age of 12.

Implications for the maternal and child population

Although implications of this virus are still being studied, pregnant women may be at increased risk for severe symptoms and there is a potential for negative effects on birth outcomes when exposed, so pregnant women are encouraged to take precautions to protect themselves from the risk of infection [[32]]. DSHS is assisting TexasAIM hospitals for readiness and response to COVID-19 by providing information and resources, as it relates to key practices in obstetric care, including through an online resource, newsletter, and discussion platform and, previously, a series of webinars. Through TexasAIM, hospitals triaged and cared for obstetric patients during the pandemic.

The risks associated with COVID-19 to pregnancy outcomes, to infants born to infected mothers, and for breastfeeding infants are still under investigation [6].

Although children infected with COVID-19 typically experience mild symptoms, some children do experience severe illness when infected with COVID-19 [[33]]. Multisystem inflammatory syndrome in children (MIS-C) has occurred in children who had or were exposed to COVID-19. MIS-C causes inflammation of heart, kidneys, lungs, brain, skin, eyes, and gastrointestinal organs. Most children with MIS-C need to be treated in the hospital or Intensive Care Unit [[34]]. As of March 15, 2021, there were 97 reported cases of MIS-C in Texas, with nearly half (45 cases) occurring in Public Health Region 4/5S [[35]].

Beyond the effects of the infection and complications from the infection, there were concerns over the impacts of closing schools (e.g., related to the health and wellbeing of children who depend on school meal programs living in food insecure situations) [[36]]. Measures to contain the spread of the virus, like social distancing and stay-at-home orders, may increase domestic abuse and child abuse and neglect due to the situational stress, social isolation, and reduced interactions with teachers who often report abuse [[37]], [[38]]. The impacts of COVID-19 on maternal and child health are not yet fully known, but the need to monitor the health and wellbeing of this population is evident.

DSHS Response

The DSHS commissioner, Dr. John Hellerstedt, declared a public health disaster on March 19, 2020. Governor Greg Abbott began issuing executives orders on April 17, 2020 to reopen the state of Texas in phases with regards to the continually-evolving situation while taking health safety precautions. He issued an executive order on July 20, 2020 requiring face covering over the nose and mouth in public places. On March 10, 2021, the governor lifted the executive order requiring face coverings and fully reopened the state of Texas. DSHS continues to work with the CDC to closely monitor the situation and disseminate the most updated information and resources on a DSHS webpage dedicated to the coronavirus. DSHS launched a COVID-19 case dashboard which is updated daily with the preliminary number of cases by county and include basic demographic information [[39]]. DSHS has also launched a COVID-19 vaccination dashboard which is updated daily with number of vaccinations administered by county [33].

Lung Injury Associated with Vaping

In 2018, DSHS announced vaping usage had reached epidemic levels. Vapes or electronic cigarettes are tobacco products that contain a battery which heat a cartridge containing nicotine, tetrahydrocannabinol (THC) and/or cannabinoid (CBD) oil, along with flavoring. The heat creates an aerosol that is then inhaled into the lungs [[40]]. These products have been on the market since 2007, but have recently experienced a rise in popularity, particularly among youth. As of 2014, these products have become the most commonly used tobacco product for youth [14]. Vaping is associated with a number of dangers including electronic devices catching on fire, nicotine use harming adolescent brain development, and poisoning from swallowing the vaping liquid. Particular attention has been drawn to the negative health outcome of bronchiolitis obliterans, a lung injury associated with vaping causing scaring of air sacs within the lungs, leading to narrowing of air ways. As the airways narrow, patients experience shortness of breath and wheezing [14].

As of February 2020, in the United States there have been about 2,800 hospitalized cases of lung injury associated with vaping. Of those cases, there were 250 cases of lung injury and four deaths associated with vaping in Texas [[41]].

DSHS Response

In response to the vaping epidemic, DSHS has utilized both existing tobacco programing, as well as developed novel vaping specific programs. Some of the existing programming include the Texas tobacco phone quitting line called 'Yes Quit.' This program includes both online and telephone resources for individuals quitting tobacco use. Other existing tobacco programming includes the 'Students and Youth Working Hard Against Tobacco!' or the 'Say What!' program which is a youth tobacco prevention collation program working to reduce youth tobacco usage.

While many of the existing tobacco initiatives have adapted to also address electronic cigarettes, more specific vaping programming has been developed. Within the DSHS Tobacco Prevention and Control Program website, there is now a specific vaping section which houses resources and information related to vaping. The tobacco unit has also developed a general presentation that can be tailored to a variety of different audiences, highlighting vaping information, health risks, and prevention strategies.

Addressing Maternal Mortality and Severe Morbidity

In April 2017, the DSHS' MCHS staff attended the National Alliance for Innovation on Maternal Health (AIM) meeting in Baltimore, MD. Key partners were identified, and the staff learned about effective and efficient strategies for implementing the Council on Patient Safety in Women's Health Care AIM-supported maternal patient safety bundles in Texas. In August 2017, the 85th Texas Legislature passed Senate Bill 17 which required the state to implement Maternal Health and Safety Initiatives. In December 2017, DSHS applied for and was selected as the lead coordinating agency to implement the AIM maternal safety bundles, starting with Obstetric Hemorrhage (launched November/December 2018), Hypertension (launched Winter 2020 due to COVID-19), and Obstetric Care for Women with Opioid Use Disorder (pilot currently being conducted).

In January 2018, DSHS created the AIM Implementation Advisory Workgroup. This group includes representatives from Texas' Perinatal Advisory Committee, the American College of Obstetrics and Gynecologists, the Consortium of Texas Certified Nurse Midwives, the Texas Hospital Association, the Texas Medical Association, the Texas Collaborative for Healthy Mothers and Babies, and the Texas Nursing Association. DSHS held webinars and sent a letter to all Texas birthing hospitals to recruit hospitals to participate. DSHS hosted the TexasAIM Leadership Summit and Orientation on June 4, 2018, which was the kickoff meeting for TexasAIM. There were over 330 attendees present at the Summit, which included at least one representative from over 150 participating hospitals. In December 2020, a "Leadership Summit and Kickoff Meeting" was held to highlight the successes of the TexasAIM OBH Program and to mark the launch of the AIM Plus Sever Hypertensions in Pregnancy (HTN) Learning Collaborative. There were over 590 attendees present at this virtual meeting. As of September 2020, 219 of Texas' 223 hospitals with obstetric lines of service were enrolled in TexasAIM and participate in the TexasAIM Obstetric Hemorrhage Bundle. These hospitals represent 98 percent of all the birthing hospitals in Texas and provide care for approximately 99 percent of the births in Texas and approximately 9.9 percent of the births in the nation [[42]]. Regarding TexasAIM HTN, there are 197 hospitals enrolled as of March 2021 representing 88% of Texas birthing hospitals and learning sessions for these participating hospitals began in April 2021. Additionally, a harvest meeting was planned for the Spring but has been replaced with a series of structured interviews with improvement team members from high performing hospitals participating in the TexasAIM Plus Obstetric Hemorrhage Learning Collaborative.

The TexasAIM Faculty Chair approached MCHS staff to disseminate information around COVID-19 to hospitals given that 98 percent of the birthing hospitals participate in TexasAIM. Weekly webinars on COVID-19 and the impact on labor and delivery practice have been discussed as it relates to readiness, recognition, response, and reporting and systems learning. Some discussions have been related to the guidelines and protocols hospitals are using for the prevention of anemia and how they are conserving blood products, transport protocols and how a rural hospital was approaching their COVID-19 response.

Additionally, MCHS has been collaborating with staff from the Substance Use Disorder Unit at the Texas Health and Human Services Commission and the Texas Targeted Opioid Response Initiative to improve the quality of care for women with substance use disorders and children with Neonatal Abstinence Syndrome. In June 2018, DSHS recruited ten hospitals to begin independently testing implementation of the newly released AIM *Obstetric Care for Women with Opioid Use Disorder* (OB-OUD) Bundle components and assessing the operational considerations and feasibility of implementation. Participating hospitals partook in a series of collaborative calls to share lessons learned to-date regarding implementation of the OB-OUD bundle components and to discuss barriers of implementation. A series of structured qualitative interviews with the hospitals' improvement teams began in the Summer of 2020 and concluded in the Fall of 2020. Lessons learned from these activities will inform development of programming and an approach to customize the bundle for implementation of a TexasAIM Plus OB-OUD Learning Collaborative.

DSHS is responsible for overseeing the maternal levels of care designation process for Texas. The maternal levels of care designation rule became effective on March 1, 2018 and the designation for maternal level of care is an eligibility requirement for Medicaid reimbursement beginning September 1, 2021.

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III.C. Needs Assessment

FY 2022 Application/FY 2020 Annual Report Update

Ongoing Needs Assessment Activities

Healthy Texas Mothers and Babies (HTMB) Data Book

The HTMB Data Book provides an overview of maternal and infant health in Texas. In 2020, MCH Epidemiology (MCHE) expanded the HTMB Data Book to include a new section on maternal mental health and made substantial revisions to the sections on Perinatal Periods of Risk (PPOR) analysis, maternal mortality, and severe maternal morbidity. More than 1,100 unique users downloaded a version of the HTMB Data Book or PPOR analyses from the DSHS website during 2020. The HTMB Data Book highlights trends and disparities in infant and maternal health outcomes and is widely used by programs and policymakers to make data-driven decisions to improve maternal and infant health outcomes in Texas. The Maternal and Child Health Section (MCHS) uses the statistics for needs assessments.

Pregnancy Risk Assessment Monitoring System (PRAMS)

Data collection for Texas PRAMS for the 2020 birth year began in April 2020. The current PRAMS survey utilizes questions developed by CDC in 2016, plus three supplemental questions on prescription drug use starting in 2017. The latest current available data is from the 2019 birth year. Texas PRAMS data continues to be used by DSHS and other state agencies and stakeholders to inform, develop, and drive policies and programs to improve the health of mothers and babies, and to understand their emerging health needs. The annual PRAMS Data Book containing an overview of the major findings using 2018 PRAMS data was made publicly available in March 2021. Starting with 2019 PRAMS data, the overview of major findings will be disseminated via the PRAMS Dashboard. The PRAMS Dashboard was published in April 2021 and currently contains data from years 2012-2018 and soon will be updated with 2019 data. Ad hoc data analysis requests for single year and multiple years of PRAMS survey data are routinely fulfilled.

Birth Defects Surveillance

In 2020, the DSHS Birth Defects Epidemiology and Surveillance Branch (BDES) entered over 25,000 cases of birth defects (i.e., individuals affected by one or more birth defects) into the web-based abstraction system during that year. By the end of Fiscal Year 2019 (FY19), BDES had nearly completed the 2017 delivery year. Data are used for cluster investigations, looking at the occurrence and patterns of birth defects, prevention and family outreach, studies of access/proximity to services, studies of mortality and survival, studies of causes of birth defects, and understanding changes over time. Noteworthy projects in 2020 included a COVID-19 hospitalization abstraction project, requested by DSHS leadership. Additionally, the Branch conducted a mortality analysis on children born with critical congenital heart defects. This report was published in the Texas Birth Defects Monitor. In 2020, BDES continued referring children with certain conditions (i.e., spina bifida, encephalocele, cleft lip, cleft palate, and Down syndrome) from the birth defects registry to social workers from the Division for Regional & Local Health Operations (RLHO) for assistance accessing health and social service programs. This initiative involves identifying services these families were receiving, new services they were referred to, and barriers to services to better understand challenges encountered by families with infants affected with birth defects and improve efforts in outreach and services. In addition, BDES continued efforts to identify recent deliveries affected by a neural tube defect (NTD) and mailing information packets to families aimed at reducing the risk of another NTD-affected pregnancy through the recommendation of consulting a health care provider regarding daily use of higher dose folic acid. An additional survey, focused on the health care of children with Critical Congenital Heart Defects (CCHDs), was completed in 2020 and was used to connect families to social workers for assistance accessing health and social services. Additionally, a brochure with resources for Children with Special Health Care Needs was developed and posted on the website for families to access.

Children and Youth with Special Health Care Needs (CSHCN) Data Analysis & Surveillance

In FY20, MCHS conducted the 2020 CSHCN Outreach Survey for Young Adults and Families. The Outreach Survey asks questions of young adults with special health care needs and families of CSHCN related to transition, care coordination, community inclusion, respite care, and emergency preparedness. MCHS distributed English and Spanish versions by mail and online and tracked responses by zip code to ensure representation of subsets of the CYSHCN population in Texas. MCHS uses data from the survey to develop programming to improve the wellbeing of CSHCN in Texas across the six core system outcomes. MCHS contractors also conducts a continuous Family Satisfaction Survey. These surveys are distributed to families who participate in Title V-funded community-based initiatives to determine whether the services provided were accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective, as well as assess the overall satisfaction of families.

Maternal Mortality and Morbidity Data Analysis & Surveillance

In 2020, the Texas Maternal Mortality and Morbidity Review Committee (MMMRC) continued reviewing all maternal death cases for 2013 (deaths that were confirmed to have occurred within 365 days postpartum, using vital statistics data matching). MCHS renewed the contract with the University of North Texas to provide medical records redaction and case synthesis support. MMMRC recommendations based on these case reviews, as well as findings from MCHE, were reported in the 2020 Joint Biennial Report for the Legislature by DSHS and the MMMRC, published in December 2020.

MCHE conducted aggregate as well as case-specific analyses of disparities in maternal mortality and severe maternal morbidity using statewide vital event, hospital discharge, Medicaid and Census data over the past year. These analyses were designed to be integrated into reports used by the Review Committee during case review and by abstractors preparing these reports.

MCHE has developed and executed an MOU with the Center for Analytics and Decision Support (CADS), the custodians of Medicaid/CHIP administrative data. This MOU provides for periodic linkage of confirmed maternal deaths to Medicaid and CHIP data on behalf of CADS. MCHE uses the information to supplement records ascertainment, and to analyze enrollment at times of delivery and death. Medicaid/CHIP information is used in case coversheets that list all claims, encounters, and prescriptions within a period of two years prior to the woman's death.

MCHE has continued the successful enhanced method for identifying maternal deaths for years beyond 2012. MCHE staff completed the enhanced method for 2013, 2014, and 2015 unconfirmed maternal deaths. In 2020, MCHE staff has also linked vital event data and Texas Health Care Information Collection (THCIC) data to identify 2016, 2017, and 2019 confirmed and unconfirmed maternal deaths and enhanced reviews are currently underway for these years. Data linking from 2018 is forthcoming. Unconfirmed maternal deaths are defined as female Texas resident deaths which did not link to an existing live birth of fetal death yet are indicated to be maternal by a positive pregnancy checkbox value, an ICD-10 obstetric code for underlying cause of death, or both. MCH epidemiologists request relevant records to either support or disprove the indicated maternal status of these deaths. MCHE continues to work with the MMMRC around health equity efforts. In winter 2020, MCHE began the development of a pilot study to evaluate the utility of a Discrimination Assessment and Social Determinants of Health (DASH) Facilitated Discussion Tool created by the Texas MMMRC. The study began in Summer 2021 and findings will be used to enhance the structure, process, and utilization of the tool for future MMMRC use in other states and jurisdictions.

MCHS is working with hospitals and other partners to implement AIM patient safety bundles/toolkits for obstetric hemorrhage, substance use disorder, and severe hypertension in pregnancy. As of September 2020, 219 of Texas' 223 hospitals with obstetric lines of service are enrolled in TexasAIM and participate in the TexasAIM Obstetric Hemorrhage Bundle. These hospitals represent 98 percent of all the birthing hospitals in Texas and provide care for approximately 99 percent of the births in Texas and approximately 9.9 percent of the births in the nation. Regarding TexasAIM Hypertension bundle, there are 208 hospitals enrolled as of August 2021 representing 94% of Texas birthing hospitals and learning sessions for these participating hospitals began in April 2021. The decision to utilize these evidence-based, standardized care toolkits was informed by analyses conducted by MCHE.

Newborn Screening

The Newborn Screening Program is a program that is required by state law for any baby born in Texas which screens newborn infants for more than 50 disorders using bloodspot samples taken from the heel. The Texas Newborn Screening (NBS) Laboratory tests nearly 800,000 specimens each year. Two samples are collected, the first at 24 to 48 hours of age and the second between 1 and two weeks of age, in order to maximize detection rates. This program includes follow-up for infants who test positive for a disorder or medical condition. The goal of the Texas Newborn Screening Program is to identify infants who have these devastating diseases before symptoms arise so that they can receive appropriate treatment and lead productive and healthy lives. Early detection of and treatment for these conditions can prevent serious complications or death. Based on provisional data as of May 14, 2021, there were 827 confirmed cases diagnosed and referred for treatment through the NBS program in 2020. Texas is preparing for Spinal Muscular Atrophy (SMA) Newborn Screening which is among the leading genetic causes of death in infants and toddlers. Texas plans to add SMA screening to the newborn screening panel in Summer 2021.

School Physical Activity and Nutrition (SPAN) Survey

The goal of SPAN is to establish a surveillance system to monitor the prevalence of overweight/obesity in school-aged children in Texas. This surveillance system allows researchers to identify and track trends in childhood obesity. SPAN identifies factors in Texas students that may underlie obesity, including dietary behaviors, nutrition knowledge and attitudes, and physical activity. MCHE reviewed changes in the SPAN 2019-2020 survey and added newly developed oral health related questions. Data collection for the 2019 survey began in fall of 2019. MCHE reviewed

changes for the 2021-2022 survey cycle which will include questions on COVID-19; data collection for this cycle is set to begin in fall 2021. MCHE continues to review all SPAN proposals and edits and co-authors abstracts and manuscripts for submission to conferences and/or publication in state and national journals.

Oral Health Needs Assessment & Surveillance

The Oral Health Improvement Program (OHIP) promotes oral health through leadership in public health practices, policy development, education, and population-based preventive services. MCHE continues to support surveillance activities for OHIP. Every five years, MCHE provides required Basic Screening Surveys (BSS), provides a list of a representative sample of schools, and conducts final weighting and analysis for the 3rd grade and Kindergarten Basic Screening Survey (BSS). In 2020, MCHE made updates to the electronic data collection system to accommodate continued data quality improvements for tracking preventive dental service and surveillance. MCHE provided technical support for several requests and action items, including a standard operating procedure for data quality management, revealed during an internal HHS OHSP audit. MCHE provided several reports/briefs for OHIP including documents utilizing data from the 2017-2018 3rd grade BSS, 2018-2019 kindergarten BSS, 2012-2018 BRFSS, and SPAN surveys. MCHE provided analysis and coauthored *Oral Health in Texas: A Comparison of Kindergarten and Third Grade Children*, a manuscript published in the September 2020 edition of the Texas Dental Journal. MCHE also provided data analysis for oral health projects including the Smiles for Moms and Babies program, a report for the State Board of Dental Examiners, and Human Papilloma Virus (HPV) vaccination data. MCHE collaborated with OHIP to create two oral health posters for the Virtual 2020 CityMatCH Leadership and MCH Epidemiology Conference entitled *Teeth Cleaning During Pregnancy in Texas: PRAMS 2012-2016* and *Dental outcomes of school children living in border and non-border counties of Texas.* MCHE continues to work closely with OHIP to enhance oral health questions for future surveys including SPAN, YRBS, and the BRFSS.

Child Fatality Review Team (CFRT)

To better understand and prevent child fatalities, a sample of child deaths are reviewed at the local level by multidisciplinary teams per Texas Family Code. These Child Fatality Review Team (CFRT) data are analyzed together with death certificate data. The data collected by the local review teams augment the death certificate data and provide further insight into the causes and circumstances surrounding child fatalities in Texas. From 2019-2020, local teams reviewed 1,243 (32%) of the 3,858 child deaths that occurred in 2016. Data trends for child deaths occurring in 2016 were published in a biennial report entitled Texas Child Fatality Data and Recommendations, with recommendations based on the leading causes of preventable child deaths, including motor vehicle crashes and drowning.

Organizational Structure and Leadership Updates

Between 2019 and 2021, several executive team organizational shifts occurred at DSHS. The next few paragraphs will outline the changes.

Cecile Erwin Young was named the Executive Commissioner of HHSC. Young has over 30 years of state government experience in Texas. She began her state career as a lecturer and research engineer at Texas Tech University and then served as a conference committee clerk for HB 7, which created HHSC in 1991, and she came to work at HHSC to implement the legislation.

Dr. Pont recently transitioned to lead the newly formed DSHS Center for Public Health Policy and Practice, which includes the preventive medicine residency program, DSHS Public Health Library, Continuing Education and Continuing Medical Education Programs, the DSHS Institutional Review Board, Policy Analyses, Health Equity, Health Economics, and Performance Management. Dr. Pont completed a BA in Biology with a concentration in Spanish from UT Austin, MD from UT Southwestern, pediatric residency at Arkansas Children's Hospital, and a research fellowship and Master of Public Health at Vanderbilt. Dr. Pont is an Associate Professor of Pediatrics and Population Health with the University of Texas at Austin Dell Medical School and Adjunct Associate Professor with Texas A&M College of Medicine.

Roberto Beaty was named the Associate Commissioner of Program Operations. Prior to that he led the IT Governance Practice for HHSC and previously worked for the Office of Attorney General in the Child Support Division. He received his B.A. in Industrial Engineering from the Instituto Tecnologico y de Estudios Superiores de Monterrey in Mexico and his Master's in Business Administration from the University of Hull in the United Kingdom. He has lived and worked in multiple countries in Europe, the Americas, and Asia. Before working for the State of Texas, he held various positions in the private sector with a focus on management consulting and business process improvement.

Dr. Jennifer A. Shuford was appointed as Chief State Epidemiologist, providing leadership for data-driven activities and policy formation aimed at improving the health of all Texans. Dr. Shuford graduated from Colorado College in

Colorado Springs with a bachelor's degree in chemistry. She received her Doctor of Medicine degree from the University of Texas Southwestern Medical School. She completed an internal medicine residency at Presbyterian Hospital of Dallas, followed by an infectious disease fellowship at the Mayo Clinic in Rochester, Minnesota. She earned her Master of Public Health degree from Harvard School of Public Health.

Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

Goals and Frameworks: The objective of conducting a comprehensive statewide Needs Assessment was to identify priority areas for Maternal and Child Health (MCH) populations and to improve existing programs to better serve these populations. The goals of the Texas 2020 Title V Needs Assessment included gaining an in-depth understanding of the current MCH issues in Texas and creating an inclusive process for Texans to voice their opinions, needs, and concerns regarding their health. Each stage of the needs assessment process depended on extensive community involvement to ensure adequate community representation. The 2020 Needs Assessment process emphasized the life course perspective as a framework to address and reduce health inequities. Special attention was given to creating a safe and inclusive process to facilitate input from under-represented populations. Care was taken to ensure the process included a broad cross-section of Texans and the data collected was representative of the needs of the entire state.

Approach: The Texas 2020 Title V Needs Assessment utilized a multi-methodological data collection approach to capture the current MCH health status, MCH health needs, and MCH workforce capacity. A mixed-methods research approach allowed the team to offset the weaknesses inherent to each type of method. The data collection included four distinct data categories inclusive of both qualitative and quantitative data collection and analysis. The qualitative data collection provided a comprehensive, contextual understanding to the quantitative findings and allowed for more detailed analysis in areas as needed.

Surveys

Three cross-sectional surveys were created, each with different data collection objectives and target populations. These three surveys included a 1) capacity survey, 2) community survey, and 3) CSHCN survey. Surveys were distributed through a web-based link using the SurveyMonkey platform. The survey design for all surveys included a mix of open-ended, ranking and selection, and dichotomous questions. Surveys were open for responses between June 2019 through December 2019, with the capacity survey closing in September 2019.

Survey respondents were recruited through email survey links shared through existing listservs. Flyers for the Community and CSHCN surveys were also passed out at focus groups sessions, encouraging focus group participants to respond.

Capacity Survey

The capacity survey was designed to seek input from professionals working with MCH populations. The questions were aimed at identifying self-reported competency in analytic skills, leadership skills, knowledge of MCH priorities and policy, as well as self-perceived success in MCH work based on individual experience. This survey also asked respondents to choose their top priorities and performance measures for the State to focus on.

Community Survey

The community survey was aimed at seeking input from all Texas residents aged 18 years or older and was distributed in both English and Spanish. This survey asked community residents to rank their priority needs from a defined list and rate the effectiveness of current MCH state programs in addressing their needs. The questions were designed to elicit clear feedback for improvement and measures of community-perceived success.

Children and Youth with Special Healthcare Needs (CSHCN) Survey

The MCH unit within DSHS designed two surveys to seek information about the CSHCN population. The first survey targeted parents caring for CSHCN, and asked about their experiences, challenges, and needs while caring for their children. The survey was distributed in both English and Spanish. The second survey targeted young adults with special health care needs who had recently transitioned to adult care.

Survey Analysis

Survey data from SurveyMonkey were downloaded directly from the website. All survey analyses were completed using SAS version 9.4.

For each survey, data were first cleaned to remove missing, incomplete or duplicate responses and only unique responses were included. Survey analyses were conducted to calculate mean, medians, percent, and standard deviation for variables of importance.

Key Informant Interviews

Key Informant Interviews (KII) were designed to incorporate the expertise of individuals working with MCH populations and programs in Texas. The MCH Epidemiology team developed an interview tool including broad, open-ended questions to elicit rich, descriptive responses. Key informants were interviewed between June 2019 and November 2019. Interviews were conducted over the phone for greater access to key informants, affordability, and ease for both interviewers and interviewees. In total, the MCH Program staff sent over 700 recruitment emails to key informants and of 122 individuals participated in the interview.

Following transcription of recorded interviews, all files were qualitatively coded by staff. All transcribed interviews were coded in Atlas.ti version 8, a qualitative analysis software designed for multi-user coding and collaboration. Each interview transcript was coded by two separate team members for reliability.

Themes were developed through a six-phase thematic analysis approach outlined by Braun and Clarke [[1]] which begins

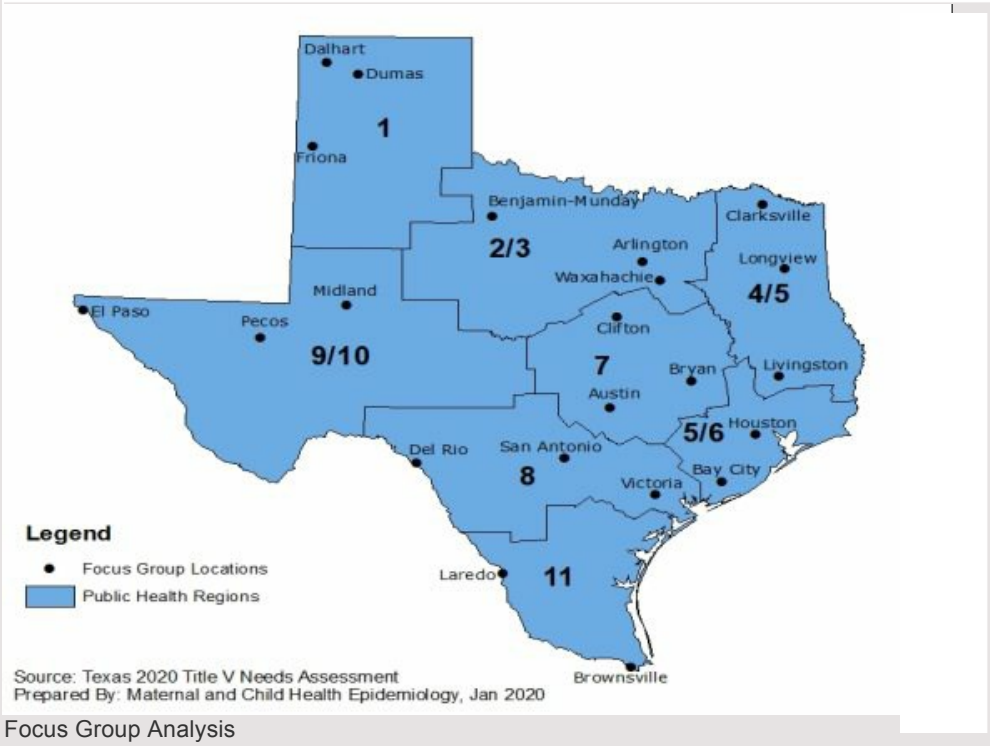
with first reading all the data, followed by examining all codes for patterns, overlap, and repetition. Codes that had overlap were merged into larger spanning topic codes. Recurring codes and quotes were examined to determine emergent themes.

Focus Groups

To seek detailed community input, focus groups were conducted in 23 cities, including cities in every public health region. For administrative purposed, the state of Texas is divided into 11 public health regions. Considering the vast size and geographic as well as regional diversity, care was taken to ensure focus groups were conducted in all regions spanning the entire breadth of Texas, as shown in Figure 2.

Focus groups were designed to target both community residents and healthcare providers and to capture diverse needs for different regions across the state. Facilities were chosen based on a few criteria including space size, hours of operation, transportation, and location. Focus group sessions included: 1) pregnant women and families with babies, 2) parents of children and adolescents, 3) parents of CSHCN, 4) providers of pregnant women and infants, 5) providers for children and adolescents, and 6) providers of CSHCN. In a few cases, focus groups were combined due to the time restrictions of the chose facility. Focus group staff were trained on a protocol using a focus group guidebook. Each focus group session had a moderator, at least one note-taker, and assistants; all roles were outlined in the guidebook.

Figure 2. Map of Focus Group Site Locations



Focus Group Analysis

A similar method of analysis was used for the focus group data as the one outlined in Key Informant Interview analysis. Additionally, focus group data was analyzed for regional patterns and themes.

Thematic analysis was completed for focus groups overall, which included the development of overarching themes, as well as domain specific themes. In addition, thematic analyses were completed by region. To complete these region-specific thematic analyses, transcripts were sorted by region, and, using Atlas.ti software, matrices were built to analyze the prevalence of each code within specific regions. For regions that had a high prevalence of codes, quotes were read thoroughly, and themes were developed from these quotes and codes.

Secondary Data Analysis

Data sources for secondary data analysis were compiled after careful consideration and input from partner programs in Texas including Texas Network of Youth Services, Public Policy Research Institute, and the Texas A&M University. A thorough analysis of existing national and state datasets was conducted to evaluate the current health status of the MCH domains. Within each dataset, specific variables were selected for analysis. Data were stratified by age, race/ethnicity, and gender, based on the topic and available years of data.

Data Sources:

American Community Survey

The American Community Survey is administered by the United States (US) Census Bureau on an on-going basis and collects information about employment, education, poverty status, income, among other topics [[2]].

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance Systems (BRFSS) is a surveillance system in partnership between the Centers for Disease Control (CDC) and DSHS, collecting information regarding preventative healthcare, health risk behaviors, and chronic health conditions for adults 18 years of age and older [[3]].

Current Population Survey

The Current Population Survey is administered by the US Census Bureau and the United States Bureau of Labor Statistics to individuals 15 years and older. The survey collects information about income, job status, school enrollment, family size, insurance status, and other work-related questions[4].

CDC WONDER

The CDC WONDER Online Database includes vital data including birth and death datasets such for all counties within the United States. [[5],[6]].

Feeding America Map the Meal Gap

The Map the Meal Gap project from Feeding America provides information about food insecurity nationwide, by state, and by county.

Healthy People 2020

Healthy People 2020 is managed by the Office of Disease Prevention and Health Promotion within the US Department of Health and Human Services. Objectives span 42 topic areas, and their searchable database includes national and statewide data for each objective [[7]].

National KIDS COUNT

The National KIDS COUNT data center contains national, state, and local data for children under the age of 18 on issues related to child and family health and wellbeing [[8]].

National Performance Measures by the Maternal and Child Health Bureau

From the US Department of Health and Human Services, the Maternal and Child Health Bureau (MCHB)'s National Performance Measures include 15 indicators that cover five maternal and child population domains [[9]].

National Survey of Children's Health

The National Survey of Children's Health (NSCH) is designed to provide national and state-level estimates on key indicators of the health and wellbeing of children, their families and communities, as well as information about the prevalence and impact of special health care needs. Additionally, the NSCH provides estimates for each state's Title V Needs Assessment and several federal and state Title V Maternal and Child Health Services Block Grant National Outcome (NOM) and Performance Measures (NPM).

Nutrition, Physical Activity, and Obesity: Trends and Maps

CDC provides an online database with information available for each state on health behaviors and indicators, [[10]] including information on overweight and obesity prevalence, physical activity, breastfeeding, and nutrition, among other topics.

Pregnancy Risk Assessment Monitoring System

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a surveillance system in partnership between CDC and DSHS. The survey is standardized by CDC and currently covers 83 percent of births in the United States. Information collected includes attitudes and experiences before, during, and after pregnancy for women of child-bearing age [[11]]. For this report, the 2017 survey was utilized.

School Physical Activity and Nutrition Survey

The School Physical Activity and Nutrition Survey (SPAN) is a state-wide surveillance system in Texas which monitors the body mass index (BMI) and related variables in children and adolescents in grades 2, 4, 8, and 11 for the 2015-2016 school year [[12],[13]].

State Vital Records

The State of Texas collects and manages Vital Records which includes birth, death, and fetal death certificates, mortality as well as marriage and divorce records [[14]].

Texas Demographic Center

The Texas Demographic Center produces population estimates and fatality for the state of Texas, as well as for individual counties in Texas. Estimates are stratified by age, sex, and race/ethnicity [[15]]. Data from the 2018 population were analyzed.

Texas Hospital Inpatient Records
The DSHS Center for Health Statistics (CHS) collects and produces reports on Texas hospital inpatient records. The Texas Inpatient Public Use Data (PUDF) [16] provided data on topics including various pregnancy outcomes and child asthma rates.

Texas STD Surveillance Report
The TB/HIV/STD Epidemiology and Surveillance Branch of DSHS generates an annual report with surveillance data on rates of chlamydia, gonorrhea, and syphilis in Texas. The reported data is stratified by age, sex, and race/ethnicity [17].

Youth Risk Behavior Survey
The Youth Risk Behavior Survey (YRBS) is a nationwide surveillance system which collects state-level information from high school students on the topics of sexual health behaviors, alcohol, drug, and tobacco use, and diet and physical activity behavior [18],[19],[20].

Prioritization and Stakeholder Involvement:
Several domain-specific and cross-cutting themes emerged from the qualitative and quantitative analysis of all collected data. A panel of over 50 stakeholders serving MCH populations in Texas was created to seek expert opinion on the needs identified through data analysis in order to prioritize key findings and guide selection of performance measures. Themes were presented to stakeholders at an all-day prioritization meeting.

Stakeholders then voted on themes using a tiered voting system (high need, moderate need, or low need), ranking themes based on their expert knowledge of the MCH population. Votes were counted to select a list of high priority needs from the themes identified.

The high-priority needs identified in this meeting served as the fundamental basis for selecting the National Performance Measures (NPMs) that will guide MCH programmatic efforts from 2020-2025. Corresponding Evidence-Based Strategy Measures (ESM) were formulated in conjunction with the selection of State Performance Measures (SPMs). These ESMs allow for annual tracking of strategies implemented by each State to stay on track with their programmatic efforts for meeting the NPMs, and are therefore crucial.

Please see Section V Supporting Document 1 for Footnote References.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

The needs assessment identified nine priorities for the health and wellbeing of maternal, infant, child, adolescent, and CSHCN populations within Texas. Priorities were developed from themes that emerged from qualitative and quantitative data, including stakeholder input, population input, and analysis of existing secondary data.

Domain	Key Needs
Women/maternal health	Addressing maternal mortality Mental health resources
Infant health	Addressing infant mortality Breastfeeding support Increasing safe sleep practices
Child health	Nutrition education and resources Child-specific mental health resources Increasing developmental screenings
Adolescent health	Addressing electronic cigarette utilization Adolescent-specific mental health and suicide prevention Mitigation of health risk behaviors
CSHCN population	Transition to adulthood support Medical home/care coordination

Across populations, access to healthcare in rural communities, mental health throughout the life course, and social determinants of health emerged as needs. Key findings that contributed to the development of the nine priorities are expanded upon by domain, below.

Women/Maternal Health:

Maternal mortality: In Texas, there were 382 confirmed maternal deaths from 2012 to 2015, defined as death during pregnancy or within 365 days postpartum[1]. The rate of confirmed maternal mortality among Non-Hispanic Black mothers (42.6 per 100,000 live births) was 1.5 times as high as the rate among White mothers (27.6 per 100,000 live births) and 2.2 times as high as the rate among Hispanic mothers (19.2 per 100,000 live births).[2] The most common specific causes of death were drug overdose (16.8%), cardiac event (14.4%), homicide (11.0%), suicide (8.6%), and infection/sepsis (8.4%). The top causes of maternal death during pregnancy or within 7 days postpartum were hemorrhage (18.8%), cardiac event (17.5%), and amniotic embolism (12.5%).2

In interviews, many key informants discussed the need to address racial disparities in maternal mortality, specifically among Black women. Some informants connected maternal mortality to infant mortality or preterm births. A 2012 review conducted by the Maternal Mortality and Morbidity Task Force of pregnancy-related deaths found that in Texas, Black women were affected by pregnancy-related death more than any other race or ethnicity.1 The pregnancy-related mortality rate for Black women was 2.3 times higher than the rate for Non-Hispanic White women (13.9 versus 6.0 per 100,000 live births). The pregnancy-related mortality rate was 9.3 per 100,000 live births for Hispanic women and 12.4 per 100,000 live births for women of Other races.2

Mental health: Depression during pregnancy or following birth is common in women. Postpartum depression is treatable, but providers must screen mothers to provide treatment resources[3]. In Texas, 74.1% of White women, 83.6% of Black women, and 81.3% of Hispanic women with postpartum depression symptoms were screened for postpartum depression. Of these women, Black women had the highest postpartum depression symptoms (27.8%), followed by White/Other (14.8%) and Hispanic women (13.6%).[4]

Many key informants and focus group participants discussed maternal mental health as an overarching theme. Respondents described the lack of information and awareness related to mental health for mothers, the limited health insurance coverage for mental health resources, and specific mental health needs like perinatal and postpartum depression. Some key informants and focus group participants linked maternal mental health to larger health outcomes such as maternal mortality.

Infant Health:

Infant mortality: In 2018, the Texas infant mortality rate (IMR) reached a historic low of 5.5 deaths per 1,000 live births. The IMR in Texas has been at or below the national rate for the past 10 years. Moreover, since 2011, the state has consistently exceeded the Healthy People 2020 (HP2020) target of 6.0 deaths per 1,000 live births.[5] However, racial and ethnic disparities in IMR have persisted in Texas, and the overall decrease in IMR observed in Texas over the past decade was not equally distributed across all race/ethnic groups. IMRs for Black mothers have been twice as high as IMRs for White and Hispanic mothers over much of this timeframe.[6]

Leading causes of infant death differed by race and ethnicity. In 2017, the leading cause of death among Black infants was short gestation and low birth weight with 18.3% of deaths per 10,000 live births. Congenital malformation was the leading cause of death among infants of all other race/ethnic groups, with the highest rate of deaths for Hispanic infants.[7]

Through key informant interviews, racial disparities in preterm births emerged as a prevalent theme. This topic was discussed both in the context of maternal and infant mortality, but through a separate lens, focusing on preterm births. Key informants discussed delayed prenatal care as a risk factor for preterm births. As with IMR, there were substantial

racial/ethnic disparities in the preterm birth rate. Black infants have had a higher preterm birth rate than do infants of any other race/ethnic group.[8]

Breastfeeding: According to the National Immunization Survey, 83.9% of infants born in Texas in 2016 were ever breastfed,[9] similar to the 2016 national rate (83.8%). Since 2012, Texas has met the Healthy People 2020 (HP2020) target for the proportion of infants having ever been breastfed.[10] However, significant racial and ethnic disparities exist in the rate of women who ever breastfed their infant. Black mothers have reported lower rates of ever breastfeeding than both White and Hispanic mothers.[11]

While a relatively large proportion of Texas mothers reported having ever breastfed, rates of exclusive breastfeeding were significantly lower.[12] Research has shown that the benefits of breastfeeding are greatest when the baby is exclusively fed breast milk for the first 6 months after birth. According to the National Immunization Survey, 24% of Texas mothers reported breastfeeding exclusively at 6 months in 2016.[13] According to the Texas WIC Infant Feeding Practices Survey, among mothers enrolled in Texas WIC in 2018, only 4% reported exclusively breastfeeding at 6 months of age.[14]

Breastfeeding was a prominent theme discussed in both key informant interviews and focus groups. Participants addressed the need for education associated with breastfeeding, including the need for more education for providers and more education for women themselves. Breastfeeding was discussed in terms of need for increased lactation support in the community. They addressed a gap in women who do not qualify for WIC and therefore have limited resources related to breastfeeding available to them within the community. In focus groups, some participants expressed concerns over infant feeding more generally, expressing concerns about family norms of formula feeding impacting mothers' interest in breast feeding, cultural impacts on likelihood to breastfeed, breastfeeding resources for teenage mothers, and general perceptions of breastfeeding within their communities.

Safe Sleep: According to Texas Pregnancy Risk Assessment Monitoring System (PRAMS) data, 78% of mothers reported placing their infant on their back to sleep in 2017. This percentage has increased by over 30% since 2008. Despite this significant increase, substantial race/ethnic differences still exist. Although the proportion of Black mothers placing their infant on their back to sleep increased by 88% between 2008 and 2017, this proportion was still significantly lower among Black mothers than among White mothers and Hispanic mothers in 2017.[15]

Key informants and focus group participants discussed the need to promote safe sleep practices and continued safe sleep education. Interviewees indicated that they had personally heard about or seen non-recommended infant sleep practices occurring in their community. As a result of these experiences, they believe there is a need to continue safe sleep education.

Child Health:

Child Nutrition: The percent of children living in food insecurity in Texas is 22%, exceeding the national average of 17% and giving the state the 5th highest rank for child food insecurity in the nation.[16] The percentage of children living in food insecurity has been declining since 2010, but nearly one in four Texas children were still living in food insecure situations in 2017, an estimated 1.66 million children. Living areas with little to no access to nutritious foods can impact the overall health of children and act as a risk factor for obesity and other conditions.[17]

Child nutrition emerged as a theme in both key informant interviews and focus group conversations. Discussions on this topic included what children were eating at school and home, nutrition education, food security concerns, and available resources. Many participants linked child nutrition to other health outcomes, such as diabetes and obesity.

Child Mental Health: Mental health services for children in Texas are extremely limited with low numbers of psychologists available within the state. Based on the 2019 data from the Health Professions Resource Center, 102 of the 254 counties in Texas do not have school psychologists.[18] Based on the National Survey of Children's Health (NSCH), 21% of children in Texas have one or more emotional, behavioral, or developmental condition as diagnosed by a doctor, such as autism, attention deficit disorder, anxiety, depression, and developmental delays.[19] Given that not all children in Texas have access to a mental health provider, the prevalence of these conditions may be under-reported; actual prevalence could be higher. Of children who needed mental and behavioral health treatment or counseling, less than half received the needed care, with similar rates in Texas to the United States.[20]

Mental health resources for children was identified as a major need through the key informant interviews and focus groups. Participants expressed concern over the lack of mental health resources and the need for mental health resources geared specifically towards children. Several respondents highlighted early childhood development as well as trauma-informed care, especially for children in the child welfare system.

Developmental Screenings: The American Academy of Pediatrics (AAP) recommends all infants and children 9 to 35 months of age receive screenings for developmental delays during well-checks using standardized screening tools.[21] In the United States and Texas, most parents (68% and 63%, respectively) reported that they did not complete a developmental screening with their doctor for their child.[22] The need for increased developmental screenings in children was discussed in focus groups among parents and providers of children. Some parents spoke from personal experience about difficulties getting their child screened. Other focus group participants explained that these screenings need to be more widely available. Participants explained the importance of both providers and families receiving education on milestones and

developmental screening.

*Adverse Childhood Experiences (ACEs):*Household dysfunction, abuse, and neglect experienced during the first 18 years of life have been found to predict a host of chronic diseases, depressive disorders, and even early death, as found by the Adverse Childhood Experiences (ACEs) Study. ACEs are a set of ten experiences reflecting childhood adversity that are linked with negative health outcomes later in life. The higher the number of ACEs a child experiences, the higher the likelihood of developing long term health problems and chronic illness.[23]

In Texas and nationwide, almost 20% of children have experienced two or more adverse childhood experiences. Some demographics are disproportionately exposed to ACEs. Exposure to ACEs declines as household income increases. White populations have overall lower exposure to ACEs compared to Black and Hispanic populations.[24] Health risks are higher for those with increased exposure to ACEs, including increased risk of future violence, chronic health conditions, Sexually Transmitted Infections (STI)s, teen pregnancy, depression, and suicide, among other risks.[25],[26] Focus group participants and key informants discussed risk factors for and outcomes of ACEs, including long term health outcomes associated with ACEs.

Adolescent Health:

Vaping: Vapes or electronic cigarettes are currently the most commonly utilized tobacco product amongst youth. According to the Texas Youth Risk Behavior Surveillance System, 50% of students have tried an electronic cigarette by 12th grade. By race and ethnic categories, use was the highest in White students at 44.6%, followed by Hispanic students at 41.3%, Black students and 36.2%, and other at 31.7%. Incidence of use increased with increasing grade level, with 50% of twelfth graders reporting trying electronic cigarette products.[27]

A significant number of key informants and focus group participants brought attention to the use of electronic cigarettes among adolescents. This was framed as an emerging issue with potential health risks and widespread use among adolescents.

Adolescent mental health and suicide related behavior: Key informant and focus group participants addressed mental health broadly, but many focused on the need for adolescent-specific mental health resources. Respondents noted that adolescents are at a unique point in their lives, transitioning to adulthood, and mental health resources should reflect these unique needs. Some addressed the difficultly accessing available resources. Many drew attention to a growing suicide rate and a need for suicide prevention. Some commented on the need for education and resources related to suicide prevention and the larger topic of mental health.

Based on 2017 data from the Child Fatality Review Team, suicide emerged as the top cause of death for 10-14 year-olds and 15-17 year-olds, followed by motor vehicle accidents.[28] The frequency of adolescent deaths by suicide has been rising in recent years in Texas and the U.S., as have suicide-related thoughts and behaviors.[29],[30] In Texas in 2018, the total teen suicide rate was 14.3 per 100,000, with a large discrepancy between males (22.7) and females (5.4). By race and ethnicity, White adolescents had the highest suicide rate, followed by Asian adolescents. The suicide rate was lowest among Black adolescents followed by Hispanic adolescents. The suicide rate was below the national average for Black teens; the other racial and ethnic categories were above the national averages.[31]

Health risk behaviors: Based on National Performance Measures from the United States Department of Health and Human Services and based on state inpatient databases, Texas has had a consistently lower rate of adolescent hospitalization for injury than the rest of the United States, and rates have been declining steadily for both the United States and Texas since 2000.[32] However, adolescents in Texas continue to have behaviors that increase the risk of injury which differs across subpopulations. Focus group participants highlighted the need to focus on health risk behaviors in adolescents. Health risk behaviors can include several components but focus group participants emphasized drugs and alcohol use, vaping, and risky sexual behaviors.

Sexual dating violence was more often reported than physical dating violence across genders, grades, and race and ethnic groups. Females reported experiencing more sexual dating violence than males (22.8% and 9.5% respectively), but physical dating violence was similar, at 7.6% for females and 6.1% for males. Twelfth-graders had the highest percentage of ever experiencing sexual dating violence.[33]

In 2017, 61% of high school students reported having at least one drink in their lifetime and 27% reported having at least one drink in the past 30 days. Percentage of students having ever tried alcohol increased with grade, reaching 74% by twelfth grade. By race and ethnicity, White students had the highest percentage of any alcohol use at 66% and Black students had the lowest percentage at 49%.[34] Use of alcohol within the last 30 days was reported by 27% of high school students. Recent alcohol use was highest amongst twelfth graders at 37%, followed by eleventh graders at 30%. It was lowest amongst ninth and tenth graders at 21% and 22% respectively.[35]

Teens within the 15-17 age range are more likely to die in motor vehicle accidents than children of other age groups.[36] Risky behaviors related to driving include talking on the phone while driving, texting and emailing while driving, driving after having one or more drinks, and riding with a driver who had been drinking. Male and female engagement in these risk behaviors were similar.[37]

Children with Special Health Care Needs (CSHCN) Population:

Transition to adulthood: healthcare and life skills: Transitioning from childhood to adulthood often presents unique challenges for youth with special health care needs. Transitioning to adulthood includes moving from the pediatric to the adult health care system, planning for future educational needs, attaining skills for employment and independent living, and addressing legal changes. In the Title V CSHCN Parental Outreach Survey, 75% of respondents said that they did not feel prepared for their child's transition, indicating that this time presents substantial challenges and uncertainty for youth and their families.

Key informants and focus group participants described the difficulties in transitioning to adulthood with an emphasis on health care transition and developing life skills for independent living as an adult. They expressed a need for supporting youth and young adults in planning for higher education and vocational training and in developing life and social skills to become productive members in the community.

Young adults may become ineligible for certain health care benefits when they reach adulthood if they fail to enroll into eligible Medicaid-based services after 21 years old. Based on 2016-2018 NSCH data, most of the CSHCN population did not receive the services necessary to transition to adult health care in Texas (87.5%) or in the United States (82.2%).[38] When asked about transition to adulthood, 75% of the Parental Outreach Survey respondents did not feel prepared for their child's transition to adulthood. Guardians were most likely to report that they had not prepared for their child's transition in multiple areas including health care, postsecondary education, and addressing legal needs, and most had no help preparing.

Medical home and care coordination: Quality of care can be enhanced for individuals that have access to a medical home. A medical home is not a place but an approach to care. The AAP defined a medical home as "medical care for children and adolescents that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective."[39],[40]

In Texas, about 40% of care received by CSHCN met the criteria for medical home. However, access to this quality of care varied by race and ethnicity, with 70% of Hispanic children, 51% of White children, and 39% of multi-racial and other children not receiving care that met the criteria for medical home, similar to national data.[41] The percentage of CSHCN who received care in a well-functioning system in Texas is 12%, compared to 15% in the United States, which NSCH determined using age-specific measures to assess adequate insurance access, having a medical home, and having no unmet needs or barriers to access of services.[42]

Focus group participants highlighted the need for improved access to primary and specialty providers, resources, and therapies for the CSHCN population, particularly. Some participants explained that they lived in rural communities but in large cities as well. Other parents and providers expressed delays in accessing care, citing barriers such as having health insurance coverage of therapies and the overall cost of therapies. In the CSHCN Parental Outreach Survey, respondents were asked about health care access barriers. The top three barriers to seeking help for their child when sick were not having a medical provider in their community who is comfortable taking care of their child (10.3%), not having money for the office visit or co-pay (10.3%), and that the medical provider is far away (9.5%).

An important aspect of a medical home is coordinating care, which refers to multiple care providers working together to organize and plan patient care and ensure that a child can access care when needed. In the Parental Outreach Survey, more than half (61%) of parents and guardians organized care themselves, suggesting that a significant portion of this population was not receiving coordinated care from health care providers. Of those with care coordination, it was most often received from a case manager, social worker, or community health worker of from someone at their child's doctor's office.

Overarching/Non-Domain Specific Health:

Difficulty accessing healthcare in rural communities: Difficulties with accessing healthcare and healthcare providers in rural communities was commonly discussed in focus groups. Many people mentioned that rural communities often lack healthcare resources. Due to this lack of resources within their immediate communities, participants explained that they must travel to see providers, and some indicated a barrier in traveling far distances. Others highlighted the increase cost associated with traveling to receive healthcare.

The Health Professional Shortage Area (HPSA) designation employs a ratio of population to primary care physicians to determine whether an area has a shortage of physicians. The ratio threshold is 3,500:1 and is reduced to 3,000:1 in areas with high needs, such as at least 20 percent of population below poverty level or more than 20 infant deaths per 1,000 live births. Areas that exceed these ratios may qualify for designation as HPSAs. Other factors, such as time/distance to nearest source of care and population composition, are also included in the federal HPSA criteria. Recruiting and retaining health care professionals is an ongoing challenge not only in rural areas but in some urban areas as well. In rural areas, retention of health care professionals is mostly due to population size, whereas in some urban areas, access is limited because many providers do not accept Medicaid or because patients are not enrolled in Medicaid and are unable to pay out-of-pocket.[43] Most counties in Texas are designated as either a whole-county or partial-county HPSA.[44]

Mental health across life course: Mental health resources were a need identified by focus group participants, key informants, and survey respondents. All groups discussed mental health across domains, explaining that nearly all women, infants, children, adolescents, and CSHCN need access and resources for their mental health and wellbeing. One essential item related to mental health across the life course is access to providers.

Respondents to the Title V Community Outreach Survey indicated that finding a mental or behavioral health professional

was very or extremely difficult, especially finding one that treats children. In Texas in 2019, only 30 counties met the recommended National Association for School Psychologists student-to-provider ratio (30,000 people or residents to 1 psychiatrist, and 20,000 people/residents to 1 psychiatrist in areas with high needs[45]), including Travis and Bexar counties, which respectively contain the large cities of Austin and San Antonio.[46] Psychiatrist shortage is also a concern. As of 2018, only three counties in Texas met the HPSA recommended mental health ratio. There are almost no child and adolescent psychiatrists in the state practicing outside of major cities in Texas.[47]

Social determinants of health: Social determinants of health encapsulate many of the needs identified through the Tile V needs assessment but can also be classified as a specific need. Key informants addressed social determinants of health (SDOH) in both a broad overview and by discussing specific dimensions of SDOH. Informants discussed implications of SDOH in general, across populations. Most key informants commented that SDOH are a large and complex issue, impacting nearly all elements of health. While informants did not provide many solutions to negative health outcomes associated with SDOH, they did reinforce that attention must be drawn to SDOH to create health equity. Informants agreed that these discussions around SDOH must be had and considered as MCH needs are addressed.

Please see Section V Supporting Document 1 for Footnote References

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

Texas has a plural executive branch system with power divided among the governor and independently elected Executive Branch officeholders. Except for the Secretary of State, all executive officers are elected independently, making them directly answerable to the public rather than the governor. The Texas Legislature has a House of Representatives with 150 members, while the Senate has 31 members. The Legislature meets in regular session once every two years (odd-numbered years). During the interim, the Legislative Budget Board (LBB) is one of several statutory bodies that provide direction to state agencies. This 10-member permanent joint committee of the legislature develops budget and policy recommendations for funding appropriations to all state agencies, and completes fiscal analyses for proposed legislation. The joint-chairs are the Lieutenant Governor and the Speaker of the House. The Health and Human Services Commission (HHSC) was created by the 72nd Texas Legislature (1991) to provide leadership and strategic direction for Texas' Health and Human Services (HHS) System.

In July 2020, Governor Greg Abbott announced Cecile Young as the new Executive Commissioner for the Texas Health and Human Services Commission (HHSC). Young previously served in various roles at HHSC, including Acting Executive Commissioner, Chief Deputy Executive Commissioner, and as the Chief of Staff.

The Department of State Health Services (DSHS) is the state agency responsible for the administration of Title V and is housed under HHS and works closely with HHSC, the state agency responsible for oversight and coordination among all health and human services-related state agencies. John Hellerstedt, MD took on the role of Commissioner of Texas DSHS in January 2016. DSHS performs its duties through staff located at the state headquarters in Austin and in eight geographical Public Health Regions statewide; through contracts with local health departments, community-based organizations, and other groups; and in concert with other state agencies and local partners. Funds for agency activities originate from federal grants and allocations, state general revenue streams and local funding provided by contractors. Title V programming and administration is housed within the Community Health Improvement Division, under the leadership of Manda Hall, MD.

III.C.2.b.ii.b. Agency Capacity

DSHS focuses on physical and behavioral health to improve the health and well-being of Texans. This mission is accomplished in partnership with academic, research and HHS stakeholders who work collaboratively to address existing and future issues. DSHS population-based services focus on prevention and education to address disease and minimize the need for future medical interventions. DSHS works closely with other federal, state and local health and human service agencies, particularly those that serve similar populations.

The statutory governance and organizational structure of DSHS play a role in how its functions are performed. As a "home rule" state, local health officials operate autonomously from, but in partnership with DSHS. HHS agencies produce a single plan addressing opportunities and challenges in the Coordinated Strategic Plan for Health and Human Services. DSHS client services, state hospitals and regulatory functions moved to HHSC in 2016 as part of a re-organization.

Contractors provide child health and dental services and prenatal medical and dental services. Primary health care contractors also provide well woman and family planning services for eligible women. The Newborn Screening Program within DSHS provides short-term follow-up for all newborns that have been screened and found to be presumptively positive for rare disorders. In addition, Texas DSHS provides point-of-service screens for hearing and critical congenital heart defects. The Newborn Hearing Screening Program, through Texas hospitals offering obstetrical services, works to ensure all children who have hearing loss as newborn infants or young children are identified early and provided appropriate intervention services needed to prevent delays in communication and cognitive skill development.

The Birth Defects Epidemiology and Surveillance program, established in 1993, identifies, investigates and monitors birth defects in Texas. The program identifies the risk factors and causes of birth defects, supports the development of strategies to prevent birth defects and maintains data in a central registry.

Legislation, focused on child passenger safety, requires children younger than 8 years old, unless they are 4’ 9” in height, to be properly restrained in a child passenger safety seat while riding in an operating vehicle. Child Fatality Review Teams (CFRTs) are authorized under Texas Family Code Sections 264.501-264.515. The CFRT State Committee is a multidisciplinary group of professionals reflecting the geographical, cultural, racial, and ethnic diversity of the state. CFRTs work to understand the causes and incidence of child deaths in Texas; identify procedures within the represented agencies to reduce the number of preventable child deaths; increase public awareness; and make recommendations to the governor

and legislature for effective changes in law, policy, and practices. A childhood immunization law, passed in 1993, mandates age-appropriate immunization of every child in Texas. Exclusions from compliance are allowable on an individual basis for medical contraindications, reasons of conscience, including a religious belief, and active duty in the U.S. Armed Forces.

Building on the success of the Texas Healthy Adolescent Initiative from 2010 to 2018, the Texas Youth Action Network (TYAN) promotes Positive Youth Development (PYD) and Youth-Adult Partnerships (YAPs). The Rape Prevention and Education (RPE) program is a primary prevention initiative aimed at reducing sexual violence.

Children with Special Health Care Needs Services Program (CSHCN SP) is authorized under Texas Health and Safety Code Sections 35.001-35.013 which states that, for children with special health care needs, the program shall provide 1) early identification; 2) diagnosis and evaluation; 3) rehabilitation services; 4) development and improvement of standards and services; 5) case management services; 6) other family support services; and 7) access to health benefits plan coverage. CSHCN SP Texas Administrative Code rules expand on the details of the above services. Texas Medicaid provides rehabilitation and acute care services to individuals under the age of 16 who are blind or disabled and receiving benefits under Title XVI.

III.C.2.b.ii.c. MCH Workforce Capacity

The Maternal and Child Health Section (MCHS) at the Texas Department of State Health Services (DSHS) is responsible for MCH Services Block Grant management, reporting, consultation, and compliance. Within the MCHS, the Maternal and Child Health Epidemiology Unit (MCHE) provides centralized epidemiologic, data, research, and reporting support to MCHS and the Title V supported efforts. MCHE maintains the capacity to provide Title V program areas with expert statistical analysis, data management and performance measure reporting, geographical/spatial analysis, research studies and consultation, and program evaluation and monitoring. The Child and Adolescent Health Branch within MCHS houses the CSHCN Systems Development Group (SDG) as well as Child and Adolescent Health programming. The HTMB Branch houses all Maternal/Women's Health and Infant/Perinatal Health programming and expertise. Key positions in the MCHU include the Title V MCH Unit Director and the State CSHCN Director/ Child and Adolescent Branch Manager. Key positions within MCHS include the State MCH Director and the Block Grant Administrator.

To assess MCH Workforce Capacity as part of the five-year Needs Assessment, Texas distributed a Capacity Survey to individuals working with and implementing Title V Maternal and Child Health (MCH) programming throughout the state. This survey was designed to assess workforce capacity by collecting data on level of experience and training and by asking respondents to self-assess their skills. Additionally, as respondents were working with the target populations and addressing MCH needs, their knowledge and experience in the field is invaluable when setting priorities and planning for the next five years. Therefore, this survey was also designed to collect their valuable input on needs and themes that should be the focal point for MCH programming for the upcoming years. The survey was completed by 430 respondents.

The capacity survey findings provide a detailed overview of the self-reported and self-perceived workforce capacity of MCH professionals in the State of Texas who responded to this survey. This survey elucidates both strengths and opportunities for growth amongst the workforce dedicated to Title V MCH programming in Texas. This survey also identifies priorities and important themes from people with direct experience working with the target populations. The following are key findings that emerged from the capacity survey.

- Over half of survey participants felt that the success of their MCH programming was average, and only four percent rated their efforts as highly successful.

- In a self-assessment of their skills and knowledge, participants ranked themselves highly in all leadership skill questions and most analytical skills. They also ranked themselves highly on knowledge of evidence-based programming and best practices and knowledge of health disparities.

- In a self-assessment of their skills and knowledge, more participants ranked themselves as having no or basic skills in MCH policy knowledge, analytical skills of identifying and collaborating with researchers with relevant skill sets to improve programs and policies, and knowledge of MCH safety programming.

- Addressing health equity and health disparities were ranked highly by participants as priority needs and cross-cutting themes. This is also relevant to the performance measures that were important to participants, particularly reducing maternal mortality.

- Two additional themes found in priority setting among participants included improved access to services and increased services for transition from childhood to adulthood, including the CSHCN population.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

Title V staff build bridges and leverage efforts to build a solid infrastructure, collect and analyze data; design, implement and evaluate programs; and provide technical support and training to promote healthy behavior and improve the health of Texas communities. Collaborative work includes partnering with Health and Human Services Commission (HHSC) to support efforts

that coordinate programs and initiatives that serve Maternal and Child Health (MCH) populations across HHSC agencies and programs. Title V partners with internal and external Department of State Health Services (DSHS) partners, stakeholders, and contractors to implement program and reach MCH populations throughout the state. Regional DSHS staff through the 8 Public Health Regions (PHR) play a critical role in assessing and addressing community needs. The Texas Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program is housed at the Department of Family and Protective Services within the Prevention and Early Intervention (PEI) Program. Title V and PEI collaborate on multiple initiatives, and most recently on the Statewide Needs Assessment process to ensure alignment, coordinate data collection and findings, and prevent duplication of efforts for both assessments.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Through the Needs Assessment process and stakeholder feedback, a list of health priorities was determined. These priorities were categorized by common areas and population health domains, then further refined ranked by Title V leadership and key MCH partners resulting in the development and selection of 9 new State Priority Needs (SPN). As DSHS continues to assess needs and address emerging issues in Texas, these priorities reflect the populations served and the ongoing work of the Title V program in the state. Several of the new state selected priorities are a continuation or broadening of priorities previously selected in the previous five-year needs assessment. The following are the SPNs for Texas:

1. Implement health equity strategies across all maternal and child health populations.
2. Improve nutrition across the life course.
3. Improve the cognitive, behavioral, physical, and mental health and development of all MCH populations.
4. Increase family support and ensure integration of family engagement across all MCH programming.
5. Support health education and resources for families and providers.
6. Promote safe, stable, nurturing environments to reduce violence and the risk of injury.
7. Improve transition planning and support services for children, adolescents, and young adults, including those with special health care needs.
8. Support comprehensive, family-centered, coordinated care within a medical home model for all MCH populations.
9. Improve maternal and infant health outcomes through enhanced health and safety efforts.

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$33,958,965	$34,534,092	$33,958,965	$34,479,259
State Funds	$40,208,728	$40,208,728	$40,208,728	$40,208,728
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$74,167,693	$74,742,820	$74,167,693	$74,687,987
Other Federal Funds	$3,527,463	$3,252,567	$4,410,557	$4,896,572
Total	$77,695,156	$77,995,387	$78,578,250	$79,584,559

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$33,958,965	$35,146,149	$34,479,260	
State Funds	$40,208,728	$40,208,728	$40,208,728	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$74,167,693	$75,354,877	$74,687,988	
Other Federal Funds	$4,139,691	$3,630,896	$5,397,579	
Total	$78,307,384	$78,985,773	$80,085,567	

	2022	
	Budgeted	Expended
Federal Allocation	$35,734,420	
State Funds	$40,208,728	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$75,943,148	
Other Federal Funds	$4,711,238	
Total	$80,654,386	

III.D.1. Expenditures

The set of Budget Forms (2, 3a, and 3b) were prepared in collaboration with the DSHS Funds Coordination and Management Branch and the Community Health Improvement Division fiscal oversight team members to provide a complete updated set of budget and expenditure data for FY20. Field Notes have been added to provide additional detail to individual form cells as needed. Expenditure information and budget planning is coordinated through ongoing communication and monthly in-person meeting between DSHS and HHSC budget and program personnel. Expenditures listed do not include agency indirect allocations. Title V is the payer of last resort, by legislation, and the services listed by the state reflect services that were not covered or reimbursed through another provider. In FY20, MCHS continued efforts to identify new opportunities to collaborate with other programs in the agency to build upon existing programs serving mothers, infants, children and youth.

Federal Expenditures noted in Form 2 amounted to $35,146,149 and reflect 39.5% of funds expended for preventive and primary care for children ($13,891,250), 38.8% for Children with Special Health Care Needs ($13,639,521), and 7.9% expended for Title V Administrative Costs ($2,743,058). Population-based and public health systems programs continued to be a focus. Non-federal MCH expenditures totaled $40,208,728, per the state required match.

Due to COVID-19, some planned FY20 activities were impacted. Many in-person efforts, including school-based activities (or initiatives involving children and adolescents), and in-person meetings, could not proceed as planned. Adjustments were thoughtfully considered and Texas made many adaptations to programming and planning as the pandemic unfolded in FY20, including shifting to virtual meetings, assisting with various COVID-19 response efforts as outlined in the annual reports. Programs worked with contractors to amend budgets as needed.

III.D.2. Budget

The budgeted federal amount of $35,734,420 for FY22 is consistent with the federal allocation per Notice of Award totals. The DSHS commitment of state general revenue for FY22 remains limited to the Texas Maintenance of Effort (MOE) requirement of $40,208,728. The Title V program makes good faith efforts to comply with allocating and spending at least 30% of the federal allotment for preventive and primary services for children and at least 30% for services for children with special health care needs. The Title V program funding supports accountants within the DSHS Budget Office whose primary responsibilities are to set-up detailed accounting and financial practices in managing the Title V budget. The accountants work closely with financial analysts within the Community Health Improvement Division (CHI) to establish internal controls to monitor expenditures of federal funds. Financial reports are prepared on a monthly basis to ensure compliance with the 30% - 30% requirement.

The CHI Division and Title V program leadership review reports, provide feedback, and adjust service delivery as needed to maintain the required spending proportions. The same rigorous monitoring process is in place to comply with the 10% cap on administrative expenditures which are budgeted at $3,475,000. Calculation methodologies for the Block Grant budget forms represent an accurate reflection of expenditures of state and federal funds for the 30/30/10 requirement. For FY22, the projected budget shows that $15,565,952 of the federal Title V awarded funds are specifically marked for preventive and primary care for children while $13,647,520 are budgeted for children with special health care needs. These dollar amounts, based on the projected FY22 federal allocation, will ensure that Texas is in compliance with federal requirements. Due to the trend in reduction of spending in direct services at Texas HHSC, there continues to be a decrease in budgeted amounts for direct services.

Texas receives other federal, state, and private grants related to women and children, including the DHHS Rape Prevention and Education (RPE) Program, Pregnancy Risk Assessment Monitoring System (PRAMS), the State Systems Development Initiative (SSDI), National Violent Death Registry grant, Universal Newborn Hearing Screening and Intervention, and Texas Early Hearing Detection and Intervention (EHDI) State Programs. Additionally, Texas is a recipient of the Center for Medicare and Medicaid (CMS) Zika Grant, and Centers for Disease Control and Prevention (CDC) grant called Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees.

Title V is planning for implementation of new efforts and continuing impactful existing efforts to address the national and state performance measures identified through the five-year needs assessment process. Texas continues to assess the impact of COVID-19 on spending in FY21 so that programmatic and budgetary modifications can be addressed in FY22 as needed.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Texas

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

Texas addresses national and state performance measures through strategic coordination of efforts with partners, families, and stakeholders to improve health outcomes for all MCH populations. To ensure statewide reach and MCH expertise throughout the Public Health Regions (PHRs), MCHS funds uniquely positioned DSHS staff in the 8 PHRs to support population-based services in communities around the state. To align with the goals of the Title V MCH Block Grant and improve accountability of performance in Texas, MCHS practices quality improvement efforts and ensures that MCH activities are evidence-based and outcome-driven. This allows for improved impact assessment of all programming to demonstrate changes in health outcomes at the state and local level. For regional population-based activities, partnerships between regional staff, MCHS, and MCHE enable implementation of precision public health activities in local areas by focusing on data, state and national priorities, and community needs to help prioritize and determine local initiatives. Regional staff also provide case management for CSHCN and their families, and MCHS continues to support child and prenatal safety net services in Texas. Newborn Screening and Oral Health programming reside within the Maternal and Child Health Section, allowing for advanced collaboration and alignment from central office and through the regions. Through coordinated efforts and statewide MCH infrastructure, Texas strives to improve the health of all MCH populations, prepare and respond to emerging issues, and meet the objectives outlined in the Action Plan.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

Texas recognizes the value in developing the Texas MCH and CSHCN workforce and enhancing MCH capacity at DSHS. To better serve MCH populations, address and adapt to the changing needs in the state, and improve health outcomes, the Title V workforce in Texas strives to maintain optimal subject matter expertise and staffing infrastructure.

The Maternal and Child Health Section (MCHS) is housed within the Community Health Improvement Division (CHI) at DSHS. The CHI Division includes MCH, Health Promotion and Chronic Disease Prevention (HPCDP), Environmental Epidemiology and Disease Registries, and Vital Statistics. MCHS consists of the MCH Unit (MCHU), MCH Epidemiology (MCHE), The Newborn Screening Unit, and the Health Screening and Oral Health Unit. The MCHU is where the core functions of MCH programs are housed. Areas within this Unit include Child and Adolescent Health Branch, the Healthy Texas Mothers and Babies (HTMB) Branch, and the Office of Injury Prevention. The Child and Adolescent Health Branch houses the CSHCN Systems Development Group (SDG) as well as Child and Adolescent Health programming. The HTMB Branch houses all Maternal/Women's Health and Infant/Perinatal Health programming and expertise. Key positions in the MCHU include the Title V MCH Unit Director and the State CSHCN Director/ Child and Adolescent Branch Manager. Key positions within MCHS include the State MCH Director and the Block Grant Administrator.

The HTMB Branch within the Unit is led by the State Breastfeeding Coordinator/MCH Nurse Consultant and includes the Maternal Mortality and Morbidity (MMM) Nurse, the Women's and Perinatal Coordinator, and the Perinatal and Infant Coordinator. Regional Population-Based activities are implemented across the state in communities through DSHS regional staff and are coordinated through the MCH Regional Programs Administrator. Child Health and Adolescent Health Coordinators work closely with the state Child Fatality Review Team coordinator and CSHCN staff on programing and surveillance activities.

The Child and Adolescent Health Branch is led by the State CSHCN Director and includes the CSHCN SDG. The CSHCN SDG oversees the implementation of the CSHCN Title V performance measure activities. The CSHCN SDG includes the Texas Title V CSHCN Director and four full time Program Specialists. Three team members have Masters level degrees in public health and education. Staff who are parents of CYSHCN participate in the development of programmatic activities and decision-making. Title V funds a health care benefit program administered by HHSC which includes Family Support Services. Case Management and Family Support and Community Resources are provided to CYSHCN and their families through community-based contractors and/or regional DSHS staff. CSHCN SDG staff serve as subject matter experts for contractors and provide technical assistance, education and resources. Program staff lead and facilitate the Medical Home and Transition to Adulthood Learning Collaboratives and participate in other statewide initiatives including the planning committees of the Baylor College of Medicine Annual Chronic Illness and Disability: Transition from Pediatric to Adulthood conference and the Texas Primary Care Consortium, Texas Council for Developmental Disabilities, Policy Council for Children and Families, and Community Resources Coordination Groups Statewide Workgroup. The CSHCN Director and the State CSHCN Health Coordinator are members of the Texas Children with Medical Complexity (CMC) Collaborative Improvement and Innovation Network (CoIIN) team led by Boston University.

MCHE provides centralized epidemiologic, data, research, and reporting support to all MCH programs. MCHE possesses the capacity to provide MCH epidemiologic, data, research, and reporting support for Title V program areas, including expert statistical analysis, data management and performance measure reporting, geographical/spatial analysis, research studies and consultation, and program evaluation and monitoring. Please refer to the supporting documents for key MCHE presentations and contributions, and to narrative section III.E.2b.iii.a MCH Epidemiology Workforce for additional details.

Manda Hall, M.D. was named the Associate Commissioner for the Community Health Improvement Division at

DSHS in September 2017. In this role, Dr. Hall oversees and provides strategic direction to four Sections within the Division: Maternal and Child Health, Environmental Epidemiology and Disease Registries, Vital Statistics, and Health Promotion and Chronic Disease Prevention. Prior to this position, Dr. Hall served as the Texas Title V MCH Medical Director for nearly two years, and the Children with Special Health Care Needs Director for over three years. Dr. Hall received her Bachelor of Science Degree in Biology from Lamar University and her Medical Degree from Texas A&M University Health Science Center College of Medicine. She completed her Internal Medicine/Pediatrics residency and an Allergy and Immunology fellowship at the University of Alabama at Birmingham. Dr. Hall was recently elected to serve as President of the Association of Maternal and Child Health Programs (AMCHP) for 2021-2022. Before her role as President, Dr. Hall served as the AMCHP Region VI Director from 2017 to 2020 and served on the Legislative and Health Care Finance Committee, and Conference Planning Committee. She graduated in May 2014 as a fellow in the Maternal and Child Health Public Health Leadership Institute at the University of North Carolina at Chapel Hill and the Texas Health and Human Services Executive Leadership Academy in 2017. She is a faculty member of the DSHS Preventative Medicine and Public Health Residency Program.

Dr. Kelly Fegan-Bohm, MD, MPH, MA is the Medical Director in the Community Health Improvement Division. Dr. Fegan-Bohm attended undergraduate school at University of Texas at Austin where she graduated with a degree in Human Biology in 2006. She received her Master's in Exercise Physiology from UT Austin in 2007. She then attended medical school at UT Health Science Center in San Antonio where she graduated in 2011 with her medical degree as well as a Master's in Public Health. She completed her pediatric residency at Doernbecher Children's Hospital in Portland, Oregon, in 2014 and her Pediatric Endocrinology Fellowship at Texas Children's Hospital in 2017. She then worked as an assistant professor at Texas Children's Hospital in the Pediatric Endocrinology Department with a focus on clinical care and Quality Improvement initiatives for children and young adults with diabetes.

Jeremy Triplett is the Maternal and Child Health (MCH) Section Director at the Texas Department of State Health Services (DSHS) and serves as the MCH Title V Director for the State. Jeremy's career has spanned over 22 years and has included work with the Texas Workforce Commission as a Lead Economist and Statistician who prepared, analyzed and disseminated labor force statistics, as the Operations Manager for Health Benefits programs at DSHS, and as the MCH Unit Director. Mr. Triplett earned his Bachelor of Arts degree in Psychology from St. Mary's University in 1998, where he learned about public health and being a servant leader in the community. Jeremy has spent his career working in the public sector and is committed to improving the health and safety of Texans across the state.

Michael Spencer was selected as the MCH Unit Director in the MCH Section in May, 2019. Mr. Spencer previously worked at DSHS from 2007 to 2014, and was the Title V Administrator for three years in the Office of Title V and Family Health. Mr. Spencer also worked at the HRSA's Maternal and Child Health Bureau in Rockville, MD as a Public Health Analyst and Title V Block Grant Project Officer. Prior to returning to DSHS, Mr. Spencer also served as the MCH Bureau Director and Title V MCH Director for the Maryland Department of Health. Mr. Spencer has a Master's Degree in Social Work from Tulane University, a Bachelor's Degree in English from Purdue University, and a Bachelor's Degree Journalism from Indiana University.

Audrey Young was named the Manager of the Child and Adolescent Health Branch and the State CSHCN Director in the MCH Unit in June 2019. Ms. Young had previously served as the Unit Coordinator overseeing initiatives including Texas AIM, and worked with the DSHS Office of Healthcare Delivery Redesign as a Health Policy Analyst. Ms. Young holds a Master of Public Health in Health Policy and Management from Texas A&M University.

Dr. Michelle Cook was named the Director of the MCH Epidemiology Unit at the Texas Department of State Health Services in February, 2019. Previously, Dr. Cook established the research department at the American Association of Nurse Practitioners where she expanded research services, standardized data collection, and executed the nurse

practitioner research agenda. She was also the Behavioral Risk Factor Surveillance System coordinator in both Texas and Michigan. Dr. Cook received her PhD in epidemiology with a minor in biostatistics from the University of Texas Health Science Center and her MPH in epidemiology from the State University of New York at Albany.

Julie Stagg, MSN, RN, IBCLC, RLC, is the Healthy Texas Mothers and Babies Branch Nurse Manager, TexasAIM Program Director, and State Breastfeeding Coordinator at the Texas Department of State Health Services, where she provides expertise and coordination for public health policies, programs and initiatives to improve women's maternal, perinatal and infant health. Ms. Stagg completed Maternity Nursing clinical nurse specialty core curriculum before receiving a Master of Science in Public Health Nursing from the University of Texas at Austin. She has worked to promote the health of women and children for over 25 years in hospital, outpatient, community, non-profit, mental health, and public health settings.

MCH Texas Title V recognizes staff accomplishments, leadership, and workforce development efforts. The Title V Block Grant supports DSHS regional staff across the 8 PHRs to plan, implement, and evaluate population-based programs in their communities to address Title V National and State Performance Measures. Title V supports 90 full-time employees throughout the PHRs, boosting the MCH infrastructure throughout the state. Staff in the regions are in a unique position to collaborate with others in assessing local needs and identifying potential solutions that reflect the values and cultural make-up of communities.

Kim Beam serves as the MCH Regional Programs Administrator in MCHU. Mr. Beam has 10 years of experience in regional/community-level public and population health work and supporting maternal and child health through program planning/development, implementation, and evaluation in Public Health Region (PHR) 6/5S. Most recently, he served as the DSHS' MCH team lead in PHR 6/5S working with a comprehensive team to develop and implement activity plans and reporting under the Title V Block Grant. He was also responsible for the training development of team members working in MCH within the regional office. Additional areas that he has coordinated and supported within the PHR 6/5S include activities in health promotion (tobacco control and prevention and obesity prevention), suicide prevention, and child fatality review. He has a Master's degree in Public Health from Texas A&M University and a Bachelor's degree in Psychology from Arizona State University. Additionally, Mr. Beam serves as Texas' Family Delegate to the Association of Maternal and Child Health Programs (AMCHP).

The MCH Regional Programs Administrator serves as the key MCH liaison between DSHS central office and the DSHS regional offices, and works to enhance the technical competence of regional staff. The MCH Regional Programs Administrators role is to improve the alignment of regional activities with the Title V MCH Block Grant objectives.

Learning needs associated with Title V Performance Measures are addressed through the monthly MCH Learning Consortium, regular Meet the Subject Matter Expert (SME) webinars and the quarterly MCH Regional Showcase. Staff utilize resources for independent learning available through MCH Navigator, CDC's Public Health 101 Series, the Georgetown National Center for Education in Maternal and Child Health (MCH Evidence), Kansas University's Community Toolbox and other resources.

The 2021 AMCHP conference was offered virtually in August 2020 due to COVID-19. Approximately 20 Texas Title V team members participated in the online conference and several team members were recognized. Dr. Manda Hall was officially named AMCHP President for 2021-2022, and she also served as moderator for a Plenary Session titled "Leading During Change". Claire Niday, the MCH Child Health Coordinator, was nominated and selected as the 2021 Emerging MCH Professional Award for Region VI. The award was presented by AMCHP to recognize current and future leaders under age 45. The award recognizes outstanding state or local MCH professionals whose work has made substantial contributions to the state's MCH program, their state's MCH outcomes, or made other significant contributions to promoting and protecting the health of women, children, and families in their state. It recognizes an individual's capacity to perform above and beyond expectations, using creativity and innovation to address pressing MCH challenges, and their emerging and future leadership potential.

To bolster statewide efforts to improve awareness of developmental milestones, Texas submitted a response to a request for application to the Centers for Disease Control and Prevention's Act Early Ambassador program. Due to Texas' size, two Ambassadors are allowed for the state. The State Child Health Coordinator applied to become the second Ambassador for Texas. In this role, MCH co-leads a Deputy Ambassador program as part of a FY21 Act Early Response to COVID-19 grant as well as pursuing an individual work plan to integrate Act Early materials into the state's early learning strategic plan. Designation as Texas' Act early Ambassador will continue through FY22.

DSHS recognizes the value of the Community Health Worker (CHW) workforce in serving as a key component in response to emerging health issues in Texas. In many areas of the state, DSHS regional staff may also be certified

CHWs and often collaborate with regional or local CHW networks or training programs. Title V supports staffing and infrastructure for the Promotor (a) or Community Health Worker Training and Certification Program, which is now housed within the HPCDP Section at DSHS. Staff include two program coordinators, three program specialists, and an administrative support specialist. The Program oversees the certification of CHWs and instructors and certifies organizations that provide initial training and continuing education.

DSHS partners with a range of CHW training programs, including community colleges, other academic institutions such as University Health Science Centers, Area Health Education Centers (AHECs), FQHCs, CHW associations, community-based organizations, and others. DSHS and the approved training programs share a deep commitment to ensuring quality CHW education. Texas was an early leader in the nation in adopting legislation to implement a statewide certification process for promotores and community health workers (CHWs) and continues to seek ways to expand the use of CHWs to assist Texans in accessing needed health and social services.

The Association of State and Territorial Health Officials (ASTHO) was funded by HRSA to work on the Alliance for Innovation on Maternal and Child Health project. ASTHO included Texas in a series of state stories to highlight state strategies for utilizing promotores or community health workers (CHWs) to improve access to care and continuity of care for pregnant women and children.

CHWs often share the same linguistic or cultural experiences of the individuals they serve and work to provide culturally competent services in a way easily understood by a target audience. CHWs receive continuing education credit for online modules developed by HHSC related to the culturally effective health care and Culturally and Linguistically Appropriate Services (CLAS) Standards.

DSHS and HHSC continue to work to increase utilization of CHWs in Texas. CHWs are employed by community-based clinics through DSHS to facilitate access to services and improve the quality and cultural competence of primary, preventive and screening health care services for women across the state. HHSC surveyed the state's Managed Care Medicaid/Children's Health Insurance Program (CHIP) health plans. Most of the plans (80%) noted that they utilize certified CHWs to improve services and access to care. CHWs provide health education, information and referral, assist clients in navigating complex health and social service systems, and provide follow-up through clinic and home visits. Maximus, HHSC contractor for Texas Health Steps (Children's Medicaid) enrollment broker operations, employs CHWs as outreach counselors. Under an 1115 Medicaid waiver, Texas funded projects to incentivize hospitals and other providers to transform service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness. Projects included expanding the use, and integration of, the CHW workforce in the Texas health care delivery system. CHWs provide services to increase access to care and facilitate appropriate use of health resources through outreach and cultural linkages between communities and delivery systems; reduce costs by providing health education, screening, detection, and basic emergency care; and improve quality by contributing to patient-provider communication, continuity of care, and consumer protection.

CHWs provide patient navigation services to enhance social support and culturally competent care to vulnerable and/or high-risk patients and serve as members of Health Home interdisciplinary teams. The number of certified CHWs in Texas continues to increase over time as awareness and utilization of the CHW workforce grows.

The Texas Birth Defects Registry was established in 1993 by the Texas Birth Defects Act (Chapter 87 of the Texas Health and Safety Code, Birth Defects). The Registry has been in operation since 1994 and is overseen by the DSHS Birth Defects Epidemiology and Surveillance Branch (BDES). Statewide data became available in 1999. Highly-trained regional staff visits medical facilities to review logs, hospital discharge lists, and other records to find babies with possible birth defects (structural malformations or chromosomal disorders). If the record indicates that the infant or fetus has a condition covered by the registry, detailed demographic and diagnostic information are abstracted and entered into the computer for processing. The Registry ascertains cases and diagnoses up to the first birthday. Quality assurance activities are conducted throughout data collection and data processing to monitor the accuracy, completeness, and timeliness of the Registry's data. Data from the Registry are used for many different reasons, including for cluster investigations, looking at the occurrence and patterns of birth defects, prevention and family outreach, studies of access/proximity to services, studies of mortality and survival, studies of causes of birth defects, and understanding changes over time. All information is held in strict confidence in accordance with state and federal privacy laws.

The Oral Health Improvement Program (OHIP) within the MCHS strives to identify the oral health needs of Texans and to provide resources that meet those needs. The OHIP staff include Central Office staff, located in Austin, and five Regional Dental Teams (RDT), each consisting of a dentist and registered dental hygienist. The regional teams are based in San Antonio, Houston, Lubbock, Tyler and Midland.

The OHIP conducts statewide oral health surveillance, including a Basic Screening Survey (BSS) of third grade and Head Start students. This is a weighted survey using probability proportionate to size sampling methodology. The OHIP is the only program that conducts oral health surveillance of this type in Texas. These surveys are conducted

every five years and the information acquired allows the OHIP to track trends of the prevalence and extent of oral disease and the presence of dental sealants.

The RDTs also provide oral health education and preventive dental services, including limited oral evaluations, fluoride varnish and dental sealants for students who qualify. The RDTs have portable dental equipment and travel to schools, Head Starts and other programs to provide their services and conduct surveillance. Title V continues to identify opportunities to collaborate on the shared goal of improving the health of mothers and children.

Rhonda Stokley, DDS, serves as both Public Health Dental Director and Health Screening and Oral Health Unit Manager for the Texas Department of State Health Services. Dr. Stokley has been with DSHS for four years and has over 10 years of state service. She has private practice experience and has also served Texas by providing dental care for adults with special needs. She received her Doctor of Dental Surgery degree from Louisiana State University Health Sciences Center School of Dentistry in 2005.

Title V funds are used to support the Newborn Screening (NBS) Program. The NBS Program screens for genetic conditions using blood spots, as required by Texas law (Health and Safety Code, Chapter 33) in order to help identify infants who may have treatable genetic disorders or medical conditions. Early identification can prevent serious complications, such as growth problems, developmental delays, deafness, blindness, intellectual disabilities, seizures, and sudden or early death. Texas operates the largest newborn screening program in the nation, testing approximately 775,000 specimens per year, or nearly 400,000 babies annually.

The NBS Program continues to meet its annual objective of 100% follow up and case management of identified presumptive positives. NBS supports workforce development and overall infant health education in the state by informing thousands of health care professionals and expectant and postpartum parents about the importance and benefit of newborn screening and follow-up to positive tests. NBS promoted quality improvement measures by monitoring the number of unsatisfactory specimens submitted to the DSHS laboratory, following up with educational resources. as well as monitoring the average statewide transit time from specimen collection to receipt in the DSHS Laboratory to ensure timely follow-up to definitive diagnosis and management of conditions.

The Texas Early Hearing Detection and Intervention (TEHDI) Program is dedicated to ensuring newborns and young children who are deaf/hard of hearing are identified as early as possible, with the goal of providing appropriate intervention services in order to prevent delays in communication and cognitive skill development. TEHDI continues to disseminate Newborn Hearing Screening Program report cards to licensed birthing facilities to communicate their performance on a set of nationally recognized benchmarks and quality indicators. The report card provides a snapshot of the birthing facility's use of the TEHDI MIS over the previous two months. These same criteria are used to evaluate birthing facilities for newborn hearing screening program certification when a facility is up for a certification review. The certification process occurs in two cycles, the first in January and the second in July. Each facility's certification is based on the data for the preceding six-month period.

David R. Martinez is the Newborn Screening Unit Manager. He maintains a BA from the University of Texas at Austin and has over 25 years of experience in state government. Mr. Martinez has managed programs related to medical dispute resolution where providers sought relief for payment of medical reimbursement for care injured workers in the Texas workers' compensation system. He also managed a quality assurance program evaluating physicians in the workers' compensation for quality of medical care and services. Currently he is responsible for expanding the Newborn Screening and Newborn Hearing screening programs for the Department of State Health Services. He is a subject matter expert for the Newborn Hearing and Newborn Bloodspot Screening programs for over 15 years.

III.E.2.b.ii. Family Partnership

Maternal and Child Health (MCH) has an established, deep-rooted understanding and appreciation of the benefits that come from collaboration with families and program participants. Promoting and strengthening family partnerships remains a key priority and area of focus at DSHS. Families bring valuable input and perspective, including the knowledge of their family strengths and individual needs, to inform program development and priorities. Promoting a holistic, culturally relevant approach to health and wellness for all families and children, including those with special health care needs, keeps families at the center of public health care practice, policy, and research.

MCH ensured that family input for all domains was in the FY19-FY20 Needs Assessment process. Focus groups, held across the state, invited families as well as frontline staff to provide their opinions on current needs. With the 83 focus groups held across 23 communities, MCH heard ongoing needs as well as identification of 'new' themes to consider in planning. Lists of needs by population health domain were shared with partners and a prioritization process was completed as part of the needs assessment. In addition to the needs by MCH population health domain, overarching needs were identified and are listed below:

- Mental health needs across populations and overall lack of mental health resources
- Health disparities and social determinants of health (SDOH)
- Lack of awareness of existing programs and services
- Increase collaboration across programs to improve patient outcomes and experiences
- Provider education on existing programs and services
- Increase home visitation programs
- Provider trainings on empathy and cultural competency

Within each domain, MCH relies on a variety of mechanisms to capture family voice – surveys, focus groups, small group discussions, monitoring family boards, staff observation, etc. The specific method varies in each domain due to challenges faced by the population served. For instance, Maternal and Infant Health looks to their partners and contractors to help understand the needs of women being that the work is focused on improving workforce capacity to support women. For Children with Special Health Care Needs (CSHCN), staff participate in events and activities for CSHCN to directly hear from families and sends out surveys to families for input. Child Health staff work with professionals who have access to children – this includes Texas Association for the Education of Young Children Agency and childcare consultants across the state. In the Adolescent Health domain, MCH funds a project to increase youth engagement and interaction with youth-serving organizations.

For this five-year cycle:

- FY21 – MCH staff:
  - Explored and selected family engagement strategies within each MCH population domain, and worked with MCH Epi to develop systems to collect metrics
  - Identified family engagement metrics for each domain including listening sessions and underserved population strategies
  - Summarized COVID-19 specific activities – especially feedback from families – to include in each domain through the annual report
  - Explored health disparity strategies for each domain
  - Reviewed new federal guidance to ensure Texas is addressing federal goals
- FY22 – MCH staff:
  - Will explore options for listening sessions and key informant interviews. Partnering with MCH Epi to develop metrics to gather and analyze listening sessions and key informant interviews.
  - Will partner with the eight Public Health Regions (PHR) to create a list of investees, especially the underserved populations, that have been formed and reinforced throughout COVID-19.

- FY23 – MCH staff will monitor and adjust programming based on metrics collected.
- FY24 – MCH staff:
    - Will re-assess the family engagement process. Review the data from each domain to determine what changes or adjustments are needed.
    - Will develop a formal plan to solicit family engagement as a separate track for the 2025 Needs Assessment.
- FY25 – MCHS will develop the next 5-year family engagement plan.

Continuous engagement with families has historically involved collaboration through numerous forums. This has worked well and will be incorporated into future plans. Internal examples include the Texas Transition to Adulthood Learning Collaborative and the Medical Home Learning Collaborative led by the CSHCN Systems Development Group (SDG), Youth-Adult Partnerships in Adolescent Health's Texas Youth Action Network, individual representation within Healthy Texas Mothers and Babies Coalitions, and in TexasAIM Learning Collaboratives in Maternal and Infant Health. In FY20, MCH was approved to work with the National Help Me Grow project. One of the components of the project is to develop an advisory group. The plan is to ensure there is family engagement by reserving at least one spot for a parent or primary caregiver.

Externally, MCH serves on multiple conference planning committees listed under each domain. Participation with conference planning helps ensure staff see and hear the presence and voice of youth and families. Membership on regional and statewide workgroups with strong family representation including the Mountain States Regional Genetics Network, Texas Council for Developmental Disabilities, and Policy Council for Children and Families is another avenue to hear from families. These workgroups offer additional opportunities for MCH to garner input about what is working well and identifying gaps.

Active, meaningful family engagement continues to be central to the HRSA-funded Collaborative Improvement & Innovation Network (CoIIN) for Children with Medical Complexity (CMC) project. The Texas CMC CoIIN team's Family Leader facilitates a Family Workgroup comprised of family members both served and not served by the primary clinic site. The Family Workgroup meets monthly, plays a key advisory role on all team activities, and participants are compensated for their time. Members of the workgroup, in partnership with Texas Parent to Parent staff, are leading the effort to survey clinic families to gauge satisfaction with clinic services. Findings are shared with clinic staff and the project's national partners to improve the quality of life for CMC and the well-being of their families. Several members of the CMC CoIIN team piloted the new Family Engagement Assessment Tool (FESAT) developed by Family Voices to measure family engagement in the project. Findings will be used to identify improvement activities and the assessment will be repeated every six months to ensure continuing progress.

In addition to review by the Family Delegate, MCH receives ongoing input on Block Grant Application narratives, satisfaction surveys, and workgroup activities through established relationships with family organizations. The Co-Director of Texas Parent to Parent (the state's Family Voices affiliate and Family to Family Health Information Center) remains a key member of the block grant review team. MCH also seeks family and stakeholder input through the block grant public comment process. CSHCN SDG contracting requires a detailed description from contractors on how families will be engaged and included in proposed projects. An additional question on family partnerships is also included on the formal MCH funding request form. This was recently included to ensure that funding proposals include details on family engagement and encourage potential partners to think of families as partners in the proposed project.

MCH engages families across the state at community events, health fairs, meetings, and workshops. Strong partnerships with community-based contractors help support initiatives and strengthen opportunities for meaningful collaboration with families (including youth). MCH will continue to promote awareness and utilization of the TexasYouth2Adult family transition to adulthood planning tool. MCH is committed to involving families and youth in system improvement initiatives. The Texas Family Delegate works closely with the CSHCN SDG on numerous

projects. Parents, youth, and young adults are invited to join the MCHS-led initiatives to share knowledge and experiences, assist in the development of strategic goals and objectives, and learn about best practices across the state.

Discussions continue around ways to increase opportunities to diversify the Family Delegate position. In FY21, Carol Harvey stepped down from the Family Delegate role to allow for new perspectives and ideas. Kim Beam accepted the role and will be working on his vision of the activities for the Family Delegate. An internal workgroup will look at the current Family Delegate role with the continued goal of establishing a process that allows for cross-domain representation and opportunities to expand Family Voice leadership within MCH.

Input from families and youth is essential for improving outcomes in all MCH populations. Efforts to increase capacity within MCH to implement, support, scale-up, and sustain quality family engagement will continue. Additionally, MCH will work with partners and stakeholders to identify opportunities for family partnerships, improve systems to reduce barriers to family engagement, encourage capacity in the workforce to encourage meaningful family participation, and identify outcomes for successful family professional partnerships in all systems.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

The Maternal and Child Health Epidemiology (MCHE) Unit provides centralized epidemiologic, data, research, and reporting support to all MCH programs. MCHE possesses the capacity to provide MCH epidemiologic, data, research, and reporting support for Title V program areas, including expert statistical analysis, data management and performance measure reporting, geographical and spatial analyses, research studies and consultation, and program evaluation and monitoring. All staff are highly skilled in multiple and complex computer programming "languages" and software (e.g., Access, ArcGIS, Python, R, SAS, STATA, Tableau), and all have received specialized training in MCH research, epidemiology, and program evaluation. MCHE directs the State Systems Development Initiative (SSDI) and the Texas Pregnancy Risk Assessment Monitoring System (PRAMS), both of which are used to inform policy and practice in MCH. Please refer to the supporting documents for key MCHE publications and presentations as well as the workforce development section of this grant application. The MCHE Unit structure transitioned in 2019 to mimic that of the MCH Unit program staff so that staff can become knowledgeable and vetted into specific domain topics. MCHE leadership encourages MCHE staff, though, to also work across teams so that life course indicators, family engagement projects, and research in these areas still occur. All staff in the unit are either funded by general revenue, Title V Block Grant Maintenance of Effort, Title V Block Grant, or the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) grant.

MCHE Leadership & Support Staff

The MCHE Director (Director I) has been with the MCHE Unit since 2019. She has her doctorate degree in epidemiology and her master's in public health epidemiology. Her expertise is in survey research and evaluation. The director has been in management for eight years. She directly oversees the Technical Team, the Surveillance and Data Analytics Manager, and the unit's Administrative Assistant IV. The Surveillance Data Analytics Manager (Manager III) oversees the work of the Healthy Texas Mothers & Babies Epidemiology (HTMB Epi) Team and the Child and Adolescent Health & Oral Health Epidemiology (CAH&OH Epi) Team. Both the director and manager make sure all staff have the training and skillsets they need to perform at the highest level possible.

Healthy Texas Mothers & Babies Epidemiology Team

The HTMB Epi Team focuses their work on the health of women of childbearing age, maternal health, and infant health. The team lead for this team has a master's degree in Public Health Epidemiology and previously served as the TexasAIM epidemiologist for MCHE. The HTMB Epi Team consists of seven FTEs (and two temporary workers) which support the work of the Maternal Mortality and Morbidity Review Committee (MMMRC), TexasAIM (a quality improvement project to address maternal safety), the HTMB Databook, legislatively-mandated data collection on postpartum depression (PPD), the Infant Feeding Practices Survey (IFPS), PRAMS, and the newborn screening Texas Early Hearing Detection and Intervention (TEHDI) program. The team consists of:

- Two Epidemiologist IIIs: One is the team lead and the other is a MMMRC data analyst and data linking specialist.
- One Epidemiologist II: This staff person works on TexasAIM and assists with the MMMRC analyses and workload.
- Three Research Specialist Vs: One staff person is focused on PPD and breastfeeding trends. Another staff person is focused on MMMRC data analytics, PPD, and PRAMS. The third staff person is the PRAMS Coordinator who recently transitioned to sit within the HTMB Epi Team rather than report directly to the MCHE Director. There will also be one temporary Research Specialist V that will be funded through the ERASE MM grant to focus on pregnancy-associated cohorts.
- One Records Analyst III: This person focuses on the record requesting for the MMMRC and record retention. This position is funded by the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) grant.
- One temporary Clerk III: This person will be focused on record requesting and will be funded through the ERASE MM grant.
- One Research Specialist IV: One research specialist is funded through the ERASE MM grant but reports to the DSHS Center for Health Statistics (CHS) management and participates on the Data Linking Team in that unit. This research specialist focuses on all our required data linking per our data use agreement (DUA) with CHS.

All epidemiologists and research specialists are required to have at least a master's degree with a preference to those having worked in MCH and knowledge in one statistical programming language. One Research Specialist V has a doctoral degree in medical anthropology.

PRAMS Working Group: This group was created so that the PRAMS Coordinator could have a working team to assist with the monthly requirements of the PRAMS grant. The team consists of the PRAMS Coordinator, one

Research Specialist V from the HTMB Epi Team, one Research Specialist IV from the Technical Team, and the Information Specialist from the Technical Team. The team currently has been working on a new interactive PRAMS dashboard and will be preparing for the Phase 9 questionnaire.

Child and Adolescent Health & Oral Health Epidemiology Team

The CAH&OH Epi Team focuses their work on child health, adolescent health, the health of Children with Special Health Care Needs (CSHCN), and oral health, in particular, child and pregnant women dental screenings. The team lead holds a master's degree in public health. The CAH&OH Epi Team consists of four FTEs which support the programmatic work of the CAH Branch in the MCH Unit and the Oral Health Improvement Program. The team consists of:

- Two Research Specialist Vs: One is the team lead and the other is the Needs Assessment Coordinator.
- Two Epidemiologist IIIs: One staff member is focused on CSHCN and the other one is focused on oral health.

Like the CAH Branch in the MCH Unit, the team structure is still newly developed. Prior to the reorganization in 2019, most MCHE staff focused on maternal mortality and morbidity.

MCHE Technical Team

The MCHE Technical Team provides technical expertise and advanced skillsets that the other two teams are encouraged to utilize if they get stuck in project. This team focuses on many technical aspects of data management including, 1) processing the unit's birth, death, and death files, 2) maintaining the unit's DUAs and memorandums of understanding (MOUs), 3) reviewing the outputs of other staff, 4) providing agency-wide technical guidance on data sharing and the implementation of an ArcGIS server which will enhance our ability to streamline MCHE mapping, and 5) focusing on the unit's public health research agenda. The team is led by a medical research specialist who concentrated in MCH while receiving his doctoral degree in epidemiology; he also has his master's in public health. His team consists of one Epidemiology III, who is also doctorally prepared, a Research Specialist IV, who has a master's degree, and an Information Specialist III, who focuses on graphic design and data dissemination.

Title V Needs Assessment Working Group

The MCHE unit works together on the comprehensive 5-year needs assessment, which is a critical and mandatory piece of the Title V Block Grant application/report. This internal MCHE working group was established so that each of the domain specialists within the unit could discuss progress and issues as the 2025 Title V Needs Assessment process begins. The group is led by the Needs Assessment Coordinator and consists of two members from the HTMB Epi Team, two members from the CAH&OH Epi Team, one member from the Technical Team, the MCHE Director, and the Surveillance and Data Analytics Manager.

COVID-19 Response

MCHE staff provided extensive expertise in state COVID-19 response efforts. Twelve staff members assisted with the effort in roles including public health follow-up, directing regional data collection efforts, training local health departments on how to use the case and public health follow-up system, analysis of trends in COVID-19 cases, and creating and maintaining dynamic dashboard systems.

1. State System Development Initiative (SSDI)

The purpose of the State Systems Development Initiative Grant (SSDI) in Texas is to complement the Title V MCH Block Grant through the objectives and activities supporting three specific goals. The first goal is to build and expand state MCH data capacity to support Title V MCH Block Grant program activities and contribute to data-driven decision making in MCH programs, including assessment, planning, implementation, and evaluation. The second goal is to advance the development and utilization of linked information systems between key MCH datasets in Texas. The third goal is to support surveillance systems development to address data needs related to emerging MCH issues in Texas.

The SSDI grant in Texas has expanded state MCH data capacity to support Title V MCH Block Grant program efforts, which include support for the PRAMS survey, extensive analytical support for content for the annual Block Grant application and annual reports, educational training for MCH Epi staff, and licensing of data analysis software.

The SSDI project also supports programmatic efforts to reduce maternal mortality and morbidity, the CSHCN

program, the Oral Health Surveillance program. Additionally, the Texas SSDI project supports Collaborative Innovation and Improvement Network (ColIN) to reduce infant mortality through improved availability and reporting of timely data to inform efforts and track outcomes that drive quality improvement and collaborative learning.

The SSDI Project Director (PD) and a member of the Technical Team provided statistical expertise in the R statistical language for the creation of daily reports for tracking COVID-19 cases and training for agency staff members in ArcGIS mapping for 10 hours a week. The SSDI PD also provides data analytic guidance on the Data Subcommittee for the Texas Collaborative for Healthy Mothers and Babies (TCHMB), the state's perinatal quality collaborative. The PD also precepted a DSHS Blue Ribbon Intern. The intern created a report exploring breastfeeding disparities using Texas PRAMS data.

In support of SSDI project goals, MCHE has provided scientific and analytical assistance and expertise for a variety of Title V MCH Block Grant activities, including the 5-year needs assessment, helping with data analysis, interview transcription, data entry, and writing for the Title V MCH Block Grant application/annual report.

Major SSDI program activities completed during this budget period include:

- Providing data-related content of the 2019 Title V MCH Block Grant report/2021 application.
- Hosted a PRAMS intern who explored breastfeeding disparities.
- Conducting an extensive 5-year needs assessment including the transcription of 122 interviews and 81 focus groups, qualitative analysis for the identification of needs, and creation of a comprehensive report.
- Legislative report analyses in support of the Maternal Mortality Review Committee, Medical Child Abuse Resources and Education System (MEDCARES) to reduce child abuse, and TexasAIM to improve hospital hemorrhage and hypertension outcomes.
- Authored a peer-reviewed journal article on oral health among Texas children. Presented at CityMatCH, the CSHCN Systems Development Group Medical Home Learning Collaborative, the Texas Public Health Association Annual Education Conference, and the TCHMB Summit.
- COVID-19 response activities including the coordination of regional and local health department data collection efforts, public health follow-up, statistical expertise for the creation of measures to track changes in COVID-19 cases.
- Submission of the 5-year Pregnancy Risk Assessment Monitoring System (PRAMS) grant application to CDC and ensured the annual contract renewal with Texas A&M University (TAMU) Public Policy Research Institute (PPRI) for data collection including printing of survey materials and survey booklets, postage, data entry of completed surveys, telephone survey interviews, training of interviewers, and incentives for participation.
- Publication of 2019 HTMB Databook, 2019 PRAMS Databook, and two reports on oral health in Texas.
- Staff training in SAS and ArcGIS systems for expanding data analysis capacity.
- Development of a new portal for Texas oral health data with 11 reports on oral health statistics and trends. Creation of an interactive dashboard for reporting Texas PRAMS data.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

The purpose of the State Systems Development Initiative Grant (SSDI) in Texas is to complement the Title V MCH Block Grant through the objectives and activities supporting three specific goals. The first goal is to build and expand state MCH data capacity to support Title V MCH Block Grant program activities and contribute to data-driven decision making in MCH programs, including assessment, planning, implementation, and evaluation. The second goal is to advance the development and utilization of linked information systems between key MCH datasets in Texas. The third goal is to support surveillance systems development to address data needs related to emerging MCH issues in Texas.

The SSDI grant in Texas has expanded state MCH data capacity to support Title V MCH Block Grant program efforts, which include extensive analytical support aimed at content for the annual Block Grant application and annual reports. This data capacity includes the reporting of grant measures, statistics and maps in the overview section, and the needs assessment component.

Maintaining consistent direct access to electronic MCH health data such as birth files, death files, hospital discharge files, and survey data from the Pregnancy Risk Assessment Monitoring System (PRAMS) is critical for informing Texas MCH program planning, evaluation, and improvement and Title V MCH Block Grant reporting. The MCHE Unit has an existing MOU with the DSHS Center for Health Statistics (CHS) to link several data sources (i.e., birth and death files), a MOU with the Texas Health and Human Services Commission (HHSC) to link vital event data with Medicaid administrative data, and an agreement to link hospital discharge data with birth and death files for the specific data needs of the Maternal Mortality and Morbidity Review Committee (MMMRC). Texas has consistent annual access to the following data sources: Vital Records Birth, Vital Records Death, Hospital Discharge Data, Medicaid records, and PRAMS. MCHE has developed products from these data sources such as the annual Healthy Texas Mothers and Babies (HTMB) Databook, the annual PRAMS Databook, legislative reports on maternal mortality, and various MCH data-driven dashboards, factsheets, white papers, conference presentations, and journal articles. The Databooks provide an overview of infant and maternal health in Texas. The trends and disparities in infant and maternal health outcomes highlighted in the reports can help inform programming and data-driven decisions on how to improve these outcomes in Texas. The purpose of the Databooks is to bring different data sources together for analysis and reporting in a way that creates a cohesive view of the status of both infant and maternal health in Texas.

The MCHE unit works together on the comprehensive needs assessment, which is a critical and mandatory piece of the Title V Block Grant application/report. Minimum/core indicators that were used in the needs assessment analysis include births, deaths, birthweight, smoking, infant sleep position, and breastfeeding.

MCHE staff provide data and analytical support for maternal mortality surveillance and reporting. This includes conducting linkage of annual finalized death data with birth and fetal death data for maternal death identification; requesting needed medical/delivery and other death records for maternal death identification and MMMRC case review; sampling a percentage of annual maternal death cases for MMMRC review; and providing other support as needed. Multiple briefing documents on maternal mortality and morbidity have been developed over the past year and are widely utilized by staff and stakeholders.

The SSDI project also supports the CSHCN program, the Oral Health Surveillance program, and PRAMS. Additionally, the Texas SSDI project supports Collaborative Innovation and Improvement Network (CoIIN) to reduce infant mortality through improved availability and reporting of timely data to inform efforts and track outcomes that drive quality improvement and collaborative learning.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

Maintaining consistent direct access to electronic MCH health data such as birth files, death files, hospital discharge files, and surveys like PRAMS, the Behavioral Risk Factor Surveillance System (BRFSS), and the Youth Risk Behavior Surveillance System (YRBSS) is critical for informing Texas MCH program planning, evaluation, and improvement and Title V MCH Block Grant reporting. MCHE has an existing Data Use Agreement (DUA) with the DSHS CHS to link several data sources (i.e., birth and death files), a MOU with the Texas Health and Human Services Commission (HHSC) to link vital event data with Medicaid administrative data, and an agreement to link hospital discharge data with birth and death files for the specific data needs of the Maternal Mortality and Morbidity Review Committee (MMMRC). Texas has consistent annual access to the following data sources: birth records, death records, hospital discharge data, Medicaid records, PRAMS, and BRFSS. MCHE has developed products from these data sources such as the annual HTMB Databook, the annual PRAMS Databook, legislative reports on maternal mortality and TexasAIM, a quality improvement project to address maternal safety, and various MCH data-driven dashboards, factsheets, white papers, conference presentations, and journal articles.

In Fiscal Year 2021, MCH (both the MCH program and MCHE) have been developing logic models around the current national and state performance measures. Part of the logic model planning has the cross-unit teams reviewing the 5-Year Needs Assessment data sources, the applicability of those data sources, and discussing data gaps in the evaluation plans of the programming that MCH is offering. Subsequently, if data gaps are identified, the teams are to strategize how, where, and what data may need to be analyzed or collected for the evaluation plan. Additionally, future work for MCHE will also include a data management plan.

The MCHE unit works together on the comprehensive 5-year needs assessment, which is a critical and mandatory piece of the Title V Block Grant application/report. The CAH&OH Epi Team was critical in the success of the 2020 Title V 5-Year Needs Assessment. Planning for the 2025 5-Year Needs Assessment is currently underway.

HTMB Epidemiology Team

MCHE staff provide data and analytical support for maternal mortality surveillance and reporting. This includes conducting linkage of provisional and finalized death data with birth and fetal death data for pregnancy-associated death identification; requesting needed medical/delivery and other records for pregnancy-associated death identification and MMMRC case review; and providing other support as needed. In July 2020, as part of the ERASE MM grant, the team started entering their 2019 case cohort data into the Maternal Mortality Review Information Application (MMRIA), a standardized data system available to support essential review functions of the MMMRC. Additionally, the team had expanded supplemental documentation for the MMMRC to have available during their review processes including a socio-spatial context dashboard that reviews community and environmental indicators in which the woman had lived prior to her death. Additionally, if the woman was on Medicaid, a Medicaid coversheet outlining key events, prescription medication claims, and service claims are documented. Having these data points standardized will allow for accurate data analysis and clear findings through the review process. Multiple briefing documents on maternal mortality and morbidity have been developed over the past year and are widely utilized by staff and stakeholders. MCHE has begun a vital record quality improvement project by coordinating with the Vital Statistics State Registrar to provide information on maternal deaths identified during the MCHE records review process.

The Texas MMMRC has a maternal health disparities subcommittee. One of the goals of this subcommittee was to create a Discrimination Assessment and Social Determinants of Health Facilitated Discussion Tool to enhance the review process as it related to having discussions about discrimination noted in medical records. MCHE and program staff have developed an evaluation plan and will be recruiting other state MMMRCs to participate in the evaluation of this new tool.

MCHE developed a DUA with the TEHDI program to support a CDC grant-funded data quality improvement project. MCHE staff will provide support to the TEHDI program by linking vital event data and program data on a quarterly basis. The SSDI PD has been in technical assistance meetings with the CDC and provided statistical programming assistance in support of the grant.

Child and Adolescent Health & Oral Health Epidemiology Team

The CAH&OH Epi staff provide data and analytical support for child and adolescent health, CSHCN, and oral health surveillance and reporting. This includes validating and running reports on quarterly MEDCARES contractor deliverables, working on the assessment and evaluation for the Help Me Grow program, and designing and analyzing data from the biennial CSHCN survey. Additional data sources are utilized to drive program decisions including specific modules added to the Texas BRFSS (i.e., adverse childhood experiences) and the Texas YRBSS (i.e., adverse childhood experiences, positive youth development, and preventive health care).

MCH also provides partial funding for the Texas School Physical Activity and Nutrition (SPAN) survey. Texas SPAN is

a state-wide surveillance system which monitors the body mass index and related variables in Texas children and adolescents in grades 2, 4, 8, and 11 for the 2015-2016 and 2019-2020 school year. The survey focuses on several BMI factors and outcomes including nutrition knowledge, nutrition attitude, physical activity, and dietary behaviors. These data are routinely analyzed; one state performance measure utilizes this data source.

The Texas Oral Health Basic Screening Survey (BSS) occurs every three to five years to collect information about the observed oral health of children; their demographics; and self-reported information on access to care. For both the Texas SPAN Survey and the Texas BSS had to end data collection early due to the COVID-19 pandemic. While the pandemic ceased data collection early, the data already collected are still useable, but with limitations.

Challenges

MCHE has expanded data capacity through use of national surveys, DUAs, and MOUs; however, challenges in data capacity continue to exist for various MCH subpopulations. Access to Texas data on children aged one to five years is challenging as school administrative data are not available and there are few national surveys that can reach this population. Neighborhood-level data, important for allocating program resources, are difficult to obtain as most surveys are limited to large regions or state-level analyses. Many data sources utilized administrative data and cannot provide individual stories, a crucial component to understanding the context of the data. Some data systems such as PRAMS, BRFSS, and YRBSS are available in Texas, but these surveys do not reach all MCH populations. Additionally, data quality has been a challenge in Texas, but efforts are underway to improve maternal mortality, PRAMS and TEHDI data.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

The Texas Department of State Health Services (DSHS) serves as the primary public health agency for the State of Texas and coordinates mitigation, preparedness, response, and recovery, for public health threats and disasters. To coordinate these efforts, the Center for Health Emergency Preparedness and Response (CHEPR) collaborates with a variety of public health and healthcare preparedness and response partners, including public health regions (PHRs), trauma service regions, regional advisory councils (RACs), local health agencies, hospitals, and emergency management agencies. CHEPR also coordinates agency funds from the Public Health Emergency Preparedness (PHEP) award from the Centers for Disease Control and Prevention (CDC). CHEPR manages and disperses these funds to PHRs and local participating health agencies across the state. The Assistant Secretary for Preparedness and Response (ASPR) awards Hospital Preparedness Program (HPP) funds to DSHS. CHEPR also manages and disperses these funds through RACs for hospital and emergency medical services initiatives. DSHS provides an oversight function to ensure the funds are used within state and federal guidelines. The positioning of the DSHS' Maternal and Child Health Section (MCHS) program staff at both the state and regional levels allows a broad and local approach in addressing current and emerging issues. MCHS offers assistance and subject matter expertise to agency-level planning and preparedness efforts as needed, and participates on agency and interagency workgroups. Within MCHS in the coming years, the CSHCN SDG will lead, fund, partner, and support efforts to improve care coordination for CYSHCN and their families, increase the percentage of CYSHCN having a medical home, and help families establish emergency plans. Contractors will continue collaborating with first responders, sharing resource information, and assisting with writing preparedness plans to help families of CYSHCN be ready in the event of a natural disaster, a need to shelter in place, and other emergencies. Contractor surveys have specific questions to assess family experience with service plan development, emergency preparedness planning, and timeliness of follow-up. To ensure data integrity, families will send completed surveys directly to CSHCN SDG for analysis. CSHCN SDG will share results with contractors to review areas of strength and those needing improvement. CSHCN SDG will continue working to increase the survey return rate and improve its processes for analysis and feedback. Emergency planning and preparedness strategies and efforts are based on lessons learned from previous emergencies, and based on the most current evidence and best practices for emerging issues. MCHS continues to advise on response efforts for new, emerging, and ongoing issues in Texas.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

Title V staff build bridges and leverage efforts to build a solid infrastructure, collect and analyze data; design, implement and evaluate programs; and provide technical support and training to promote healthy behavior and improve the health of Texas communities. Collaborative work includes partnering with Health and Human Services Commission (HHSC) to support efforts that coordinate programs and initiatives that serve Maternal and Child Health (MCH) populations across HHSC agencies and programs. Title V partners with internal and external Department of State Health Services (DSHS) partners, stakeholders, and contractors to implement program and reach MCH populations throughout the state. Regional DSHS staff through the 8 Public Health Regions (PHR) play a critical role in assessing and addressing community needs. The Texas Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program is housed at the Department of Family and Protective Services within the Prevention and Early Intervention (PEI) Program. Title V and PEI collaborate on multiple initiatives, and most recently on the Statewide Needs Assessment process to ensure alignment, coordinate data collection and findings, and prevent duplication of efforts for both assessments.

DSHS focuses on physical and behavioral health to improve the health and well-being of Texans. This mission is accomplished in partnership with academic, research and HHS stakeholders who work collaboratively to address existing and future issues. DSHS population-based services focus on prevention and education to address disease and minimize the need for future medical interventions. DSHS works closely with other federal, state and local health and human service agencies, particularly those that serve similar populations.

The statutory governance and organizational structure of DSHS play a role in how its functions are performed. As a "home rule" state, local health officials operate autonomously from, but in partnership with DSHS. HHS agencies produce a single plan addressing opportunities and challenges in the Coordinated Strategic Plan for Health and Human Services. DSHS client services, state hospitals and regulatory functions moved to HHSC in 2016 as part of a re-organization.

Contractors provide child health and dental services and prenatal medical and dental services. Primary health care contractors also provide well woman and family planning services for eligible women. The Newborn Screening Program within DSHS provides short-term follow-up for all newborns that have been screened and found to be presumptively positive for rare disorders. In addition, Texas DSHS provides point-of-service screens for hearing and critical congenital heart defects. The Newborn Hearing Screening Program, through Texas hospitals offering obstetrical services, works to ensure all children who have hearing loss as newborn infants or young children are identified early and provided appropriate intervention services needed to prevent delays in communication and cognitive skill development.

The Birth Defects Epidemiology and Surveillance program, established in 1993, identifies, investigates and monitors birth defects in Texas. The program identifies the risk factors and causes of birth defects, supports the development of strategies to prevent birth defects and maintains data in a central registry.

Legislation, focused on child passenger safety, requires children younger than 8 years old, unless they are 4’ 9” in height, to be properly restrained in a child passenger safety seat while riding in an operating vehicle. Child Fatality Review Teams (CFRTs) are authorized under Texas Family Code Sections 264.501-264.515. The CFRT State Committee is a multidisciplinary group of professionals reflecting the geographical, cultural, racial, and ethnic diversity of the state. CFRTs work to understand the causes and incidence of child deaths in Texas; identify procedures within the represented agencies to reduce the number of preventable child deaths; increase public awareness; and make recommendations to the governor and legislature for effective changes in law, policy, and practices. A childhood immunization law, passed in 1993, mandates age-appropriate immunization of every child in Texas. Exclusions from compliance are allowable on an individual basis for medical contraindications, reasons of conscience, including a religious belief, and active duty in the U.S. Armed Forces.

Building on the success of the Texas Healthy Adolescent Initiative from 2010 to 2018, the Texas Youth Action Network (TYAN) promotes Positive Youth Development (PYD) and Youth-Adult Partnerships (YAPs). The Rape Prevention and Education (RPE) program is a primary prevention initiative aimed at reducing sexual violence.

Children with Special Health Care Needs Services Program (CSHCN SP) is authorized under Texas Health and Safety Code Sections 35.001-35.013 which states that, for children with special health care needs, the program shall provide 1) early identification; 2) diagnosis and evaluation; 3) rehabilitation services; 4) development and improvement of standards and services; 5) case management services; 6) other family support services; and 7) access to health benefits plan coverage. CSHCN SP Texas Administrative Code rules expand on the details of the above services. Texas Medicaid provides rehabilitation and acute care services to individuals under the age of 16 who are blind or disabled and receiving benefits under Title XVI.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

DSHS maintains that direct clinical services are provided through Title V only when no other coverage is available. Title V funded programs that include direct clinical care benefits to clients provide information on available local, state, and federal resources that can help meet health care needs.

Title V is the payer of last resort, by legislation, and the services listed by the state reflect services that were not covered or reimbursed through another provider. The DSHS Title V Maternal and Child Health Program and the HHSC Texas Medicaid Program (Medicaid) established a practical working relationship for the purpose of providing and promoting prompt access to high quality health care and services for pregnant women, infants, children and adolescents eligible for benefits under Title V and Medicaid. Together these programs have the capacity to reduce morbidity and mortality among women, infants, children and adolescents, and to improve the health status of women and children in Texas. A Memorandum of Understanding (MOU) was developed between Title V and Medicaid to outline this relationship. A renewed version went into effect on July 1, 2020, and will continue through August 31, 2025.

As outlined in the MOU, DSHS and HHSC will continue collaborating to provide coordinated and integrated delivery of maternal and child health services to improve birth outcomes and reduce maternal, infant and child morbidity and mortality in Texas. Title V and Medicaid share similarities in that both program objectives target populations and recognize the benefits from cooperation in the attainment of the mutual goals. The benefits include promotion of quality and continuity of care; compliance with state and federal statutes, regulations and guidelines requiring the proper expenditure of public funds for the administration; shared expertise among staff and efficient use of personnel and resources; reduction of unnecessary duplication and overlap of efforts; and assurance that the services provided under Medicaid and Title V are consistent with the needs of recipients, and are complementary and supportive of each program’s goals.

DSHS and HHSC both maximize the efficient use of federal and state funds for the provision of health services through interagency cooperation. DSHS coordinates with HHSC to implement interagency systems for serving pregnant, postpartum and breastfeeding women, infants and children, including CSHCN. Texas strives to improve the health of pregnant women and children by supporting systems to provide and assure access to quality prenatal and child health services to women and children of low income or limited availability of services in a timely and appropriate manner.

DSHS and HHSC collaborate on the establishment of quality improvement standards and performance measures relative to the delivery of maternal and child care, and participate in and collaborate on the development of program policies, regulations and quality of care standards for services to pregnant women, infants, children and adolescents, and CSHCN.

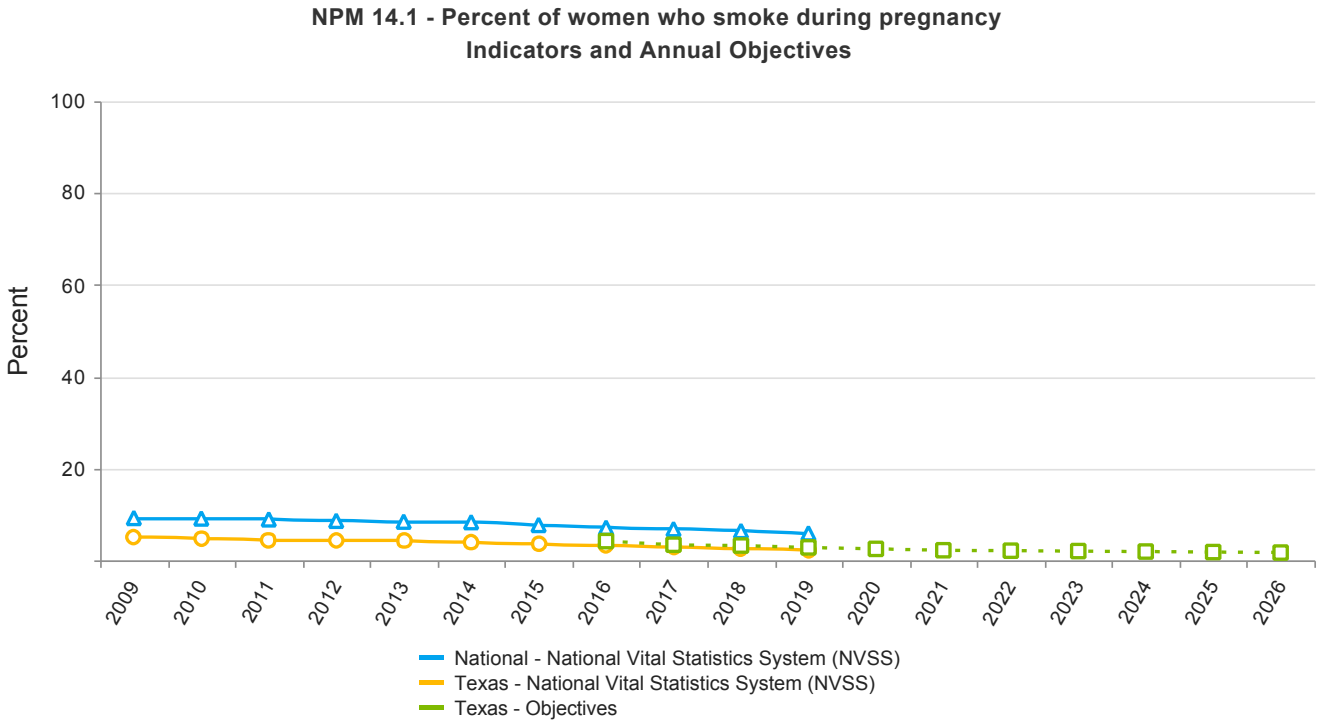
III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	66.2	NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	20.4	NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	8.4 %	NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	11.0 %	NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	31.2 %	NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	5.2	NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	5.5	NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	3.6	NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.8	NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	177.5	NPM 14.1
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	90.1	NPM 14.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	89.4 %	NPM 14.1

National Performance Measures



Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	4.3	3.5	3.3	2.9	2.6
Annual Indicator	3.6	3.3	3.0	2.7	2.4
Numerator	14,521	12,978	11,394	10,239	9,206
Denominator	403,518	397,971	381,948	378,549	377,097
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	2.3	2.2	2.1	2.0	1.9	1.8

Evidence-Based or –Informed Strategy Measures

ESM 14.1.1 - Number of health organizations engaged in a DSHS maternal or infant health improvement effort involving integration of tobacco/e-cigarette screening, education and referral.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	10.0	40.0	40.0	80.0	200.0

State Performance Measures

SPM 4 - Maternal Morbidity Disparities: Ratio of Black to White severe maternal morbidity rate.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	2	1.8
Numerator	299.4	275
Denominator	146.3	149
Data Source	Texas Hospital Inpatient Public Use Data Files	Texas Hospital Inpatient Public Use Data Files
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.9	1.8	1.7	1.6	1.5	1.4

SPM 5 - Percent of women of childbearing age who self-rate their health status as excellent, very good, or good

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			86	86.1
Annual Indicator			87.5	82.9
Numerator			4,780,630	4,597,793
Denominator			5,461,979	5,546,052
Data Source			Texas Behavioral Risk Factor Surveillance System	Texas Behavioral Risk Factor Surveillance System (
Data Source Year			2018	2017
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	86.2	86.3	86.4	86.5	86.5	86.5

State Action Plan Table

State Action Plan Table (Texas) - Women/Maternal Health - Entry 1	
Priority Need	
Support health education and resources for families and providers.	
NPM	
NPM 14.1 - Percent of women who smoke during pregnancy	
Objectives	
By 2025, increase abstinence from cigarette smoking among pregnant women by 10%. (CDC WONDER Online Database, Natality public-use data; 2017 baseline = 97%)	
By 2025, decrease any cigarette smoking during the three months before pregnancy by 10% (CDC PRAMS , 2017 baseline = 17.7)	
By 2025, decrease any cigarette smoking during the last three months of pregnancy by 10% (CDC PRAMS , 2017 baseline = 8.1)	
By 2025, decrease any cigarette smoking in the postpartum period by 10% (CDC PRAMS , 2017 baseline = 11.7%)	
By 2025, decrease any e-cigarette use during the three months before pregnancy by 10% (CDC PRAMS , 2017 baseline = 3.7%)	
By 2025, decrease any e-cigarette use during the last three months of pregnancy by 10% (CDC PRAMS , 2017 baseline = 1.1)	
Strategies	
Strategy 1: Assess needs, gaps and opportunities to increase implementation of recommended smoking prevention and cessation best practices.	
Strategy 2: Foster partnerships with stakeholders to strengthen collaboration and increase synergy and collective impact of programmatic activities.	
Strategy 3: Develop, promote and disseminate materials, communications, and programmatic activities that reduce tobacco exposure among women, children and families.	
ESMs	**Status**
ESM 14.1.1 - Number of health organizations engaged in a DSHS maternal or infant health improvement effort involving integration of tobacco/e-cigarette screening, education and referral.	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Texas) - Women/Maternal Health - Entry 2

Priority Need

Improve maternal and infant health outcomes through enhanced health and safety efforts.

SPM

SPM 5 - Percent of women of childbearing age who self-rate their health status as excellent, very good, or good

Objectives

By 2025, increase the proportion of women who had a health care visit in the 12 months before pregnancy to meet a target of 60.0% or higher (CDC PRAMS, 2017 baseline = 67.7%).

By 2025, decrease the Non-Hispanic (NH) Black to NH White and Hispanic to NH White disparity gap in getting prenatal care as early as wanted. (Texas PRAMS 2018 baseline: % getting prenatal care as early as wanted: NH Black: 82.1%; Hispanic: 77.8%; NH White: 87.6%)

By 2025, increase the proportion of women giving birth who attend a postpartum care visit with a health care worker to meet a target of 90% or higher (Texas PRAMS, 2018 baseline = 88.1%).

By 2025, increase the proportion of birthing hospitals in Texas with one or more physicians participating at least annually in DSHS maternal health continuing medical education learning events to 70%.

By 2025, reduce severe maternal complications (excluding blood transfusions) identified during delivery hospitalizations by 15% from baseline (HP3030 MICH-05).

Strategies

Strategy 1: Assess needs, gaps, and opportunities to strengthen systems and expand initiatives to increase women’s and maternal health awareness throughout the state.

Strategy 2: Develop and promote educational opportunities for health care professionals and other stakeholders on women’s and maternal health topics related to pregnancy, birth outcomes, chronic disease, infectious disease, mental health, behavioral health, preventive health and health promotion affecting women’s, maternal and infant health.

Strategy 3: Foster partnerships and promote best practices and to increase uptake of recommended maternal and women's health practices that reduce risk and prevent feto- infant and maternal harm.

Strategy 4: Partner with health care organizations and provide technical assistance and support for maternal health care quality improvement.

State Action Plan Table (Texas) - Women/Maternal Health - Entry 3

Priority Need

Implement health equity strategies across all maternal and child health populations.

SPM

SPM 4 - Maternal Morbidity Disparities: Ratio of Black to White severe maternal morbidity rate.

Objectives

By 2025, decrease the Black- White SMM disparity gap ratio from 1.9 (2019 baseline) to 1.4.

Strategies

Strategy 1: Identify best and promising practices to increase maternal health equity and prioritize reduction and elimination of disparate outcomes in all DSHS maternal health programming.

Strategy 2: Develop structures, processes, and a culture of equity to support health equity work.

Strategy 3: Strengthen community engagement in health equity work.

Strategy 4: Implement, and use continuous quality improvement and evaluation to assure, use of evidence based/evidence informed interventions to reduce disparities and increase health equity.

Strategy 5: Develop and promote educational opportunities for health care professionals and other stakeholders on maternal health equity.

Strategy 6: Foster partnerships, promote best and promising practices, and increase uptake of recommended health and racial equity practices.

Strategy 7: Partner with health care organizations and provide technical assistance and support for health and racial equity quality improvement.

NPM 14.1: Percent of women who smoke during pregnancy,

Activity: Maternal Mortality and Morbidity Review

The multidisciplinary Texas Maternal Mortality and Morbidity Review Committee (MMMRC), with facilitation and support from MCH, continued throughout FY20 to comprehensively review deaths of women during or within a year of pregnancy and state trends in maternal mortality and morbidity to understand causes, contributors, risk factors, and racial and ethnic disparities to inform development of targeted, actionable recommendations to prevent future deaths

The MMMRC assessed tobacco use as part of the case review process. Tobacco use may be selected by the MMMRC as a contributing factor on the Maternal Mortality Review Information Application (MMRIA) Committee Decisions Form (versions 18 and 19) to describe the patient's use of tobacco as compromising the patient's health status.

The MMMRC Subcommittee on Maternal Health Disparities created the Discrimination Assessment and Social Determinants of Health Facilitated Discussion Tool (DASH Tool), which provides a standardized process to guide targeted discussion, evaluate information relevant to each case, and determine whether social determinants of health factors contributed to the death. Section B of the DASH Tool includes a checkbox for tobacco use of the decedent as a life course factor that potentially impacts family wellbeing. MCH piloted an early version of the DASH Tool in October 2019. Findings and priority recommendations of the MMMRC raised awareness among partners and stakeholders of the Perinatal Quality Improvement Network on the drivers of maternal mortality.

Healthy Texas Mothers and Babies (HTMB) Community Coalitions

The HTMB Community Coalitions provided programmatic and technical assistance to support perinatal community coalitions across Texas in communities with the greatest disparities in infant health. The Maternal and Child Health (MCH) Unit directs each HTMB Community Coalition to develops and maintains a network of partners in maternal and infant health. These partnerships allowed the Community Coalitions to carry out assessment activities to identify needs in their communities, including reviewing and assessing infant morbidity and mortality data such as Perinatal Periods of Risk mapping. Additionally, the HTMB Community Coalitions conducted strategic planning to develop, implement, and evaluate data-driven programs, initiatives, and community outreach, education, and awareness activities tailored to their population to address specific identified needs and factors. All four Healthy Start sites in Texas were part of these HTMB Community Coalitions. DSHS funded and collaborated with local health structures, including public health departments and a public hospital district, to establish multidisciplinary community coalitions to reach target populations in their communities. The fiscal year (FY)20 HTMB Community Coalitions were:

1. Healthy Amarillo Women – City of Amarillo Public Health Department (five counties in Public Health Region [PHR] 1)
2. Breastfeeding for a Healthy Brownsville – City of Brownsville (located in PHR 11)
3. Dallas Healthy Start Community Action Network – Parkland Health & Hospital System (seven counties in PHR 2/3)
4. Laredo Health Coalition – City of Laredo Health Department (located in PHR 11)
5. Healthy Me, Healthy Babies – Northeast Texas Public Health Department (one county in PHR 4/5N)
6. Healthy Mothers and Babies of Jefferson County – Port Arthur City Health Department (one county in PHR 6/5S)
7. Healthy Families Network – San Antonio Metropolitan Health Department (one county in PHR 8)
8. Infant Health Network – Tarrant County Public Health Department (one county in PHR 8)
9. Healthy Waco Women – Waco-McLennan County Public Health Department (one county in PHR 7)

HTMB Community Coalitions are important partners at the grassroots level to implement evidence-based efforts to change behaviors and connect pregnant women to resources. Examples of HTMB community coalitions' community-based maternal health interventions in FY20 included:

- Provision of 6-month supplies of prenatal vitamins to pregnant women.
- Classes to increase understanding about key health topics such as pre-eclampsia and gestational diabetes.
- Community outreach through education and professional support using social media, promotional materials,

community-based events, and partnerships. Topics of education included:

- Preconception, prenatal, and postpartum health.
- Substance abuse (smoking and alcohol consumption).
- COVID-19 prevention for women and mothers.

Texas Health Steps Online Provider Education

MCH collaborated with the Health and Human Services Commission (HHSC) Texas Health Steps Online Provider Education (THS OPE) program to promote its MCH-supported suite of continuing education modules focused on preconception and prenatal health. Physicians, nurses, social workers, and other providers completed a variety of modules related to women's and maternal health in FY20. In FY20, 550 providers completed *Preconception Health: Screening and Intervention* and 632 providers completed *Prenatal Health: Screening and Intervention*. DSHS released a new module, *Postpartum Health: Screening and Intervention* at the beginning of FY20 and 560 providers completed the module. In FY20, DSHS also released the revised and redesigned *Breastfeeding* module. Nearly 2,300 providers completed this module. These modules contain information about screening, brief intervention, referral, and treatment to promote tobacco cessation in the preconception, prenatal, postpartum, and interpregnancy periods.

Information for Parents of Newborn Children

Texas Health and Safety Code 161.501 requires hospitals, birthing centers, physicians, nurse-midwives, and midwives who provide prenatal care to pregnant women during gestation or at delivery to provide the parents or adult caregiver for the infant with a resource pamphlet. This pamphlet includes information about a variety of maternal and infant health considerations including information about the importance of smoking cessation and smoke free environments for maternal and infant health. Providers may distribute the DSHS booklet or develop and use a similar material that contains the information that is required by statute.

In FY20, DSHS distributed 47,784 physical pamphlets in English and 10,544 physical pamphlets in Spanish to health care providers to share with parents of newborns. These numbers may not accurately reflect demand, as the ability to print pamphlets during some of FY20 was impacted by the COVID-19 pandemic. Additionally, there were 77 pamphlets (63 English, 14 Spanish) downloaded from the MCH website.

High-Risk Maternal Care Coordination Services Program Pilot

In Regular Session 2019, the Texas Legislature added Texas Health and Safety Code 1001 Subchapter K directing DSHS to develop and implement a high-risk maternal care coordination services pilot program (HRMCCSP) in one of more areas of Texas.

DSHS is charged to implement and study a pilot program to provide one or more sites with guidance, resources, training, and support to complete risk assessments in a clinical setting with pregnant women at elevated risk for poor pregnancy, birth, or postpartum outcomes. As indicated by the risk assessment, women will be referred into a program that integrates services of community health workers (CHWs) into the women's care.

DSHS will develop, adapt, or adopt: CHW training courses to prepare promotoras and CHWs in assessing risk and educating and supporting women at risk for serious complications during pregnancy and in the postpartum; a model of care coordination services for women at high risk; and an assessment tool or tools for identifying women who are at higher risk for poor pregnancy, birth, or postpartum outcomes. The design and implementation of the pilot will be guided by best practices in pilot studies and will focus on assessing feasibility and acceptability of the interventions being tested while using rapid-cycle testing and scaling of the model. [1],[2],[3],[4],[5]

Research on existing resources and best practices for development of a risk assessment tool, a CHW training curriculum, and a care coordination model began in March 2020. Staff began work to create a risk assessment tool prototype for the pilot based on existing risk assessment tools and stakeholder input.

Additionally, staff conducted a statewide scan of 27 existing CHW training modules certified by DSHS as well as modules developed for the national Healthy Start program. Staff reviewed the modules to identify those that included information in the modules' learning objectives and content of the courses about risk factors and risk assessment for high-risk pregnancy. Recommendations from the scan of CHW module topics included health equity and maternal outcomes in Texas, the role of CHWs and care coordination for women with maternal risk factors, and maternal health promotion, risks, and warning signs.

MCH staff also reviewed over 40 CHW care coordination models from statewide and national programs to guide model development. The pilot model will integrate CHWs into care coordination as part of multidisciplinary care teams which will enable timely response for women at elevated risk, including those with chronic health conditions and behavioral health needs.

In FY20, MCH staff began coordinating with the DSHS CHW Certification Program staff to create a long-term plan for development of a specialty certification track within the DSHS CHW Certification Program. MCH will continue to work with the DSHS CHW Certification Program to design a High-Risk Maternal Care Coordination Services Certification for CHWs who complete a suite of specialized trainings for educating and supporting women with maternal risk factors. The suite of trainings will be based on the trainings developed and tested as part of the HRMCCSP.

Regional Activities

DSHS Public Health Regional (PHR) staff conducted several activities to educate communities about the dangers of smoking and the importance of not smoking during pregnancy. PHR 7 continued to provide smoking cessation education to individuals who visited PHR clinics and promoted the Texas Tobacco Quitline, a confidential advice and information service for people who want to quit smoking. Staff participated in webinars offered by DSHS and other agencies to increase their knowledge of the dangers and current trends of smoking, including the use of e-cigarettes, vaping, hookah, and the use of synthetic marijuana among adolescents. This education enabled staff to provide smoking cessation education more effectively to the community.

PHR 9/10 partnered with hospitals, local health care providers, community health organizations, the U.S. Department of Housing and Urban Development, and other organizations to promote smoking prevention and cessation activities. Activities from these partnerships reached 92 individuals and included:

- Promoting THS OPE modules to local hospitals and providers.
- Providing education and support for tobacco-free multi-family housing units.
- Promoting the Texas Tobacco Quitline to DSHS clinic patients.
- Engaging CHWs in smoking cessation and prevention activities.

PHR 11 collaborated with the DSHS Regional Tobacco Prevention Coordinator and DSHS Office of Border Public Health to translate the DSHS CHW curriculum, *Helping Pregnant Women Quit Smoking: Best Practice Interventions*, into Spanish. Fifty CHWs completed the Spanish module, which included education on the dangers of secondhand smoke exposure to pregnant women and children and information about the Quitline. Through partnerships with the Regional Tobacco Prevention Coordinator, United Way, and local schools, PHR 11 staff also educated 27 pregnant teens on the dangers of secondhand smoke exposure and vaping to their health and the health of their baby and their families.
Other PHR activities included:

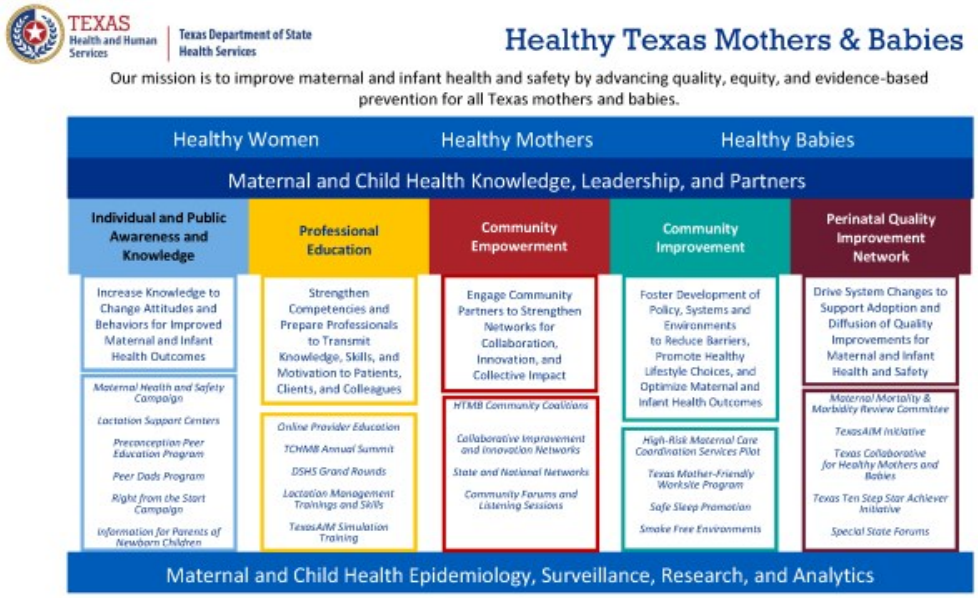
- Educating women on the harmful effects of smoking and vaping during pregnancy through *Becoming a Mom/Comenzando Bien*, a comprehensive prenatal program designed by the March of Dimes.
- Presenting on the dangers of vaping and e-cigarettes to school nurses and counselors, middle and high school students, and professional organizations. These presentations were a request from the Educational Training Center in East Texas. PHR 4/5N staff presented 38 times to approximately 4,330 people.

Adopted in December 2017, the DSHS Healthy Texas Mothers and Babies (HTMB) Strategic Framework is modeled after the Prevention Institute's *Spectrum of Prevention*, and provides strategic direction for alignment, improvement, and development of existing and new interventions to support the triple aim of healthy women, healthy mothers, and healthy babies. The HTMB Framework integrates all of DSHS Maternal and Child Health (MCH) women's, maternal, perinatal, and infant health programming and expands upon MCH commitment and investments toward improved infant health outcomes through the previous Healthy Texas Babies (HTB) Initiative by elevating and amplifying an emphasis on women's and maternal health and safety.

The HTMB framework includes the domains of Individual and Public Awareness and Knowledge, Professional Education, Community Empowerment, Community Improvement, and the Perinatal Quality Improvement Network, which includes a variety of interrelated and complementary initiatives that provide public health knowledge, partner mobilization, and implementation resources to drive system changes to support adoption and diffusion of quality improvements for maternal and infant health and safety.

Effective February 1, 2019, the HTMB Branch was established within the MCH Unit to elevate this framework and provide structure to support MCH ongoing commitment to women's, maternal, and infant health improvement.

Figure 1: Healthy Texas Mothers and Babies Framework



The 2020 Title V Needs Assessment identified care coordination and health disparities among maternal and child health populations as priority needs. MCH programmatic efforts in the women's and maternal health domains included policy, environmental, and systems level approaches to improve systems of care, increase health equity, prevent and control acute morbidity and chronic disease, and promote wellness throughout a woman's reproductive years. Women in Texas experienced high rates of obesity, diabetes, hypertension, substance abuse disorder, and other morbidities as well as marked racial, ethnic, and geographic disparities.

Self-reported health status is a helpful measure to account for the multiple factors that impact a woman's preconception and interpregnancy health beyond the primary care visit. As described by Broussard et al (2011), DSHS epidemiology and program subject matter experts contributed, along with experts in other states, to a multi-state consensus-based selection process to develop a set of Core State Preconception Health and Health Care Indicators. SPM 5 is a core preconception health indicator and is the only indicator of general health status included by the Council of State and Territorial

Epidemiologists in this core measure set. A lower rating of self-rated health status has consistently been associated with "increased mortality, incident adverse health events, health care utilization, and illness severity, even after medical risk factors have been accounted for." [6]

Maternal Mortality and Morbidity Review (MMMRC)

The 86th Texas Legislature, Regular Session, 2019 added several additional charges relating to the MMMRC. Actions of the 86th Texas Legislature, Regular Session, 2019, relating to the MMMRC that impacted work in FY2020 included:

- Senate Bill (SB) 436 – amended Texas Health and Safety Code (HSC), Chapter (Ch.) 34, by adding § 34.0158 to direct the Department of State Health Services (DSHS), in collaboration with the MMMRC, to develop statewide initiatives to improve maternal and newborn health for women with opioid use disorder.
- SB 748 – amended HSC Ch. 34 to direct the Health and Human Services Commission (HHSC) to:
  - Collaborate with the MMMRC to perform annual data collection of specific information from the Medicaid and Healthy Texas Women (HTW) programs,
  - Consult with the MMMRC for development of a telehealth or telemedicine services program, and
  - Conduct program evaluations, including to explore expanding certain services.

  The bill added § 34.021 to direct the HHSC Executive Commissioner (via DSHS), to apply for grants under the Federal Preventing Maternal Deaths Act of 2018 (PMD). The bill also amended HSC Ch. 1001 by adding Subchapter K, which charges DSHS to develop and implement a high-risk maternal care coordination services pilot program (HRMCCSP) in one or more areas of Texas.
- SB 750 – amended HSC Ch. 34 to change the committee's name from the "Maternal Mortality and Morbidity Task Force" to the "Texas Maternal Mortality and Morbidity Review Committee" and added a provision making limited allowances for reporting in compliance with the Federal Preventing Maternal Deaths Act (PMD).
- SB 2132 – added HSC § 531.0995 and directs HHSC to consult with the MMMRC on improving the process for providing required information to women enrolled in the HTW program.
- 2020-21 General Appropriations Act, House Bill (HB) 1 (Article II, Health and Human Services, Rider 28) – over the biennium, appropriated:
  - $1.33 million and six Full Time Employees (FTEs) to implement maternal safety initiatives statewide,
  - $1.17 million and two FTEs to develop and establish the previously mentioned high-risk maternal care coordination services pilot, and
  - $1 million to increase public awareness and prevention activities related to maternal mortality and morbidity.
- HB 25 – added HSC § 531.024141 directing HHSC to collaborate with the MMMRC to develop and implement a pilot program for providing services to women and children under the Medicaid medical transportation program

In December 2019, the MMMRC received the DSHS Commissioner's Partner in Public Health Shine Award for the group's outstanding contribution in partnership with DSHS to advance the mission and vision of the agency.

The DSHS commissioner appointed two members to the MMMRC: Dr. Sherri Onyiego, a physician specializing in family practice, and Kimberley Williams, a community advocate. Both members began participating in MMMRC activities in September 2019. In March 2020, the DSHS commissioner appointed Dr. Kelly Fegan-Bohm, DSHS Community Health Improvement Medical Director, as the State Epidemiologist Interim Designee.

The MMMRC established the Subcommittee on Maternal Health Disparities (Subcommittee) in December 2018 to further investigate factors contributing to disparities in maternal mortality. MCH provided administrative and programmatic support for the activities of the Subcommittee. In September 2019, *Changing the Conversation: Applying a Health Equity Framework to Maternal Mortality Reviews* was published in the American Journal of Obstetrics by Kramer et al. [7] The article provided a call to action for maternal mortality review committees and provided a framework for the Subcommittee to guide the MMMRC to ground its case review processes in a health equity framework to study drivers and root causes of racial disparities in maternal mortality in Texas.

The Subcommittee conducted the following activities in FY20:

1. Studied pregnancy-related death cases in the 2012 case cohort and the association of women's race or ethnicity with the number and types of contributing factors that the MMMRC identified during their review. In December 2020 during the MMMRC Quarterly Public Meeting, MCH Epidemiology Director, Dr. Michelle Cook, presented the findings from this analysis.
2. Provided consultation to DSHS on the development of the Texas Socio-Spatial Context Dashboard to provide community-level context when studying pregnancy-associated deaths. The MMMRC began to use the dashboard as part of its standard review process in November 2019.
3. Drafted a review committee-facilitated discussion tool for social determinants that may impact a woman's health, health care experiences, and health disparities throughout her life and in the time leading up to her death (called the *Social Determinants of Health and Discrimination Assessment Facilitated Discussion Tool*). The MMMRC began testing the use of this tool during case review to enhance their identification of factors that contribute to preventable maternal mortality.

DSHS and MMMRC members continued to contribute to and learn from national conversations about reducing maternal mortality and severe maternal morbidity.
Dr. Carla Ortique, MMMRC Vice-Chair and Subcommittee Chair, participated in a national workgroup to develop standard definitions for state maternal mortality review committees. The conclusion of this work was formally presented via webinar in April 2020, by the workgroup chair Dr. Elizabeth Howell. Subsequently these contributing factors and supporting definitions were added to the MMRIA Committee Decisions Form, Version 19 in May 2020.

The Association of Maternal and Child Health Programs (AMCHP), the Centers for Disease Control and Prevention (CDC) Foundation, and the CDC Division of Reproductive Health partnered to develop a resource called Review to Action, which promoted the maternal mortality review process as the best way to understand causes and contributors to maternal mortality to prioritize interventions to improve maternal health.

In September 2019, DSHS received funding through the CDC's Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program. This funding supports DSHS efforts to coordinate and manage MMMRC activities to identify, review, and characterize maternal deaths as well as identify prevention opportunities.

In partnership with the MMMRC and the University of North Texas Health Science Center (UNTHSC) and with consultation from CDC, DSHS worked throughout FY20 to hire four MCH staff and develop the infrastructure to increase capacity for case review. The ERASE MM grant supports DSHS efforts to identify pregnancy-associated deaths within one year of the date of death and supports the MMMRC in review of potentially pregnancy-related deaths that fall within the defined scope of the MMMRC. DSHS, in coordination with UNTHSC contract partners, aims to abstract and enter clinical and non-clinical data into the Maternal Mortality Review Information Application (MMRIA) data system, support the MMMRC to conduct timely multidisciplinary pregnancy-associated death reviews, and enter committee decisions in MMRIA within two years of death. Through ERASE MM funding, MCH aims to improve data quality, completeness, and timeliness through use of quality assurance processes in partnership with the CDC. Activities of the ERASE MM grant will also support analysis and communication of findings with stakeholders throughout the Perinatal Quality Improvement Network to inform policy and prevention strategies to reduce maternal mortality in Texas.
In December 2019, DSHS staff and the MMMRC Chairs, Dr. Lisa Hollier and Dr. Carla Ortique, participated in the CDC ERASE MM MMRIA User Meeting. Dr. Carla Ortique presented on MMMRC work, including:

- *High Volume Case Review: The Texas MMMRC Experience*- This presentation details the primary review case categorization process. A process developed by MCH staff, in coordination with a small pilot group of the MMMRC to increase case review efficiency; and
- *Innovations for Improvement*- This presentation focused on the work of the Subcommittee on Maternal Health Disparities.

MCH work throughout FY20 focused on MMMRC-related infrastructure building activities, including hiring four ERASE MM

grant-funded FTEs and developing an ERASE MM Workplan and Evaluation and Performance Management Plan. The CDC Maternal Mortality Prevention Team visited Texas in March 2020 to provide on-site technical assistance and provide subject matter expertise during the MMMRC's maternal mortality case review meeting. After execution of a data use agreement with the CDC, MMRIA went live in Texas in July 2020. In FY20, MCH continued to contract with UNTHSC to ensure high quality case redaction and case abstraction reporting for MMMRC case review. MCH staff worked to coordinate strategies to support UNTHSC's internal quality assurance process and met weekly with UNTHSC program staff to optimize contract efficiencies and ensure completion of 15-25 cases per quarter for review by the MMMRC. MCH provided ongoing subject matter expertise for additional quality assurance oversight and feedback. UNTHSC and DSHS staff participated in virtual CDC ERASE MM MMRIA training in June 2020. MCH staff worked throughout FY20 to plan for integration of the MMRIA system into the case abstraction and data management processes.

Before COVID-19 emergency orders beginning in March 2020, the MMMRC met in person quarterly and the MMMRC review teams met by phone monthly for preliminary review and analysis of each case. After March 2020, case calls and virtual web-based quarterly meetings continued throughout FY20. From September 2019 through June 2020, the MMMRC reviewed and closed 79 cases from the 2013 pregnancy-associated death cohort. Quarterly MMMRC meetings included programmatic updates from DSHS programs relevant to the MMMRC, presentation of data on severe maternal morbidity and mortality trends in Texas, refinement of MMMRC processes, and closed-session confidential case reviews.
Dr. Lisa Hollier, the MMMRC chair co-authored *Maternal Mortality from Coronavirus Disease 2019 (COVID-19) in the United States*. The manuscript published in August 2020 highlights the role of maternal mortality review committees in understanding emerging health issues and the utility of contemporary case review.[8]

Many MCH-supported maternal health and safety activities of the HTMB are informed by previously published MMMRC recommendations and resulting legislation, including the TexasAIM Initiative and work to develop the HRMCCSP Program and a Maternal Health and Safety Campaign. In late FY20, MCH coordinated the development of the 2020 MMMRC/DSHS Joint Biennial Report for release on December 1, 2020.

Online Provider Education for Preconception, Prenatal, and Postpartum Health
MCH collaborated with Texas Health Steps Online Provider Education (THS OPE) to promote its MCH-supported suite of continuing education modules focused on preconception, prenatal, and postpartum health. The modules were refreshed in FY19 and are designed to equip health care professionals with knowledge and resources to improve the health of Texas women before and during pregnancy. In FY20, 550 health professionals completed 1.25 hours of continuing education in *Preconception Health: Screening and Intervention,* 632 health professionals completed 1.25 hours of continuing education in *Prenatal Health: Screening and Intervention,* 560 health professionals completed 1.25 hours of continuing education in *Postpartum Health: Screening and Intervention,* and 2,298 health professionals completed 2.0 hours of continuing education in Breastfeeding. Health professionals also completed quick courses and tutorials that were available without continuing education, including: Fetal Alcohol Spectrum Disorders: Promoting Early Identification and Support for Children; Integrating Postpartum Depression Screening into Routine Infant Medical Checkups; Opioid and Substance Use: Caring for Texas Mothers and Babies; Oral Health and Dental Services for Pregnant Women; and The Virus Among Us: Protecting Texas Mothers and Babies from Cytomegalovirus. The modules may be accessed at www.txhealthsteps.com.

HTMB Community Coalitions
HTMB Community Coalitions worked to reduce racial and ethnic health disparities in maternal and infant health in their communities by applying evidence-based multi-pronged approaches. These approaches include tailored programs designed to meet the needs of women, mothers, and infants based on identified gaps and needs of their respective communities. Specific activities are listed below.

- The coalition in Laredo collaborated with March of Dimes Foundation to launch a nine-week educational course called *Becoming a Mom/Comenzando Bien*. This course covered topics related to pregnancy health, healthy lifestyle behaviors, labor, birth preparation, infant care, familial support, and mental health and reached 6,000 community members.

- The Breastfeeding for a Healthy Brownsville coalition facilitated 11 educational and outreach events addressing maternal and infant health disparities. Events and information reached 26,200 community members.
- The Healthy Waco Women Community Coalition (HWCC) partnered with a local Federally Qualified Heath Center to encourage women to receive annual well women exams. They distributed 400 Healthy Waco Women Wellness Bags—including a multi-vitamin with folic acid, among other wellness items—at 13 clinics for clients that redeemed vouchers after receiving their annual exam. Women who signed up to receive a voucher also received subscriptions to a monthly newsletter with women's health tips.
- HWCC offered contraception counseling training to 30 key stakeholders caring for women of color to improve knowledge and skills on motivational interviewing, reproductive life planning, and contraception options.
- HWCC Women's Health Advocacy Committee held key informant meetings with seven active participants to learn more about the health needs of women of color between the ages of 18-25 and how best to engage these populations in preventive health services and programs.
- HWCC offered continuing education opportunities at monthly meetings with approximately 20 maternal and child health program and service providers to increase awareness about implicit biases and maternal and child health disparities.
- Despite setbacks related to COVID-19, Tarrant County Public Health in collaboration with the Infant Health Network community coalition implemented the Preconception Peer Educator Program with local universities. Staff used the student training guide published in 2008 from the Office of Minority Health and the program outline from HTMB staff to create a relevant and relatable curriculum.

Additionally, PHR staff conducted various activities to promote health and wellness for women of childbearing age. PHR 6/5S hosted *Becoming a Mom/Comenzando Bien*. Classes were in English and Spanish. Women received educational information on prenatal care, nutrition, stress, things to avoid during pregnancy, labor and birth, postpartum care, and newborn care. In PHR 7, staff continued to implement the Whole Person Project. The Whole Person Project promotes consideration for all health needs and concerns of the person instead of just the issues for the clinical visit. When women of childbearing age visited the clinic, staff routinely asked clients the One Key Question (OKQ), "Would you like to become pregnant in the next year?" Staff offered tailored support based on the response and individual needs of the woman including encouraged over 80 clients to visit a primary care giver, distributed 60 bottles of prenatal vitamins, provided contraception to women, and provided referrals to food assistance programs, the Texas Tobacco Quitline, and social workers.

High Risk Maternal Care Coordination Services Program Pilot (HRMCCSP)

In FY20, MCH started developing the HRMCCSP Program to pilot test a program for identification of, and improvement of care coordination for, women at increased risk for poor pregnancy, birth, and postpartum outcomes for prevention of severe maternal morbidity and mortality. HTMB staff convened an internal pilot design team. The team's FY20 activities included:

- Review of existing risk assessment tools from other states and programs that determine if a woman is at risk for poor pregnancy, birth, or postpartum outcomes. Staff analyzed and compared tools and made recommendations for essential health status factors to include in an adapted high-risk assessment tool prototype.
- A statewide scan of 27 DSHS-certified Community Health Worker (CHW) training courses related to maternal health. Staff used the scan to create recommendations for the development of a suite of trainings to prepare CHWs to educate and support women with maternal risk factors. The training suite prototype will be one of the HRMCCSP Program components tested during the pilot. Additionally, MCH staff began work with the DSHS CHW Certification Program to plan for development of a CHW specialty certification track recognizing CHWs who have received continuing education through completion of the final training suite.
- A literature review of over 40 models of high-risk care coordination from statewide and national programs. Staff used lessons learned from other programs to identify and refine model components. The proposed model included use of a high-risk assessment tool, multidisciplinary care teams, CHW-led care coordination, health education and outreach, and a focus on health equity.
- Development of a logic model for the program, defining maternal high-risk, and identifying maternal outcomes that

the program will address.

- Efforts to share research findings with a multidisciplinary team of stakeholders from DSHS and the Texas Health and Human Services Commission (HHSC). Staff also held separate meetings with the DSHS Health Equity Advisor, CHW Program managers, and HHSC Medicaid team to ensure awareness, coordination, and alignment of the pilot program with related initiatives.

In August 2020, MCH began to develop a proposal for participation in the Virtual CDC/Harvard MCH Program Evaluation Practicum for development of an evaluation framework for the pilot. Each year in January, the CDC Division of Reproductive Health, Harvard's T.H. Chan School of Public Health (HSPH), and the Association of Maternal and Child Health Programs co-present a hands-on Program Evaluation Practicum course. HSPH students who apply and enroll in the course are matched with a MCH program in need of evaluation.

The HRMCCSP that will be piloted will be designed with the goal of improving coordination of care for maternal and child health populations, particularly women with elevated risk and Non-Hispanic Black women. The program will reach women of reproductive age in the pilot area, specifically women who are at high-risk for negative pregnancy, birth, or postpartum outcomes. The pilot will also reach CHWs and CHW Trainers with expanded training material and skills and continuing education on maternal health, particularly for populations at elevated risk.

The design and implementation of the pilot project will be guided by best practices in pilot study design and will focus on assessing feasibility and acceptability of the interventions being tested while using rapid-cycle testing and scaling of the model.

Maternal Health and Safety Campaign

In FY20, MCH began to plan and procure a contract for development of a maternal health and safety awareness, education, and communication campaign. Staff identified a contractor through a competitive process and identified Fleishman Hillard (FH) with the contract beginning in May 2020.

FH conducted market research in July 2020 to inform development of messaging and communication methods. This research included engagement with Texas women through focus groups and phone interviews and stakeholders through key information sessions. Focus groups and phone interviews took place with women ages 18-44 in Dallas and Tarrant Counties, Bexar and Atascosa Counties, Nueces County, Southeast Texas, West Texas, and the Texas-Mexico border region. The women were primarily of low-income; were in preconception, interpregnancy, prenatal, or postpartum periods; and spoke English and Spanish. Additionally, FH conducted in-depth telephone interviews with key stakeholders to gather insights and experiences related to Texas women before, during, and after pregnancy. Interviews focused on women most at risk for maternal health complications. FH also reviewed past and existing maternal health and safety awareness, education, and communication campaigns. FH provided a summary report of the research and held stakeholder meetings to present this information and receive feedback for campaign development.

Because of this research, work is in progress to develop marketing and educational materials, campaign website, a media strategy, and a robust outreach plan. Additionally, staff have aligned this campaign with national efforts, including the CDC's Hear Her Campaign and the Council on Patient Safety's Maternal Urgent Warning Signs.

Messaging for the campaign efforts will focus on:

- The impact of severe maternal morbidity and mortality on Texas women, families, communities, and the state overall.
- The disproportionate impact of severe maternal morbidity and mortality on Non-Hispanic Black and Hispanic women, particularly those with a low income.
- Activities that communities can do to lower the risk and improve health outcomes.
- The importance of, and opportunities for, promotion of maternal health, safety, and wellbeing.

- Evidence-based or promising prevention strategies and the role and responsibility of providers to implement these strategies.

The campaign will apply a health equity lens to address disparities in all strategies. Through this work, MCH will disseminate information and initiatives to mothers, their support networks, and providers statewide through targeted public awareness and community mobilization.

The maternal health and safety campaign will reach Texas women, their support networks, and providers. The primary target audience includes women of childbearing age (18-44 years) in the preconception, interpregnancy, prenatal, and postpartum periods, focusing on Non-Hispanic Black and Hispanic women. The secondary target audience will include families, support networks, professionals, and paraprofessionals that provide health or social services to women; health and social service institutions; and professional organizations, collaboratives, and networks.

Objective 5: By 2020, enroll 75% of Texas birthing facilities in the TexasAIM Initiative with 50% enrolled at the Plus Level in a Learning Collaborative.

TexasAIM

MCH is the lead coordinating entity in Texas with the Council on Patient Safety in Women's Healthcare's Alliance for Innovation on Maternal Health (AIM) as administered by the American College of Obstetricians and Gynecologists. MCH has committed to implement AIM-endorsed maternal patient safety bundles to address leading and causes of maternal mortality in Texas through a large-scale quality improvement effort called the TexasAIM Initiative. DSHS started TexasAIM with a five-cohort learning collaborative to support Texas birthing hospitals to implement the Obstetric Hemorrhage (OBH) Bundle and with a limited pilot of the Obstetric Care for Women with Opioid Use Disorder (OB-OUD) Bundle. DSHS will launch learning collaboratives to support hospitals to implement the Severe Hypertension in Pregnancy (HTN) Bundle and the OB-OUD Bundle in FY21. The TexasAIM Initiative was recognized with the DSHS *Commissioner's Excellence in Public Health* Shine Award in December 2019.

Hospitals engaged in TexasAIM started work to implement the AIM OBH Patient Safety Bundle in August 2018. Since the enrollment began in 2018 through August 31, 2020, a total of 223 hospitals with obstetric (OB) lines of service have enrolled to participate in implementation of the TexasAIM OBH Bundle. However, some hospitals have subsequently discontinued their OB service lines or closed services altogether. Accounting for closures, 218 of an estimated 223 hospitals with OB service lines were participating in TexasAIM as of August 31, 2020. These hospitals represent approximately 98% of all the birthing hospitals in Texas and provide care for approximately 99% of births in Texas and approximately 10% of births in the nation.

Hospital participation in TexasAIM is voluntary. Participating hospitals may choose to join one of two levels of participation: TexasAIM Basic or TexasAIM Plus. Hospitals that participated at the Basic level received the fundamental tools to adopt AIM bundles. All enrolled hospitals committed to forming a quality improvement team within their hospitals for implementing the bundles; reporting structure and process measures in the AIM National Data Center portal; and participating in TexasAIM surveys. TexasAIM Basic hospitals worked independently to adopt AIM bundle practice changes. TexasAIM provided them with access to webinars, annual networking events, and technical assistance upon request.
TexasAIM provided programming to support hospitals enrolled at the Plus level with process and quality improvement through shared learning and collaboration using the Institute for Health Care Improvement (IHI) Breakthrough Series (BTS) Collaborative Model for Achieving Breakthrough Improvement.[9] TexasAIM Plus Learning Collaboratives created a structured framework for incremental rapid-cycle improvement; access to a team of expert faculty who have experience with, and provide coaching in, implementing practice changes for improvement in the topic; and a network of support from partnering hospitals for accelerated improvement through collaborative learning to support uptake of the AIM bundles' recommended practices by participating hospital improvement teams.

TexasAIM Plus hospitals completed all the TexasAIM Basic requirements and reported on the same quarterly measures but had the option to report on additional TexasAIM monthly process improvement measures. In the Learning Collaborative,

hospitals identified goals for improvement and made plans to achieve them. Participating TexasAIM Plus hospitals received access to quality- and process- improvement training and guidance as well as practical information about the bundles' components from experts. They could access shared learning and support of their peers across the state through in-person Learning Session (LS) meetings, networking calls, peer-to-peer mentoring, targeted coaching, online toolkits and discussion boards, a bi-weekly newsletter, and other supports, resources, and partnerships including support with using monthly and quarterly data to drive their improvement.

TexasAIM Plus hospitals were assigned to one of five geographic cohorts for in-person LSs. DSHS developed cohorts based on Public Health Regions (PHRs), Perinatal Care Region (PCR)/Regional Advisory Council (RAC) territories, and the number of hospitals per geographic area. Each cohort had 30-50 participating hospitals.

Figure 2. TexasAIM Plus Cohorts by Perinatal Care Region

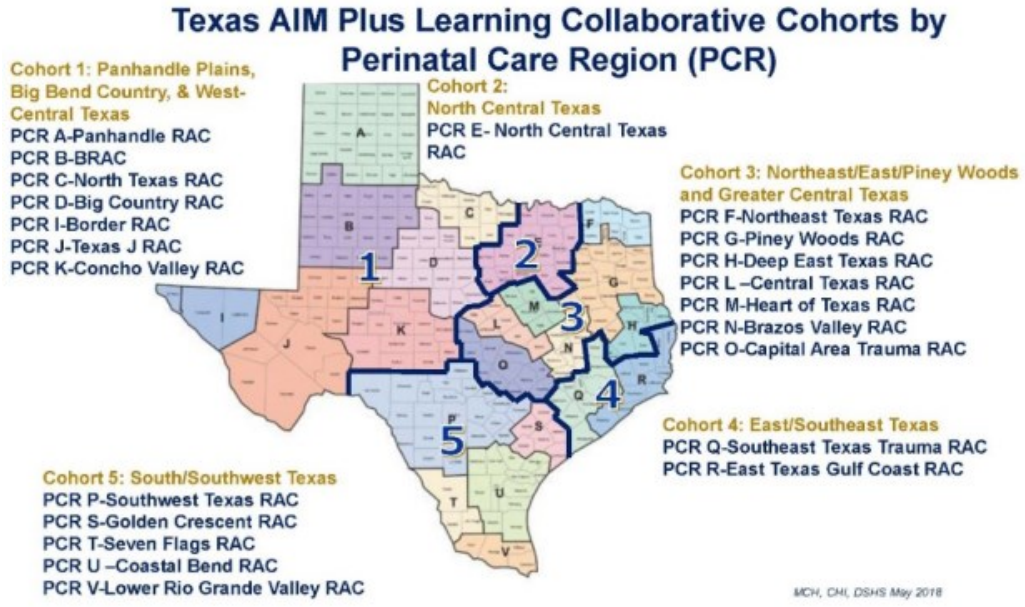
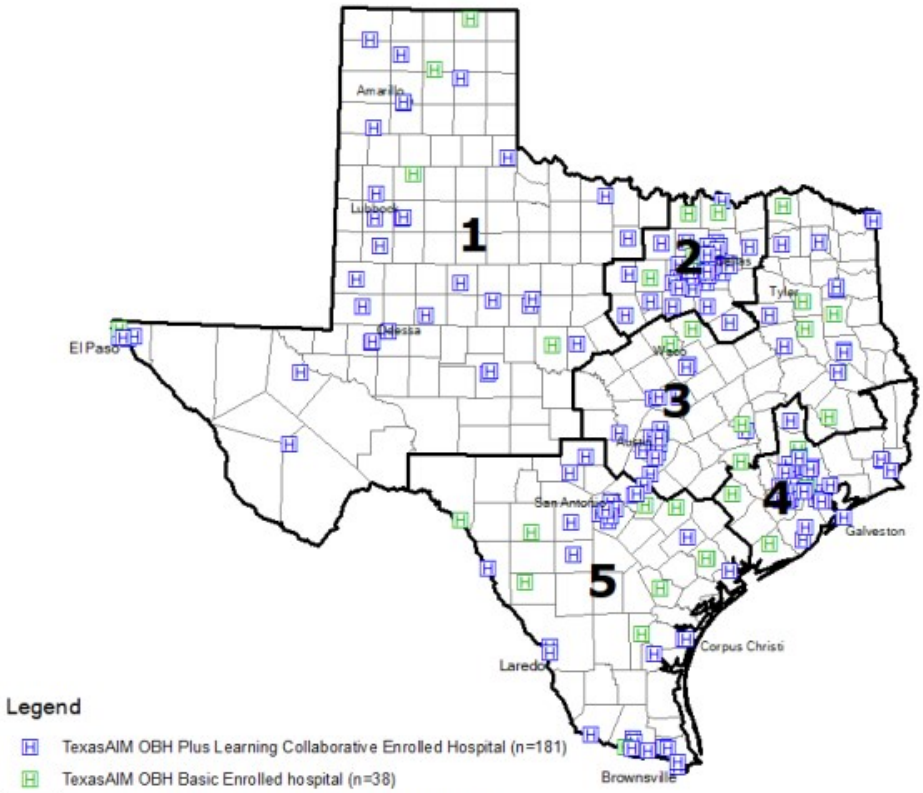


Figure 3 TexasAIM Hospitals by TexasAIM Cohort Region, September 15, 2020[i][10]

Hospitals Enrolled in the TexasAIM Obstetric Hemorrhage (OBH) Initiative as of September 15, 2020
By TexasAIM Cohort Region



Legend

- TexasAIM OBH Plus Learning Collaborative Enrolled Hospital (n=181)
- TexasAIM OBH Basic Enrolled hospital (n=38)
- TexasAIM OBH Plus Learning Collaborative Cohort Region

Source: TexasAIM Enrollment Data
Prepared by: Maternal & Child Health Epidemiology, 9/17/2020.

Of hospitals enrolled in TexasAIM, 180 hospitals (83%) were enrolled as TexasAIM Plus hospitals as of August 31, 2020. TexasAIM Plus OBH activities facilitated and directed by MCH from September 1, 2019 through August 31, 2020 included:

- Action Period 2 September 2019 Collaborative Call: Reporting and Systems Learning (190+ participants)
- Action Period 2 October 2019 Cohort Calls: A cohort-specific networking call was held for each of five cohorts (148+ participants across five calls)
- Cohort Learning Sessions 3 in November and December 2019 (472 attendees at five cohort-specific 2-day meetings held across Texas)
- Action Period 3 January 2020 Collaborative Call: Simulation and Drills (170+ participants)
- February 2020 TexasAIM Teamwork, Communication, and Simulation Training of Trainers Course (described below)
- Facilitation of collaboration among 1,068 subscribers within the TexasAIM Plus Obstetric Hemorrhage Information and Resources Online Collaboration Portal
- Communication with 1,505 subscribers in the TexasAIM Bi-Weekly Bulletin

During Action Periods 2 and 3, TexasAIM Plus hospitals worked to test and scale up OBH bundle components for full implementation, and submitted quarterly and monthly data, engaged in online platforms, and networked together.

TexasAIM Teamwork, Communication, and Simulation Training of Trainers Course

MCH TexasAIM staff worked with partners to schedule and recruit TexasAIM training teams that included a nurse leader and physician leader for Train-the-Trainer workshops held in February 2020 in five locations across Texas.

Safety Program for Perinatal Care (SPPC-II) Project Train-the-Trainer Workshop

Beginning in November 2018, DSHS partnered with the American College of Obstetricians and Gynecologists (ACOG)/AIM National, the Johns Hopkins University (JHU) Armstrong Institute for Patient Safety and Quality, and the Agency for Healthcare Research and Quality (AHRQ) to support JHU in coordinating a one-day workshop (Day 1) to pilot a training course on teamwork and communication as part of the of the Agency for Healthcare Research and Quality (AHRQ) Safety Program for Perinatal Care-II, Phase 2 (SPPC-II) demonstration project. The workshop was designed to apply teamwork and communication methods for implementation of the obstetric hemorrhage bundle.

TexasAIM *Practicing for Patients Obstetric Hemorrhage* Simulation Workshop

DSHS and partners planned and organized a one-day Train-the-Trainer course (TexasAIM *Practicing for Patients Obstetric Hemorrhage* Simulation Program). While the SPPC-II training took place on Day 1 of the *TexasAIM Teamwork, Communication and Simulation Training of Trainers Course*, MCH and partners hosted the TexasAIM Simulation Training-of-the-Trainer on Day 2. This full-day Simulation Training was a free event offered to all Texas birthing hospitals, regardless of TexasAIM enrollment status. The training was planned in partnership with Dr. Shad Deering (a recognized expert in obstetric simulation), Dr. Carey Eppes, who is the TexasAIM Plus Faculty Chair, members of the TexasAIM Plus OBH Learning Collaborative Faculty Team, additional volunteer faculty with simulation expertise, and partner hospitals who volunteered to host the events.

The training was one of the first of its kind in the country to happen at a state-wide level. During the simulation training, training teams learned to run in situ (onsite, within the unit) obstetric hemorrhage drills to practice technical skills, teamwork, communication, and debriefs on their units for standardized responses.

DSHS provided a simulation implementation kit to participating training teams, including a spiral bound Practicing for Patients manual and laminated blood product and vital signs scenario training aids, to facilitate the attendees' ability to train others within their facility on running low-fidelity unit-based simulations. There were five trainings with a total of 297 attendees representing 120 hospitals. MCH was able to award continuing education unit credits to those who attended the event.

DSHS began working to procure for each TexasAIM hospital the low-fidelity birthing simulator which includes a simulated

uterus with adjustable tone, placenta (delivered complete, partially retained, or fully retained), neonate, umbilical cord, blood reservoir, urine bladder, a rectum, and a postpartum uterus for placement of obstetric balloon tamponade use.

COVID-19 Support

Beginning in March 2020, the TexasAIM Faculty Chair, Dr. Carey Eppes, who has expertise in infectious disease and who had begun to feel an impact of COVID-19 in the hospital where she practices, described a sense of urgency for hospital collaboration around COVID-19. The TexasAIM Team quickly mobilized to review literature and practice guidance and to organize the first TexasAIM OB Care & COVID-19 webinar. MCH hosted the first webinar on March 20, 2020. The TexasAIM team developed an OB Care & COVID-19 "4 Rs" Framework to organize recommendations of the CDC, ACOG, and the Society for Maternal-Fetal Medicine into four patient care domains used by AIM to address quality care: Readiness, Recognition and Preparedness, Response, and Reporting and Systems (4 Rs) learning. MCH developed an online information, resources, and collaboration space as well as a bi-weekly electronic newsletter to round out the program. All hospitals with OB service lines were invited to use these resources. The hospitals' informational needs were assessed through polls during the calls and with surveys between webinars. Webinars were initially held weekly, reduced to biweekly webinars in the latter half of May and all of June, with a final webinar scheduled in September 2020. Over the course of the 12 calls, there were an average of more than 250 attendees each week. More than 1,200 health professionals from approximately 220 Texas hospitals and other organizations within and outside of Texas accessed information from the subscription-based TexasAIM OB Care & COVID-19 portal. Additionally, more than 1,500 health professionals received information from the bi-weekly newsletter.

Obstetric Care for Women with Opioid Use Disorder

Starting in June 2018, ten "early adopter" hospitals with experience caring for infants with neonatal abstinence syndrome convened OB-OUD improvement teams to independently plan and begin trial implementation of components of the bundle while also participating in the TexasAIM Plus OBH Learning Collaborative. MCH TexasAIM staff shared information related to the OB-OUD bundle information with these hospitals as it became available from the National AIM program.

Throughout FY20, DSHS gathered resources to support the implementation of the opioid bundle and worked to identify gaps, challenges, and lessons learned from National and State partners to inform programming. MCH and Texas Hospital Association (THA) hosted a "Deep Dive" meeting in October 2019 for Hospital OB-OUD improvement teams. Improvement teams participated in gap analysis, brainstorming, and process mapping exercises to identify opportunities to improve obstetric care for women with opioid use disorder.

MCH held a series of five collaborative calls between November 2019 and February 2020 for the participating hospitals to share experiences and discuss implementation barriers and knowledge gaps. Some topics covered during these calls included pain management; screening, brief intervention, referral, and treatment (SBIRT); maternal and family participation in care of opioid exposed newborns; and incorporating breastfeeding and infant care into prenatal, intrapartum, and postpartum clinical pathways. Additionally, participating hospitals were added to the AIM National Data Center's OB-OUD portal to begin trialing collection and entry of the bundle's measure set.

Qualitative research involving interviews with the hospitals' improvement teams and with state and national stakeholders began in the summer of 2020. The purpose was to capture lessons learned from their experiences with implementing OB-OUD bundle components. This research is still underway and will continue through winter 2021. While assessment is ongoing, MCH began applying lessons learned from these activities, and from consultation with state and national experts, to inform development of an approach and programming to support implementation of OB-OUD practice changes in Texas hospitals and their communities.

MCH plans to launch a TexasAIM "First Wave Cohort" OB-OUD Innovation and Improvement Learning Collaborative in spring 2021 to support the early adopter hospitals and will continue to plan for the subsequent roll out of the TexasAIM Plus OB-OUD Learning Collaborative in cohorts across the state.

Planning for Future TexasAIM Efforts

In summer 2020, MCHS resumed planning for several TexasAIM activities that had been delayed due to COVID-19. Planning began for the TexasAIM 2020 Leadership Meeting and Summit. The Summit, originally scheduled for June 2020, will be held in December 2020 to highlight the successes of the TexasAIM OBH Program and to mark the launch of the TexasAIM Plus Severe Hypertension in Pregnancy (HTN) Learning Collaborative. Planning also resumed for the HTN Learning Collaborative, a rural hospital maternal health and safety forum, and a TexasAIM birthing center project to adapt OBH and HTN Bundles for the needs of birthing center settings. Additionally, MCH and the TexasAIM Plus Faculty Chair, who was also Chair of the Texas Collaborative for Healthy Mothers and Babies (TCHMB), began working with TCHMB to develop a collaboration framework to better align efforts to address regionally and locally specific issues that impact hospitals' implementation of AIM Bundles.

Peer Dads

MCH funded two community-based Peer Dads contracts in Cameron County and in Smith County (south and east Texas respectively). Each of the Peer Dad programs are housed within a Women, Infants, and Children (WIC) local agency but may provide services throughout the community. Peer Dads are men who have partners and a child currently or previously enrolled in the WIC program and whose child was breastfed. Peer dads received training on the United States Department of Agriculture's (USDA) *Loving Support Peer Counselor Training* with opportunities for continued education to build capacity to engage and support community-based fathers with education and support for:

- Breastfeeding
- Infant safe sleep
- Baby behavior
- Appropriate introduction of solid foods
- Responsive feeding
- Maternal and infant health, safety, risk factors, and warning signs
- Sudden Infant Death Syndrome (SIDS) awareness
- Community-based referrals

Peer Dads coached WIC clinic staff on how to best engage fathers in WIC's education to support breastfeeding success for WIC mothers. WIC clinic staff incorporated input from Peer Dads in messaging for training, materials, and communications. Approximately 100 fathers were engaged in Peer Dad activities and education in FY20.

Outreach for Peer Dad services was conducted through promotional efforts at health fairs, on social media, web-based training platforms, radio ads, posters, bulletin boards within WIC clinics, and with use of specialized fliers with information just for dads.

In Smith County, the WIC director reported the value of having a Peer Dad, noting "we now have pictures of fathers on the outside and inside of the clinic, so they feel welcome to enter the clinic. We no longer allow fathers to sit outside in the parking lot, we invite them into the clinic." Peer Dads involved WIC fathers in the WIC assessment process and provided teaching during weight and height assessments as well as nutrition and breastfeeding counseling. Fathers were positioned as the "Keeper of Information" and education was offered on the impact of maternal fatigue and on remembering important health and breastfeeding information. WIC Clinic staff modified nutrition and breastfeeding classes to include information

Health and Human Services Postpartum Depression Strategic Plan

In the 2019 86th Regular Legislative Session, HHSC was directed to develop and implement a five-year strategic plan to improve access to postpartum depression (PPD) screening, referral, treatment, and support services. MCH staff collaborated in the development of the Postpartum Depression Strategic Plan FY21, including exploration of current practices of DSHS-administered programs relevant to perinatal mood and anxiety disorders and identification of specific activities to initiate or continue in FY21. Featured MCH activities included:

- Promoting awareness and screening for PPD with program partners including contractors and hospitals that participate in the TexasAIM initiative,

- Promoting public awareness about perinatal mood and anxiety disorders through the Maternal Health and Safety Public Awareness Campaign that is currently in development;
- Promoting awareness about perinatal mood and anxiety disorders through the Information for Parents of Newborn Children pamphlet that is distributed to pregnant women, their partners and other adult caregivers of infants;
- Ensuring that perinatal mood and anxiety disorders is addressed as a part of the High-Risk Maternal Care Coordination Services Pilot Program currently in development; and
- Planning and hosting a DSHS Grand Rounds series of continuing education presentations on perinatal mood and anxiety disorders with lectures to include information about the prevalence and effects of perinatal mood and anxiety disorders on outcomes for women and children; and PPD signs, symptoms, screening, diagnosis, treatment, and referral.

Perinatal Depression Awareness and Screening

MCH staff incorporated mental and emotional health content from the Eunice Kennedy Shriver National Institute of Child Health and Human Development's *Mom's Mental Health Matters* campaign into the WIC breastfeeding promotion campaign *Breastmilk: Every Ounce Counts*. The campaign's website, BreastmilkCounts.com, included information, tips, and resources on self-care for women during pregnancy and after birth, information for women and their support networks on identifying the signs of perinatal depression and anxiety, and where to get help. This mental health content is available at the links below:

- Self-Care: Mental and Emotional Health section
- Teamwork: For Dad, For Grandma, and Friends and Family sections

In FY20, Information About Mental and Emotional Health Self-care had 36,553 (12,148 English and 24,405 Spanish) unique pageviews and helpful resources including resources for mental and emotional help and had 3,226 (2,385 English and 841 Spanish) unique page views. The Teamwork for Dads page had 8,235 (5,947 English and 2,288 Spanish) unique page views, the Teamwork for Grandma page had 2,237 (1,453 English and 784 Spanish) unique page views, and the Teamwork for Friends and Family page had 835 (353 English and 482 Spanish) unique page views.

HTMB-funded Lactation Support Centers (LSCs) in Austin, Dallas, Houston, McAllen, and San Antonio used the Edinburgh Postnatal Depression Scale in their intake- and follow-up assessment and referral procedures and workflow. LSCs staff provided depression screenings for all women seeking services. Women who screened positive for signs of depression received referrals to mental health resources.

***High-Risk Screening and Referral "Red Flags"* Training for WIC Staff**

MCH staff had previously provided maternal and infant health subject matter expertise in development of the WIC High Risk Referral policy and, in FY19 reviewed and provided subject matter expertise and content for development of the *High-Risk Screening and Referral "Red Flags"* training to support implementation of the policy. At minimum, the policy required referral for signs of breastfeeding difficulties, labor initiation, substance use, and perinatal mood disorders. Referral guidelines also addressed anemia, low weight gain, weight loss, excessive weight gain during pregnancy, and signs of fetal demise, blood clots, hemorrhage, and preeclampsia/eclampsia. Over 252 WIC staff completed the Red Flags Training since 2019. Policy development was initiated in FY20 to consider requiring this training for WIC local agency staff.

PHR staff conduct various activities to promote health and wellness for women of childbearing age. The regional staff in Houston hosted the March of Dimes program *Becoming a Mom/Comenzando Bien*, a comprehensive prenatal program for pregnant women in a supportive group setting.

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i. PREPARED BY: Maternal & Child Health Epidemiology, Division for Community Health Improvement, the Department of State Health Services (DSHS).

NPM 14.1: Percent of Women Who Smoke During Pregnancy

Maternal tobacco use is one of the most preventable risk factors of poor pregnancy and birth outcomes. Smoking and exposure to second-hand smoke during pregnancy increases the maternal risks of spontaneous abortion, ectopic pregnancy, and cancers and increases fetal risks of stillbirth, premature birth, stunted growth, cleft palate, low birth weight, and sudden infant death syndrome (SIDS). Many women who are affected by nicotine addiction continue to smoke during and after pregnancy.

In fiscal year (FY)22, Texas Maternal and Child Health (MCH) will implement the High-Risk Maternal Care Coordination Services Pilot (HRMCCSP) Program, which will address smoking during pregnancy. Smoking is one of the behaviors included in risk assessment and smoking cessation will be among the provided services. Community Health Worker (CHW) curriculum will address healthy pregnancy behaviors, including the importance of not smoking during pregnancy.

MCH will disseminate information and provide education about tobacco screening. MCH will refer the community to health care workers and community support programming to improve quality of maternal health care, including screening and referral for tobacco use during and after pregnancy.

The Texas Department of State Health Services (DSHS) Public Health Region (PHR) MCH staff will continue to develop relationships that can amplify education and referrals to the Quitline among women of childbearing age (WCBA) as well as Ask, Advise, and Refer. MCH will continue to work with DSHS Tobacco Prevention and Control partners to identify additional shared goals and potential collaboration.

SPM 4: Maternal Morbidity Disparities: Ratio of Black to White Severe Maternal Morbidity Rate

Racial and ethnic disparities in health outcomes between non-Hispanic Black women and other populations must be addressed. Severe maternal morbidity (SMM) has been defined as the "unintended outcomes of the process of labor and delivery that result in significant short-term or long-term consequences to a woman's health."[1] In the recently released *Healthy Women, Healthy Pregnancies, Healthy Futures: The U.S. Department of Health and Human Services' (HHS) Action Plan to Improve Maternal Health*, HHS recognizes racial disparities as a significant challenge to reducing maternal mortality and morbidity and achieving the action plan's target to reduce the maternal mortality rate by 50 percent in five years.[2]

Rates of SMM are increasing in the U.S. while remaining relatively stable in Texas from 2010-2019.[3],[4] Non-Hispanic Black women are disproportionality impacted by SMM with rates of SMM approximately 100% higher among non-Hispanic Black than White women, with no reduction in the Black-White disparity over time.[5],[6] As with maternal mortality, SMM is often preventable. When SMM is not ameliorated, it may result in maternal death.[7]

Based on the findings and recommendations published in the *Maternal Mortality and Morbidity Task Force* (now *Texas Maternal Mortality and Morbidity Review Committee,* or *MMMRC*) *and Department of State Health Services Joint Biennial Report, 2018*, the MMMRC established the Subcommittee on Maternal Health Disparities (subcommittee). In the most recent *Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report, 2020*, the MMMRC reported several ongoing activities of the subcommittee and recommended the subcommittee continue to study drivers and root causes of racial disparities in maternal mortality and morbidity in Texas.

Texas' Alliance for Innovation on Maternal Health (TexasAIM) will continue to support the integration of best practice principles, including the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care into the launch of TexasAIM's Severe Hypertension in Pregnancy (HTN) Learning Collaborative. Additionally, MCH will establish a Maternal Health and Safety Workgroup to support Texas birthing hospitals with addressing racial and ethnic disparities in maternal mortality and morbidity.

In FY22, work will continue to develop and implement a Maternal Health and Safety Awareness, Education, and Communication Campaign. The campaign creates a culture of maternal health and safety and includes prevention of maternal mortality and morbidity in Texas activities. The campaign will be promoted to women, health care professionals, community stakeholders, and the public; and will leverage existing maternal safety programming and amplify state and national maternal safety recommendations, initiatives, and campaigns.

The High-Risk Maternal Care Coordination Services Pilot (HRMCCSP) Program will be implemented in FY22 and will address racial disparities in maternal morbidity. As part of the pilot, a risk assessment tool is being developed that will assess perceived discrimination and consider race and ethnicity in risk determination. The Community Health Worker (CHW) curriculum will include modules on racial disparities in maternal mortality and morbidity.

MCH will continue to work with MCH's Healthy Texas Mothers and Babies (HTMB) Community Coalitions to align their focus on racial and ethnic disparities in birth outcomes and achieving women's, maternal, and infant health and birth equity. Ongoing community needs assessments and strategic planning will inform coalition initiatives. MCH will work with HTMB Community Coalitions to develop locally relevant outreach and awareness campaigns to support their strategic objectives and align with the HTMB Framework. HTMB Community Coalitions will assess opportunities to engage Historically Black Colleges and Universities (HBCUs) in Texas and other interested organizations and colleges with large Black student populations to expand and enhance the Preconception Peer Educators program (PPE). PPE is the national Office of Minority Health's program focused on improving preconception health to reduce infant mortality and improve maternal health outcomes in Black communities. College-age women and men are trained to educate their peers and community members about the importance of preconception health, the impact of social determinants of health on their well-being, seeking regular preventive care, and creating a reproductive life plan.

State Performance Measure (SPM) 5: Percent of Women of Childbearing Age (WCBA) Who Self-Rate Their Health Status as Excellent, Very Good, or Good.

Self-reported health status can account for multiple factors that impact a woman's preconception and interconception health. Self-reported health status is a measure of health-related quality of life and is recognized as an indicator of a population's overall well-being. SPM 5 is the General Health Status measure from the Council of State and Territorial Epidemiologists (CSTE) Core State Preconception Health Indicators measure set. The measure set was developed by the Core State Preconception Health Indicators Working Group and was finalized in 2010 after incorporating stakeholder feedback. A DSHS epidemiologist and the HTMB Manager served as one of seven state teams comprising the Core State Preconception Health Indicators Working Group. According to the CSTE Core State Preconception Health Indicators Detail Sheet, *Self-rated Health Status (A1)* (2009), this indicator is highly correlated with various adverse health outcomes, and lower self-ratings of this subjective measure have consistently been associated with "increased mortality, incident adverse health events, health care utilization, and illness severity, even after medical risk factors have been accounted for."[8],[9]

A woman's health in the preconception and interconception periods affects her health, safety, and well-being throughout her life course, including outcomes of any future pregnancies and subsequent maternal, infant, and child health. The recent Surgeon General's Call to Action to Improve Maternal Health recognizes that optimizing maternal health is

an important public health goal for the U.S. and is crucial to the well-being of future generations. Additionally, it highlights that efforts to improve maternal health must extend beyond the perinatal period and begin with promoting mental and physical health in young girls and adolescents and continue throughout the reproductive years.[10] Furthermore, through the *Healthy Women, Healthy Pregnancies, Healthy Futures: The U.S. Department of Health and Human Services' (HHS) Action Plan to Improve Maternal Health*, HHS lays out a vision, goals, targets, and action items for ensuring the U.S. is one of the safest countries in the world for women to give birth. The action plan applies a "life course" approach organized around four goals, including the first goal of achieving healthy outcomes for all women of reproductive age by improving prevention and treatment.[11]

Women in Texas have experienced rising rates of obesity, diabetes, hypertension, and substance abuse disorder; and low rates of health insurance coverage and access to care. High rates of unintended pregnancy, preterm birth, maternal morbidity, and maternal mortality indicate a need to improve quality of care, health care access, provider education, and systems to support women's health.

MCH will continue to foster collaboration with partners to increase capacity, synergy, and impact of initiatives to improve women's health and health care delivery including mental and behavioral health. Initiatives will include the HRMCCSP Program, a maternal health and safety awareness campaign, the TexasAIM Initiative, support of the work of the Texas Collaborative for Healthy Mothers and Babies (TCHMB), and other efforts. Strategic planning will continue to inform the direction of women's and maternal health programming, including a focus on the preconception, prenatal, postpartum and interconception periods.

MCH recognizes that work for improving preconception, prenatal, postpartum, and interconception health is shared with partners across DSHS and the Health and Human Services (HHS) system and beyond, including those working in chronic disease prevention and behavioral health. As such, MCH will continue to build and strengthen partnerships across and beyond HHS to assess the landscape for women's and maternal health initiatives and promote the integration of women's and maternal health into population-based and health service programs.

MCH will partner with Health and Human Services Commission (HHSC) to advance work described related to maternal substance use, perinatal mood and anxiety disorders, care coordination for women with high-risk pregnancies, and maternal health care quality.

MCH will continue to work with a broad range of state and community partners to explore opportunities to expand preconception and interconception health, and health care educational outreach efforts across Texas and to promote integration of preconception health principles into stakeholder programming.

MCH will continue to promote provider education opportunities, including the Texas Health Steps Online Provider Education (THS-OPE) health-focused preconception, prenatal, and postpartum care continuing education modules. The modules are focused on equipping health care professionals with knowledge and resources to improve the health of Texas women before, during, and after pregnancy. The modules are available at www.txhealthsteps.com.

MCH will continue to collaborate with CHW training programs to integrate best practices for women's and maternal health, high-risk maternal care, and health care promotion into curricula. Promotion of health care provider education on women's preventive health and health care will continue via DSHS Grand Rounds presentations and other web-based resources.

MCH will continue to fund and coordinate with TCHMB to support an annual TCHMB Summit. The summit serves to increase capacity for TCHMB membership recruitment and retention while serving to engage, inform, and educate health care professionals to support improved and more equitable birth outcomes in Texas.

Women with under- or unaddressed mental and behavioral health conditions, including substance use disorders, prior to pregnancy are more likely to enter prenatal care late and experience pregnancy complications including preterm birth, low birth weight baby, and fetal demise. These outcomes are marked by racial and ethnic disparities. Additionally, the MMMRC has found that mental and behavioral health issues contribute to SMM and pregnancy-related deaths in Texas. In the most recent *Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report, 2020*, the MMMRC found that mental disorders (with or without substance use) were a leading cause and contributor to pregnancy-related death. Both mental health and substance use are preconception health areas identified by the CDC as having important ramifications for birth outcomes. MCH will continue to strengthen the HHS system and other partnerships to identify opportunities for clinical- and population-based interventions that support improved mental and behavioral health among WCBA and perinatal mood and anxiety disorders. One partnership activity includes collaboration on an HHSC postpartum depression (PPD) Strategic Plan. MCH will continue to look across existing programs including quality improvement initiatives, awareness campaigns, lactation support center services, peer support programming, and coalitions to integrate awareness and prevention strategies. MCH will continue to provide information on PPD through the Information for Parents of Newborn Children webpage (also available as a booklet) to support obstetric care providers in distributing information about PPD and perinatal mood disorders to caregivers and families.

MCH will continue collaborating with HHSC in developing annual updates to the five-year PPD Strategic Plan to improve access to PPD screening, referral, treatment, and support services. The strategic plan includes activities to increase provider awareness of the prevalence and effects of PPD on women, children, and families; establish a referral network of community-based resources and support services; increase women's access to peer support services; and raise public awareness about the stigma associated with PPD.

MCH will continue to use existing surveillance methods to assess mental health and substance use and disparities in WCBA. MCH will support a TexasAIM Obstetric Care for Opioid Use Disorder (OB-OUD) Innovation and Improvement Learning Collaborative as well as supportive activities at the state and regional levels to increase uptake of recommended practices. Recommended practices include limiting access to Screening, Brief Intervention and Referral to Treatment (SBIRT), improving access to medication assisted treatment (MAT), and naloxone to prevent overdose for care of women with Opioid Use Disorder.

MCH will continue to assess and monitor maternal mortality and SMM rates through the analysis of surveillance data. MCH will continue to coordinate and support the MMMRC. MCH will continue to contract with the University of North Texas Health Science Center to assure capacity for timely and comprehensive case review by the MMMRC and data collection for the Maternal Mortality Review Information Application (MMRIA) System as a participating state in the ERASE MM program.

MCH will continue to coordinate and partner with the DSHS Vital Statistics Section (VSS), Center for Health Statistics (CHS), and other partners to identify opportunities to improve the availability and quality of data for identification and review of pregnancy-associated deaths. MCH will continue to identify and leverage resources to expand its capacity for case preparation of pregnancy-associated deaths and to support continuous quality improvement for comprehensive and timely review of pregnancy-related deaths development of recommendations by the MMMRC, dissemination of MMMRC findings, and translation of MMMRC findings into action for improvements in maternal health and safety. This work is bolstered through MCH's participation in the CDC ERASE MM grant. MCH activities will continue to address findings and recommendations from the MMMRC Legislative Reports.

MCH will continue implementing the TexasAIM Initiative. In January 2018, Texas' application to become an AIM state

was accepted with DSHS as the lead coordinating body. MCH joined the AIM program to implement data-driven AIM maternal safety bundles. As of December 2020, 98% of birthing hospitals in Texas were participating in the TexasAIM Obstetric Hemorrhage Bundle (OBH), with 83% of enrolled hospitals participating in the TexasAIM Plus program. This represents approximately 99% of births in Texas, which is over 378,600 women every year, and 10% of births in the U.S. TexasAIM opened enrollment for the TexasAIM Severe Hypertension in Pregnancy (HTN) bundle in December 2020 and continues to see hospital engagement. The Learning Collaborative for the HTN Bundle started in April 2021 and will continue in FY22.

TexasAIM will continue to work with hospitals in FY22 to sustain improvements related to the AIM OBH bundle while also beginning learning collaboratives to support implementation of the HTN bundle and the OB-OUD bundle. The OB-OUD bundle includes increasing provider education on trauma-informed care and perinatal mood disorders, screening, and referral because mood and anxiety disorders frequently co-occur with Substance Use Disorder. TexasAIM will engage selected Texas birthing centers and other stakeholders to adapt and pilot the AIM-Supported OBH and HTN Bundles in out-of-hospital birthing centers. TexasAIM will intensify a focus on racial and health disparities in maternal health.

MCH will continue to participate in the National Network of Perinatal Quality Collaboratives (PQC). MCH will learn from and share lessons learned with other states and state PQCs about building an effective PQC, implementing effective quality improvement initiatives, and identifying and using tools, training, and resources necessary to foster the sharing of best practices that support a sustainable PQC infrastructure.

MCH will continue to fund and oversee facilitation and support services for Texas Collaborative for Healthy Mothers and Babies (TCHMB) and the Texas PQC through a contract with the UT Health Science Center at Tyler. TCHMB aims to implement initiatives that will improve quality of care and enhance women's, perinatal, and infant health outcomes. Support will continue for development and implementation by TCHMB of evidence-informed quality improvement projects. Currently there is an Executive Committee which oversees four TCHMB Committees: Community Health, Neonatal, Obstetrics, and Data.

MCH will coordinate with the DSHS EMS-Trauma Systems Program, Regional Advisory Council Perinatal Care Regions (PCRs), and other partners and stakeholders to identify opportunities to support uptake of recommended practices among hospitals to achieve maternal and neonatal levels of care designation. DSHS Maternal and Child Health Epidemiology (MCH Epi) will continue to provide program support for risk-appropriate levels of maternal care by calculating maternal health outcome measures for ongoing program evaluation, monitoring, and re-designation of hospitals' levels of care every three years by DSHS' Consumer Protection.

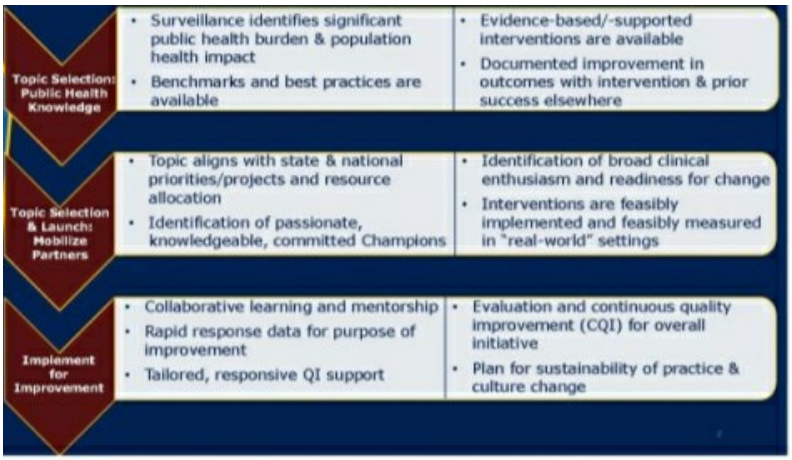
MCH will continue to leverage partnerships with community-based, professional, and governmental organizations across the state and at a national level, including the HTMB Community Coalitions, TCHMB, the Texas Perinatal Advisory Council (PAC), AIM, the National Network of PQCs, the National Preconception Health and Health Care Initiative, and others to keep abreast of, promote, and implement evidence-based practices that promote women's and maternal health and safety.

MCH will continue to assess, build, and leverage partnerships to increase dissemination and implementation of recommended maternal and women's health best practices. In collaboration with partners, MCH will continue to work to establish a strong Texas Perinatal Quality Improvement Network (TPQIN) to support quality improvement efforts in clinical and community settings related to women's and maternal health. Key partners and stakeholders for a successful TPQIN include relevant state agencies and their advisory councils, membership associations and professional groups, public and consumer groups, regional and local health- and health care structure, and academic institutions and centers (see Figure 1).

Figure 1 Texas Perinatal Quality Improvement Network Partners and Stakeholders (adapted from the CDC Perinatal Quality Collaborative Guide Working Group's Resource Guide for States: *Developing and Sustaining Perinatal Quality Collaboratives)*

Figure 2 outlines steps to effectively develop, launch, and implement a statewide, large scale quality improvement initiative, including steps required to use public health knowledge to select an appropriate quality improvement topic; mobilization of partners to successfully launch a large-scale quality improvement project; and consideration of elements needed to support effective implementation, sustainability, and impact of the initiative.

Figure 2 Key Steps in Launching a State Wide TPQIN Initiative. (adapted from the CDC Perinatal Quality Collaborative Guide Working Group's Resource Guide for States: *Developing and Sustaining Perinatal Quality Collaboratives)*



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Perinatal/Infant Health

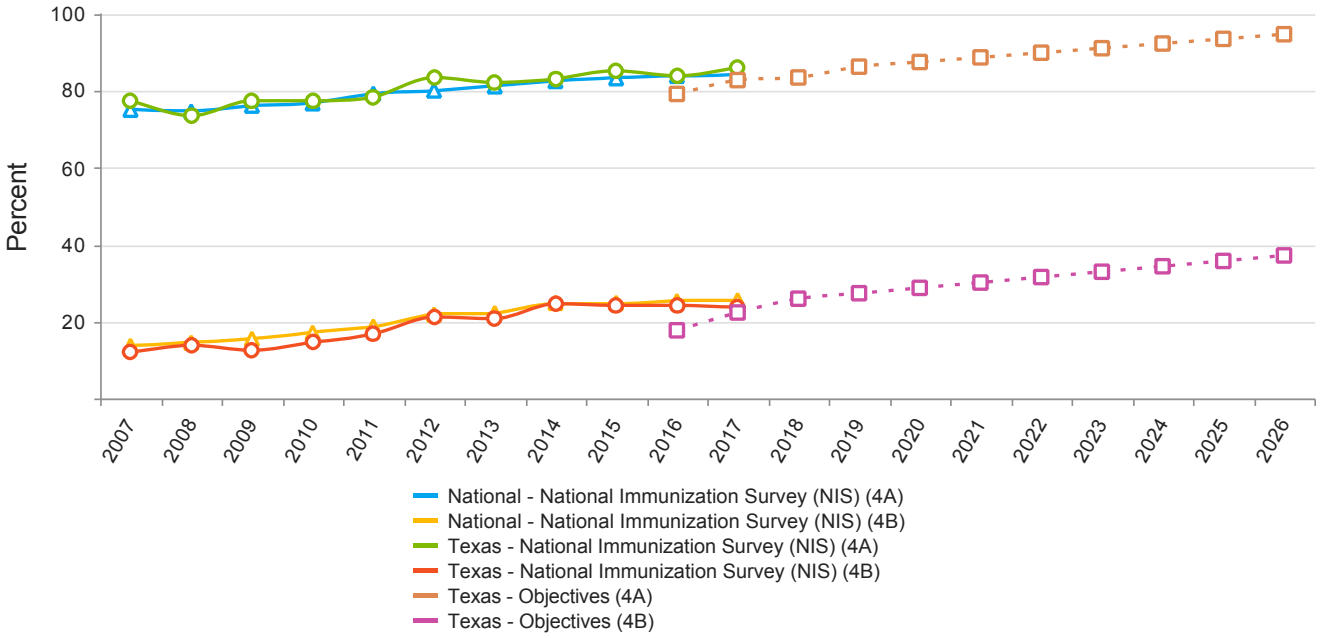
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	5.5	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.8	NPM 4 NPM 5
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	90.1	NPM 4 NPM 5

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	79.1	82.7	83.4	86.2	87.4
Annual Indicator	81.9	83.1	85.0	83.9	85.9
Numerator	302,196	305,258	339,365	306,509	308,498
Denominator	368,965	367,465	399,450	365,530	359,027
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	88.6	89.8	91.0	92.2	93.4	94.6

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	17.8	22.4	26	27.4	28.8
Annual Indicator	21.0	24.6	24.1	24.1	23.9
Numerator	75,605	88,501	93,997	84,785	82,687
Denominator	360,397	359,467	390,543	351,763	346,287
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	30.2	31.6	33.0	34.4	35.8	37.2

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percent of births occurring in hospitals with policies consistent with the WHO/UNICEF Ten Steps to Successful Breastfeeding and recognized by the Texas Ten Step designation.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0

ESM 4.2 - Estimated minimum number of Texas workers employed at a worksite with a written and communicated worksite lactation support policy and recognized by the Texas Mother-Friendly designation

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0

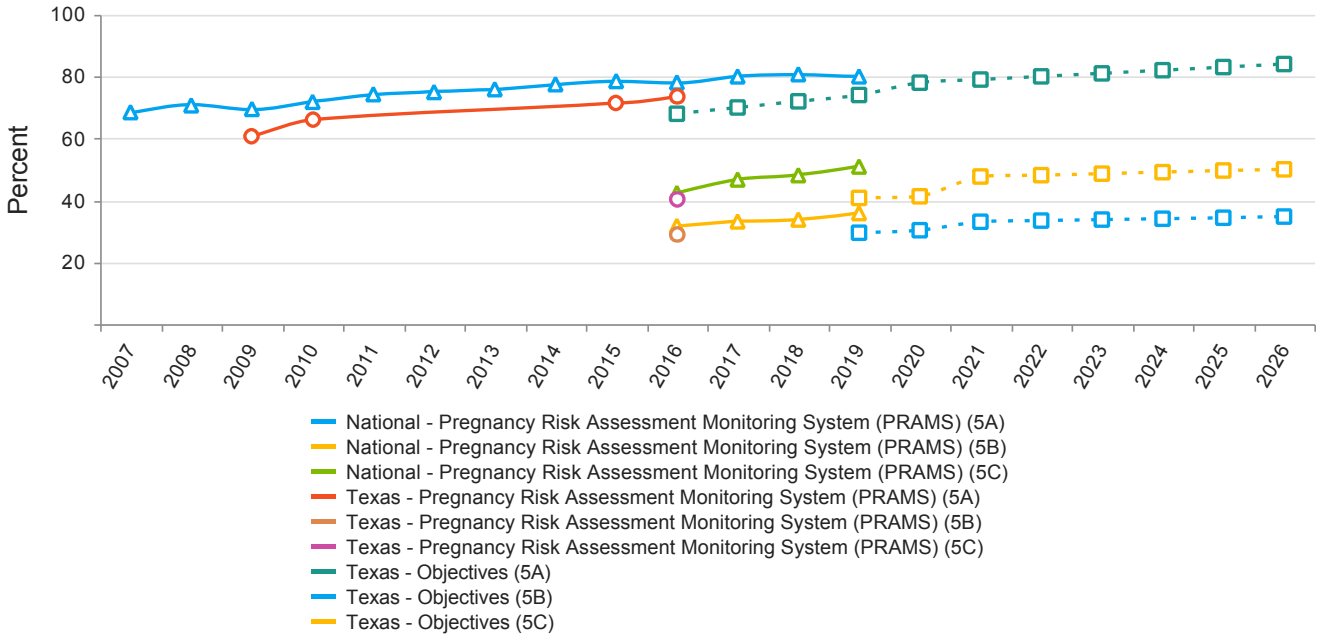
ESM 4.3 - Number of after-hours calls to Texas' lactation support hotline

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding Indicators and Annual Objectives



NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	67.9	69.9	71.9	73.9	77.9
Annual Indicator	66.0	71.2	73.3	73.3	73.3
Numerator	240,305	273,155	277,214	277,214	277,214
Denominator	364,373	383,419	378,111	378,111	378,111
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2010	2015	2016	2016	2016

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	67.9	69.9	71.9	73.9	77.9
Annual Indicator	69.4			77.7	74.2
Numerator	263,609			282,659	265,154
Denominator	379,932			363,606	357,195
Data Source	PRAMS			PRAMS	PRAMS
Data Source Year	2014			2017	2019
Provisional or Final ?	Final			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	78.9	79.9	80.9	81.9	82.9	83.9

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		29.6	30.4
Annual Indicator	28.8	28.8	28.8
Numerator	102,501	102,501	102,501
Denominator	356,249	356,249	356,249
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2016	2016

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			29.6	30.4
Annual Indicator	27.6		30.2	32.8
Numerator	102,501		103,958	111,212
Denominator	370,983		344,288	338,553
Data Source	PRAMS		PRAMS	PRAMS
Data Source Year	2016		2017	2019
Provisional or Final ?	Final		Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	33.1	33.5	33.8	34.1	34.4	34.8

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		40.8	41.3
Annual Indicator	40.5	40.5	40.5
Numerator	143,846	143,846	143,846
Denominator	355,525	355,525	355,525
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2016	2016

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			40.8	41.3
Annual Indicator	39.8		41	47.2
Numerator	143,846		141,045	161,328
Denominator	361,249		343,877	341,873
Data Source	PRAMS		PRAMS	PRAMS
Data Source Year	2016		2017	2019
Provisional or Final ?	Provisional		Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	47.7	48.1	48.6	49.1	49.6	50.0

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Number of health professionals who received Texas HHS CE credits on SUID prevention or safe sleep practices in the past year

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0

State Performance Measures

SPM 3 - Infant Mortality Disparities: Ratio of Black to White infant mortality rate

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		2.1	2.1	2.1	2
Annual Indicator	2.2	2.3	2.4	2.4	2.3
Numerator	10.9	10.7	10.8	11.9	11.5
Denominator	4.9	4.7	4.5	5	5.1
Data Source	Texas natality and mortality data	DSHS Center For Health Statistics	Texas natality and mortality data	Texas natality and mortality data	Texas birth file (natality data) and death file (m
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2.0	2.0	2.0	2.0	2.0	2.0

State Action Plan Table

State Action Plan Table (Texas) - Perinatal/Infant Health - Entry 1
Priority Need
Improve nutrition across the life course.
NPM
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Objectives
By 2025, decrease the proportion of breastfed newborns who receive formula supplementation within the first 2 days of life from 22.5% to 21.5%. (National Immunization Survey, 2017 births).
By 2025, increase the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies from 20% to 25%. (CDC Breastfeeding Surveillance Sources, 2020 births).
By 2025, increase the average Texas score on the CDC Maternity Practices in Infant Nutrition and Care (mPINC) Survey score from 77 (2018 baseline) to >81. (CDC Maternity Practices in Infant Nutrition and Care Survey (mPINC).
By 2025, increase the number of Texas Mother-Friendly Worksites from 3200 (end of 2020) to > 3500. (Program data).
By 2025, decrease the proportion of women who ever breastfed that reported they did not breastfeed for as long as they wanted to from 59.4%(2018) to 51.8% DSHS/ HHSC Texas WIC IFPS).
Strategies
Strategy 1: Assess needs, gaps and opportunities to strengthen systems for provision of recommended breastfeeding support practices using methods including surveys and qualitative research.
Strategy 2: Foster coordination, collaboration, partnership, and collective impact with stakeholders across sectors -- including birthing facilities, employers, state and local agencies, professional associations, insurers, coalitions, health care providers, service providers, community-based organizations, mothers, advocates, and other stakeholders— to address known barriers to breastfeeding through increased uptake and implementation of recommended practices in infant nutrition and care.
Strategy 3: Develop and disseminate materials, communications, outreach methods, and programmatic strategic plans for promotion of breastfeeding support practices.
Strategy 4: Facilitate educational opportunities, such as through online breastfeeding modules, to increase breastfeeding support and lactation management knowledge and skills of health care professionals who care for lactating mothers and their babies.

ESMs	Status
ESM 4.1 - Percent of births occurring in hospitals with policies consistent with the WHO/UNICEF Ten Steps to Successful Breastfeeding and recognized by the Texas Ten Step designation.	Active
ESM 4.2 - Estimated minimum number of Texas workers employed at a worksite with a written and communicated worksite lactation support policy and recognized by the Texas Mother-Friendly designation	Active
ESM 4.3 - Number of after-hours calls to Texas' lactation support hotline	Active

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Texas) - Perinatal/Infant Health - Entry 2

Priority Need

Improve maternal and infant health outcomes through enhanced health and safety efforts.

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

By 2025, increase by 15% the percent of mothers who report they lay their babies down to sleep on their back only (Baseline= 74.1, 2018 Texas PRAMS)

Strategies

Strategy 1: Assess needs, gaps and opportunities to strengthen systems for support of recommended sleep safety and SIDS risk reduction practices.

Strategy 2: Partner to expand, coordinate, and integrate sleep safety and SIDS risk reduction programmatic efforts and outreach across health and human service programming.

Strategy 3: Develop and disseminate materials, communications, outreach methods, and programmatic strategic plans for promotion of sleep safety and SIDS risk reduction.

Strategy 4: Facilitate educational opportunities for health care professionals, health and social service providers, and other stakeholders on topics related to promotion and assurance of recommended sleep safety and SIDS risk reduction practices, including through Texas Health Steps Online Provider Education.

ESMs	Status
ESM 5.1 - Number of health professionals who received Texas HHS CE credits on SUID prevention or safe sleep practices in the past year	Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Texas) - Perinatal/Infant Health - Entry 3

Priority Need

Implement health equity strategies across all maternal and child health populations.

SPM

SPM 3 - Infant Mortality Disparities: Ratio of Black to White infant mortality rate

Objectives

By 2025, increase by 15% from baseline (baseline to be established) the percentage of live births among Black women that occur in facilities that provide recommended care for lactating mothers and their babies hospitals.

By 2025, increase by 15% from baseline (baseline to be established) the percentage of Black mothers reporting that that a health care worker told information about infant safe sleep practices.

By 2025, decrease the Non-Hispanic (NH) Black to NH White disparity gap in getting prenatal care as early as wanted. (Texas PRAMS 2018 baseline: % getting prenatal care as early as wanted: NH Black: 82.1%; NH White: 87.6%)

Strategies

Strategy 1: Carry out community-specific needs assessments and evidence-based strategic programming to address high fetal and infant mortality rates among Black infants.

Strategy 2: Redesign DSHS preconception health and health care public awareness campaign and support local campaigns and outreach in counties with high Black infant mortality rates.

Strategy 3: Improve the quality of perinatal care, education, and support provided to Black women through the work of the Healthy Texas Mothers and Babies Initiative and other projects, including the DSHS Infant Feeding Workgroup.

Strategy 4: Collaborate with universities and community colleges with high rates of Black student enrollment to promote preconception health education and outreach.

Strategy 5: Conduct targeted public health messaging in counties with high Black infant mortality rates in the PPOR for Maternal Health and Maternal Care through use of the Healthy Texas Babies' Public Awareness Campaign, Someday Starts Now, and in partnership with entities such as Healthy Start and WIC.

NPM 4: (a) Percent of infants who are ever breastfed, (b) percent of infants breastfed exclusively through 6 months

The Texas Department of State Health Services (DSHS) offers a comprehensive program of breastfeeding support to address known breastfeeding barriers where Texans live, give birth, work, and play to improve infant feeding outcomes, including breastfeeding initiation, duration, exclusivity, and appropriate introduction of complementary foods. Additionally, DSHS offers population-based breastfeeding support services and coordination of breastfeeding support activities in worksites and communities. All breastfeeding support activities are coordinated through the DSHS Infant Feeding Workgroup, with oversite from the DSHS State Breastfeeding Coordinator, housed in the Maternal and Child Health (MCH) Unit.

Objective 1: By 2020, decrease the proportion of breastfed newborns who receive formula supplementation within the first 2 days of life from 23.1% to 21.5%. (National Immunization Survey)

Lactation Support Centers and Texas Lactation Support Hotline
The DSHS MCH Healthy Texas Mothers and Babies (HTMB) Branch partners with the Texas Health and Human Services Commission (HHSC) Women, Infants, and Children (WIC) program through distinct but complementary scopes of work to provide lactation support centers (LSCs) in five locations across the state. Locations include Austin/Travis County, City of Dallas, the Greater Houston Area (via the University of Texas Health Science Center at Houston McGovern Medical School), McAllen/Hidalgo County, and the newest LSC in San Antonio (via San Antonio Metro Health Department (SAMHD)). LSCs provide a range of lactation support services for Texas families, including:

- Lactation education, counseling, and support for lactating mothers and their infants;
- Education, skills training, and support resources for WIC staff and health professionals;
- Targeted population-based services to increase community capacity for breastfeeding support; and
- A Texas Lactation Support Hotline that provides 24/7 access to breastfeeding counselors and skilled clinical lactation specialists who provide information, counseling and referrals related to infant feeding for Texas families and reliable, evidence-based information on breastfeeding and lactation for health care professionals.

As a part of this collaboration, MCH contributed resources so the previously established LSCs could provide public health programming through the MCH HTMB Lactation Support Center Services-Strategic Expansion Program (LSCS-SEP) scope of work. Additionally, MCH established a contract at the beginning of fiscal year (FY)20 with SAMHD for the newest LSC in San Antonio. The LSCS-SEP supported a variety of activities at the 5 LSCs, including population-based lactation education, counseling, support, and referrals for families who do not participate in WIC. LSCS-SEP also supported provider awareness by:

- conducting activities to increase competencies and skills of health care workers;
- working with community partners to support organizational policy and process improvements;
- developing community-based capacity for breastfeeding support;
- providing enabling services, such as transportation services and outreach; and
- coordinating infrastructure building services including needs assessment, workforce training, and policy, environmental and systems development activities to increase community capacity for breastfeeding support.

In addition to lactation promotion and support services, the LSCS-SEP required LSCs to provide mothers and families with information, education, and referrals about key maternal, infant, and early childhood health topics that impact infant feeding outcomes, such as perinatal mood disorders. As an activity of their LSCS-SEP programming, the LSCs provided perinatal depression screening and referrals to women receiving LSCs lactation counseling and support services.

MCH continued to fund the after-hours operations of the Texas Lactation Support Hotline (Hotline). HHSC WIC and the City of Dallas fund daytime hours of the hotline as part of the base operating costs. Daytime hours are typically 8 a.m.-4:30 p.m. on non-holiday weekdays, during which time the hotline is managed with support from the Dallas LSC's peer counselor and Internationally Board-Certified Lactation Consultant (IBCLC) staff. In the remaining hours of each week required to ensure 24-hour per day, 7-day per week coverage, hotline services were funded by MCH and provided through a contract between the City of Dallas and a company that provided 24/7 tele-consult services for lactation support and referrals to local WIC services. After-hours calls were directed to an IBCLC each time the caller was seeking lactation support. A total of 3,400 calls were completed through the after-hours hotline in FY20, including 3,082 calls that provided a phone consultation with a mother and an IBCLC.

There were a total of 9,668 lactation education, support, and consultation encounters with breastfeeding mothers provided through the LSCS-SEP in FY20. A total of 3,061 unique non-WIC enrolled participants received skilled lactation support through in-person and tele-consult appointments with an IBCLC in one or more visits. Collectively the 5 LSCs identified 2,409 "WIC-Conversions" in FY20. WIC-Conversions are non-WIC clients who received IBCLC services including consultations or, in FY20, specifically related to COVID-19, and IBCLC phone follow-up services based on referrals from hospitals and were subsequently screened for WIC eligibility and referred for WIC enrollment. Other LSC-SEP activities implemented by the LSCs included:

- More than 211 health professionals received hands-on skills training and education at the LSCs including licensed medical providers, residents, medical students, nursing students, IBCLC candidates, clinical lactation practicum students, and dietetic interns.
- Managers from the City of Dallas, Austin, and McAllen LSC locations presented *Making a Difference: Using your Lactation Clinic as a Training Facility for Residents and Professional Students* for 785 attendees at the International Lactation Consultant Association's professional conference in Texas. The presentation included the process to initiate a program, best practices, and lessons learned.
- The Lactation Care Center Dallas:
  - Continued its partnership to increase breastfeeding friendly practices using the American College of Obstetricians and Gynecologists' (ACOG) Breastfeeding Toolkit. The OBGYN and pediatric offices offered in-person prenatal monthly classes, which had 101 attendees in FY20. The clinic conducted surveys with the 101 mothers (in their 3rd trimester of pregnancy) that attended in-person classes to assess knowledge and attitudes related to breastfeeding. The clinic also hosted web-based prenatal classes on their Facebook page and website. Clinic practitioners used survey findings to refine topics and scripts used in the patient education flip chart.
  - Developed a "Knowledge/Perception Tool" to determine knowledge and perception of breastfeeding during medical training, and is administered during the hospital clinical rotation. Seventy-three medical students completed the questionnaire and LSC staff analyzed results to provide information on trends and to personalize training.
  - Facilitated an in-person Baby Behavior education with 100 hospital nursing staff in the Greater Dallas area to increase awareness about infant stress and appropriate responsiveness to baby behaviors.
  - Collected 5,973 ounces of human donor breastmilk from approved donors by serving as a drop-off depot for the Mothers Milk Bank North Texas.
  - Developed a system to track referrals to lactation support centers from the MCH-funded Texas Lactation Support Hotline. Components of the tracking system included:
    - Audits of 10% of the 3,082 calls received during after-hours service that involved an IBCLC consultation.
    - Monthly reports based on audit findings.
      - Quarterly calls with the vendor that is sub-contracted by City of Dallas to support after-hour services for the Texas Lactation Support Hotline. The purpose of these calls is to identify opportunities for improvement, address client and staff concerns, and identify the educational needs for the professionals that staff the hotline.
- The Lactation Care Center Rio Grande Valley (LCC RGV) in McAllen:
  - Conducted a marketing and awareness campaign to establish brand identity and increase awareness about LCC RGV services. Campaign activities included:
    - Texting monthly positive messaging to mothers.
    - Posting informative Facebook posts to increase awareness of services.
    - Linking LCC RGV information on the Hidalgo County website.
    - Marketing at community health fairs.
    - Participating in stakeholder networking meetings.
    - Ensuring LCC RGV presence and location on Google Maps, Bing, and *2-1-1 Texas.*
    - Creating and distributing outreach materials at local physician's offices, hospitals, WIC clinics, and local businesses.
  - Planned and facilitated 2 Ten Step Community Partner Meetings to focus community coordination and collaboration for Steps 3 (prenatal education) and 10 (post-discharge community linkages) of the World Health Organization/United Nations Children's Fund's (WHO/UNICEF) *Ten Steps to Successful Breastfeeding*. There were 19 attendees from three area hospitals including nursing directors, WIC staff, and advanced care providers responsible for in-patient and out-patient health services to childbearing families.
  - Conducted in-person outreach and education on LCC RGV services and prenatal classes with 40 advanced practice care providers and their practices.
  - Developed a memorandum of understanding at 4 of 6 partner birthing facilities to provide training at each facility.
  - Held virtual prenatal breastfeeding class development because of COVID-19 restrictions and adapted a live prenatal class into a recorded version to continue to meet client needs. It had 200 views in the last 4 months of FY20.
- The San Antonio Lactation Support Center:
  - Conducted community classes for 107 attendees on relevant topics such as breastfeeding, pumping, postpartum depression, introducing solid foods to babies, and baby behavior.
  - Conducted collaborative classes with partners like Catholic Charities (Infant Massage and Sign Language class), Harper's Embrace (Infant CPR), and Poison Control (safety tips and resources to prevent accidental poisoning and how to respond).
  - Held a virtual breastfeeding support group in response to COVID-19 restrictions on in-person gatherings.

- Facilitated 15 meetings with various key community partners such as Southwest Pediatric clinic, San Antonio Military Medical Center, Methodist Hospital, University Health System, St. Luke's Baptist Hospital, Christus Santa Rosa Hospital, Any Baby Can, and other community-based and private health care providers within the city of San Antonio.

- The Houston LSC, Lactation Foundation Houston:
  - Hosted monthly classes including *Breastfeeding Basics* and *Return to Work* and *Pumping* with a cumulative total of 114 attendees, and a weekly support group with at least 329 attendees (300 mothers and 29 support persons) in FY20. Lactation Foundation Houston used social media platforms, such as Facebook, to reach 51,789 viewers with 103 new posts on breastfeeding support, education, and event promotion and achieved 2,650 likes on these posts. Additional activities included:
    - Collaborating with Santa Maria Hostel, a rehabilitation housing facility that serves women facing challenges including trauma, criminal justice, and Children's Protective Services involvement and homelessness or housing instability providing group and phone support for their breastfeeding mothers.
    - Assisting the Marriott Marquis hotel to obtain Texas Mother-Friendly worksite designation, an initiative prompted by the facility's plans to host the 2020 International Lactation Consultant Association conference (subsequently moved to online due to COVID-19 restrictions).
    - Serving as a host site for all the Houston Area Lactation Consultants and Educators Association (HALCEA) meetings.
    - Serving as a community partner to the 4 Houston area Nurse-Family Partnership branches and attending quarterly meetings as well as serving clients with lactation services and educating staff registered nurses (RNs) on breastfeeding topics.
    - Offering educational opportunities to community health care partners including a Grand Rounds lecture for approximately 30 HCA Houston Healthcare Family Medicine and OBGYN residents, providing breastfeeding talks for 12 MD Anderson staff during quarterly breastfeeding mothers' support luncheons, and hosting 2 World Breastfeeding Week events (IBCLC Q&A sessions) with Texas Children's Center for Women & Children.
- The Austin LSC, Mom's Place:
  - Enabled access to lactation support services by providing taxi vouchers to 88 participants.
  - Collected 3,214 ounces of human donor breastmilk from approved donors by serving as a drop-off depot for the Mothers Milk Bank Austin.
  - Conducted outreach meetings and education activities with various community partners in the Greater Austin area to promote WIC services as well as breastfeeding services available through MCH expanded funding for non-WIC enrolled mothers including:
    - Central Texas Breastfeeding Coalition meeting to discuss coalition, WIC, and expanded funding projects.
    - Early Childhood Coalition meeting to discuss expanded services offered.
    - Travis County Correctional Facility education to provide monthly breastfeeding classes by the Breastfeeding Peer Counselor for housed inmates.
    - Bastrop County Interagency Nonprofit education connecting Bastrop county residents with WIC and expanded funding resources and services.
    - Gabriel Project pregnancy center partnership meeting to develop breastfeeding support.
    - Prenatal Referral Workgroup meeting with community partners interested in inter-agency meetings and activities to promote cross-referral to all involved.
    - Mother-Friendly Workgroup meeting to focus on providing WIC literature at all designated Texas Mother-Friendly worksites.
    - Texas AgriLife Food and Nutrition education to promote expanded funding services and educational opportunities for community.
    - Hunger Free Communities meeting to promote expanded MCH funding services.
    - Austin Public Health Emergency Preparedness meeting with city public health leaders to discuss disease outbreaks that affect Mom's Place clients.
  - Provided hands-on breastfeeding skills training for 12 OB resident students.
  - Provided a tailored *Breastfeeding Management* course for three clinic nurses at El Buen Samaritano family practice clinic.
  - Met with Family Connects (Bastrop) to schedule skills training for their staff.
  - Participated in People's Community Clinic breastfeeding fair promoting WIC and non-WIC breastfeeding assistance in the community.
  - Attended a St. David's Foundation meeting to promote expanded services available in community.

Additionally, DSHS Public Health Region (PHR) staff stayed involved in various community-based activities to promote breastfeeding awareness and support. Activities included providing private breastfeeding areas at community events like the Syrup Festival, the Dogwood Festival, the Hot Pepper Festival, and the Nacogdoches Festival. PHR staff partnered with United Way and local school districts to provide prenatal breastfeeding education to high school-aged pregnant teens.

Ten Step Continuum

According to the Centers for Disease Control and Prevention (CDC) 2020 Breastfeeding Report Card, 22.5% of Texas infants born in 2017 who were ever breastfed received infant formula supplementation within two days of life. This was up

from 18.3% among 2015 births. This measure is used by the Centers for Disease Control and Prevention (CDC) to assess progress toward the Healthy People (HP) 2020 Objective, Maternal, Infant, and Child Health (MICH)-23 to reduce the proportion of breastfed newborns who receive formula supplementation within the first 2 days of life. The objective is to reduce this proportion to 8.1% across all populations by 2020.

In April 2018, the CDC released the Texas Results Report of the CDC's 2018 Maternity Care Practices in Infant Nutrition and Care (mPINC) survey. The mPINC survey for hospitals assesses implementation of recommended maternity care practices in infant nutrition and care. The practices form the core components of the Ten Steps to Successful Breastfeeding and are associated with improved infant behaviors and other improved infant health and safety outcomes. Possible scores range from 0 to100, with higher scores indicating better maternity care practices and policies.

Texas' 2018 composite score of 77 was lower than the national score of 79. Texas and national sub scores were tied with a score of 92 for the *Feeding Education & Support* subdomain and a score of 70 for the *Institutional Management* subdomain. Texas trailed the national sub scores for the *Feeding Practices, Immediate Postpartum Care, Discharge Support*, and *Rooming In* subdomains. The mPINC survey was redesigned in 2018, therefore results are not comparable with results from previous years' surveys and may not be used to assess Texas' progress in maternity care practices over time.

Along with providing the state's composite score and sub scores for 6 practice sub-domains, the mPINC Texas Results Report also provides details about the percentage of responding hospitals with ideal responses for 22 practice areas across the 6 subdomains. These details provide insights about areas where recommended practices have been standardized as well as those practice areas where improvement is needed.

Eighty percent or more of responding hospitals appear to have standardized recommended care in 5 of the 22 assessed practice areas, as indicated by 85% or more of respondents providing the ideal responses for those areas. The recommended practice areas, and the percentage of hospitals reporting the ideal response, included:

- Postpartum support includes follow-up visits, phone-calls, and/or referrals (92%),
- Hospital tracks exclusive breastfeeding rates (92%),
- Hypoglycemia protocols did not require routine glucose monitoring (89%),
- Discharge protocols included scheduling pediatric follow-up visits (85%),
- Mother-infant dyads are not separated after vaginal births before rooming in (84%), and
-

Approximately 70-76% of hospitals reported ideal responses for 5 practices related to patient education and support on formula preparation, recognition of feeding cues, and breastfeeding skills; clinical observation and assessment of feeding; and requirements for assessment of clinical competencies.

Fewer than 70% of hospitals reported ideal responses for 11 of 22 practices. The recommended practice areas with poor uptake across the state, and the percentage of hospitals reporting the ideal response, included:

- Continuous monitoring of newborns for 2 hours after birth (65% of hospitals have standardized; 35% have not)
- Hospital has a protocol for frequent observations of high-risk mother-infant dyads (65% have standardized; 35% have not)
- Nurses are required to demonstrate competencies in assessing and assisting with breastfeeding, teaching milk expression, teaching safe preparation of infant formula and feeding, and demonstrating safe skin-to-skin practices (63% have standardized; 37% have not)
- Adherence with recommended standards for uninterrupted skin-to-skin contact after vaginal delivery (63% have standardized; 37% have not)
- Hospital does not provide commercial marketing and gifts, samples, coupons, discounts or informational materials promoting infant formula, feeding devices, or pacifiers (58% have standardized; 42% have not)
- Staff counsel families about the consequences of formula supplementation when breastfeeding mothers request formula (54% have standardized; 46% have not)
- Adherence with recommended standards for uninterrupted skin-to-skin contact after cesarean delivery (42% have standardized; 58% have not)
- Hospital pays fair market price for infant formula (31% have implemented; 69% have not)
- Hospital has 100% of written policy elements (25% have implemented; 75% have not)
- Few breastfed newborns are fed infant formula during the hospital stay (22% have standardized; 78% have not)
- Routine newborn exam, procedures, and care occur in the mother's room (21% have standardized; 79% have not)

The HP 2020 MICH-24 objective to increase the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies. The measure for this objective is the proportion of live births occurring in Baby-Friendly Hospitals. The following efforts (depicted in Figure 1) supported uptake of recommended practices and promoted achievement of the Baby-Friendly Hospital Initiative (BFHI) designation as the standard for providing recommended care.

Figure 1 DSHS-HHSC Ten Step Continuum

This continuum of initiatives was created to accelerate the uptake of the WHO/UNICEF's *Ten Steps to Successful Breastfeeding* and included:

- The *Right from the Start* awareness campaign targeted hospital leaders and health care decision-makers and messaged awareness that hospital policies have a role in improving exclusive breastfeeding rates and should provide information on the framework for best practices known as the WHO/UNICEF's Ten Steps to Successful Breastfeeding. Previous iterations of this campaign were released in 2011 and 2016. Work began in FY20 on the third phase of this campaign but was delayed to FY21 due to prioritization of COVID-19 response.
- Health care professional training and educational resources.
- The HHSC Texas Ten Step (TTS) Program, which recognizes hospitals that have adopted policies which address 85% of the Ten Steps.
- The Texas Ten Step Star Achiever (TTSSA) Initiative (previous work in the Texas Breastfeeding Learning Collaborative during 2012-2017), with plans for continued activities under the TTSSA initiative in FY21.

Texas Mother-Friendly Worksite Program

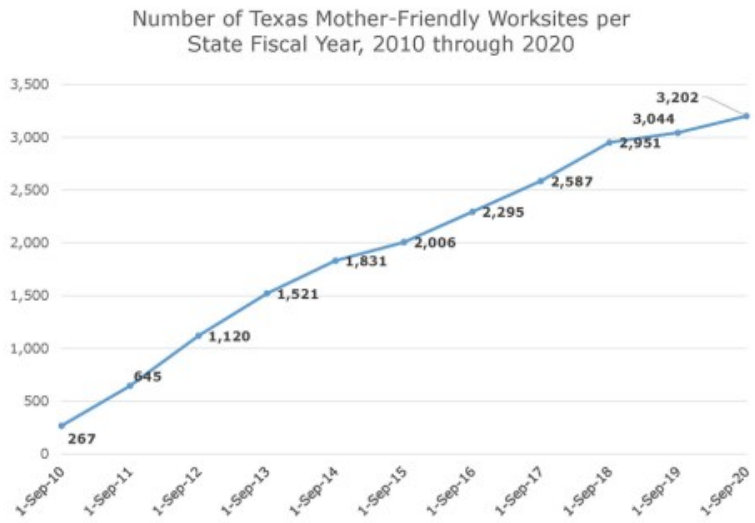
In 1995, the Texas Health & Safety Code Chapter 165, section 165.003 authorized the Texas "Mother-Friendly" Business Designation and established the Texas Mother-Friendly Worksite (TMFW) program at DSHS. Beginning in 2015, MCH began funding the Texas Mother-Friendly Worksite Technical Assistance and Support Partnership (TMFW-TASP) program, administered by the Michael & Susan Dell Center for Healthy Living at the University of Texas Health Science Center School of Public Health in Austin. TMFW-TASP helps employers develop worksite lactation support policies and programs offering technical assistance and recognition of employers' efforts through TMFW designation.

TMFW-TASP staff participated in nine outreach events including in-person and virtual conference and promotional events. There were 4,271 total attendees at the nine events which helped build awareness for program designation. During conference interactions, TMFW-TASP staff connected with 142 event attendees representing 125 employers with interest in the program. As a result, 11 new employers entered the designation process.

During FY20, there were 159 new designations from 27 employers. New designations represented worksites from diverse industries including two independent school districts, one municipality, one manufacturing company, and a health spa. Of the 159 new designations, there were 143 basic-level designations, 15 silver-level designations, and one gold-level designation. Employers must meet basic criteria for designation but may receive additional recognitions (Silver or Gold) for programs providing more comprehensive worksite programs like amenities in their worksite lactation rooms (i.e., refrigerators or hospital grade multiuser breast pump) and paid lactation breaks.

A total of 159 worksites were designated through the TMFW program in FY20, resulting in a total of 3,202 designated worksites at the end of FY20 (See Figure 2). Numbers for FY16 through FY19 have been adjusted from previous reports to reconcile duplicate designations reported in FY16.

Figure 2: Number of Texas Mother-Friendly Worksites per state fiscal year, 2010-2020



Despite COVID-19, promotion efforts to increase awareness about the TMFW Program and the importance of worksite lactation support continued. Activities included:

- Presenting a Knowledge Hub presentation titled, *Pump up Your Worksite: Meeting Your Business and Employee Needs with Mother-Friendly Policies* and exhibiting at the Human Resource Southwest Conference 2019.
- Exhibiting at the Texas Association for the Education of Young Children Conference, which expands outreach to childcare centers and resulted in 27 key contacts and one employer designation.
- Exhibiting at the Texas Collaborative for Healthy Mothers and Babies Conference, which yielded communication from attendees on the need for materials in Spanish. Additionally, communications about the Texas Mother-Friendly Worksite Program with HTMB Community Coalition staff during this conference led to the designation of five additional worksites within the City of Brownsville.

In FY20, the TMFW-TASP staff participated in conducting a systematic review to understand relationships between components of worksite lactation support and infant feeding outcomes. The TMFW-TASP team submitted the report to CDC's *Preventing Chronic Disease* and will work into FY21 on refining the manuscript for acceptance and publication.

Per-month applications increased from an average of 14 applications per month in FY19 to an average of approximately 33 applications per month in FY20. There have been approximately 36 designations per month in FY20, which is higher than FY19's 21 designations per month. Despite the transition to working from home, the third quarter (March-May 2020) was the most active quarter for technical assistance, with the most designations of the year. In the third quarter, the technical assistance email updates to all employers in the pre-application and post-application process prompted some employers to prioritize designation.

PHR staff promoted the Texas Mother-Friendly Worksite designation through awareness, technical assistance with policy development, and education to small, rural communities. Of note, one public library changed their policies and environment to become a Mother-Friendly Worksite. Another city, with technical support from the PHR staff, rewrote policy which was adopted and approved for multiple sites: city hall, a convention and visitor's bureau, and ten additional city-owned sites. One PHR adjusted 11 regional and field offices to become Texas Mother-Friendly designated worksites themselves. Through clinical encounters, PHR staff provided education on Sudden Infant Death (SIDS) prevention and breastfeeding as well.

Objective 5: By 2020, decrease the proportion of women who ever breastfed who report that they did not breastfeed for as long as they wanted to from 53.8% to 51.6%. (WIC IFPS)

Assessment and Monitoring
DSHS MCH organized development of the DSHS MCH /HHSC WIC 2018 Texas WIC Infant Feeding Practices Survey (TXWIC IFPS) in collaboration with the HHSC State WIC Breastfeeding Coordinator and WIC Infant Feeding Strategist to disseminate the survey in WIC clinics across the state. The State Breastfeeding Coordinator worked with DSHS' MCH Epidemiologists to clean and analyze survey data through the summer of 2019. The report was released in February 2020. The proportion of mothers who ever breastfed who reported that they breastfed for as long as they wanted remained below 50%.

The proportion of infants who ever breastfed met the Healthy People 2020 target, but rates of continued breastfeeding and exclusive breastfeeding still fell below targets. The rate of exclusive breastfeeding significantly increased over the past five

years. National Immunization Survey data from the Centers for Disease Control and Prevention (CDC) 2020 Breastfeeding Report Card indicated that breastfeeding prevalence among Texas infants born in 2017 was 85.9% initiation, 55.1% at six months, 31.3% at 12 months, 45.8% exclusive at three months, and 23.9% at six months.

HTMB Community Coalitions
HTMB Community Coalitions that chose to address perinatal and infant health launched campaigns to increase awareness of breastfeeding and available resources and services within communities.

In Laredo, on behalf of the HTMB Community Coalition and City of Laredo Health Department, Mayor Pete Saenz declared August *Breastfeeding Awareness Month* to increase breastfeeding awareness and its benefits to infants. To ensure consistent messaging, Laredo Health Community Coalition collaborated with a Certified Lactation Counselor to produce an informational video dedicated to breastfeeding mothers. The video reached more than 4,000 individuals. In addition to the use of social media, Laredo community coalition promoted breastfeeding messaging through billboards and other advertising to reach community members. This resulted in increased interest in HTMB maternal and infant health services at the City of Laredo Health Department.

For breastfeeding moms in areas affected by hurricanes, HTMB Community Coalitions developed preparedness kits, which include a basin, cleaning supplies, steam bags, and CDC guidelines for cleaning breast pumps. Coalitions developed and launched a series of Facebook posts related to emergency preparedness for breastfeeding moms.

In FY20 HTMB Community Coalitions conducted outreach using radio, newspaper, news flyers, and social media to promote issues around prematurity, COVID-19 and pregnancy, and breastfeeding. HTMB Community Coalitions also provided support to mothers impacted by COVID-19 by creating and strengthening partnerships with mental health agencies.

Information for Parents of Newborns
Texas Health and Safety Code 161.501 requires hospitals, birthing centers, physicians, nurse-midwives, and midwives who provide prenatal care to pregnant women during gestation (at the first prenatal care visit) and at delivery to provide the parents or adult caregiver for the infant with a resource pamphlet. This pamphlet includes information and resources about postpartum depression, breastfeeding, shaken baby syndrome, immunizations, newborn screenings, and other required information. The pamphlet is available in English and Spanish.

In FY20, DSHS distributed 47,784 physical pamphlets in English and 10,544 physical pamphlets in Spanish to health care providers to share with parents of newborns. Additionally, there were 77 pamphlets (63 English, 14 Spanish) downloaded from the MCH website.

Online Provider Education
The State Breastfeeding Coordinator provided subject matter expertise on the HHSC Texas Health Steps Online Provider Education (THS OPE) Course, *Breastfeeding*. The revised version of this module was released for 2.0 hours of continuing education credits in October 2019. The State Breastfeeding Coordinator also provided subject matter expertise to update the Ten Step suite of 4 modules to provide information about implementation of the Ten Steps to Successful Breastfeeding for providers.

In FY20, providers completed a total of 2,505 courses related to breastfeeding. Course completion totals included:

- *Breastfeeding* (2.0 hours of continuing education)– 2,298
- *Ten Steps to Successful Breastfeeding: Breastfeeding Overview* – 81
- *Ten Steps to Successful Breastfeeding: Prenatal and Postnatal Practices that Support Breastfeeding* – 59
- *Ten Steps to Successful Breastfeeding: Birth Practices that Support Breastfeeding* – 67

PHR staff assisted in the promotion of THS OPE Breastfeeding Modules with community health care providers.

Other Outreach and Education Efforts
During FY20 throughout Texas, the State Breastfeeding Coordinator gave presentations about 2018 TXWIC IFPS data, including information related to mother's experiences with hospital practices, worksite lactation support, and the ability to carry out planned infant feeding practices.

There were 3,933,606 visits to the HHSC WIC Breastmilkcounts.com website by 1,027,736 unique visitors in FY20. Breastmilkcounts.com is Texas' one-stop breastfeeding resource and provides information to prepare new moms on what to expect, help current breastfeeding moms continue breastfeeding, give working moms tips on how to continue breastfeeding once they have gone back to work, and other resources. MCH staff contribute MCH, breastfeeding, and worksite lactation support subject matter expertise to develop the site's content.
In beginning of FY18, MCH funding for the WIC Peer Dad (PD) programs was interrupted due to transition of WIC from DSHS to HHSC and new contracting processes. In the beginning of FY20, funding for the Peer Dad program in East Texas

and the Rio Grande Valley was reinstated.

The State Breastfeeding Coordinator provided technical assistance and subject matter expertise to DSHS programs, state and local agencies, breastfeeding coalitions, other state health departments, and national organizations, including support to the DSHS Obesity Prevention Program in the Health Promotion and Chronic Disease Prevention Section to develop programmatic strategies and projects to include in the competitive component of the CDC State Physical Activity and Nutrition Program 1807 funding.

Challenges/Opportunities:
It is important to note that overall, there are far fewer HP 2030 measures across all topic areas than were targeted by the HP 2020 initiative. HP2030 infant feeding behavior measures include only outcome measures for exclusive breastfeeding through 6 months and breastfeeding at 1 year. HP 2020 process measures related to infant feeding and care— including MICH-21.1 and 21.2 (related to breastfeeding initiation and continuation through 3 months), MICH-21.4 (exclusive breastfeeding through 3 months) MICH-22 (relating to employers with worksite lactation support programs), MICH-23, MICH-24—do not have HP 2030 targets.

The CDC 2018 mPINC survey demonstrated there is low uptake by Texas hospitals for many recommended practices in infant nutrition and care. Additionally, the number of Texas Baby-Friendly hospitals has decreased with some hospitals and a hospital network withdrawing from the initiative.

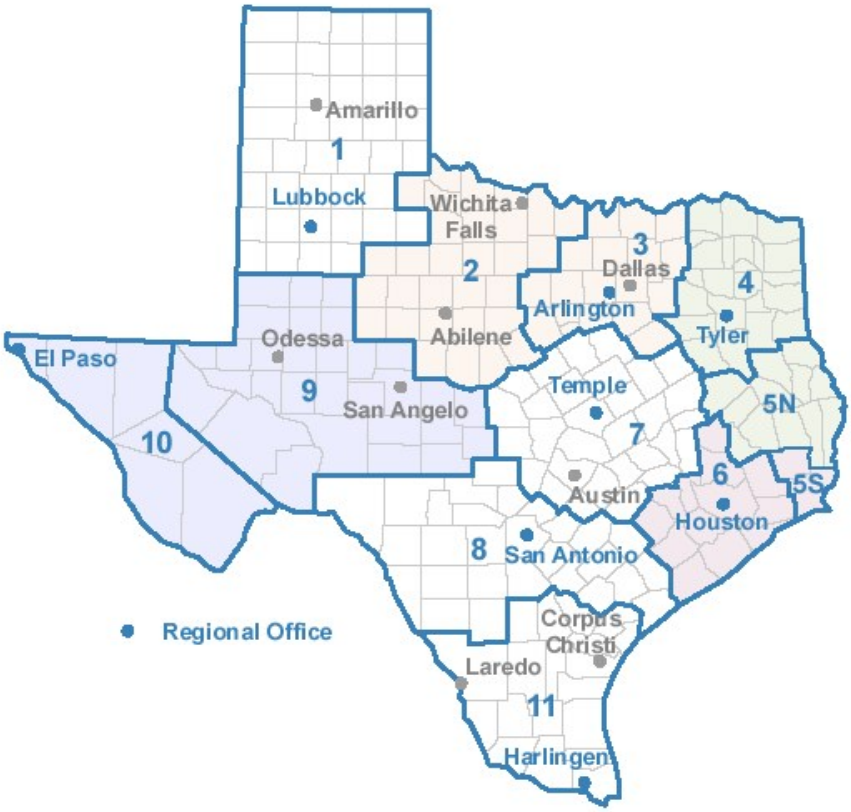
NPM 5: (a) Percent of infants placed on their backs to sleep, (b) percent of infants placed to sleep on a separate approved sleep surface, (c) percent of infants placed to sleep without soft objects or loose bedding

MCH continues to facilitate trainings and educational opportunities for health care professionals, social services providers, and other stakeholders on topics related to promotion and assurance of recommended sleep safety and Sudden Infant Death Syndrome (SIDS) reduction practices. These educational opportunities include Child Fatality Review Team (CFRT) trainings, webinars, Texas Health Steps Online Provider Education (THS OPE), and other opportunities developed as part of the Safe Sleep Messaging Interagency Workgroup strategic action plan.

The Healthy Texas Mothers and Babies (HTMB) Branch Manager provided subject matter expertise for the review and revision of the THS OPE Course, *Infant Safe Sleep*. The revised version of this module was released for 1.5 hours of continuing credits on Oct. 3, 2019. Providers completed the newest version of the module 1,804 times in FY20. THS OPE Courses are available for continuing education credits at no cost at https://www.txhealthsteps.com/.

Breastfeeding is a protective behavior that reduces the risk of SIDS. Data from the TXWIC IFPS can be used to assess respondents' awareness about the association of infant feeding behaviors and maternal and infant health outcomes, including the reduced risk of SIDS among infants whose mothers breastfeed them. Among 2018 TXWIC IFPS respondents, 45.7% reported belief that the statement, "breastfed babies are less likely to die from sudden infant death syndrome (SIDS)" is true, 20.2% reported the statement is false, and 34.1% reported that they did not know whether the statement is true or false. Respondents in some of Texas' public health regions (PHRs) were more likely than respondents in the state overall to report belief in the statement. As indicated by percentage of respondents reporting that the statement is true, PHR 7 (50.9%) had the highest level of awareness that breastfeeding reduces the risk of SIDS, followed by PHR 5 (50.0%), PHR 10 (48.5%), and PHR 6 (47.4%). Respondents in PHR 2 had the highest level of disbelief in the statement (24.9% reported the statement was false). Respondents in PHR 8 had the greatest uncertainty about whether breastfeeding reduces the risk of SIDS, with 35.7% reporting not knowing whether the statement is true or false 40.9% reporting that the statement is true, and 23.4% reporting the statement is false.

Figure 3: Texas Department of State Health Services Center for Health Statistics 11 Public Health Regions (source: https://www.dshs.texas.gov/chs/info/info_txco.shtm)



Information for Parents of Newborns
HTMB Community Coalitions
Examples of activities implemented by HTMB Community Coalitions to increase awareness about infant sleep safety included:

- Coordinating with community partners including hospitals, home visiting programs, WIC clinics, and other sites to distribute infant sleep sacks and educational materials to model and educate families about infant safe sleep.
- Coordinating with community partners and with hospitals to implement innovation and quality improvement to improve infant sleep safety and support of breastfeeding through participation in the National Action Partnership to Promote Safe Sleep Improvement and Innovation Network (NAPPSS-IIN).
- Providing infant safe sleep education to community partners and to families using the Cribs for Kids Safe Sleep Ambassador Model.
- Providing education about infant safe sleep and safe sleep environments for families who did not have infant safe sleep environments.
- Providing ABC's of Safe Sleep posters to area hospitals, pediatrician offices, daycares, and health departments to post in public restrooms.
- Creating educational packets with infant safe sleep materials to be given out by area coalition members.
- Using social media to reach 5,300 individuals with information about sudden infant death syndrome (SIDS) and infant sleep safety.

Additionally, Public Health Region (PHR) 1 staff distributed 36 Safe Sleep Survival Kits. The contents included safety approved pack-n-plays, a fitted sheet, and safe sleep educational materials as well as education targeting caregivers of young children. PHR 11 staff received training to become Cribs for Kids Ambassadors and distributed 20 Safe Sleep Survival Kits and five pack-n-plays. PHR 1 distributed 715 Safe Sleep onesies as well.

PHRs provided Safe Sleep education during other community safety education events, such as car seat check stations, or when unsafe sleep environments are identified in the hospital or clinic setting or during home visits. Staff also partnered with the Texas Department of Family and Protective Services, the Office of Border Health, Nurse-Family Partnerships, local Child Fatality Review Teams (CFRTs), child care providers, specialized health and social services, local injury prevention and mental health coalitions, pregnancy centers, WIC clinics, women's shelters, and hospitals for distribution of information

and education. Specifically, PHR 2/3 distributed 210 flyers, 1,500 brochures, and 84 posters to 21 child care centers promoting safe sleep education. Staff also distributed safe sleep educational materials to 674 clients and partners at health fairs, trainings, and at 17 coalition meetings in 16 counties.

Culturally specific considerations for safe sleep education in North Texas were offered for a large Guatemalan population and included translation of materials in K'iche by request with future plans to reach out to trusted community members to help navigate engagement of the Guatemalan community in education of all important health and safety topics.

PHR 4/5N provided Safe Sleep presentations utilizing the DSHS' Safe Sleep for Communities curriculum to 97 (up from 77 in 2018) families who were also provided pack-n-plays.

Texas Collaborative for Healthy Mothers and Babies
Through a contract with the University of Texas Health Science Center at Tyler and the University of Texas System, MCH provides funding for the Texas Collaborative for Healthy Mothers and Babies (TCHMB), the perinatal quality collaborative in Texas. TCHMB is a collaboration of over 150 health care providers, hospitals, state agencies, and other stakeholders with a shared goal of developing strategies, designing projects, and collecting data to improve birth outcomes in Texas.

In February 2020, TCHMB hosted its annual summit in Austin. Among other maternal and infant health topics, the summit included a continuing education session that included information on infant sleep safety.

Approximately 500 people attended the summit. Attendees comprised 82% nurses, 10% physicians, 4% social workers, and 4% other professions. Among the attendees, 167 registered nurses and 33 physicians received continuing education. Additionally, 59 participants attended a pre-summit quality improvement workshop. More information about the summit, including an impact report, is available at: https://www.tchmb.org/2020-annual-conference. TCHMB also began planning for the 2021 Virtual Summit, which will focus on health disparities.

SPM 3: Infant mortality disparities – ratio of black to white infant mortality rate

Breastfeeding
In FY20, breastfeeding support activities continued to target known barriers to breastfeeding that disproportionately impact Non-Hispanic Black infants. Non-Hispanic Black mothers are more likely to return to work in the first year after delivery and to return to work earlier, on average, than mothers of other races or ethnicities. Previous analysis of WIC Infant Feeding Practices Survey data showed that Non-Hispanic Black mothers were less likely than mothers of other races or ethnicities to report that their worksites were supportive of breastfeeding. The Texas Mother-Friendly Worksite Program provided targeted technical assistance to employers in sectors where Non-Hispanic Black women were represented (e.g., retail, hospitality, service, government) and school districts in Dallas County, a community with high rates of Non-Hispanic Black infant mortality.

The Baby-Friendly Hospital Initiative (BFHI) demonstrated a reduction in racial and ethnic disparities in breastfeeding for both exclusive and duration rates. The Texas Ten Step Star Achiever Initiative Texas Breastfeeding Learning Collaborative, along with national initiatives, motivated and supported hospitals across the state to initiate and achieve BFHI designation. BFHI-designations have been focused in North and Southeast Texas, where Texas' Non-Hispanic Black populations are concentrated. Parkland hospital, Texas' largest public health hospital, achieved Baby-Friendly Hospital designation in FY20. Additionally, 19 hospitals are currently in the designation pathway.

HTMB Community Coalitions
HTMB Community Coalitions reaching Non-Hispanic Black women and mothers conducted activities to reduce racial health disparities in Texas. One example is the Mom Squad, a breastfeeding support group for women of color that educates mothers on breastfeeding best practices to improve exclusive breastfeeding for at least 6 months. Because of COVID-19, some programs have had interruptions in their projects interrupted for the safety of families and staff. Some HTMB Community Coalitions partnered with the Bright by Text program to send informative posts through text messages in English and Spanish. Additional outreach and education includes involvement of professionals and subject matters experts as guest speakers to discuss infant safe sleep, preeclampsia, gestational diabetes, breastfeeding, employment entrepreneurship, childcare, and emotional well-being.

To reduce racial disparities, HTMB Community Coalitions collected data on safe sleep practices to understand barriers and misconceptions in families bridging the gap for Non-Hispanic Black women and babies to reduce infant mortality. This process included empowering Non-Hispanic Black women to be champions of infant safe sleep within their communities.

Additionally, PHR 1 staff participated in the Combest Community Health Center and Nurse-Family Partnership (NFP) Community Advisory Coalition Meeting to provide resources and advance NFP initiatives and collaborative efforts in East Lubbock. This MCH partnership with NFP and Combest allowed staff to provide safe sleep education materials to Non-Hispanic Black families in PHR 1. PHR staff aim to increase the number of Non-Hispanic Black families that receive messaging and outreach region-wide.

Texas Collaborative for Healthy Mothers and Babies
In partnership with the University of Texas Health Science Center at Tyler and the University of Texas System, MCH provides funding for the Texas Collaborative for Healthy Mothers and Babies (TCHMB), which is the perinatal quality collaborative in Texas. TCHMB is a collaboration of over 150 health care providers, hospitals, state agencies, and other stakeholders with a shared goal of developing strategies, designing projects, and collecting data to improve birth outcomes in Texas.

In February 2020, TCHMB hosted its 2020 annual summit in Austin. The summit included presentations on Maternal Early Warning Systems (MEWS), implementing the AIM hypertension bundle in Oklahoma, postpartum care, and other maternal and infant health topics. TCHMB has a workgroup that aims to help reduce and eliminate health care disparities.

NPM 4: A) Percent of infants who are ever breastfed; and B) Percent of infants breastfed exclusively through 6 months.

Texas has created a strong foundation to promote breastfeeding because of its positive impact on maternal, infant, and child health outcomes throughout the life course. Breastfeeding reduces common childhood infections; rare but serious child health conditions such as necrotizing enterocolitis, childhood leukemia, and sudden infant death syndrome (SIDS); and chronic health conditions including childhood asthma, obesity, celiac disease, and diabetes. Additionally, breastfeeding increases chances for optimal maternal health conditions including cardiovascular disease, hypertension, breast and ovarian cancers, and rheumatoid arthritis.

The Texas Department of State Health Services (DSHS) breastfeeding activities are overseen by the state breastfeeding coordinator in the Maternal and Child Health Unit (MCH) through the DSHS Infant Feeding Workgroup (IFW). The IFW has worked since 2009 to integrate data-driven strategies to develop, implement, and evaluate a comprehensive breastfeeding support program to address known barriers to breastfeeding; address geographic, racial, ethnic, socioeconomic, and other disparities in infant feeding outcomes; and increase breastfeeding support.

DSHS offers a continuum of initiatives, technical assistance, educational materials, and in-person and online continuing education opportunities to support communities, birthing facilities, neonatal intensive care units (NICUs), health care professionals, employers, and child care centers to implement recommended practices that support breastfeeding. DSHS works to develop community capacity for lactation support and strengthen state and local systems of support and continuity of care for lactating mothers and their babies to promote improved infant feeding outcomes in Texas. MCH also coordinates several assessment and evaluation activities to ensure data-informed, programmatic planning and resource allocation while providing ongoing feedback on current initiatives.

State quantitative and qualitative data and other research demonstrate the substantial systemic barriers that low-income, Black, Hispanic, and other groups of women face in meeting their personal infant feeding goals. Data also illuminate the barriers to meeting public health objectives for breastfeeding. The DSHS Infant Feeding Position Statement affirms support of the principle of informed decision-making, whereby infant feeding choices are made in the context of an environment that:

- provides access to and supports consideration of full, accurate, and un-biased information about the risks and benefits of feeding options, and
- promotes and supports a woman's ability to carry out her choices.

MCH has outlined strategies to continue to build upon effective efforts to improve the policy, systems, and environmental contexts across sectors including in health care, worksites, and community settings. In FY21, Healthy Texas Mothers and Babies (HTMB) staff updated the DSHS Infant Feeding Position Statement.

The IFW plans to continue to assess the current state of breastfeeding support and identify needs, gaps, and opportunities to strengthen systems for provision of recommended breastfeeding support practices through a variety of methods, including examining data and findings from multiple assessment and surveillance sources. These include DSHS/Health and Human Services Commission (HHSC) Texas Women, Infants, and Children (WIC) Infant Feeding Practices Survey, the Texas Behavioral Risk Factor Surveillance System (BRFSS), the Texas Hospital Association Survey, and formative assessment reports. The DSHS/HHSC Texas WIC Infant Feeding Practices Survey was not conducted in FY21 due to COVID-19-related barriers that prevented the distribution of the survey to WIC participants. As the coordinator and principal investigator of the Texas WIC Infant Feeding Practices Survey, the DSHS state

breastfeeding coordinator in HTMB will work with MCH Epidemiology and HHSC Texas WIC to design and administer the next phase of the Texas WIC Infant Feeding Practices Survey in FY22. MCH will continue to examine existing data sources to increase knowledge about breastfeeding practices. MCH will also continue to engage in formative and summative assessment activities related to hospital quality improvement on the Ten Steps to Successful Breastfeeding and to worksite lactation support to provide insight into continuing or emerging needs, promising practices, and lessons learned from ongoing work in these areas.

The IFW will continue to foster coordination, collaboration, partnership, and collective impact with stakeholders across sectors to address known barriers to breastfeeding through increased uptake and implementation of recommended practices in infant nutrition and care. Stakeholders include health care providers, employers, state and local agencies, independent school districts, professional associations, insurers, state and local area programs, social service providers, community-based organizations, mothers, and advocates. =

The IFW will continue to strengthen connections between organizational stakeholders (e.g., professional organizations, local WIC agencies, fitness or wellness councils, coalitions, municipalities, nonprofits, public health grantees, and foundational grantees) throughout Texas to maximize statewide and local coordination and impact for improvements in breastfeeding support.

The IFW will continue to leverage partnerships to support hospitals with obstetric and neonatal service lines and their community stakeholders with information and assistance to increase uptake of the Ten Steps to Successful Breastfeeding (Ten Steps), including the steps associated with hospital care practices and Steps 3 and 10, which are related to prenatal and postpartum breastfeeding support and community linkages. The Ten Steps is an evidence-based bundle of recommended patient care practices demonstrated to improve infant feeding outcomes and reduce breastfeeding disparities. Birthing facilities that provide this full bundle of recommended practices can ultimately be recognized as a Baby-Friendly Hospital, a designation offered through Baby-Friendly, USA.

The IFW offers a continuum of activities to encourage and support birthing facilities at all stages of readiness (from pre-contemplation through full integration of the Ten Steps) to make improvements to achieve Baby-Friendly designation and increase exclusive breastmilk feeding throughout the entire hospital stay and beyond. The IFW will continue development and begin implementation of a second phase of the Texas Ten Step Star Achiever Initiative in FY22. This second phase will engage stakeholders (e.g., community providers, hospitals, and other partners) in quality improvement to improve breastfeeding outcomes and reduce disparities in infant feeding practices.

MCH will continue to partner with The Michael and Susan Dell Center for Healthy Living at the University of Texas at Houston School of Public Health Texas Mother-Friendly Worksite-Technical Assistance and Support Program (TMFW-TASP) team to provide support for application review and mother-friendly worksite designation. This will maximize MCH staff's ability to leverage the TMFW program for strategic partnerships to promote maternal and infant heath. Efforts toward this goal began in FY21, during which TMFW-TASP staff worked with MCH to transition and reassume all responsibilities to provide outreach support and information to employers on best practices for providing breastfeeding-friendly policies and environments to their employees. Employers with written and communicated policies that meet or exceed the minimum criteria for the TMFW Program are eligible to have their worksites designated and recognized through the TMFW program.

Within MCH Public Health Regions (PHRs), staff will provide mother-friendly stations at local events that include the availability of private non-bathroom lactation and breastfeeding spaces in public settings (e.g., airports, conference spaces, fair grounds, libraries, courthouses, city halls, etc.). Initial groundwork will include environmental scans, policy analysis, gap analysis, support of local coalitions, and education of key stakeholders. PHR staff will set up portable breastfeeding stations, work with businesses to establish policies, and share guidelines on how to

become mother-friendly worksites.

In FY22, MCH will work to develop a social marketing and communications strategy to expand the reach of the TMFW program and target specific employers to increase breastfeeding support for populations with significant barriers to breastfeeding while working. Specific employers include employers of low-wage earners, Texas school districts, and child care centers.

Breastmilk use to optimize short- and long-term health outcomes is particularly critical among fragile and ill infants. MCH will continue to promote increased access to breastmilk for vulnerable infants through a variety of activities and partnerships with WIC, Medicaid, Lactation Support Centers (LSCs), Peer Dad programs, HTMB Community Coalitions, the Texas Ten Step Program, the TexasAIM Initiative, and the Texas Pediatric Society. DSHS will continue to coordinate with partners to explore opportunities for increased access to human donor milk and mom's own milk for infants in the NICU. Partnership activities include coordinating efforts across programs to facilitate timely access to appropriate pumps, education, and support to establish and maintain milk supply. In addition, MCH will continue to support partnerships with Human Milk Banking Association of North America (HMBANA)-affiliated mother's milk banks in Texas, including helping LSCs to administer HMBANA milk bank-affiliated milk collection depots.

MCH will continue funding two MCH Peer Dad programs in East Texas and South Texas. Peer Dads programs provide community outreach, education, counseling, and community service referrals to fathers, WIC participants, and members of the community. Education and support services focus on areas such as breastfeeding, infant sleep safety, baby behavior, and men's and women's interconception health, as well as caring for the mother.

MCH will continue to support the LSC Services – Strategic Expansion Program (LSCS-SEP) which expands services at the LSCs beyond services funded through WIC to include the following activities:

- Provide population-based lactation education, counseling, and referral services to non-WIC participants.
- Develop and implement locally appropriate activities to engage and mobilize community partners in assessment, planning, and coordination to improve coordinated systems of care for lactation support consistent with recommendations of the Surgeon General's Call to Action to Support Breastfeeding, the Centers for Disease Control and Prevention Guide to Strategies to Support Breastfeeding Mothers and Babies, and other best practice resources.
- Conduct outreach, training, and education programs to increase the competencies and skills of maternity service direct care staff, clinicians, and other health professionals who care for women and children.
- Provide enabling services (e.g., transportation services; extended hours; mobile clinics; home visiting; language services) to increase access to family centered, culturally relevant, timely care.

MCH will continue to support after-hour, holiday, and weekend hours of the Texas Lactation Support Hotline to provide skilled lactation support, information, and referrals to breastfeeding mothers in Texas.

The IFW will continue to plan, develop, and disseminate materials, public-facing communications, outreach methods, and programmatic strategies to promote breastfeeding support practices. Promotion includes existing breastfeeding campaigns as well as other communication platforms to reach mothers and families, health care professionals, employers, service providers, child care professionals, and public health and outreach partners.

The IFW will continue to facilitate educational opportunities, including online breastfeeding modules hosted on the Texas Health Steps Online Provider Education (THS-OPE) platform, and through various live training and continuing education opportunities. These include continuing education offered through the LSCS-SEP to increase breastfeeding support and lactation management knowledge and skills of health care professionals who care for lactating mothers and their

babies.

Breastfeeding and maternal-infant contact will be promoted as part of comprehensive, patient-centered maternal care through the TexasAIM Obstetric Care for Women with Opioid Use Disorder Innovation and Improvement Learning Collaborative.

NPM5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding.

Prevention of infant mortality remains a key priority for DSHS. The 2020 Texas Five-Year Title V Needs Assessment findings still showed disparities in infant mortality, including sleep-related infant deaths.

Analyses conducted in 2011, 2013, and 2018 (https://dshs.texas.gov/healthytexasbabies/data.aspx) using the Perinatal Periods of Risk (PPOR) analytic approach identified the populations, areas of Texas, and Periods of Risk (PORs) with the greatest burden of potentially preventable (excess) fetal-infant mortality, and targeted specific interventions to those areas for the greatest impact. PPOR has illustrated that efforts targeting the Infant Health POR, including interventions to promote and support sleep safety practices, breastfeeding, and reduction of tobacco smoke exposures have great potential to reduce disparities and overall rates of infant mortality in Texas.

Nationally, several public health efforts have worked to identify effective strategies for comprehensively approaching the AAP Policy Statement risk reduction recommendations, including the Association of State and Territorial Health Officials (ASTHO) Safe Sleep Roundtable, the Safe Sleep Learning Network of the Collaborative Innovation and Improvement Network (CoIIN), and the National Action Partnership to Promote Safe Sleep (NAPPSS) project. These initiatives and the AAP Policy Statement account for the cultural, familial, and social determinants of infant care behaviors, including sleep-related behaviors, and they acknowledge the importance of caregiver experience and ultimate role as decision-makers for infant care. A commentary (Moon RY, Hauck FR, 2016) on a study (Goldstein RD, et al, 2016) in *Pediatrics* reinforces that, while efforts aimed at reducing risks in the sleep environment remain important, "[p]ublic health efforts will need to also focus on decreasing intrinsic risk through the promotion of smoking cessation, elimination of in utero drug and alcohol exposure, and increasing rates of breastfeeding and access to high-quality prenatal care," each of which are recommended in the AAP Policy Statement. MCH is committed to applying a comprehensive public health approach to sleep safety and risk reduction for sleep-related deaths that addresses both extrinsic and intrinsic risks in a family centered, public health-oriented, and evidence-based manner consistent with the comprehensive, multi-factorial recommendations of the AAP Policy Statement.

MCH will continue to assess needs, gaps, and opportunities to strengthen systems for support of recommended sleep safety and SIDS risk reduction practices. This work will include ongoing surveillance and monitoring of practices and program impact, as well as ongoing formative work to better understand needs and barriers related to implementation of sleep safety recommendations, strengths and best practices along with factors that potentiate behavior change among populations most at-risk for sleep-related infant deaths. MCH will continue to share monitoring and environmental scan findings through a variety of platforms to inform community-based safe sleep efforts. MCH will work with communities, including through the HTMB Community Coalitions, to engage stakeholders in community-level assessment processes with the goal of developing locally appropriate plans to address preventable infant deaths in areas of the state with higher-than-expected prevalence of sleep-related deaths.

MCH will continue to partner broadly to expand, coordinate, and integrate sleep safety and SIDS risk reduction strategies and to identify and act upon points of intervention to address potentially preventable child deaths using a public health prevention and risk reduction approach. MCH will work with partners including state agencies and regional and local partners to continue to develop and implement strategically planned activities supportive of the Safe Sleep

Messaging Interagency Workgroup (SSMIW) Safe Sleep Strategic Action Plan.

MCH will continue to coordinate with the National Action Partnership to Promote Safe Sleep Improvement and Innovation Network (NAPPSS-IIN) Collaborative and amplify its strategies. NAPPSS-IIN is designed to positively influence the proportion of infants who:
(1) are placed to sleep on their backs in a safe sleep environment that follows the AAP recommendations;
(2) are ever breastfed; and
(3) continue to breastfeed at six months.

Texas participated in the first wave of this national initiative with the goal of making safe infant sleep and breastfeeding a national norm. Specifically, the NAPPSS-IIN project aims to increase infant caregiver adoption of safe infant sleep practices as well as breastfeeding, as recommended by the American Academy of Pediatrics (AAP), by empowering champions for these protective behaviors within systems that serve families at risk. Ultimately this program seeks to reduce the rate of infants who tragically die due to sudden unexpected infant deaths (SUID) with a focus on reducing racial disparities in SUID.

MCH will continue facilitating training and educational opportunities for health care professionals, health and social service providers, and other stakeholders on topics related to promotion and assurance of recommended sleep safety and SIDS risk reduction practices. These include Child Fatality Review Team (CFRT) trainings, webinars, THS-OPE, and other opportunities developed as part of the SSMIW strategic action plan.

PHR staff will provide safe sleep training for community stakeholders with a recommendation that agencies complete the Cribs for Kids Ambassador training. PHRs will partner with community stakeholders to distribute “Pack n Plays” and infant survival kits to promote safe sleep practices. The injury survival kits include wearable blanket, onesie, pacifier, safe sleep, thermometer, educational materials, and a Pack n Play.

MCH will work to develop a strategic communications plan and targeted activities to encourage sustainable social and behavior change. MCH will also work to develop an awareness campaign to develop strategies, messages, communication channels to disseminate messages, an implementation plan, and a monitoring and evaluation plan to promote infant sleep safety and breastfeeding.

PHRs will assist hospital staff to update SIDS curriculum to include current recommendations on infant safe sleep practices, SIDS risk reduction for hospital staff, and child care provider training sessions.

SPM 3: A) Ratio of black to white feto-infant mortality rate; B) Ratio of black to white infant mortality rate.

MCH will continue to work with local communities to examine data related to disparate risks for excess fetal and infant mortality rates among non-Hispanic Black infants and to identify evidence-informed strategies to address identified disparity gaps. Title V Needs Assessment findings and data analysis informs MCH development of targeted messaging for non-Hispanic Black women on topics such as seeking medical care for chronic health conditions, breastfeeding and safe sleep practices, early entry into prenatal care, tobacco prevention and control, and perinatal and maternal health and wellness issues. MCH will continue working with local community coalitions and other partners to develop and disseminate locally relevant public health messaging.

MCH will continue to work to develop the HTMB Community Coalitions (HTMB Coalitions) as a key component of DSHS’ efforts to reduce infant mortality and specifically address racial and ethnic disparities in birth outcomes. The HTMB Coalitions are a point of engagement for local providers and stakeholders to work together to address infant

mortality disparities and promote culturally effective care. MCH will work with community partners to continue collecting and assessing feto-infant health, morbidity, and mortality data; reviewing existing infant mortality strategies; identifying appropriate community stakeholders and leaders to involve; and carrying out additional needs assessment work as identified. The HTMB Coalitions will continue to engage community partners and stakeholders and facilitate training and capacity building.

DSHS will coordinate a statewide network of local perinatal coalitions for collaborative learning, and for sharing best practices, resources, and information. Information and initiatives will be disseminated to reach mothers, their support networks, and providers through developing new state and locally targeted public awareness campaigns that leverage the different components of the HTMB Strategic Framework (i.e., activities designed to increase awareness and knowledge, provider education, community empowerment, community improvement, and quality improvement). MCH will explore opportunities to expand the preconception peer educator programs to reach women and men in populations at risk for preconception health disparities. MCH will continue to work with the HTMB Coalitions to establish and support universities and colleges in their targeted communities to provide information about preconception health, social determinants of health, and risk factors that can impact pregnancy outcomes later in life including obesity, smoking, and sexually transmitted infections.

MCH will continue to focus on understanding barriers to infant sleep safety practices among non-Hispanic Black families within targeted communities. MCH will also focus on increasing coordination and collaboration among services in these communities to mobilize assets supportive of infant health and safety among childbearing families.

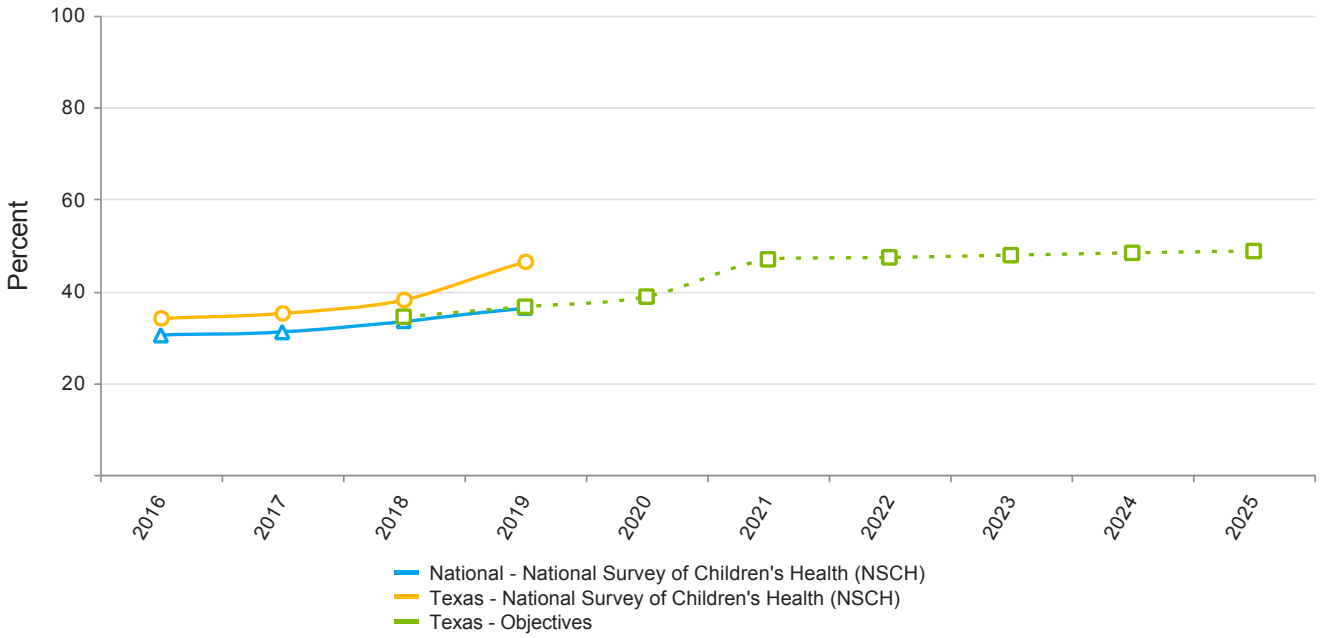
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	66.2	NPM 14.2
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	20.4	NPM 14.2
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	8.4 %	NPM 14.2
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	11.0 %	NPM 14.2
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	31.2 %	NPM 14.2
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	5.2	NPM 14.2
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	5.5	NPM 14.2
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	3.6	NPM 14.2
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.8	NPM 14.2
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	177.5	NPM 14.2
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	90.1	NPM 14.2
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2019	17.9	NPM 7.1
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	34.4	NPM 7.1
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	12.9	NPM 7.1
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	12.3	NPM 7.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	89.4 %	NPM 6 NPM 14.2

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			34.4	36.6	38.8
Annual Indicator		34.1	35.2	38.2	46.4
Numerator		295,528	306,220	349,190	420,111
Denominator		867,587	868,865	915,008	905,526
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	46.9	47.3	47.8	48.3	48.7	49.2

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Number of Texas Health Steps Online Provider Education (OPE) users completing developmental screening modules

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			6,750	13,005	13,655
Annual Indicator	6,429	18,552	12,386	17,632	9,223
Numerator					
Denominator					
Data Source	Texas Health Steps Online Provider Education (OPE)	Texas Health Steps Online Provider Education (OPE)	Texas Health Steps Online Provider Education (OPE)	Texas Health Steps Online Provider Education (OPE)	Texas Health Steps Online Provider Education (OPE)
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	14,337.0	15,053.0	15,805.0	16,595.0	17,425.0	18,296.0

ESM 6.2 - Number of developmental screenings provided in the Healthy Child Care Texas Grant

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	482	438
Numerator		
Denominator		
Data Source	Healthy Child Care Texas	Healthy Child Care Texas
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

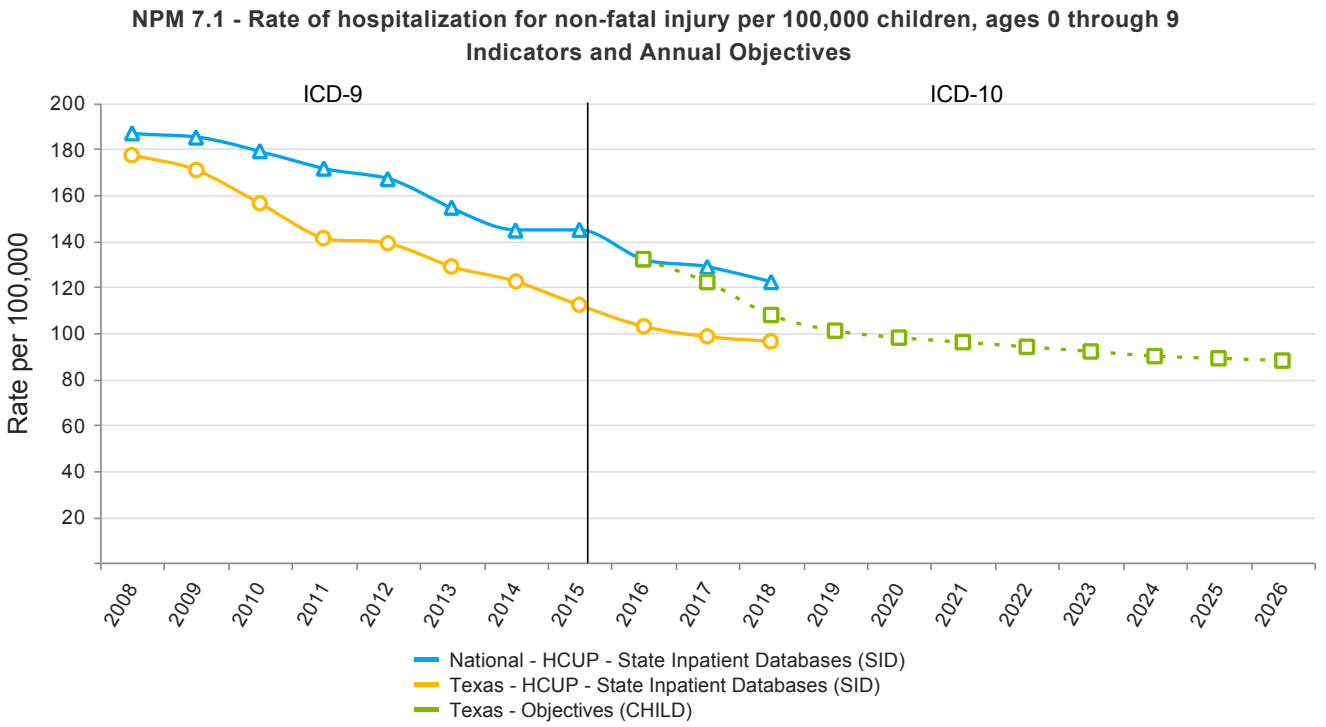
Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	250.0	0.0	0.0	0.0	0.0	0.0

ESM 6.3 - Percent of families participating in Help Me Grow Texas (HMGTX) who receive a developmental screening

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	132	122	107.7	100.9	97.9
Annual Indicator	125.3	111.7	102.9	98.3	96.1
Numerator	4,981	3,372	4,175	4,003	3,914
Denominator	3,974,223	3,017,993	4,057,490	4,072,971	4,071,873
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	95.9	93.9	91.9	89.9	88.9	87.9

Evidence-Based or –Informed Strategy Measures

ESM 7.1.1 - Number of School Health Friday Beat newsletters per fiscal year with at least one injury prevention resource provided

Measure Status:	Active				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			25	25	25
Annual Indicator	40	45	48	42	43
Numerator					
Denominator					
Data Source	DSHS School Health Program	DSHS School Health Program	DSHS School Health Program	DSHS School Health Program	DSHS School Health Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

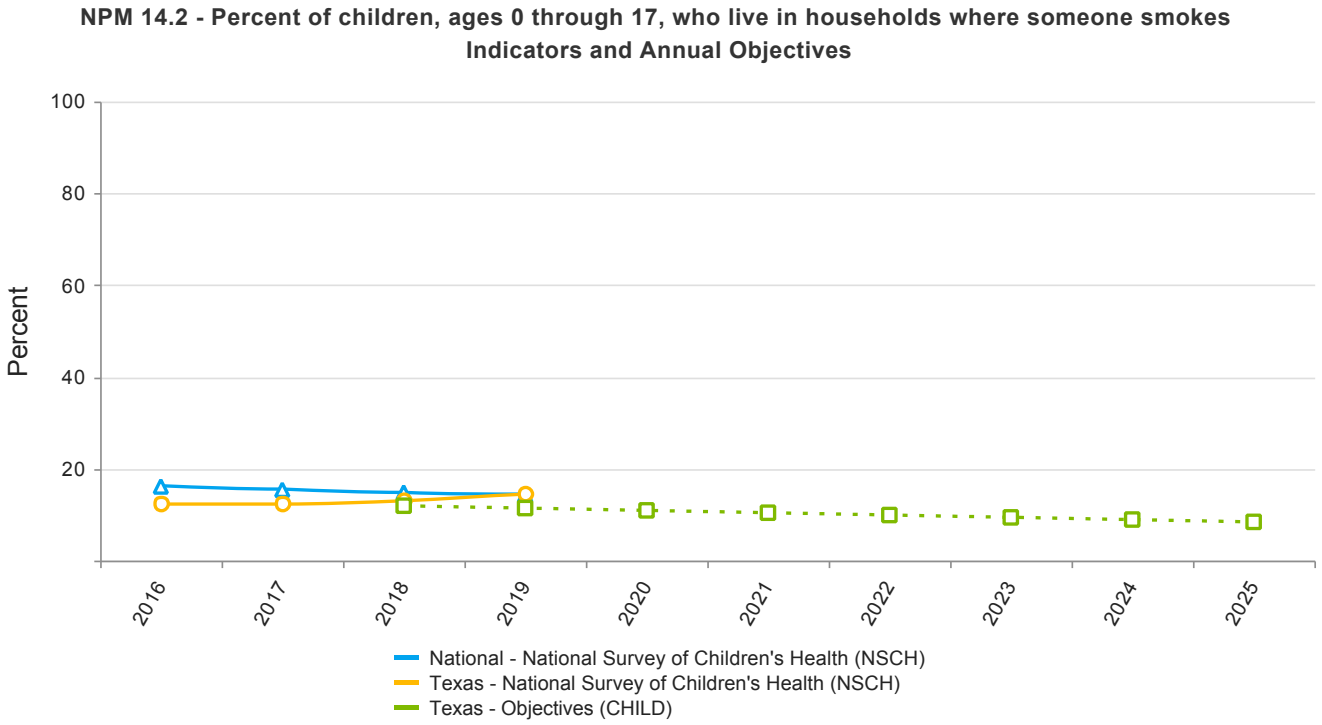
Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	25.0	25.0	45.0	45.0	45.0	45.0

ESM 7.1.2 - Number of individuals trained on injury prevention through the Medical Child Abuse Resources and Education System (MEDCARES) grant

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	4,806	21,652
Numerator		
Denominator		
Data Source	Medical Child Abuse Resources and Education System	Medical Child Abuse Resources and Education System
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	22,000.0	22,500.0	23,000.0	23,500.0	24,000.0	25,000.0



NPM 14.2 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			12	11.5	11
Annual Indicator		12.5	12.5	13.1	14.6
Numerator		883,263	892,707	945,028	1,056,499
Denominator		7,040,867	7,126,660	7,195,034	7,225,038
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	10.5	10.0	9.5	9.0	8.5	8.0

Evidence-Based or –Informed Strategy Measures

ESM 14.2.1 - Number of materials distributed to household members and caregivers intended to raise awareness about the risk of infant and child exposure to tobacco.

Measure Status:	Active			
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			220,000	220,500
Annual Indicator			0	123,455
Numerator				
Denominator				
Data Source			Pending	DSHS MCH Published Materials
Data Source Year			2019	2020
Provisional or Final ?			Provisional	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	221,000.0	221,500.0	222,000.0	222,000.0	222,000.0	220,000.0

State Performance Measures

SPM 2 - Percent of overweight and obesity in Texas children ages 2-21.

Measure Status:	Active				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		27.8	27.1	26.4	40.2
Annual Indicator	28.5	28	28	40.7	40.7
Numerator	113,597	88,319	88,319	139,579	139,579
Denominator	398,359	315,808	315,808	343,339	343,339
Data Source	Texas WIC client data	2017 Texas WIC Client data	2017 Texas WIC Client data	Texas SPAN	Texas SPAN
Data Source Year	2016	2017	2017	2015-2016	2015-2016
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	40.2	39.8	39.4	39.0	38.6	38.2

State Action Plan Table

State Action Plan Table (Texas) - Child Health - Entry 1	
Priority Need	
Promote safe, stable, nurturing environments to reduce violence and the risk of injury.	
NPM	
NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9	
Objectives	
By 2025, decrease the rate of emergency room visits among children ages 0-19 years by 5% (Baseline wlll be established).	
Strategies	
Strategy 1: Assess and monitor injury prevention data and trends, factors that impact injury prevention, and community needs and assets for reducing injuries among children.	
Strategy 2: Lead state and national initiatives including the Child Safety Learning Collaborative and State Child Fatality Review Team Committee.	
Strategy 3: Lead, fund, and partner on dissemination of injury prevention information, trainings, and resources to providers, state and community partners, and regional staff.	
Strategy 4: Support Safe Riders and regional staff with existing child passenger safety seat distribution and education programming.	
ESMs	**Status**
ESM 7.1.1 - Number of School Health Friday Beat newsletters per fiscal year with at least one injury prevention resource provided	Active
ESM 7.1.2 - Number of individuals trained on injury prevention through the Medical Child Abuse Resources and Education System (MEDCARES) grant	Active
NOMs	
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	

State Action Plan Table (Texas) - Child Health - Entry 2

Priority Need

Improve the cognitive, behavioral, physical, and mental health and development of all Maternal and Child Health populations.

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

Objective1: By 2025, increase the percentage of children, ages 9 through 35 months, who received a developmental screening in the past year to 60%. (NSCH 2018-2019 baseline = 46.4%)

Strategies

Strategy 1: Assess needs, gaps, risk factors, and opportunities to strengthen systems and expand initiatives to increase implementation of best practices related to optimal development.

Strategy 2: Lead, fund, and partner on activities and initiatives, such as Help Me Grow Texas and Learn the Signs. Act Early., to make developmental screening and monitoring tools and information accessible to families.

Strategy 3: Lead and partner on the development, promotion, and dissemination of health information and resources about best practices to promote optimal early childhood health and development.

Strategy 4: Partner with early childhood state agencies to establish and improve statewide systems to increase access to resources and services that are supportive of optimal child development.

ESMs	Status
ESM 6.1 - Number of Texas Health Steps Online Provider Education (OPE) users completing developmental screening modules	Active
ESM 6.2 - Number of developmental screenings provided in the Healthy Child Care Texas Grant	Active
ESM 6.3 - Percent of families participating in Help Me Grow Texas (HMGTX) who receive a developmental screening	Active

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Texas) - Child Health - Entry 3

Priority Need

Support health education and resources for families and providers.

NPM

NPM 14.2 - Percent of children, ages 0 through 17, who live in households where someone smokes

Objectives

By 2025, decrease number of children living in a household where someone smokes to 13.9% (NSCH 2019 baseline=14.6%)

Strategies

Strategy 1: Assess needs, gaps, risk factors, and opportunities to strengthen systems and expand initiatives to increase implementation of recommended smoking prevention and cessation best practices.

Strategy 2: Lead and partner on the development, promotion, and dissemination of educational materials, communications, and programming that reduce child exposure to secondhand smoke.

Strategy 3: Partner with and support the Texas Tobacco Prevention and Control Program and the Texas Asthma Control Program, such as promoting the Texas Tobacco Quitline and supporting implementation of the Strategic Plan for Asthma Control in Texas, 2021-2024.

ESMs	Status
ESM 14.2.1 - Number of materials distributed to household members and caregivers intended to raise awareness about the risk of infant and child exposure to tobacco.	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Texas) - Child Health - Entry 4

Priority Need

Improve nutrition across the life course.

SPM

SPM 2 - Percent of overweight and obesity in Texas children ages 2-21.

Objectives

By 2025, decrease the percent of children in 4th grade with a BMI in the overweight or obese range from 45.9% to 44.5% (SPAN 2019-2020).

Strategies

Strategy 1: Assess needs, gaps, and opportunities to strengthen systems and expand initiatives to increase awareness of overweight and obesity in children.

Strategy 2: Fund the implementation of the Texas School Physical Activity and Nutrition surveillance project to identify state and regional trends in health status of children in Texas.

Strategy 3: Lead, partner and support efforts to educate and build capacity among providers and health professionals to understand healthy weight status, promote healthy behaviors across the life course, and implement best practices in obesity prevention.

Strategy 4: Support the promotion of best practices to increase uptake of recommended nutrition and other health behaviors that reduce risk of and prevent overweight and obesity in children.

NPM 6: Percent of children, ages 9 through 35 months, receiving a developmental screen using a parent-completed screening tool in the past year.

The American Academy of Pediatrics recommends all infants and children from nine to 35 months of age receive screenings for developmental delays during well checks using standardized screening tools. Most parents (68% for the U.S. and 63% for Texas) reported that they did not complete a developmental screening with their doctor for their child.

The Substance Abuse and Mental Health Services Administration (SAMHSA) -funded Linking Actions for Unmet Needs in Children's Health (LAUNCH) expansion grant ended in fiscal year (FY)19. Texas implemented LAUNCH to improve the developmental, social, and emotional outcomes of children from birth to age 8 in three communities across the state. Texas LAUNCH activities focused on implementing best practices within an array of systems supporting young children. One of the lasting strategies from the grant was sustaining the efforts of three workgroups focusing on developmental screening, mental health consultation, and prevention of suspensions and expulsions.

At the beginning of FY20, LAUNCH's developmental screening workgroup transferred to MCH while the other two workgroups were absorbed elsewhere. The group was renamed the Texas Developmental Screening Workgroup (DSW). In FY20, the DSW met every other month to collaborate on increasing developmental screenings and developing quality service referral mechanisms statewide. The DSW consisted of representatives from early childhood state agencies, child health advocacy groups, the Texas chapter of the American Academy of Pediatrics, local communities leading efforts in early childhood screening, non-profits, and a university. The cross-sector participants provided agency- and regional-specific expertise on trends and initiatives regarding screening and surveillance efforts. In FY20, the DSW explored opportunities for creating a statewide data system to house developmental screening data and allow providers access to results. The DSW also conducted a statewide crosswalk of developmental screening and monitoring initiatives for project alignment and collaboration opportunities.

In August 2020, the DSW agreed to support Texas' application to the "Act Early Response", a COVID-19 project funded by the Centers for Disease Control and Prevention (CDC) and the Association of University Centers on Disabilities (AUCD). In support of the Act Early grant, MCH agreed to leverage the DSW as the convening group for the state team. The grant goal is to integrate and strategically disseminate the CDC's suite of developmental promotion materials, *Learn the Signs. Act Early.* (LTSAE) into far-reaching statewide programs. Sixteen early childhood agencies and organization, including Title V and the six Help Me Grow Texas communities, signed on in support of this grant application. More information can be found on Help Me Grow in Objective 2. Beginning in FY21, these entities will work on a statewide strategic integration and dissemination plan for LTSAE messaging and materials. The goal of this effort is to align statewide messaging with quality materials which fulfills numerous agencies' preexisting goals and strategies. The DSW also agreed to participate in a statewide needs assessment to identify barriers due to COVID-19 and opportunities across early childhood systems and programs to improve early detection and intervention. The state team will conduct the needs assessment in FY21.

Another FY20 goal of the DSW was to identify gaps in stakeholder representation. Through thoughtful evaluation and by partnering with the state's CDC/AUCD grant, the membership of the DSW increased to include nine additional agencies and organizations throughout the state.

To expand on the momentum created during the LAUNCH grant, MCH began leading efforts in creating and implementing a coordinated early childhood system in FY20. The programs, resources, and services that families may need – such as health care, quality early learning opportunities, healthy nutrition, and parent support – must work together as a coordinated system to have the greatest impact on children's healthy development. Early childhood agencies in Texas were interested in a system framework that utilizes and builds on existing resources to develop and enhance a comprehensive approach to early childhood system-building. The Help Me Grow (HMG) model was identified as a potential system framework. HMG strengthens the network of community resources, linking families to an organized flow of resources allowing them to easily

access the services and supports they need. More information on how MCH is implementing the HMG framework can be found in Objective 2.

In the 2015 Texas Legislative Session, lawmakers directed 18 state agencies to develop a collaborative five-year behavioral health strategic plan. In addition to developing this plan, stakeholders identified the need to develop a Statewide Intellectual and Developmental Disabilities (IDD) Strategic Plan. The IDD Strategic Plan was intended to unify state agency leaders and stakeholders to identify and prioritize goals and address gaps in the IDD system. In outlining the strategic plan, an inventory of existing IDD programs and services was completed in FY19. In this inventory, MCH's LAUNCH project was included. With the conclusion of LAUNCH, MCH identified actions that will continue to make improvements to the IDD system. One such example is the proposal of two developmental screening recommendations by MCH to the Children and Youth Behavioral Health Subcommittee (CYBHS). The CYBHS is a subgroup of Texas Health and Human Services Commission's (HHSC) Behavioral Health Advisory Committee (BHAC). The subcommittee serves as the advisory board for the Texas System of Care, a framework to provide a spectrum of accessible, responsive, and effective services and supports. The BHAC operates as the state mental health planning council, providing consumer and stakeholder input to the Health and Human Services system. The BHAC considers and makes recommendations to the HHSC Executive Commissioner. In FY19, MCH proposed two developmental screening recommendations to the CYBHS based on work from the Texas LAUNCH Early Childhood Committee. In June 2020, the BHAC unanimously accepted the recommendations which included:

1. Create (or improve an existing) early childhood developmental screening web platform and data portal; and
2. Implement a state policy that Child Care Regulation and the Texas Rising Star Quality Rating Improvement System require child care and education centers to offer developmental screenings for all children in their care.

These recommendations will be included in a report to HHSC and considered for inclusion in the Statewide IDD Strategic Plan. MCH represents DSHS on the CYBHS and will continue efforts to implement these recommendations.

MCH funded the production and dissemination of *A Parent's Guide to Raising Healthy, Happy Children* (Guide). Per legislation, a physical copy of the Guide is available for free for providers to distribute to their prenatal care or delivery patients enrolled in Medicaid. Eligible providers include hospitals, birthing centers, physicians, nurse midwives, and midwives. Ineligible providers can order the Guide at cost. In April 2020, MCH contracted with a new organization to design, update content, and distribute the Guide. The new organization, Best Press, has prior experience assisting MCH's former vendor in these tasks. The comprehensive guide is in print and online (https://www.dshs.texas.gov/mch/), and includes information on:

- The essential stages of a child's development, from birth to age five and a place within the Guide to record family milestones;
- Developmental milestones, with helpful tips for doctor's visits, and building literacy; and
- Resources especially for Texan families, such as health care and appropriate child care.

The Guide exists in a five-by-seven-inch pocket booklet with a tear-away page containing key resources, topics, and space to note important information for medical visits. It is available in English and Spanish.

In FY19, 86,500 Guides were distributed to providers. In FY20, 62,050 Guides were distributed. Based on this pattern, more Guides may be distributed in FY21. Second, the onset of the COVID-19 pandemic changed priorities for many providers in the state and may have affected the number of Guides ordered by Medicaid providers during this period. Additionally, the increased use of telemedicine could have affected the number of physical Guides providers distributed during COVID-19. Third, while Medicaid providers are required to provide families with a parent resource guide, providers may use an alternate resource to comply with legislation. Fourth, MCH re-bid the publishing contract and changed vendors. HHSC identified Texas Health Steps (THS) regional staff as an avenue for education on the benefit of supplying the Guide to parents. THS is the Medicaid healthcare program for children, teens, and young adults, birth through age 20.

MCH funded another parent education initiative with the creation of "Tracking Your Child's Development" (https://www.youtube.com/watch?v=x2dDOY2FgBA) in collaboration with the Texas Department of Family and Protective Services' (DFPS) Prevention and Early Intervention division (PEI). The 2-minute video, produced in English and Spanish

during FY19, reviewed key milestones, how to address concerns, developmental screenings, and the importance of early detection. The video received over 780 views since its release in early FY20. The success of this video led to renewal of the interagency contract to produce another video in FY21.

MCH funded the second annual Pediatric Brain Health Summit (PBHS) in FY20. The purpose of the PBHS was to bring together community-based organizations and health care professionals to discuss and learn about strategies for promoting pediatric brain health. The PBHS was a collaboration between DFPS, DSHS, Episcopal Health Foundation, the St. David's Foundation, Casey Family Programs, The University of Texas System, and The University of Texas Health Science Center at Tyler. The Title V Director participated on the planning committee and was selected as a featured speaker. The PBHS was planned for spring 2020 but, due to the pandemic, was delayed until fall 2020.

MCH partnered with other organizations and agencies to address NPM 6, including membership on the Texas Early Learning Council, participation in the Interagency Workgroup, attendance at BUILD state meetings, and contribution to *Learn the Signs. Act Early.* efforts.

The Texas Early Learning Council (TELC) serves as the state's advisory council, as required by the federal Improving Head Start for School Readiness Act of 2007, to improve the quality of and access to early childhood services across Texas. The TELC is comprised of cross-sector stakeholders who work to increase coordination and collaboration across state agencies and local entities. The Title V Children with Special Health Care Needs Director/Child and Adolescent Health Branch Manager represents DSHS on TELC. In the absence of the Preschool Development Grant Birth through Five Implementation Grant award, the TELC used FY20 to identify existing strategies within the state's Early Learning Strategic Plan that ensure all Texas children are ready for school and ready to learn. MCH's work as the Help Me Grow Texas hub was identified as a way to accomplish several strategic plan activities.

The Interagency Workgroup (IAW) is a collaboration of early childhood state agencies that are coordinating initiatives to achieve a significant collective impact in the child wellness sector. The Title V Director represents DSHS on the workgroup. In FY20, the IAW met monthly to discuss ongoing activities and align agency work with other statewide efforts, such as the state Pritzker grant awarded to the Prenatal-to-Three Collaborative and the Texas Early Learning Strategic Plan. In response to COVID-19, the IAW took on support of the Child Care Taskforce to assist in providing health and safety information. Through this effort, the Taskforce designed and released the Frontline Child Care website for frontline workers seeking available and operating childcare centers (https://frontlinechildcare.texas.gov/). Once the website was available to the public, the IAW began discussion of repurposing the site post-COVID-19 to be inclusive of more early childhood topics, including developmental awareness and education. These efforts will continue in FY21.

In relation to IAW and TELC efforts, MCH attended three BUILD Initiative State Team meetings in FY20. The BUILD Initiative provides technical assistance to support early childhood system development. In November 2019, the BUILD team finalized the Texas Early Learning Strategic Plan. MCH identified areas of potential collaboration through this process, including opportunities to incorporate Help Me Grow and provide developmental screening and monitoring expertise. In March 2020, the BUILD team met right before state offices were closed because of COVID-19. The meeting identified actionable steps for Texas' early childhood agencies to conduct without additional Preschool Development Grant funding. By this time, MCH was the hub for Help Me Grow and the collaborator with *Learn the Signs. Act Early.*, and therefore took on support of these activities. Some meeting time was devoted to discussing plans for addressing COVID-19 within different sectors and identifying unified strategic messaging to stakeholders. In May 2020, the BUILD team had a virtual retreat to advance goals and strategies of the Texas Early Learning Strategic Plan even during the pandemic. The BUILD team focused on counties of high need and areas of program collaboration.

In conjunction with numerous statewide efforts, MCH partnered with Texas' Act Early Ambassador to integrate the CDC's *Learn the Signs. Act Early.* (LTSAE) program. LTSAE promotes early detection and intervention of developmental concerns. MCH recommended LTSAE materials as the standard content for the developmental screening strategy outlined in the Texas Early Learning Strategic Plan and the Prenatal-to-Three Collaborative's Texas Plan. To bolster the statewide efforts,

Texas submitted a response to a request for application to the Act Early Ambassador program. Due to Texas' size, two Ambassadors are allowed for the state. The State Child Health Coordinator applied to become the second Ambassador for Texas. In this role, MCH could co-lead efforts of the LTSAE grant as well as develop and implement an individual workplan. For the workplan, MCH proposed working on the integration of LTSAE in the Texas Early Learning Strategic Plan and supporting a statewide promotional campaign across 16 partners. The work for new Ambassadors will begin in FY21. Before being selected as the state's second Act Early Ambassador, MCH supported the first Ambassador's promotion of LTSAE. In FY20, 1,812 orders were placed for a total of 25,437 sets of LTSAE materials. Seventy individuals across the state also completed the *Watch Me!* Training video on child developmental milestones.

Texas Prenatal-to-Three (PN-3) Collaborative, led by three Texas child advocacy organizations, became a Pritzker grantee in FY20. The PN-3 Collaborative is working with advocacy allies, policymakers, philanthropists, and state and community leaders to develop and implement a policy agenda that supports families and children during the first three years of life. A key goal of the PN-3 Collaborative is to expand a "universal connection" system to assess, screen, and refer families to support services in the postpartum period and early childhood years. In FY20, MCH met with PN-3 leaders and identified the following areas of the PN-3 Texas Plan that MCH can lead and support:

- Increase the number of low-income infants and toddlers who receive a developmental screening and are successfully referred to necessary services;
- Increase parent and provider understanding of healthy child development and support services available for families with young children;
- Increase detection and intervention efforts and connecting medical providers to a grid of resources for families; and
- Integrate *Learn the Signs. Act Early.* checklists into community early childhood coalition efforts to engage families in the process of developmental monitoring.

In FY21, MCH will coordinate efforts with the PN-3 Collaborative.

The Early Childhood Intervention (ECI) Advisory Committee advises HHSC's Division for Early Childhood Intervention Services on development and implementation of policies that constitute the state ECI system. The Title V Director represents DSHS on the Advisory Committee. In FY20, the ECI State System Improvement Plan Committee entered year four of the implementation and evaluation phase.

In FY20, 16,983 Texas Health Steps' Online Provider Education (THS- OPE) modules on early childhood development and screening were completed. The module topics related to child development included:

- Adverse childhood experiences
- Attention-deficit/hyperactivity disorder
- Autism spectrum disorder
- Behavioral health screening and intervention
- Childhood anxiety
- Childhood depression
- Developmental surveillance and screening
- Pediatric newborn hearing and vision screening
- Using developmental screening tools

In April 2020, MCH provided subject matter expertise during the update of the THS-OPE module titled *Developmental Surveillance and Screening: Birth Through 6 Years*. MCH participated in a brainstorming session with the module developers, reviewed module content for accuracy, beta-tested the changes, and provided an evaluation of the review process. THS-OPE released the updated module in August 2020.

MCH created and maintained a webpage devoted to child health in Texas. A landing page was created for the child health domain (https://www.dshs.texas.gov/mch/Child-Health-in-Texas.aspx). The page included information about healthy child development, Help Me Grow Texas, resources for parents regarding COVID-19, and a reminder for caregivers to stay on

track with vaccines and screenings during the pandemic.

To enhance the work of Texas LAUNCH, MCH led the implementation and expansion of Help Me Grow Texas. Further information about LAUNCH can be found in NPM 6, Objective 1.

In late 2019, the Help Me Grow National Center (HMGNC) approached Texas with an opportunity to support the implementation of the Help Me Grow (HMG) model in the state. HMG is a system framework that utilizes and enhances existing community resources to meet the needs of families with young children. Families connect to a network of community organizations, allowing them to access the services and support they need to support their child's development. HMG strengthens the network by fostering partnerships, service provider alignment, and interconnected operations. The system is available to all children ages 8 years old and younger, including those whose family may have concerns or simply want to learn more about their child's development.

The HMG System Model is comprised of four cooperative and interdependent core components:

- Centralized Access Point: assists families and providers with connecting children to the network of community resources that help them thrive.
- Family & Community Outreach: builds parent and provider understanding of healthy child development, supportive services available to families in the community, and how both are important to improving children's outcomes.
- Child Health and Care Provider Outreach: supports early detection and intervention efforts and connects providers to the network of community resources to best support families.
- Data Collection and Analysis: supports evaluation, helps identify systemic gaps, bolsters efforts, and guides quality improvement.

The HMGNC received a grant allowing them to provide technical assistance to six communities on readiness, planning, implementation, and evaluation stages of the model. This opportunity allowed Texas to enhance the HMG implementation already occurring in the Fort Worth area, a former LAUNCH community, as well as onboard five new communities across the state. In late April, MCH became the organizing entity for statewide implementation and expansion of the model in Texas. The organizing entity provides administrative oversight, system coordination, and sustainability planning. During FY20, MCH conducted the following core functions:

- Engaged formally with HMGNC
- Designed and supported the HMG Texas steering committee
- Implemented a year-long cohort for a collective learning experience
- Connected localities to technical assistance

To leverage the grant provided to HMGNC, MCH implemented a collective learning experience through a year-long cohort. During the cohort, MCH will work with the cohort communities to identify and implement strategies that position them for success. In parallel, the HMGNC provided technical assistance to those communities to advance existing early childhood systems through the implementation of the HMG System Model.

As the organizing entity for statewide expansion, MCH began with the selection of six regional Texas communities via an open application for Help Me Grow Texas (HMGTX) in June 2020. Interested communities applied to receive technical assistance for the length of the cohort. Applicants had to consist of one lead organization and a minimum of two community partners. The cohort communities committed to:

- Working with MCH to identify and implement strategies that position communities for success;
- Receiving technical assistance from HMGNC to advance existing early childhood systems;
- Engaging in strategic planning in partnership with MCH;
- Collaborating with existing HMGTX communities for mentorship; and
- Providing documentation of implementation progress to MCH and HMGNC.

MCH received 12 applications from seven of the eight public health regions. Applicants were evaluated on readiness, need, capacity, infrastructure, and history of the lead organization's performance. The lead organizations selected to participate in the cohort included:

- Easterseals Rio Grande Valley (south Texas)
- My Health My Resources of Tarrant County (Dallas/Fort Worth)*
- North Texas Area United Way (Wichita Falls)
- Paso del Norte Children's Development Center (El Paso)*
- United Way for Greater Austin (Austin)
- United Way of San Antonio & Bexar County (San Antonio)*

*Fort Worth, El Paso, and San Antonio had previously participated in Texas LAUNCH.

In preparation for FY21, MCH began exploring opportunities for statewide expansion, including sustainability plans for continued implementation of the first cohort.

In congruence with HMGTX efforts, MCH funded the Healthy Child Care Texas (HCCT) grant to improve the state's developmental screening capacity.

HCCT is a Child Care Health Consultant (CCHC) train-the-trainer program funded by MCH and implemented by the Texas Association for the Education of Young Children (TXAEYC). CCHCs are licensed health professionals with a background in pediatrics who are trained to work with early childhood education programs. The consultants address the health and safety needs of young children in child care. FY20 was the second year of the three-year HCCT grant. Year Two goals included:

- Provide a statewide listing of CCHCs in each community via the Texas CCHC Database;
- Train CCHCs to provide trainings, assessments, and site visits to support early care and education providers;
- Coordinate and provide Ages & Stages Questionnaires® (ASQ®) Train-the-Trainer Curriculum trainings;
- Develop, coordinate, oversee, and fund the Social and Emotional Development (SED) project; and
- Create a portal to collect data on assessed child care centers.

The CCHC certification curriculum equips CCHCs to provide training and consultation to early childhood professionals on health and safety and includes a three-day in-person training, 10-week distance learning modules, a capstone experience, and an application to the Texas Trainer Registry. In FY20, two modules for Developmental Screening in Early Childhood and Childhood Obesity Prevention were added to the 14-module curriculum covering 19 health topics. During COVID-19, CCHCs took more time to complete the certification due to the limited ability trainees had to enter child care centers during the pandemic. As of August 2020, the Texas CCHC Database included 116 certified CCHCs serving 30 counties across the state. In FY20, TXAEYC trained 74 CCHCs. Compared to FY19, 54 more CCHCs were trained. Since the beginning of the HCCT grant, 149 CCHCs have been trained. Of those, 53 consultants were certified and 96 still needed to complete actions for certification. TXAEYC created a plan to meet with uncertified CCHC trainees to increase certification completion. This plan will be implemented in FY21.

In addition to the CCHC curriculum, TXAEYC coordinated and conducted train-the-trainer sessions for administering the ASQ® tools in child care programs. The ASQ® tools screen young children ages one month to six years to help determine if their development is on schedule or if further evaluation may be needed. Seventy-four CCHC trainees were trained on ASQ® in FY20. During the summer of 2020, the ASQ® training was not conducted in person due to COVID-19 restrictions. TXAEYC adapted the train-the-trainer curriculum for virtual administration, allowing them to conduct a final late-summer virtual training. Participation more than doubled for this virtual training compared to prior in-person events.

For the HCCT-SED pilot project, TXAEYC developed, coordinated, and funded a child care provider scholarship program for 50 child care centers. The scholarship program covered the cost of general CCHC services, a six-hour ASQ® training, ASQ® screening kits, and 10 hours of technical assistance. Fifty child care centers were selected in the Houston area and supported by 18 CCHCs. Compared to FY19, 15 more child care centers participated in the FY20 pilot program. The

CCHCs initiated contact with child care center directors, scheduled on-site implementation meetings, and scheduled the ASQ® training. CCHCs completed all trainings by March, before the pandemic. The ASQ® screeners were planned to be administered to parents and caregivers at the pilot sites between mid-March and April 2020 and the CCHCs anticipated scoring screeners, interpreting results, sharing results with caregivers, and making necessary referrals by May 2020. Delays occurred due to COVID-19. Nearly half of all child care centers in Texas closed in the spring of FY20 and most open centers were not accepting clients at their usual capacity. During this time, CCHCs were unable to implement the developmental screeners, nor provide training and support as planned. Brookes Publishing, the creator of the ASQ® tools, allowed TXAEYC access to online screeners for free so CCHCs could continue their outreach.

Of the 50 pilot participants, 16 centers completed the project, 16 centers received an extension through the end of November 2020, and 18 centers withdrew because of temporary or permanent closures due to COVID-19. Through a mix of online and in-person screeners (completed pre-pandemic), CCHCs administered 438 screens to 312 children in the FY20 HCCT-SED pilot. Compared to FY19, CCHCs screened 62 more children for a 24% increase in reach. CCHCs provided 511 hours of training and consultation to center directors and staff, including training 378 teachers on ASQ® administration. TXAEYC is working with the remaining centers to complete the pilot during fall enrollment in early FY21. As part of this pilot wrap-up, CCHCs will be using one hour of consultation for creating a sustainability plan with the child care center.

Performance Analysis:
Although Objective 2 was met in FY18 and exceeded in FY19, MCH acknowledges the importance of continued trainings on screenings and referrals.
Compared to FY19, CCHCs screened 62 more children for a 24% increase. Through a mix of online and in-person screeners (completed pre-pandemic), consultants administered 438 screens to 312 children in the FY20 Healthy Child Care Texas-Social Emotional Development pilot. In FY20, 1,812 orders were placed for a total of 25,437 sets of *Learn the Signs. Act Early.* materials. In FY20, 62,050 parent resource guides for developmental milestones were distributed to Medicaid recipients with infants. A large part of the increase in developmental screening is due to the implementation of web-based screenings and statewide efforts to align promotion of developmental milestones.

Challenges/Opportunities:
Due to COVID-19, some planned FY20 activities were impacted. Many FY20 activities consisted of parent and provider education and awareness regarding developmental milestones. While awareness is key in recognizing developmental delays, action is required of parents and providers in completing a developmental screening. With the implementation of Help Me Grow Texas in FY21, MCH can connect awareness of milestones and completion of screenings with referrals to necessary resources and services. This will ensure that not only are screenings being conducted but that the screening results are being used to intervene in cases of delay or disability.

NPM 7: Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9.

The Title V FY20 Needs Assessment identified several statewide injury prevention areas of concern. First, the top causes for child fatalities included preventable deaths such as accidental drowning and motor vehicle incidents. Additionally, adverse childhood experiences (ACEs) was a top concern among focus group participants. In Texas and nationwide, the 2017-2018 National Survey of Children's Health data showed that almost 20% of children have experienced two or more adverse childhood experiences.

Various types of child abuse and neglect are categorized as ACEs. Data from Child Protective Investigations indicates that neglect is the most prevalent type of child maltreatment in Texas. In 2018, 73% of confirmed cases of child maltreatment were cases of neglectful supervision. Physical and sexual abuse cases were 11.3% and 8.8%, respectively. Cases of neglectful supervision have been consistently higher for the past decade among all types of child maltreatment.

Another focus of injury prevention among parents and providers of children in Texas include bullying and its relation to child mental health. Mental health for children was also identified as one of the major needs in Texas through key informant and

focus group interviews. Participants expressed concern over the lack of mental health resources and addressed the need for mental health resources geared specifically towards children.

MCH public health region (PHR) staff led several initiatives aimed to reduce the rate of hospitalization for non-fatal injured children, including child passenger safety checkups, an abusive head trauma prevention initiative, water safety education, and bike safety.

Most PHR staff partnered with DSHS's Safe Riders program. Safe Riders manages a child safety seat (CSS) distribution and education program and provides helpful information about child passenger safety. Activities supported by PHR staff are listed below. In total, 957 CSSs were inspected or installed, 770 were distributed, and multiple education classes were held.

Activities	Participating PHR	Results
Education events	1	Facilitated rural and frontier area child passenger safety (CPS) checkups to educated adults who care for and transport children
	2/3	Hosted 18 Safe Riders classes
	4/5N	6 hyperthermia presentations in 8 counties reaching 220 participants
	6/5S	A staff member who is also a CPS Technician Master Trainer provided subject matter expertise on the curriculum development of the THS-OPE course on car seat safety
	11	Hosted 12 Safe Riders classes
CSS inspection/installation	1	44 CSS inspected/installed
	4/5N	243 CSS inspected/installed
	6/5S	383 CSS inspected/installed
	7	85 CSS inspected/installed
	9/10	130 CSS inspected/installed
	11	72 CSS inspected/installed
CSS distribution	1	38 CSSs distributed
	2/3	51 CSSs distributed
	6/5S	318 CSSs distributed
	7	75 CSSs distributed
	9/10	96 CSSs distributed
	11	192 CSSs distributed

PHR staff promoted evidence-based information on the prevention of abusive head trauma and child maltreatment. PHR 1 staff conducted educational outreach to local caregivers regarding the Period of PURPLE Crying (POPC), an infant health injury prevention program. Staff partnered with the nine rural birthing hospitals to train nurses to provide parent education and distribute Period of PURPLE Crying materials. In FY20, 735 Period of PURPLE Crying multilingual booklets and DVD bundles were distributed in PHR 1.

PHR staff promoted evidence-based information and activities on water safety as well. Water safety education was provided to six Boy and Girls Clubs locations reaching over 1,500 children and staff. This was a 130% increase in reach over the last time the training was conducted in FY18. PHR 6/5S staff distributed 30 lifejackets to local pools, waterparks, rivers, lakes, and beaches. In PHR 11, staff determined a significant increased incidence of child death through drowning in two counties. To address this issue, staff members created and distributed 175 Water Safety Kits that contained guardian reminders, posters on water safety, sunscreen, and sunglasses.

PHR staff promoted evidence-based information and activities on bike safety. PHR 9/10 provided bike helmet fittings to 106 children. This is 33 more helmets provided than in FY19. Staff also provided bike and road safety education to 191 individuals. PHR 11 staff conducted four Bike Rodeo train-the-trainer programs to local police departments, school districts, and community health organizations. Staff in PHR 7 provided all-terrain vehicle safety awareness education to 500 participants, including children and adolescents.

MCH funded several initiatives in FY20 aiming to reduce the rate of hospitalization for non-fatal injuries in children, including the Medical Child Abuse Resources and Education System, *A Parent's Guide for Happy, Healthy Children* re-design and distribution, and the Healthy Child Care Texas grant.

MCH continued to implement the legislatively mandated Medical Child Abuse Resources and Education System (MedCARES) grant program in FY20. This program awards grants to develop and support regional programs to increase child maltreatment prevention, education, and partnership building. An additional goal of the program is to build infrastructure that increases access to medical child abuse experts and improves timely and accurate diagnoses. MCH used a competitive grant process to award funds through contracts to hospitals, academic health centers, and health care facilities with expertise in pediatric healthcare. To maximize funds and activities, DSHS revised and re-competed the grant in FY19 and selected 11 MedCARES contractors around the state. Of the 11 contractors, six are designated as a Center of Excellence (COE).

MedCARES contractors provided education and training in their communities to individuals who work with children at risk of abuse and neglect and other members of the public, including medical professionals, case workers, law enforcement, and the judiciary. The contractors frequently provided information and trainings on topics related to:

- How to identify various types of abuse
- Abuse or neglect reporting requirements
- Medical conditions that mimic abuse or neglect
- Child safety
- PPC

In FY20, MedCARES contractors completed 1,658 trainings and presentations, totaling over 2,842 hours and 20,652 attendees. The total estimated number of individuals reached through prevention program activities is 7,094,727. Prevention activities completed by MedCARES contractors in FY20 included:

- Publishing articles in local and national newspapers;
- Developing safety plans for families with adolescents expressing suicidal thoughts;
- Creating a statewide protocol to identify and evaluate children for whom there is a concern for abuse or neglect;
- Participating in community adverse childhood experiences taskforce and pilot programs;
- Serving on human trafficking workgroups and child protection team executive boards;
- Hosting Grand Rounds and conferences;
- Participating in and chaired local Child Fatality Review Teams;
- Developing resource brochures and messaging series to provide families with tools to prevent abuse and neglect; and
- Serving on the American Academy of Pediatrics Council on Child Abuse and Neglect's Executive Committee.

MedCARES contractors employed 21 CAPs, of which there are 337 nationwide. MedCARES contractors also provided direct services for children and adolescents for whom there is a concern for abuse or neglect. Medical services included comprehensive medical evaluations; in-person and telephonic consultations; access to subspecialties, specialized equipment, and specialized care; and case reviews and court testimony. The 11 MedCARES contractors conducted 8,509 face-to-face initial visits and 5,584 follow-up visits in FY20.

In April and May 2020, MCH hosted twice monthly voluntary meetings for the MedCARES contractors to discuss concerns regarding possible increases in child abuse and neglect cases and severity during COVID-19. These meetings allowed MedCARES contractors an opportunity to discuss emerging trends, share resources, and collaboratively brainstorm solutions to the unique challenges COVID-19 created.

In August 2020, MCH completed the writing of the legislatively mandated 2019-2020 MedCARES biennial report. The purpose of this 34-page report is to detail grant recipient activities, program results, and outcomes. MCH worked with MCH Epidemiology, which analyzed and wrote the data components. The MedCARES Biennial Report 2019-2020 can be found here: https://www.dshs.texas.gov/legislative/2020-Reports/MedCARES-BiennialReport2019-2020.pdf and the updated MedCARES webpage can be found here: https://www.dshs.texas.gov/mch/medcares.shtm/.

MCH continued to fund the distribution of *A Parent's Guide to Raising Healthy, Happy Children.* Per legislation, a physical copy of the Guide is available for free for providers to distribute to their prenatal care or delivery patients enrolled in Medicaid. The Guide includes age-appropriate tips on how to keep a baby and toddler safe such as:

- Safe sleeping positions;
- Baby-proofing the home;
- Reducing choking hazards;
- Car seat and bike safety; and
- Safe sibling play.

In FY20, 62,050 Guides were distributed to Medicaid providers. Further information about the Guide can be found in NPM 6.

Funding continued for the Health Child Care Texas (HCCT) grant in FY20. MCH utilized the HCCT grant to provide Child Care Health Consultant (CCHC) certification and training. This training ensured qualified health and childcare professionals were available to provide health and safety assessment to out-of-home child care facilities in Texas. CCHCs are trained in injury prevention in child care settings, including:

- Drowning
- Poisoning
- Falls
- Recognizing abuse and neglect
- Toxin- and chemical-free environments

In FY20, 74 CCHCs were trained. During COVID-19, CCHCs took more time to complete the certification due to the impact of the pandemic on childcare programs and the limited ability trainees had in entering child care centers. Even with the pandemic, HCCT trained 54 more CCHCs than in FY19. Further information about the HCCT program can be found in NPM 6.

MCH partnered with other organizations and agencies to address NPM 7, including participation in the National Child Safety Learning Collaborative (CSLC) and membership on the Violence Prevention Advisory Panel which was created in response to COVID-19. The Advisory Panel convened experts for the creation and promotion of messaging that would help families cope with stress during the pandemic.

MCH participated in the National CSLC throughout FY20. The CSLC is an opportunity for states and jurisdictions to increase the adoption of evidence-based policies, programs, and practices at state and local levels. The Texas CSLC team is part of the second cohort that began in May 2020 and continues through October 2021. MCH staff chose to focus on three topics:

- Bullying prevention
- Motor vehicle traffic safety
- Suicide and self-harm prevention

In FY20, MCH participated in one learning session, one state technical assistance call, and six topic-focused calls.

MCH supported multiple initiatives to address NPM 7, including membership on the DFPS Prevention Framework Workgroup, participation in the Early Childhood System Integration Group, production of Friday Beat school health newsletter, and dissemination of THS-OPE modules.

MCH represented DSHS on the DFPS Prevention Framework Workgroup. The workgroup, comprised of state agencies, local organizations, and community leaders, formed to delineate the state's and communities' role in supporting prevention efforts to strengthen families. In FY20, members traveled to Boulder, Colorado to learn how other communities and states integrate prevention concepts across different agencies. The workgroup applied what they learned from Colorado and adopted prevention framework foundations to exemplify how the supports of strong communities intertwine to wrap around a family and promote their success.

MCH remained an active participant in the Early Childhood Systems Integration Group (ECSIG). ECSIG is a multi-state agency workgroup that tracks trends via Results Based Accountability measures, a disciplined way of thinking and acting to improve entrenched and complex social problems, by standardizing data collection across state agencies. These measures were presented in a visual dashboard with user-friendly analysis. In FY20, the ECSIG drafted the second iteration of The State of Texas Dashboard for Early Childhood Outcomes (DECO) for three priority areas:

1. Children in Texas are healthy
2. Children in Texas are safe
3. Children in Texas are on track to be school-ready

MCH participated in ECSIG meetings regarding health outcome measures and recommendations for available data sets. DSHS-owned data was used to represent several key indicators for these goals. MCH will continue to provide epidemiological and subject matter expertise during DECO reviews in FY21. MCH will also promote the DECO to relevant stakeholders.

MCH supported and collaborated with the DSHS School Health program in the creation and distribution of the *Friday Beat*, an e-newsletter that is sent to over 7,900 school health stakeholders every Friday (https://www.dshs.texas.gov/schoolhealth/fridaybeat.shtm?terms=friday%20beat). In FY20, DSHS released 49 issues of the *Friday Beat* and featured injury prevention resources and articles in each edition. The *Friday Beat* provided 43 unique articles, resources, and educational opportunities related to injury prevention to 7,937 weekly users by the end of FY20, almost a 18% increase from FY19. The information provided school stakeholders with resources on student safety, emerging best practices, and programs to implement within a school setting. FY20 *Friday Beat* resources and topics included:

- Brain injury awareness and prevention
- Suicide risk and prevention
- Implementing Play Streets in rural communities, an intervention to create safe places for physical activity
- Car seat safety courses
- Sun and pool safety lesson plans
- Sports injury prevention
- Preventing home injuries during COVID-19
- Keeping kids safe around hand sanitizer

MCH, PHR staff, and the Office of Injury Prevention continued to promote THS-OPE injury prevention modules to stakeholders statewide. In FY20, a total of 9,168 pediatric injury prevention THS-OPE modules were completed. The module topics included:

- Childhood trauma and toxic stress
- Pediatric head injury
- Preventing unintentional injury
- Reporting and prevention of child abuse

MCH led multiple initiatives to address NPM 7, including support to state and local Child Fatality Review Teams (CFRTs) and creation of the CFRT legislatively mandated recommendation report.

In 1995, Texas enacted legislation establishing the State CFRT Committee (SCFRT). The SCFRT is a multidisciplinary group of professionals representing law enforcement, the medical community, child advocacy organizations, the court system, the behavioral health community, and other state agencies. In FY20, the group met quarterly to:

- Develop an understanding of the causes and incidences of child death in Texas;
- Identify procedures within agencies represented on the committee to reduce the number of preventable child deaths; and
- Promote public awareness and make recommendations to the Governor and Legislature for changes in law, policy, and practice to reduce the number of preventable child deaths.

The Title V Director represented MCH on the SCFRT.

Local CFRTs mirror that of the SCFRT in purpose and composition. Local groups are volunteer-based and organized by county or multi-county geographic areas. They conduct retrospective reviews of deaths of children 17 years of age or younger in their geographic areas. A major purpose of these reviews is to determine if a child's death was preventable. As of December 2019, there were 83 active local CFRTs covering 211 of the 254 Texas counties. This coverage resulted in 94% of Texas children residing in a county where child deaths are reviewed.

Local CFRTs submitted recommendations for the SCFRT to consider for the FY20 legislatively mandated report. In FY20, the local CFRTs submitted 14 recommendations for review. Each recommendation was voted on by the SCFRT in November 2019. Of the 14 proposals, five recommendations were approved to be sent to the Governor and Legislature. The recommendations impacting children ages 0 to 9 years were:

- Pass legislation that requires new residential swimming pools to have a circumferential isolation pool fence installed that is at least 4 feet in height and completely separates the house and play area of the yard from the pool;
- Amend Texas Family Code to require professionals to report to DFPS all cases of children less than 6 years old who have died due to unexplained or non-natural causes, excluding motor-vehicle occupant deaths unless there is a suspicion of alcohol or substance use;
- Fund CFRT Coordinators in each of the DSHS PHRs; and
- Amend Texas Transportation Code to create an additional offense related to rear-facing child passenger restraint systems.

Current child fatality data and statistics, as well as the recommendations above, were detailed in the April 2020 State Child Fatality Review Team Committee biennial report (https://www.dshs.texas.gov/legislative/2020-Reports/Texas-Child-Fatality-Data-and-Recommendations-April-2020.pdf).

PHR staff continued participating in and supporting their local CFRTs. PHR 2/3 supported 28 CFRTs within their 49-county region. Twenty-one of these teams are in counties without a local health department. Staff in PHR 9/10 attended six local CFRTs, covering all 36 counties in the region. PHR 11 staff supported local CFRTs through case reviews, data-driven and evidence-based injury prevention presentations, and coordinating local injury prevention teams. Once COVID-19 restrictions were in place, many teams struggled with regular meetings.

Performance Analysis:

In FY20, 957 car safety seats were installed and inspected, and 770 seats were distributed across the state. Over 1,500 children participated in water safety education via local Boys and Girls Clubs which is 130% increase in reach since last conducted in FY18. Bike and road safety was provided to 691 individuals in the PHRs. MedCARES contractors conducted 1,658 trainings and presentations, totaling more than 2,842 hours and 20,652 attendees. The reach of MedCARES injury prevention activities is estimated to be 7,094,727 individuals. MCH distributed 62,050 *A Parent's Guide to Healthy, Happy Children* resource guides providing information on safe home environments for children. Seventy-four Child Care Health Consultants were trained to provide health and safety assessments of child care centers. Forty-nine issues of a DSHS

school resource newsletter containing injury prevention resources were distributed to 7,937 school health stakeholders. This was an 18% increase in subscribers compared to FY19. Texas had 83 active local child fatality review teams covering 211 of the 254 counties in the state. This resulted in 94% of Texas children residing in a county where child fatalities are reviewed. COVID-19 was a major challenge to the child fatality review process for FY20.

Challenges/Opportunities:

Due to the outbreak of COVID-19, some planned FY20 activities were impacted. To meet the needs of the population, MCH and its' contractors adjusted plans accordingly. Many staff, contractors, and partners transitioned to virtual administration of education and programming. However, some events were unable to be hosted virtually. With the continuation of numerous advisory panels and committees, MCH has an opportunity to learn about trends, disseminate information to partners and stakeholders, and identify areas that may be enhanced by educational support.

NPM 14: Percent of children, ages 0 through 17, who live in household where someone smokes.

The Behavioral Risk Factor Surveillance System indicated that the overall prevalence rate of current childhood asthma for ages 0-17 in Texas was 7.9% in 2015. Of children ages 3- to 17-years old, 3- to 11-year-olds have the highest exposure to secondhand smoke, with a disproportionately higher exposure among non-Hispanic Black children. Children with secondhand exposure experience increased frequency of ear infections, acute respiratory illnesses, lower respiratory tract infractions, sudden infant death syndrome, and severe asthma.

National asthma guidelines recommended people with asthma avoid exposure to secondhand smoke. Half of children (54%) with asthma are exposed to secondhand smoke in the home; this exposure is linked to a 63% increase in asthma-related emergency department visits. Secondhand smoke exposure before birth is a risk factor for childhood asthma. Therefore, national asthma guidelines recommend pregnant women avoid both smoking and exposure to secondhand smoke.

MCH continued to fund the distribution of *A Parent's Guide to Raising Healthy, Happy Children* (the Guide). The Guide is legislatively mandated to be distributed by healthcare professionals who provide prenatal care or deliver an infant of a pregnant woman who is enrolled in Medicaid. The Guide includes age-appropriate tips on how to keep a baby and toddler safe such as creating a smoke-free environment. In FY20, 62,050 Guides were distributed to Medicaid providers. MCH also worked with DSHS Tobacco Prevention and Control Program (TPCP) to identify opportunities to update the Guide with additional secondhand smoke and smoking cessation information. TPCP agreed to provide content expertise in future Guide revisions. Further information about the Guide can be found in NPM 6.

MCH supported several initiatives in FY20 related to reducing childhood exposure to secondhand smoke in the home, including participating in DSHS Texas Asthma Control Collaborative, partnering with DSHS Tobacco Prevention and Control Program, and promoting smoking prevention and cessation education.

The DSHS Texas Asthma Control Program (TACP) began in FY20 as part of a competitive grant award from the Centers for Disease Control and Prevention. The TACP began developing a statewide strategic plan which includes addressing asthma triggers like secondhand smoke. The goal of this strategic plan component is to reduce tobacco smoking among adults and child exposure to secondhand smoke. MCH was represented on the Texas Asthma Control Collaborative (TACC). The TACC advises the TACP and will form workgroups in FY21 to implement strategies identified in the strategic plan. MCH will participate in relevant workgroups in FY21.

In mid-FY20, MCH met monthly with DSHS Tobacco Prevention and Control Program (TPCP). The purpose of these meetings was to explore opportunities to collaborate with TPCP to reduce secondhand smoke. Exploration efforts included targeted outreach and dissemination of information to appropriate MCH populations. TPCP agreed to provide content expertise for MCH educational materials. These meetings will continue in FY21.

MCH continued to promote THS-OPE tobacco modules to stakeholders statewide. In FY20, a total of 2,028 THS-OPE modules related to secondhand smoke were completed. The module topics included childhood asthma and dyspnea triggers and treatments. MCH will continue to provide subject matter expertise for module reviews in FY21.

MCH continued to support and collaborate with the DSHS School Health program in the creation and distribution of the *Friday Beat*, an e-newsletter that is sent to over 7,900 school health stakeholders every Friday. The *Friday Beat* provided 23 unique articles, resources, and educational opportunities related to smoking prevention and cessation to 7,937 weekly users. FY20 *Friday Beat* resources and topics included:

- DSHS alert on pulmonary illness and vaping
- How to talk to students about the harms of e-cigarettes
- DSHS-created vaping materials
- Vaping prevention for elementary school professionals

Further information about the *Friday Beat* can be found in NPM 7.

Performance Analysis:

In FY20, 62,050 *A Parent's Guide to Healthy, Happy Children* resource guides were distributed to Medicaid providers. The Guide includes age-appropriate tips on how to keep a baby and toddler safe such as creating a smoke-free environment. In FY20, MCH worked with TPCP to coordinate updates to the Guide with additional secondhand smoke and smoking cessation information. MCH and TPCP began meeting regularly, with three meetings taking place in FY20. In FY20, a total of 2,028 THS-OPE modules related to secondhand smoke were completed. The *Friday Beat*, a weekly e-newsletter sent to school health stakeholders, provided 23 unique articles, resources, and educational opportunities related to smoking prevention and cessation to 7,937 subscribers. Compared to FY19, the Friday Beat had an 18% increase in subscribers but three fewer smoking-related articles.

Challenges/Opportunities:

Due to COVID-19, some planned FY20 activities were impacted. To meet the needs of the population, MCH and its' contractors adjusted plans accordingly. Workgroups and meetings were conducted virtually. However, the collaboration process was generally slower than pre-pandemic.

SPM 2: Reduce the prevalence of overweight and obesity in Texas children ages 2-21.

Based on body mass index calculations for second and 4th graders from the 2015-2016 Texas School Physical Activity and Nutrition (TXSPAN) data, DSHS estimated about 40% of students are over the normal weight range for their height and about one out of four students are obese.

Child nutrition also emerged as a theme in both the key informant interviews and focus group conversations for the Title V Needs Assessment. The 2015-2016 TXSPAN data estimated that only 22% of second grade students, and only 9% of 4th grade students are meeting daily physical activity recommendations.

MCH led several initiatives aimed to reduce the prevalence of overweight and obesity among young children, including the Children's Healthy Weight Collaborative Improvement and Innovation Network (CHW CoIIN), the Maternal and Child Health Workforce Development Center's 2020 Cohort program, and regional initiatives.

In FY17, Texas was selected to participate as a technical assistance site for the CHW CoIIN. The CHW CoIIN concluded in FY20. The aim of the CHW CoIIN was to facilitate the development, implementation, and integration of evidence-informed policies and practices to support State Title V programs to improve health behaviors related to the following workstreams: breastfeeding, physical activity, and nutrition. Texas focused on the nutrition work stream for FY20, with the goal of increasing the number of DSHS program employees aware of and utilizing nutrition resources. MCH began developing a nutrition toolkit to enhance workforce knowledge of childhood nutrition and weight management. The toolkit included:

- Local, state, and national nutrition resources
- Examples of nutrition programming best practices
- Introduction to the use of data sets
- Nutrition environment scan of existing initiatives for cross-programming

- Media kit for National Nutrition Month activities

In FY20, MCH enhanced the work from the CHW CoIIN by participating in the Maternal and Child Health Workforce Development Center's 2020 Cohort (MCH WDC Cohort) program. The seven-month cohort involved working with the Center to develop and implement a transformational change. The MCH WDC Cohort team explored options for joining efforts across the life course by breaking down program silos and implementing a comprehensive initiative promoting nutrition and healthy eating behaviors. Additionally, the team aimed to integrate health disparity principles and the family voice in the initiative. To accomplish these goals, the team decided to create a suite of presentations that incorporate parent, caregiver, and individual youth strategies. The intended outcome of this deliverable was to:

- Give parents, caregivers, and adolescents the tools to make healthy eating decisions;
- Encourage cross-domain collaboration;
- Enhance MCH workforce knowledge of nutrition across the lifespan; and
- Increase collaboration between Central Office and PHRs.

The MCH WDC Cohort team consisted of 12 members representing the following areas:

- Title V child health, adolescent health, and children and youth with special health care needs (CYSHCN) subject matter experts
- Health disparity subject matter expert
- Family partners for youth and CYSHCN
- Representative for PHR staff
- Measurement Liaison
- MCH WDC Coach
- MCH WDC graduate student
- Senior sponsor from DSHS Executive Leadership

In February 2020, a portion of the team attended a 4-day Learning Institute in North Carolina. This travel team clarified the project aim statement, practiced implementing new work processes and tools, and explored opportunities for technical assistance. Upon completion of the Learning Institute, the full team began meeting monthly to begin program design. In July 2020, the full team participated in a remote consultation before the conclusion of the cohort.

In FY20, staff began monthly professional development meetings aimed at increasing awareness and understanding of health disparities. The team explored personal biases and strategized to identify ways to reduce health disparities throughout the MCH domains.

MCH funded multiple initiatives to address SPM 2, including the Healthy Child Care Texas Grant (HCCT) and *A Parent's Guide to Raising Healthy, Happy Children* design and distribution.

To address obesity in early child care, MCH continued to fund the HCCT grant in partnership with DSHS' Obesity Prevention Program and Texas A&M AgriLife Extension. Part of the grant was used to create obesity prevention online training modules for child care staff, parents, Child Care Health Consultants (CCHCs), and trainers on the Texas Trainer Registry. The CCHCs educated child care professionals on the Texas Rising Star child care quality rating system standards regarding healthy eating and active living. Technical assistance was provided to help create better child care environments that support healthy habits. Two programs focused on obesity are incorporated into the HCCT grant. First, the Outdoor Learning Environment (OLE!) initiative improved outdoor spaces at child care centers by adding design elements that encourage children to be active, learn in nature, and develop motor skills. Second, the Nutrition and Physical Activity Self-Assessment for Child Care (Go NAPSACC), a resource to help programs improve practices, policies, and environments to instill healthy habits for children in child care centers, provided an avenue for child care centers to assess their facility and identify topics of technical assistance need. With the statewide rollout of Go NAPSACC, a designation system was designed to highlight centers who are going above and beyond basic health recommendations. This new designation is called the Texas Healthy

Building Blocks recognition program. Further information about the HCCT project and CCHCs can be found in NPM 6.

MCH also funded the production and dissemination of *A Parent's Guide to Raising Healthy, Happy Children* (Guide). Per legislation, a physical copy of the guide is available for free for providers to distribute to their prenatal care or delivery patients enrolled in Medicaid. The comprehensive Guide is in print and online and includes information on healthy nutrition and feeding practices for children ages 0 to 5 years old. In FY20, 62,050 Guides were distributed to Medicaid providers. Further information about the Guide can be found in NPM 6.

MCH supported several initiatives to address SPM 2, including the Early Childhood Obesity Prevention Committee and regional activities.

The Early Childhood Obesity Prevention Committee is a multisector collaboration to improve the weight status of children in Texas. The committee divided into four subgroups that follow the socio-ecological model: policy, community, facility, and professional. Each subgroup convened to identify goals, define activities, and develop steps to achieve each activity. MCH participated in the community- and facility-level subgroups in FY20.

PHR staff supported obesity prevention efforts at the local level as well. PHR 2/3 staff participated in seven coalitions addressing childhood obesity, resulting in 24 meetings attended across 12 counties.

MCH led several initiatives aiming to prevent obesity in 4th graders, including the CHW CoIIN, the MCH WDC 2020 Cohort program, and regional initiatives.

MCH led an innovative nutrition initiative to address the prevalence of overweight and obese children in Texas as part of the CHW CoIIN. Texas focused on the nutrition work stream for FY20 with the goal of increasing the number of DSHS program employees aware of and utilizing nutrition resources. MCH decided to develop a nutrition toolkit to enhance workforce knowledge of childhood nutrition and weight management. Further information about the toolkit and CHW CoIIN can be found in SPM 2, Objective 1.

In FY20, MCH enhanced the work from the CHW CoIIN by participating in the MCH WDC 2020 Cohort program. Further information about the seven-month cohort can be found in SPM 2, Objective 1.

PHRs supported obesity prevention efforts at the local level. PHR 2/3 staff assisted in three 5-2-1-0 Healthy Children program trainings, certifying ten people to implement the program at local elementary schools. The 5-2-1-0 campaign is an evidence-based, nationally recognized campaign that makes healthy eating and active living fun and easy to remember. PHR 4/5N staff implemented Learn, Grow, Eat, & Go! (LGEG), an evidence-based program providing classroom lessons on healthy foods, gardening, and hands-on demonstrations for elementary school student. LGEG was presented in three elementary schools and a high school special education class for a total of 56 participants. This is a 20-student increase over the previous year of implementation. Staff also conducted a subset of the Texas School Physical Activity and Nutrition (TXSPAN) project in one school district, measuring body mass and health behaviors of 173 students. Similarly, PHR 6/5S assisted in the recruitment of school districts for participation in TXSPAN for the region. More information about the project can be found below.

MCH funded the TXSPAN project to address the prevalence of overweight and obese children in Texas.

In FY20, MCH continued to contract with the University of Texas Health Science Center at Houston (UTHealth) to support the activities of the TXSPAN project (https://sph.uth.edu/research/centers/dell/project.htm?project=3037edaa-201e-492a-b42f-f0208ccf8b29). TXSPAN is a statewide surveillance system which monitors trends in body mass index and health behaviors of children in 2nd, 4th, 8th, and 11th grades. The questionnaire administered in the project included questions about:

- Dietary behaviors
- Nutrition knowledge and attitudes

- Physical activity
- Social and environmental factors impacting health
- Body image
- Depression and other psychological impacts on health
- Sleep patterns
- Screen time

UTHealth recruited over 280 schools to participate in the project during FY20. An informational video produced in FY19 was provided to the schools during the recruitment process (https://vimeo.com/onestory/review/364344483/a6bb6b137d). The video provided an overview of participant expectations and benefits. UTHealth reported increased success in recruitment of schools through the distribution of this video.

UTHealth planned to conclude the 5th cycle of data collection for the project in FY20. Typically, most of the data collection occurs in late spring. As a result of COVID-19, TXSPAN cancelled all further data collection efforts for the fiscal year. Data was collected for only half of the sample size before the start of the pandemic. By the time schools in Texas closed, TXSPAN's data sample did not meet requirements to be representative of all PHRs and a border versus non-border comparison. However, TXSPAN collected enough data to produce a representative snapshot of body weight and health trends at the state level. UTHealth administered 8,706 surveys across 227 public schools.

UTHealth and MCH convened regularly to discuss alternative and contingency plans due to COVID-19 delays. MCH pursued a contract renewal that would allow UTHealth to conduct another round of TXSPAN post-COVID-19. This round of data collection would allow the Texas to analyze child health behaviors pre- and post-pandemic. TXSPAN plans to complete data collection during the 2020-2021 school year, pending COVID-19 restrictions.

Although 2019-2020 data collection ceased, UTHealth continued data analysis and dissemination of the 2015-2016 TXSPAN data. In conjunction with MCH Epidemiology, UTHealth worked on publication and presentation efforts. In FY20, TXSPAN had 36 publications with 15 manuscripts in progress. The 2015-2016 data was used in creating one-pagers used to educate policymakers on the importance of child health in Texas. In FY20, UTHealth created and released the following one-pager topics:

- Child obesity crisis in Texas
- Child nutrition
- Child physical activity
- Child screen time
- Child sleep quality
- Child sugar-sweetened beverage consumption

UTHealth also began analyzing data for upcoming FY21 one-pager topics:

- Youth fast food consumption
- Breakfast consumption
- Youth sports participation

MCH participated on the Texas SPAN Advisory Committee in June 2020. In this role, MCH provided subject matter expertise to UTHealth on the creation and revision of survey instruments, sample design, project implementation, and other aspects of the statewide surveillance system. MCH also helped identity contingency plans for conducting statewide data collection during and after COVID-19.

MCH supports several initiatives to address SPM 2, including the Early Childhood Obesity Prevention Committee, the THS-OPE program, and the production of the *Friday Beat* school health newsletter.

The Early Childhood Obesity Prevention Committee is divided into 4 subgroups that follow the socio-ecological model: policy, community, facility, and professional. Each subgroup convenes to identify goals, define activities, and develop steps to achieve each activity. MCH participated in the community- and facility-level subgroups in FY20. The goal of the community-level subgroup was to support participation in the Child and Adult Care Food Program (CACFP), a federal program that provides reimbursements for nutritious meals and snacks to eligible participants. The subgroup identified and shared targeted, unified messaging about meeting CACFP standards for parents and child care providers. The goal of the facility-level subgroup was to increase parent awareness about childhood obesity and parent demand for healthy physical activity and nutrition in child care environments. The workgroup identified methods to increase awareness via dissemination through Go NAPSACC parent training, development of childhood obesity resources for AgriLife extension agents to disseminate, and revision of the Guide during MCH's next round of review.

MCH continued to promote THS-OPE modules. In FY20, a total of 2,380 obesity prevention modules were completed.

MCH continued to support and collaborate with the DSHS School Health program in the creation and distribution of the *Friday Beat*, an e-newsletter that is sent to over 7,900 school health stakeholders every Friday. The *Friday Beat* provided 217 unique articles, resources, and educational opportunities related to obesity prevention to 7,937 weekly users. FY20 *Friday Beat* resources and topics included:

- National Childhood Obesity Awareness Month
- Texas School Physical Activity & Nutrition (TXSPAN) Child Health Status Reports on various obesity-related topics
- School Nutrition Resources Toolkit
- How to involve families in physical activities in school
- Active People, Healthy Nation initiative
- Cookbook for schools and childcare centers
- Healthy meal finder tool
- How to stay healthy and active while at-home learning
- Staying active while social distancing

Further information about the *Friday Beat* can be found in NPM 7.

Performance Analysis:
In FY20, MCH began the first cross-domain initiative focusing on the state's newest priority needs of nutrition and disparities. In FY20, the MCH WDC Cohort project enhanced workforce development of MCH, PHRs, and project partners. In FY21, MCH will have the opportunity to directly impact Texas children through the implementation of the MCH WDC Cohort nutrition resource toolkit.

With the statewide rollout of Go NAPSACC, all Texas child care centers now have access to resources for improving the physical health of the children in their care. As more centers are enrolled in the project, MCH expects to see an increase in centers providing healthy environments and opportunities in order to be rated on the Texas Healthy Building Blocks designation.

Although data collection was cancelled halfway through, TXSPAN surveyed 8,706 students to get a representative sample for the state. The ability to collect data earlier in the school year was due to lead time written into the current contract that allowed for an extended recruitment period. Based on this success, MCH plans to continue the same process for future contracts for TXSPAN. Additionally, the pursuit of another data collection cycle in the 2021-2022 school year allows MCH a unique data set for pre- and post-pandemic comparisons of health and body weight trends in Texas children.

The *Friday Beat* provided 217 unique articles, resources, and educational opportunities related to obesity prevention to 7,937 subscribers. Compared to FY19, the Friday Beat had an 18% increase in subscribers but 12% fewer obesity-related articles.

Challenges/Opportunities:
Due to COVID-19, some planned FY20 activities were impacted. To meet the needs of the population, MCH and contracted organizations adjusted plans accordingly. Many staff, contractors, and partners transitioned to virtual administration of education and programming. However, some components were unable to be done virtually.

Opportunities also exist to work with community partners, local school systems, school health advisory committees, child care centers, state partners, and PHRs to identify promising and evidence-based practices to increase education of child care providers, teachers, and parents on healthy eating and active living programs designed to decrease obesity in children.

Child Health - Application Year

NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.

The American Academy of Pediatrics recommends all infants and children ages 9-35 months receive screenings for developmental delays during well-checks using standardized screening tools. These screenings involve a questionnaire administered by the doctor to the parent and include age-appropriate questions for parents about the child's development, including communication and social development. The National Survey of Children's Health includes a question about screening for developmental delays, and its 2016-2018 data supports the participant's perceptions regarding a need for developmental screenings. In the U.S. and Texas, most parents (68% and 63%, respectively) reported that they did not complete a developmental screening with their doctor for their child.

The fiscal year (FY)20 Title V Needs Assessment identified the need for increased developmental screenings for children in Texas. The finding came up in focus group discussions among parents and providers of children. Some parents spoke from personal experience, explaining that it was difficult to get their child developmental screenings. Other focus group participants explained that these screenings need to be more widely available. An education component was also a topic of discussion, as participants explained that both providers and families should be educated about milestones and developmental screening.

In FY22, Maternal and Child Health (MCH) will lead several efforts to improve the state's developmental screening capacity, including serving as the Help Me Grow Texas (HMGTX) organizing entity, facilitating the Texas Developmental Screening Workgroup (DSW), participating in *Learn the Signs. Act Early*. (LTSAE) activities, and creating and updating content for the child heath webpage and the Texas Department of State Health Services (DSHS) social media platforms.

MCH will lead HMGTX, a statewide network of partners working together to build strong, connected communities and healthy, resilient families. HMGTX promotes early identification of developmental concerns, then links children and families to community-based services. The focus of HMGTX in FY22 is to sustain the FY21 Cohort, implement the HMGTX Evaluation Plan, and improve the two-generation approach to model implementation. Lessons learned from the FY21 Cohort will be summarized in a case study and disseminated to local, state, and national stakeholders. This insight will inform MCH's plan to conduct a Request for Application (RFA) process in FY22 to support HMGTX's six local affiliates in scaling HMG Model implementation, leading to an increased evidence-base for implementation in Texas. In addition to lessons learned, MCH will begin intentional integration of a two-generation approach to address child health in the context of the family and caregivers. Collaborating with maternal and family health partners will allow MCH to position HMGTX as a holistic system that can be more agile in addressing child health. Also, HMGTX participated in the FY21 Harvard School of Public Health (HSPH) Practicum Program, which matched MCH with two practicum students who designed an evaluation plan for the initiative. MCH will finalize and begin implementing the evaluation plan. By implementing the evaluation plan, MCH will assess the value and impact of HMGTX and use the information collected to improve the system. In FY22, MCH will continue to provide technical assistance and guidance to local affiliates that support implementation of the HMG Model to fidelity. Activities will be based on the needs of the local affiliates and may include logic modeling and strategic planning, community readiness assessments, environmental scans, network and system mapping, and data management and system guidance. As MCH continues to scale HMGTX, MCH will explore opportunities for cross-domain integration to support a variety of NPMs outside of the Child Health domain. MCH will also continue to enhance family engagement and reduce health disparities in the statewide system. Leading HMGTX will increase MCH's ability to reduce duplication in work and provide comprehensive and continuous support to MCH populations.

MCH will facilitate the DSW with the purpose of increasing developmental screenings and enhancing quality service referral mechanisms statewide. The DSW will continue to meet every other month in FY22. The cross-sector participants will provide agency- and region-specific expertise on trends and initiatives related to screening and surveillance efforts. In these bimonthly meetings, DSW members will participate in identifying relevant initiatives to partner with, disseminating screening resources to providers and families, and generating standard language and definitions across sectors and applicable data sets where possible. In FY21, the DSW began exploring opportunities for creating a statewide hub to house developmental screening data. The DSW will continue exploring this effort through identifying potential platforms and generating recommendations for implementation in FY22. This work supports the state's capacity to host and manage a screening repository for organizations that do not have a database to store screening results. A central hub would allow for easier generation of reports, timely data analysis, sharing screening results across community settings, and enhancing the opportunity for referrals. Work conducted by the DSW can be used to inform other projects such as HMGTX, LTSAE, and others.

MCH will also lead efforts supporting the Centers for Disease Control and Prevention's (CDC) LTSAE program. The program aims to improve early identification of children with developmental delays and disabilities, so children and families can get the services and support they need. A component of LTSAE is the Act Early Ambassador program. The State Child Health Coordinator is one of two Act Early Ambassadors for Texas. Act Early Ambassadors collaborate with early childhood programs in their states to advance developmental monitoring and support screening. The primary avenue for this is contributing to the CDC's health education campaign. The campaign increases awareness of developmental milestones through the dissemination of free checklists, children's books, a mobile app, and other resources. MCH will continue to collaborate with Texas' second ambassador to increase the reach of the campaign and engage with stakeholders interested in integrating LTSAE into their programs. Additionally, the Texas Deputy Ambassador (DA) program will be sustained in FY22. DAs assist the Texas' Act Early Ambassadors in integrating LTSAE materials in programs across the state. The program is application based, with DAs committed to serving on behalf of their agency or program for at least one year. Participants will receive access to professional development opportunities, networking with other DAs, and access to free materials for distribution by the organization. MCH intends to expand the DA program to include additional partners and recruit a Family Leader. Each HMGTX local affiliate has also agreed to participate in the DA program. By integrating LTSAE into HMGTX and Title V, MCH expects to increase the proportion of young children with developmental delays who are screened, evaluated, and enrolled in early intervention services in a timely manner.

MCH will continue to maintain a webpage devoted to child health in Texas. The webpage includes content about child health programs, stakeholder resources, and information relevant to each NPM. In addition, MCH will disseminate information through social media and newsletter distribution lists. By conducting communications activities, MCH expects to increase awareness and knowledge of various child health topics and related MCH programs.

In FY22, MCH will fund several efforts throughout Texas aimed to improve the state's developmental screening capacity, including expanding HMGTX efforts, the Healthy Child Care Texas (HCCT) grant program, the Pediatric Brain Health Initiative (PBHI), and *A Parent's Guide to Raising Healthy, Happy Children* design and distribution.

In conjunction with HMGTX, MCH will continue to fund two contracts for early childhood systems development in FY22. The first contract is with My Health, My Resources of Tarrant County (MHMR), the first implementer of the Help Me Grow model in Texas. Successful implementation of the HMG System Model requires MHMR to identify existing resources, think creatively for maximizing existing opportunities, and sustain a coalition to work toward a shared agenda. With Title V funds, MHMR aims to stabilize their system through continuous quality improvement and replicate their systems development success in 12 surrounding rural counties. MHMR also serves as a mentor to the HMGTX network by providing expertise in community coalition development, central intake and referral system implementation, capacity planning, and other activities that support core component implementation. A mentor and

replication site allows MCH to enhance the state's capacity to dynamically support HMGTX communities while DSHS completes infrastructure building.

The second contract is with the Texas Institute for Excellence in Mental Health (TIEMH) for Project Thrive. Project Thrive will conduct an analysis of HMGTX, MHMR, and similar systems building activities in Texas, with the goal of developing an implementation guide for the expansion of community-based early childhood systems. TIEMH will conduct a landscape analysis of existing early childhood programs, fiscal mapping of funding structures and opportunities, and build capacity in a cohort of communities working towards a comprehensive early childhood system. For local capacity building, TIEMH will conduct a readiness assessment and provide training to enhance capacity for implementation of an early childhood system, support the development or enhancement of an early childhood wellness council, and provide technical assistance to identify funding sources for systems development. By exploring systems-building efforts that are alternatives to HMGTX, MCH enhances the state's capacity to be flexible in meeting the needs of various communities throughout Texas.

Lessons learned from MHMR's and TIEMH's experience, in addition to those from HMGTX local affiliates, will be collected throughout FY22 for incorporation into HMGTX's FY23 action plan.

MCH will continue to fund the HCCT grant in FY22. The HCCT program is implemented by the Texas Association for the Education of Young Children (TXAEYC). HCCT is a state initiative dedicated to promoting optimal health, safety, nutrition, and development for children in out-of-home child care programs. The primary mechanism for accomplishing this is by training and deploying Child Care Health Consultants (CCHC). CCHCs are certified professionals trained to work with early childhood education programs. TXAEYC trains CCHCs to provide technical assistance and consultation to child care directors and educators to improve the quality of the care and learning children experience. TXAEYC will also conduct the fourth year of the HCCT-Social Emotional Development (HCCT-SED) project. HCCT-SED supports early learning programs in implementation of developmental screening practices for children enrolled in care. This project strengthens Texas' child care workforce's capacity to raise parents' awareness of their child's development, making it easier to expect and celebrate developmental milestones. Fifty child care centers will be selected and matched with a CCHC who will assist the site with developmental screening implementation. A contingency plan will be proposed at the start of FY22 if activity alterations are required due to the continuation of COVID-19. Plans will likely include virtual trainings and site visits, electronic administration of developmental screening tools, and extensions for completing certification. Lessons learned from the FY20 and FY21 implementation of the HCCT-SED regional pilots will inform the FY22 pilot. MCH anticipates an increase in the number of children screened and the number of screenings conducted.

MCH will also fund the PBHI. This is a two-part contract with The University of Texas Health Science Center at Tyler (UTHSCT), inclusive of an annual Pediatric Brain Health Summit (PBHS) and creation of *Building Stronger Brains* curriculum for a community health worker (CHW) training. PBHS is a multi-sector, multi-agency collaboration focused on convening experts of the prenatal to age three developmental window. The purpose of the PBHS is to bring together community-based organizations and health care professionals to discuss and learn about strategies for promoting pediatric brain health. The PBHS is a collaboration between the Texas Department of Family and Protective Services (DFPS), DSHS, Episcopal Health Foundation, the St. David's Foundation, Casey Family Programs, The University of Texas System, and UTHSCT. The FY22 PBHS is projected to occur in January 2022. The theme is expected to focus on the application of science and theory in medical practice. In FY22, DSHS staff will continue to contribute to the planning and execution of the summit.

Simultaneously, the PBHI will continue supporting the dissemination and enhancements of the *Building Strong Brains* CHW curriculum. For CHWs in Texas, there is no CHW curriculum focused on child development in the birth

to age three range. DSHS aims to provide high-quality training to use the strength of Texas' CHW workforce to promote positive parenting and early brain development. The training will align with the framing of development work and with the core competencies of CHWs. Existing brain health materials will be translated into Spanish, including the Brain Architecture Game, early brain health infographics from UTHSCT and DFPS, executive functioning games for parents by the Harvard Center for the Developing Child, LTSAE messaging, and select Core Brain Health Certification modules that will be useful for training and guiding language to be used with families. UTHSCT will work with The University of Houston Honor College for CHWs to take the information from the above resources to build a CHW curriculum focused on promoting early childhood brain development. This curriculum will aim to capture the core concepts of early brain development and provide CHWs with practical actions they can take with families. UTHSCT will use components of the CHW curriculum for online videos and modules. These digital resources will be available for use by other community partners.

MCH will continue to fund the dissemination of *A Parent's Guide to Raising Healthy, Happy Children* (Guide) to promote the use of regular developmental monitoring and screening, among other critical health behaviors impacting early childhood. The Guide is legislatively mandated to be distributed by health care professionals who provide prenatal care or deliver an infant to a woman who is enrolled in Medicaid. Descriptions and contact information of related services and resources are also included. Revisions to the Guide were initially planned for FY21. However, MCH decided to postpone the editing process until after the conclusion of the Texas Legislative Session to incorporate potential additional legislative requirements. The FY22 revision process will include a comprehensive review of content, vetting proposed edits, and coordinating with the vendor on production of a new booklet printing template.

In FY22, MCH will partner with other organizations and agencies to address NPM 6, including participating on the Interagency Early Childhood Team (IAECT) and Early Childhood Systems Integration Group (ECSIG).

MCH will partner with the IAECT, formerly known as the Interagency Workgroup. IAECT is a collaboration of early childhood agency directors working to implement the Texas Early Learning Strategic Plan. The team includes representatives from DSHS MCH, DFPS, Health and Human Services Commission (HHSC), Texas Education Agency (TEA), and Texas Workforce Commission (TWC). MCH will continue to participate in meetings every other week. In response to COVID-19, the IAECT supported the Child Care Taskforce to assist in providing health and safety information. If needed, support of the Taskforce will continue in FY22.

MCH will also continue partnering with the DFPS-led ECSIG. ECSIG is a collaboration of Texas state agencies working together to identify, coordinate, and implement cross-sector initiatives for young children. Membership includes staff from MCH, DFPS, TEA, HHSC, TWC, Texas Head Start, and the Office of the Attorney General. The ECSIG will continue identifying opportunities to further its three priorities: children are healthy, children are safe, and children are school-ready. The workgroup collectively tracks metrics using a dashboard based on Results-Based Accountability. MCH will continue to provide DSHS-owned data, and epidemiological and subject matter expertise. By participating in the ECSIG, MCH will ensure health is a key topic in early childhood work.

In FY22, MCH will support initiatives aimed at improving the state's capacity to improve NPM 6, including the Texas Early Learning Council (TELC), Texas Prenatal-to-Three (PN-3) Collaborative, Children and Youth Behavioral Health Subcommittee (CYBHS), Early Childhood Intervention (ECI) Advisory Committee, and the Texas Health Steps' Online Provider Education (THS-OPE) program.

The Title V Children with Special Health Care Needs Director will represent DSHS on the TELC, the state's advisory council as required by the federal Improving Head Start for School Readiness Act of 2007. The goal of the TELC is to improve the quality of and access to early childhood services across Texas. The TELC is comprised of cross-

sector stakeholders who work to increase coordination and collaboration across state agencies and local entities. In FY22, the council will continue assessing the impact of COVID 19 on Texas' early childhood services and identifying solutions.

MCH will support the Texas PN-3 Collaborative, a state-level Pritzker grantee. The collaborative is led by three Texas child advocacy organizations working with advocacy allies, policymakers, philanthropists, and state and community leaders. The goal of the PN-3 Collaborative is to develop policy solutions that support families and children during the first three years of life. The PN-3 Collaborative has the support of over 110 partner organizations throughout Texas focusing on three key areas: increasing the quality of and access to prenatal and postpartum health services; increasing the number of low-income infants and toddlers who are screened and successfully connected to services; and increasing access to high-quality child care programs. A key goal of the PN-3 Collaborative is the expansion of a "universal connection" system to assess, screen, and refer families to support services in the postpartum period and early childhood years. MCH will support these efforts through HMGTX, LTSAE, DSW, and related work conducted by MCH contractors to ensure alignment and collective impact.

MCH will represent DSHS on the CYBHS, a subgroup of the Behavioral Health Advisory Committee (BHAC). The BHAC serves as the primary advisory voice to HHSC for issues related to mental health and substance use. The CYBHS provides recommendations on children and youth behavioral health topics and serves as the advisory body for the Texas System of Care, a framework to provide a spectrum of accessible, responsive, and effective services and supports. During FY22, MCH will attend quarterly subcommittee meetings, provide subject matter expertise, and collaborate on cross-sector initiatives.

The Title V Director represents DSHS on the ECI Advisory Committee. The committee, as required by Part C of the Individuals with Disabilities Education Act, advises HHSC's Division for ECI Services on development and implementation of policies that constitute the state ECI system. In FY22, the director will attend quarterly meetings and provide subject matter expertise.

MCH will support THS-OPE, an award-winning online program offering free continuing education courses for primary care providers and other health professionals. The courses offer updated clinical, regulatory, and best practice guidelines for a range of preventive health, including developmental monitoring and screening. MCH staff will continue to provide subject matter expertise for updates to modules relevant to early childhood development. To increase the number of health professionals completing this course, MCH will also promote the module through the DSW, HMGTX, and other forums.

NPM 7: Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9.

The Title V FY20 Needs Assessment identified several statewide needs related to injury prevention. First, the top causes for child fatalities included preventable deaths such as accidental drowning and motor vehicle incidents. Additionally, Adverse Childhood Experiences (ACEs) was a top concern among focus group participants. ACEs are recognized as contributors to chronic disease, depressive disorders, and even early death. In Texas and nationwide, 2017-2018 National Survey of Children's Health (NSCH) data showed that almost 20% of children have experienced two or more adverse childhood experiences.

Another focus of injury prevention among parents and providers of children in Texas include bullying and its relation to child mental health. Focus group participants noted that bullying could lead to outcomes like school shootings and suicide. Mental health for children was also identified as one of the major needs in Texas through key informant interviews and focus groups. Participants expressed concern over the lack of mental health resources and

addressed the need for mental health resources geared specifically towards children.

In FY22, MCH will lead several initiatives aimed to reduce the rate of hospitalization for non-fatal injuries in children ages zero to nine years, primarily through MCH Public Health Region (PHR) staff. PHR staff will support initiatives related to child maltreatment prevention, child passenger safety seat (CPSS) distribution and inspections, water safety, bike safety, and local Child Fatality Review Teams (CFRT).

MCH's PHR staff will provide education to parents and caregivers of infants on the dangers of Shaken Baby Syndrome/Abusive Head Trauma (SBS/AHT). SBS/AHT is a term used to describe the variety of signs and symptoms resulting from shaking or impacting of the health of an infant or small child. Violent shaking for just a few seconds has the potential to cause severe injuries. PHR staff will implement the Period of PURPLE Crying (POPC) program, an evidence-based SBS/AHT prevention program. Staff in PHR 1 will provide the nine rural birthing hospitals with POPC educational materials for distribution to new parents. These staff will also provide POPC education during infant CPSS checks and for those who access immunization services in the DSHS field office. In PHR 7, staff will provide SBS/AHT prevention education in conjunction with Safe Sleep training to local pregnancy centers, child care centers, and other agencies serving infants. The training will include a baby simulator and accompanying curriculum from Reality Works, and a video promoted by the Shaken Baby Alliance. PHR staff anticipate an increase in the number of stakeholders trained on SBS/AHT.

PHR staff will provide education and promote awareness about effective use of CPSS. Staff in PHR 2/3, 7, 8, 9/10, and 11 will partner with Safe Riders, a child occupant safety program sponsored by DSHS Office of Injury Prevention (OIP) in cooperation with the Texas Department of Transportation. Safe Riders operates a statewide CPSS distribution and education program with the goal of reducing the number of motor vehicle crash injuries and fatalities to children in Texas who are unrestrained. The distribution portion of Safe Riders targets families with low-income status who may be unable to afford a CPSS. Staff will recruit health care providers and community organizations to become Safe Riders distribution sites. PHRs will also provide technical assistance on the implementation of CPSS initiatives. To improve the correct use of CPSS, PHR staff will work with local Certified Passenger Safety Technicians (CPST) to conduct monthly educational events at DSHS clinics. Additionally, several PHRs will conduct presentations related to hyperthermia prevention during CPSS events. PHRs anticipate an increase in the number of Texans educated on CPSS installation and use.

PHR staff will provide education and promote awareness of water safety. Water safety education can help prevent drowning incidents among children when addressing multiple layers of the environment. PHR staff will conduct water safety education, lead life jacket initiatives, and facilitate awareness campaigns. PHR 4/5N and 7 will use the American Red Cross Longfellow's WHALE Tales. WHALE is an acronym for Water Habits Are Learned Early and is a water safety curriculum for children ages 5 through 12. Also, staff will promote the use of life jackets as a core component of water and boating safety. Staff will distribute life jackets to community pools and apartment complexes, marinas, and camps. PHR 11 will distribute water safety kits to local partners who have received water safety education.

PHR staff will conduct bicycle safety outreach projects and pedestrian safety. Such projects include bike rodeos and bicycle helmet giveaway programs. A bike rodeo is an event that teaches participants the primary bicycle handling skills and traffic concepts that will help them to avoid the most common types of crashes and accidents. PHR staff anticipate an increase in the number of bike rodeos conducted and number of helmets provided during giveaway programs.

In conjunction with PHR efforts, the Office of Injury Prevention (OIP) will lead efforts to reduce the rate of child injury in Texas. The mission of OIP is to improve the health of Texans by reducing morbidity and mortality resulting from

unintentional and intentional injuries.

The goal of the State Child Fatality Review Team Committee (SCFRT) is to provide review team coverage for all 254 Texas counties and increase the percentage of child deaths reviewed. According to Texas' 2020 CFRT Report, local and regional CFRTs cover 211 of the 254 Texas counties resulting in 94% of Texas children residing in a county where child deaths are reviewed. MCH will continue to focus on establishing coverage in all of Texas' 254 counties by review teams and increasing the percentage of deaths reviewed. In FY22, the short-term goal will be to add or re-instate five more counties involved in CFRT activities.

MCH will continue to provide technical assistance to local CFRTs to increase quality and quantity of reviewed deaths and will work to determine COVID-19 impact on local team operations by conducting a survey and will assist local teams as needed to reinstate local child fatality review. To streamline the steps in death review facilitation, MCH will create one technical assistance training webinar related to electronic death certificate distribution to local CFRTs, child death review processes, and death review data entry in FY22. Continuing education opportunities for local CFRTs will focus on improving the review process in communities and addressing preventable deaths in Texas. PHR staff will assist in the maintenance, reactivation, and establishment of local CFRTs. Staff will also plan and implement prevention events and activities with CFRTs, attend local meetings, and provide subject matter expertise.

In FY22, MCH will fund several initiatives addressing NPM 7, including the distribution of *A Parent's Guide to Raising Healthy, Happy Children* and the HCCT grant.

MCH will continue to fund the dissemination of *A Parent's Guide to Raising Healthy, Happy Children*. The Guide promotes safety measures such as safe sleep practices, child car seat safety, and safe sibling interactions, among other critical health behaviors impacting early childhood. By producing and disseminating the Guide, MCH aims to provide valuable information for Texans starting their journey as a new parent. Further information about the Guide can be found in NPM 6.

MCH will fund the certification and training of CCHCs through the HCCT grant program. CCHCs provide health and safety assessments to out-of-home child care facilities in Texas. Most young children are enrolled in out-of-home child care programs. CCHCs help facility directors evaluate child care settings to assure the health and safety of the children in their care, then provide TA to improve any areas of concern. MCH anticipates an increase in the number of children attending a CCHC-assessed child care facility. Further information about HCCT can be found in NPM 6.

The Medical Child Abuse Resources and Education System (MedCARES) Grant Program will end in FY22. MCH will conduct contract closeout procedures and collaborate with OIP to identify supplemental injury prevention activities.

In FY22, MCH will support initiatives aimed at preventing childhood injury, including the CYBHS, THS-OPE, and the *Friday Beat* e-newsletter.

MCH will serve on the CYBHS as it relates to childhood injury prevention, particularly in preventive mental and behavioral health strategies. The CYBHS provides recommendations to the Texas System of Care, an HHSC framework to provide a spectrum of accessible, responsive, and effective services and supports. The implementation of the system of care framework has resulted in decreased suicide attempts, improved child functioning, and increased school attendance. MCH will provide subject matter expertise related to community-based service systems, care coordination, and family-driven and youth-centered approaches. Further information about the CYBHS can be found in NPM 6.

MCH will support THS-OPE, an award-winning online program offering free continuing education courses for primary care providers and other health professionals. MCH staff will continue to provide subject matter expertise for updates to modules relevant to child injury prevention. MCH will also promote the modules through relevant forums. By promoting these modules, MCH expects to increase the number of health professionals completing injury prevention courses. Further information about THS-OPE can be found in NPM 6.

MCH will collaborate with the DSHS School Health program in the creation and dissemination of the *Friday Beat*, a weekly e-newsletter that is sent to over 7,900 school health stakeholders every Friday. The *Friday Beat* will continue to feature articles and resources related to injury prevention in each edition.

NPM 14: Percent of children, ages 0 through 17, who live in household where someone smokes.

The Behavioral Risk Factor Surveillance System indicates that the overall prevalence rate of current childhood asthma for ages 0-17 in Texas was 7.9% in 2015. Of children ages three to 17-years old, three to 11-year-olds have the highest exposure to secondhand smoke, with a disproportionately higher exposure among non-Hispanic Black children. Children with secondhand exposure experience increased frequency of ear infections, acute respiratory illnesses, lower respiratory tract infractions, sudden infant death syndrome, and severe asthma.

In FY22, MCH will lead several initiatives aimed to reduce child exposure to secondhand smoke, primarily through PHR activities. PHR staff will support initiatives related to school-based health education, partnering with local public housing authorities, and promoting the Texas Tobacco Quitline.

PHR staff will partner with local school districts and School Health Advisory Councils (SHAC) to promote evidence-based and evidence-informed educational programs for students on tobacco and vaping prevention and cessation. PHR staff will also partner with local public housing authorities and apartment complexes to educate staff and residents on comprehensive smoke-free policies and enforcement methods, as well as the dangers of secondhand smoke. Smoke-free policies are associated with an increase in tobacco use cessation and a decrease in tobacco use prevalence. Smoke-free policies that prohibit smoking fully protect nonsmokers from involuntary exposure to secondhand smoke indoors. Additionally, PHR staff will promote the Texas Tobacco Quitline to clients visiting field offices through tobacco use questions on client intake forms, displaying Quitline business cards on clinic reception desks, and providing referrals to the Quitline. PHR staff will partner with their Regional Tobacco Coordinators where available.

In FY22, MCH will fund the dissemination of *A Parent's Guide to Raising Healthy, Happy Children* (Guide). The Guide provides age-appropriate tips on how to keep a baby and toddler safe, such as creating a smoke-free environment. MCH will conduct revisions to the Guide during FY22. Revisions will include updates to tobacco cessation guidance and resources, as well as enhancing the section related to elimination of secondhand smoke in the home. DSHS Tobacco Prevention and Control Program (TPCP) will provide support during the revision process. By producing and disseminating this Guide, MCH aims to provide valuable information for Texans starting their journey as a new parent. Further information about the Guide can be found in NPM 6.

In FY22, MCH will support initiatives focusing on secondhand smoke reduction and smoking cessation, including the Texas Asthma Control Collaborative (TACC), THS-OPE, and the *Friday Beat*.

MCH will support the TACC in implementing relevant activities identified in the DSHS Texas Asthma Control Program's strategic plan related to asthma education. A component of the strategic plan aims to reduce tobacco smoking among adults and child exposure to secondhand smoke using the CDC's EXHALE framework to support asthma control. MCH will continue attending quarterly TACC meetings, participate in quarterly TACC Asthma

Education Work Group meetings, and share TACC information with MCH stakeholders.

MCH will support the creation and dissemination of the *Friday Beat.* The *Friday Beat* will continue to feature articles and resources related to secondhand smoke and tobacco cessation. Further information about the *Friday Beat* can be found in NPM 7.

SPM 2: Reduce the prevalence of overweight and obesity in Texas children ages 2-21.

Based on body mass index calculations for second and fourth graders from the 2015-2016 Texas School Physical Activity and Nutrition (SPAN) data, DSHS estimates that about 40% of students are over the normal weight range for their height and about one out of four students are obese.

Child nutrition also emerged as a theme in both the key informant interviews and focus group conversations for the FY20 Title V Needs Assessment. Discussions included what children were eating at school and home, nutrition education for children, food security concerns, and nutritional resources available to children. When looking at child nutrition as a need, the focus was mostly on addressing food insecurity and increasing education and awareness about nutrition.

Based on 2015-2016 Texas SPAN data, it is estimated that only 22% of second grade students, and only 9% of fourth grade students are meeting this recommendation.

In FY22, MCH will lead several initiatives addressing SPM 2, including a nutrition toolkit initiative, awareness and education activities, and supporting implementation of several MCH contracts.

MCH will implement the nutrition toolkit initiative. This initiative continues the FY21 work of the Children's Health Weight Collaborative Improvement and Innovative Network cohort and the MCH Workforce Development Center's 2020 Cohort program. The nutrition toolkit was designed and created by MCH staff for use by PHRs. MCH will partner with the DSHS Obesity Prevention Program and other health promotion subject matter experts. In FY22, MCH will explore and identify expansion opportunities specific to the child health domain. MCH anticipates the nutrition toolkit will enhance the Title V workforce's awareness and understanding of nutrition-based needs and resources for the child population.

PHR staff will participate in obesity prevention coalitions and provide subject matter expertise. Staff will also partner with local SHACs to provide technical assistance on implementation of evidence-based school health programs such as Coordinated Approaches to Child Health, 5-2-1-0 Healthy Children, and Learn, Grow, Eat, Go!. To further support school health, PHR staff will support the implementation of TXSPAN by facilitating recruitment of school districts and schools to participate in data collection. Similarly, staff will promote physical activity and nutrition in child care through the HCCT grant program. Finally, PHR staff will promote obesity prevention resources, such as THS-OPE modules and WIC services, to field office clients. MCH PHRs anticipate these activities will increase awareness and knowledge of nutrition-based needs and resources for the child population.

In FY22, MCH will fund several efforts to reduce the prevalence of childhood overweight and obesity, including the HCCT grant program, the Texas School Physical Activity and Nutrition (TXSPAN) project, and *A Parent's Guide to Raising Healthy, Happy Children* design and distribution.

MCH, in partnership with DSHS's Obesity Prevention Program, will continue to oversee the HCCT grant to address obesity in child care settings. Three components of HCCT support this effort. First, CCHCs will complete online

training modules related to obesity. CCHCs will also provide technical assistance and consultation to child care directors and educators on best practices and improvements that facilitate healthy behaviors and provide education on Texas' child care quality rating system standards regarding health eating and active living. Second, the Texas Healthy Building Blocks project is designed to recognize early childhood education facilities that demonstrate a commitment to children's lifelong health. Third, the HCCT grant will continue to fund the Outdoor Learning Environment (OLE!), a statewide initiative which promotes healthful, nature-based outdoor spaces at early child care programs. A healthful outdoor environment helps preschool children be more physically active while they play. The initiative is based on the Preventing Obesity by Design model which is associated with a reduction in sedentary behavior among preschools.

MCH will continue to fund the University of Texas Health Science Center at Houston School of Public Health in Austin (UTHealth) TXSPAN project in FY22. TXSPAN is a statewide surveillance system that monitors trends in body mass index and health behaviors of children in 2nd, 4th, 8th, and 11th grades. Data collection typically occurs every four to five years. Due to the COVID-19 pandemic, data collection in FY20 and FY21 were cancelled. TXSPAN plans to enter schools for data collection beginning in FY22 with the option to extend into FY23 for schools that will not allow research on their campuses due to the pandemic. Data collected during this project will be used to update and create additional Child Health Status Reports, which are one-pagers used to educate policymakers on the importance of child health in Texas. Additionally, trends identified by TXSPAN will inform future Title V Needs Assessments and obesity prevention activities.

MCH will fund the dissemination of *A Parent's Guide to Raising Healthy, Happy Children* (Guide). The Guide provides age-appropriate tips on healthful nutrition behaviors and feeding best practices. MCH will conduct revisions to the Guide during FY22 and include any relevant updates to child nutrition advice and guidelines. By producing and disseminating this Guide, MCH aims to provide valuable information for Texans starting their journey as a new parent. Further information about the Guide can be found in
NPM 6.

In FY22, MCH will support prevention efforts, including the Early Childhood Obesity Prevention Committee (ECOPC), THS-OPE, and the *Friday Beat*.

MCH will serve on the ECOPC, a multi-sector collaboration to improve the weight status and relevant health behaviors of children throughout Texas. The committee focuses on intervention at numerous levels of the socio-ecological model, including policy, community, infrastructure, and workforce development. By addressing obesity prevention from multiple levels, Texas will make the healthier choices the easier choices. MCH will provide subject matter expertise to the community- and infrastructure-level work groups.

MCH will provide subject matter expertise for modules relevant to childhood obesity prevention and education for THS-OPE. MCH will also promote the modules through relevant forums. By promoting these modules, MCH expects to increase the number of health professionals completing obesity prevention courses. Further information about THS-OPE can be found in NPM 6.

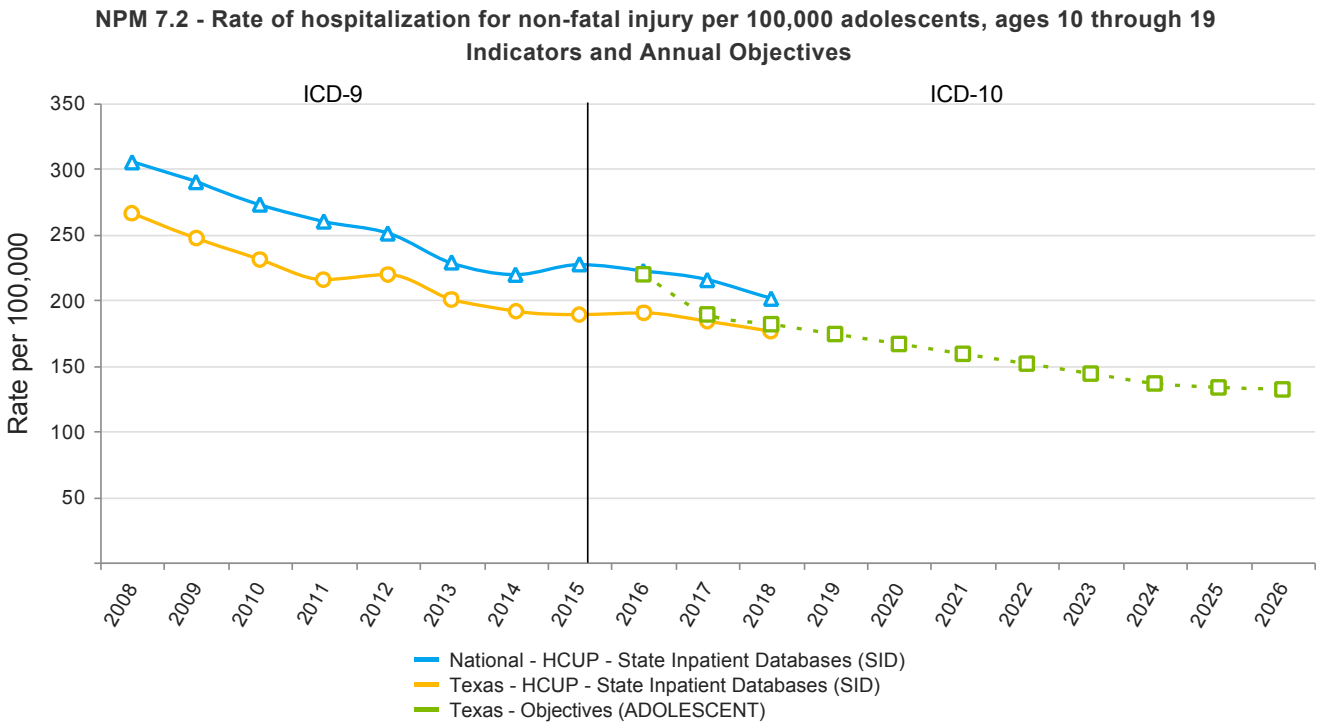
MCH will support the creation and dissemination of the *Friday Beat.* The *Friday Beat* will feature articles and resources related to obesity prevention and education. Further information about the *Friday Beat* can be found in NPM 7.

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2019	17.9	NPM 7.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	34.4	NPM 7.2
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	12.9	NPM 7.2
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	12.3	NPM 7.2

National Performance Measures



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	219.3	188.9	181.4	173.9	166.4
Annual Indicator	194.7	188.8	190.6	184.1	176.0
Numerator	7,599	5,595	7,624	7,492	7,256
Denominator	3,902,181	2,963,378	3,999,650	4,069,972	4,123,762
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	158.9	151.4	143.9	136.4	133.4	131.9

Evidence-Based or –Informed Strategy Measures

ESM 7.2.1 - Number of Texas Health Steps Online Provider Education (OPE) users completing injury prevention modules.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		12,893	13,538	26,276	27,589
Annual Indicator	12,279	18,514	25,025	29,139	28,948
Numerator					
Denominator					
Data Source	Texas Health Steps Online Provider Education (OPE)	Texas Health Steps Online Provider Education (OPE)	Texas Health Steps Online Provider Education (OPE)	Texas Health Steps Online Provider Education (OPE)	Texas Health Steps Online Provider Education (OPE)
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	28,968.0	30,416.0	31,936.0	33,532.0	35,209.0	36,969.0

ESM 7.2.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		68	70	70	79
Annual Indicator	0	78.9	78.9	76.3	76.3
Numerator			1,605	997,819	997,819
Denominator			2,035	1,307,757	1,307,757
Data Source	YRBS	Texas YRBS	Texas YRBS	Texas YRBS	Texas YRBS
Data Source Year	2016	2017	2017	2019	2019
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	79.5	79.5	80.0	80.0	80.5	80.5

State Performance Measures

SPM 2 - Percent of overweight and obesity in Texas children ages 2-21.

Measure Status:	Active				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		27.8	27.1	26.4	40.2
Annual Indicator	28.5	28	28	40.7	40.7
Numerator	113,597	88,319	88,319	139,579	139,579
Denominator	398,359	315,808	315,808	343,339	343,339
Data Source	Texas WIC client data	2017 Texas WIC Client data	2017 Texas WIC Client data	Texas SPAN	Texas SPAN
Data Source Year	2016	2017	2017	2015-2016	2015-2016
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	40.2	39.8	39.4	39.0	38.6	38.2

State Action Plan Table

State Action Plan Table (Texas) - Adolescent Health - Entry 1	
Priority Need	
Promote safe, stable, nurturing environments to reduce violence and the risk of injury.	
NPM	
NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19	
Objectives	
By 2025, increase the number of programs utilizing positive youth development in their programs by 55 organizations. (FY20 TYAN Baseline= 9 Community Partners)	
By 2025, decrease the rate of emergency room visits among children ages 0-19 years by 5% (Baseline willl be established).	
By 2025, increase the number of CFRT, educators and providers that are provided adolescent injury education, support and community resources from baseline by two percentage points. (Baseline will be established.)	
Strategies	
Strategy 1: Assess and monitor injury prevention data and trends, factors that impact injury prevention, and community needs and assets for reducing injuries among youth and young adults.	
Strategy 2: Lead and fund efforts to strengthen, support, and mobilize organizations' capacity to build youth-adult partnerships and integrate youth voices in decision-making.	
Strategy 3: Support providers, state and community partners, and regional staff's injury prevention efforts by providing injury prevention information, trainings, and resources such as the Texas Health Steps Online Provider Education and supporting efforts in the Public Health Regions.	
Strategy 4: Lead and partner on the development, promotion, and dissemination of educational materials, communications, and programmatic activities that effectively inform and educate Texans about injury prevention, factors that influence it, and how to reduce injuries among youth and young adults.	
Strategy 5: Improve and innovate injury prevention efforts through ongoing evaluation, research, and continuous quality improvement of implementation efforts to reduce injury.	
ESMs	**Status**
ESM 7.2.1 - Number of Texas Health Steps Online Provider Education (OPE) users completing injury prevention modules.	Active
ESM 7.2.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19	Active

NOMs

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

State Action Plan Table (Texas) - Adolescent Health - Entry 2

Priority Need

Improve nutrition across the life course.

SPM

SPM 2 - Percent of overweight and obesity in Texas children ages 2-21.

Objectives

By 2025, decrease the percent of adolescents in 11th grade with a BMI in the overweight or obese range from 42.1% to 41.5% (SPAN 2019 – 2020).

Strategies

Strategy 1: Assess needs, gaps, and opportunities to strengthen systems and expand initiatives to increase awareness of overweight and obesity in youth and young adults.

Strategy 2: Lead the development and dissemination of health information and resources about best practices to promote healthy behaviors across the life course related to improved nutrition and obesity prevention.

Strategy 3: Fund the implementation of the Texas School Physical Activity and Nutrition surveillance project to identify state and regional trends in health status of youth and young adults in Texas.

Strategy 4: Lead, partner and support efforts to educate and build capacity among providers and health professionals to understand healthy weight status, promote healthy behaviors across the life course, and implement best practices in obesity prevention.

Strategy 5: Support the promotion of best practices to increase uptake of recommended nutrition and other health behaviors that reduce risk of and prevent overweight and obesity in youth and young adults.

NPM 7.2: Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19.

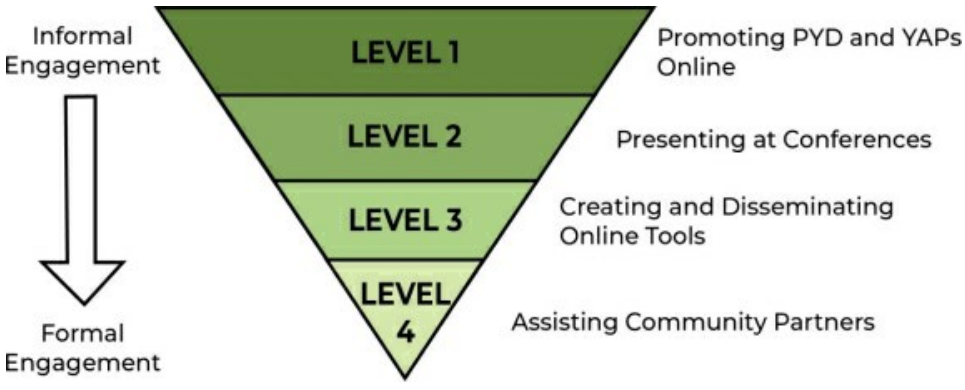
Unintentional injury is the leading cause of non-fatal injury among adolescents (youth ages 10 through 18 and young adults ages 19 through 24). Additionally, unintentional injury has been and continues to be the leading cause of death among youth and young adults, according to the Centers for Disease Control and Prevention (CDC) Web-based Injury Statistics Query and Reporting System (WISQARS) data on Texas. Unintentional injury accounts for 38.1% of all deaths among youth ages 10 through 14, 42.1% of all deaths among 15 through 19, and 48.7% of deaths among 20 through 24.

The foremost model of holistic prevention is positive youth development (PYD). Maternal and Child Health (MCH) focused on PYD to address the wellbeing of youth and young adults. Adults who recognize, use, and enhance young people's strengths can promote positive outcomes for young people by providing opportunities for engagement, fostering positive relationships, and furnishing the support needed to build on their personal strengths. Current literature supports PYD as a strategy to increase resilience against risky behaviors and injury, both intentional and unintentional. For example, the CDC (www.cdc.gov), Substance Abuse and Mental Health Services' (www.samhsa.gov) Center for Mental Health Services, The Community Guide (www.thecommunityguide.org), and Youth.gov (www.youth.gov) all promote PYD. Individuals who demonstrate the capacity to recover quickly in response to one form of adversity may not necessarily do so in response to another.

In fiscal year (FY)20, MCH continued to fund the Texas A&M University's Public Policy Research Institute to support the Texas Youth Action Network (TYAN). TYAN is tasked to develop a statewide support infrastructure to promote Youth-Adult Partnerships (YAPs) that connect youth and young adults (between the ages of 10 and 24) with caring adults. The program aims to support change within individuals and organizations to increase youth voice in planning and decision-making, while offering young people authentic experiences involving problem-solving, healthy experimentation, and risk-taking in collaboration with caring adults. TYAN aims to strengthen youth attachment, engagement, and sense of belonging, to promote resilient, healthy adolescents and adults.

The below Figure, TYAN Program Engagement Overview, shows TYAN's four main interventions offered to diverse constituencies. Internet-based resources (Level 1) provide the broadest-level meant to reach a general audience. Conference presentations (Level 2) are directed toward youth-serving professionals. Online tools (Level 3) offer advanced structured learning opportunities for individuals. The most intense level of support delivers customized training and technical assistance to organizations (Level 4) willing to undertake a two-year commitment as a TYAN Community Partner. Community Partners are organizations that formally join TYAN to create or expand YAPs in their community. TYAN provides training, technical assistance, and grant funding to these Community Partners to help them with YAPs in their community.

Figure: TYAN Program Engagement Overview



In FY20, TYAN staff interacted with 3,800 individuals interested in learning more about PYD and YAPs or becoming involved in the network through the four interventions. Interactions for each intervention level are:

- Level 1: Internet-based resources to 1,219 website users (doubled from FY19), 407 social media followers (more than double of FY19), and 602 email list subscribers (on par with FY19);
- Level 2: Conferences and Presentations through exhibiting and presenting to 302 individuals;
- Level 3: Online trainings with 323 unique enrollees (on par with FY19); and
- Level 4: Community Partner support to 192 adults (doubled since FY19) and 753 youth (five times the amount in FY19).

In FY20, there were 753 youth involved in YAPs through the Community Partners – a four-fold increase from FY19 and a twenty-fold increase from the baseline of 39 adolescents in FY15.

Each spring, Community Partners are asked to quantify and report on community linkages and partnerships they established over the past 12 months. Community Partners indicated their YAPs are integrated into the fabric of their communities. The reach of the Community Partners is categorized into three groups:

- **YAP Members** – Youth, adults, and organizations enrolled at any time as members. In FY20, the 28 Community Partners reported links to 753 youth, 192 adults, and 98 organizations as YAP Members.
- **Participants in YAP-Affected Programs and Services** – Participants in programs or services informed by input from the YAP (e.g., youth and adults in programs benefitting from YAP-informed integration of youth voice). In FY20, the Community Partners reported 31,907 youth and 20,413 adults participating in YAP-affected Programs and Services.
- **Total Contacts through YAPs** – Youth, adults, and organizations YAP reached out to for any reason and by any means (e.g., mail, email, texts, social media, radio/television, surveys, special events, program participants, meeting attendees, or other). The 28 Community Partners reported 37,498 youth, 21,975 adults, and 291 organizations contacted through Community Partner's YAPs for FY20.

The FY20 reported reach of TYAN Community Partners showed an impressive scope of impact by these organizations. Participation ranged from startup YAPs with no active members to well-established organizations with hundreds of members. Most of the partners had direct supporters that provided momentum to their work. Most of the partners also proactively sought input from adult influencers that could help youth understand and connect to needs and opportunities in the community. Many YAPs stated they helped youth express their thoughts to others in the programs and activities that affect them. Though YAPs came in all sizes, the overall scope of impact is quite large for many of these organizations, ranging into the thousands.

Effective YAPs have practices that provide youth opportunities to explore, take chances, safely learn from mistakes, and celebrate successes while being guided by caring, connected adults. In turn, youth have better resiliency-related positive youth development outcomes in areas like self-confidence, life skills, and core values and they are prepared to make better choices at all stages of life. TYAN collected evaluation data between March 1 and August 31, 2020 to measure these processes and outcomes. Demographic attributes of the YAP members that responded are displayed in the table below.

Table: Demographic Attributes of TYAN Community Partners' YAP Members, reported between March 1 - August 31, 2020, n=200

Demographic Attributes	Adults* (n=99, 49%)	Young Adults** (n=17, 9%)	Minors*** (n=84, 42%)
Gender			
Female	67 (67%)	14 (82%)	45 (54%)
Male	31 (32%)	3 (18%)	39 (46%)
Other	1 (1%)	-	-
Race/Ethnicity			
Black/African American	37 (37%)	2 (12%)	22 (26%)
Hispanic/Latinx	17 (17%)	8 (47%)	14 (17%)
Asian	7 (7%)	3 (18%)	28 (33%)
White	25 (25%)	1 (6%)	8 (10%)
Multi-ethnic	6 (6%)	3 (18%)	11 (13%)
Other	2 (2%)	-	-
Unknown	5 (5 %)	-	1 (1%)

*Adults were members over the age of 25 years. More than 40% of adult members were YAP staff, another 28% were volunteers, and the rest were either community organization representatives (21%) or other (7%).
**Young adults are members between the ages of 18-24 years.
***Minors are members under the age of 18 years. Youth and young adults were primarily YAP members (91%) and the rest (9%) hold positions as staff, volunteers, or community organization representatives within the YAP.

To assess the extent to which TYAN Community Partners were achieving the intended outcomes of the PYD framework, TYAN evaluated three constructs - Positive Core Values, Positive Life Choices, and Sense of Self. YAP members were asked to report on PYD-related behaviors before and after joining the YAP. Comparison of baseline scores showed:

- In terms of Positive Core Values: Some youth already engaged in assessed behaviors before joining the YAP. Nonetheless, youth reported small but meaningful advances in every area examined. The greatest growth (23% increase) was in their interest in community and world problems, indicating growing awareness and consideration of matters outside of themselves. Progress was also measured in caring for other people including greater sensitivity to their feelings and treatment. Youth expressed increased personal accountability in a number of ways such as taking a stand or telling the truth. Young people said they take more responsibility for their actions since joining the YAP. Overall, the Positive Core Values Scale score increased 12% indicating a statistically significant difference in “before” and “now” scores.
- Regarding Positive Life Choices: Young respondents were significantly more likely to say “no” to things they know are wrong, and to stay out of trouble generally. Scores rose 8% indicating a desirable shift toward improved decision-making capacity.
- For the Sense of Self scale: The greatest advance occurred in youth’s belief that they could make a difference (29% increase), though other measures of confidence – ability to handle whatever comes along and to learn new things – also grew. In addition to greater control over things that might happen, youth reported more positive feelings about themselves and their future. The overall Sense of Self scale increased 14%.

TYAN-assisted YAPs achieved many important milestones through the YAP model. In genuine partnerships with adults, they learned critical life skills needed to establish a solid foundation for the future. Stronger core values, better decision-making skills, and increased self-esteem, self-confidence, and self-efficacy gained through partnerships with adults which seemed to make youth more resilient, thereby informally validating the YAP model.

MCH staff leveraged collaboration with Public Health Region (PHR) staff throughout Texas to connect TYAN to community organizations. Additionally, in FY20, MCH and TYAN identified a project to create a “training library” for PHRs on all topics related to adolescent health. Due to COVID-19, TYAN postponed the project, but efforts will resume in FY21.

MCH participated in the National Network of State Adolescent Health Coordinators (NNSAHC) throughout FY20 to remain abreast of nationwide efforts in adolescent health. NNSAHC provides a space for collaboration and sharing of evidence-based practices and tips on any barriers or successes faced, as well as sharing strategies to connect adolescents, families, and public health professionals to PYD programs. Participation included attending a biennial orientation for new State Adolescent Health Coordinators, NNSAHC meetings, HRSA Region 6 NNSAHC meetings, and COVID-19 topic-specific meetings in the second half of FY20. MCH shared appropriate and relevant information with TYAN staff and was able to brainstorm additional efforts to connect Texans to PYD programs amidst the pandemic.

TYAN offers two tools to allow individuals and organizations interested to learn more about PYD and youth engagement. The first tool, the Organizational Readiness Assessment for Youth- Adult Partnerships (ORAYAP), is an assessment tool, designed for youth-serving professionals to rate their organization's capacity to engage young people. The content covers seven key capacity areas essential to building and sustaining youth-adult partnerships. These include: 1) Youth-Friendly Environment, 2) Youth Empowerment, 3) Organizational Culture, 4) Evaluation & Qualitative Management, 5) Diversity, 6) Caring Adults & Mentors, and 7) Community Connectedness. When completing the instrument, organization representatives (frontline youth workers, administrators, teachers, etc.) review youth engagement policies and practices in each of these areas, then rate whether their organization has "not started," "somewhat met," or "fully met," each standard.

Between September 2019 and February 2020, 107 individuals completed the ORAYAP. Fifty-five percent of responders worked at organizations in Texas; 31.7% outside of Texas; and 13.1% were unknown. A majority of the responders were geographically from DSHS PHR 11, represented non-profits, and worked with youth 10 through 13 years old. The average total ORAYAP score was 75.2 out of 114 points.

The second tool offered by TYAN is the Youth Development Training Series (YDTS), an online curriculum devoted to the philosophies of PYD and youth engagement. As a series of modules, the YDTS allows individuals to complete a module by itself or the whole series to earn a certificate of completion.

The YDTS is offered at no-cost through the Texas A&M University continuing education as a series of online modules. Over 1,100 individuals were enrolled in the modules as of the end of FY20, however students may, and often do, enroll in multiple modules. Around 62% were unique students, representing 685 students since the launch of YDTS. Approximately 320 unique students enrolled in the YDTS modules during FY20. The most popular module was Diversity and Cultural Competency followed by Youth Development Approach.

The process of creating a third tool – the adolescent health dashboard – started in FY20. This dashboard intends to compile all publicly available data on adolescent health in Texas for users to query. With input from the PHRs and Community Partners, TYAN identified various publicly available data sources on adolescent health including:

- Texas School Survey of Drug and Alcohol;
- Youth Risk Behavior Surveillance System; and
- Robert Wood Johnson Foundation.

The result will be a publicly available tool that will showcase data at the county, regional and state level. The tool is not finalized, and development will continue in FY21.

In FY20, TYAN made great progress in refining the recruitment process. By using a trial-and-error approach, TYAN was able to better identify what works and what may create barriers, which has helped to pinpoint the most efficient recruitment strategies. Conference exhibiting, networking, and referrals were the main sources for Community Partners leads in FY20, but TYAN staff began having success making connections through social media. TYAN registered to exhibit at five conferences focused on topics such as health and public health, youth networking and programming, teen pregnancy prevention, and adolescent mental health. Three were held in person, where TYAN staff tabled in exhibit halls, one was canceled, and one was switched to a virtual format. Tabling allowed for the opportunity to talk with prospective leads face-to-face, hand out branded materials and "swag", and provide a sign-up sheet to join the TYAN mailing list. Networking through social media showed promise as a strong recruitment strategy. TYAN began using this strategy in June 2020 and gained two Community Partner commitments by August as a result.

Recruitment through referrals and networking proved to be a successful method. TYAN received approximately 19 referrals from various organizations and individuals, which resulted in 16 recruitment calls and 12 Community Partner commitments.

Many referrals were a result of positive word-of-mouth conversations by active Community Partners. Referrals were also received from PHR 4/5 staff and 2 members of the TYAN youth advisory board. Other networking efforts included the TYAN Leadership Academy held in the previous fiscal year, which resulted in one recruitment call and one Community Partner commitment during this fiscal year. Presentations by Darlene Locke, an AgriLife Extension Specialist as well as a member of the TYAN curriculum team at the department of Recreation, Park and Tourism Sciences, resulted in one Community Partner commitment.

By continuing to increase the number of social media accounts TYAN follows and reaching out to potential Community Partners, TYAN increased TYAN's network. Some of TYAN's most engaged social media content revolved around recruiting new Community Partners.

In FY20, 19 new Community Partners joined the nine Community Partners recruited in FY19. The geographical distribution of the 28 Community Partners throughout Texas showed that the organizations cover five out of eight of the PHRs. Most Community Partners that joined TYAN in FY20 were from PHR 6/5S (58%) and did not already have a YAP at the time (58%) they applied to join TYAN.

TYAN offers three main supports to the Community Partners – training, technical assistance, and funding support. Once Community Partners officially sign up with TYAN, three deliverables are required - completion of the ORAYAP, completion of at least two of the five YDTS modules, and a site visit. The TYAN online learning collaborative is the second tier of training for Community Partners that takes place after the completion of the first set of deliverables. The TYAN learning collaborative is a 12-month interactive curriculum and is an opportunity for Community Partners to positively impact their organization in the development of YAPs. Community Partners can expect to: 1) gain knowledge on the current evidence-based practices for YAPs, 2) network, 3) share their expertise, and 4) learn from the experiences of others within the cohort. Community Partners practice using tools and strategies in their YAPs and organizations, which include identifying and creating a YAP structure, learn how to recruit and retain youth, and understand how to involve youth in the evaluation and sustainability of their organizations.

Community Partners have access to lesson plans and action items on the TYAN portal within the collaborative materials. This learning collaborative allows the partners to review the information with their peers in the cohort, to learn through sharing of ideas, knowledge, skills, and experiences, as well as use the training tools offered. The first cohort started collaborative meetings in June 2020 and had two additional meetings in FY20. The first cohort consisted of 13 community partners, 10 of which attended sessions. The first cohort will continue into FY21. A mix of older and newer sites were the most engaging partners, providing insight about beginning partnerships, recruiting, and their status as related to COVID-19.

In addition to training, each Community Partner receives regular technical assistance (TA) in the form of phone calls. When a Community Partner joins TYAN, calls are monthly for the first three months then quarterly thereafter. Discussions during TA calls in FY20 ranged from 45-minutes to one hour and concentrated on five areas:

- Updates since last call or site visit, which included opportunities to share about the overall status of the YAP;
- Efforts in recruiting youth and caring adults into their YAP or organization;
- Project Updates including status of current projects, upcoming projects or sharing ideas and getting feedback from TYAN about how to plan new projects;
- Success and challenges; and
- TYAN summary of the call.

There were 60 TA calls across 16 Community Partner sites in FY20. Common themes discussed were program expansion, recruiting youth, and COVID-19. Some Community Partners were concerned with sustaining recruitment efforts and bringing the right youth to the table at the beginning of their partnerships. Other Community Partners wanted to expand their YAPs to multiple campuses or within the community and grow their impact and visibility. The most common theme was how COVID-19 was impacting their organizations.

In addition to training and TA, TYAN offered mini grants to Community Partners to implement YAPs. Community Partners had deliverable-based Scopes of Work (SOWs) meaning they received funding to complete certain activities within TYAN. The most common categories where Community Partners expended their funding included:

- Hosting events in the community or the organization as part of YAP projects or costs associated with hosting

meetings;
- Personnel salaries to organize YAPs or stipends for the youth for their work in the YAPs; and
- Travel expenses which included conference opportunities for the YAPs or general costs for travel to YAP activities.

In FY20, MCH led efforts to share PYD and YAP information, strategies, and resources through the DSHS website, AH Quarterly Meetings, the AH distribution list, and the digital messaging platform, Granicus.

MCH oversees 11 Adolescent Health webpages (https://dshs.texas.gov/adolescent/default.shtm) on the DSHS website. The webpages aim to increase knowledge about adolescent health-specific topics and PYD efforts as well as serve as a connecting opportunity to resources. Webpages covered the latest adolescent health information, important phone numbers, resources, and related sites for adolescents and parents to use depending on their needs. Additionally, pages with information targeted to teens, parents, and health care providers on adolescent health and how to approach this topic based on their role were available. Lastly, overview and efforts specific to PYD, sexual violence prevention, and TYAN were provided as a reference and an opportunity to increase the involvement of adolescents in PYD programs and efforts. In FY20, the homepage encompassed recommendations to adolescents amidst COVID-19. As a whole, the webpages received a total of 4,968 unique views and 6,463 total webpage views in FY20. The webpage most visited in FY20 was the homepage.

MCH continued to spearhead and facilitate the Adolescent Health Quarterly Meeting (formerly known as the Adolescent Health Workgroup) for the past 5 years. Membership in FY20 increased from 58 to 72 contacts. This group shared information and updates about current projects and identified opportunities to collaborate and coordinate activities. In FY20, the frequency of the group meeting decreased because of shifted priorities amidst COVID-19 and State Adolescent Health Coordinator vacancy. Activities will resume in FY21.

Another FY20 activity supporting efforts to promote adolescent health, PYD, and the importance of youth participation in PYD programs is Granicus (Formerly known as GovDelivery.) Granicus is an e-blast mechanism to deliver updates to subscribed users. At the start of FY20, the Adolescent Health distribution list had 9,110 subscribers. By the end of FY20, the number had increased to 10,281. FY20 topics included teens and vaping in September and suggestions for 2020 resolutions in December.

In FY20, DSHS released 52 issues of “The Friday Beat”, an e-newsletter geared for school nurses and other professionals, to disseminate information about health-related topics. School Health staff continued to use CDC’s Whole School, Whole Community, Whole Child approach during this fiscal year. The Whole School, Whole Community, Whole Child model expands on the 8 elements of CDC’s coordinated school health and is combined with the Association for Supervision and Curriculum Development’s (ASCD) Whole Child framework focused on ensuring every child is healthy, safe, engaged, supported, and challenged. CDC and ASCD developed this expanded model to strengthen a unified and collaborative approach designed to improve learning and health in schools. Editors of the Friday Beat used these elements to guide their selection of articles, webinars, and other resources. The Friday Beat provided 43 unique articles, resources, and educational opportunities related to Injury Prevention and NPM 7.2. There were 7,937 weekly users by the end of FY20 showing an 18% increase from FY19. The articles provided school stakeholders with resources on student safety, emerging best practices, and programs to implement within a school setting. FY20 Friday Beat resources and topics related to NPM 7.2 included:

- Explore Safety Tips to Minimize Concussion and Brain Injury Risk
- September Is Suicide Prevention Month
- Rural Play-Street Guide
- AAP Soccer Injuries and Prevention
- Save the Date for Texas School Safety Center Virtual Conference; and
- 4th of July Safety Tips.

MCH funded a Youth Engagement Specialist (YES) by contracting with Texas Institute for Excellence in Mental Health (TIEMH) at the University of Texas at Austin. FY20 was the last year of this funding. Activities included training and TA of PHR staff on PYD, youth engagement, and adolescent health-focused conversations. Additionally, YES created a Youth Participation Guide. The guide provides ideas for youth and adults on how to authentically bring youth to decision-making tables. The guide walks youth and adults through several types of meetings and the best way for adults to support youth in diverse types of engagement. The guide can be adapted to focus on any topic-focused education such as injury prevention. As priorities shifted amidst COVID-19, the YES contractor continued to develop content that could help organizations bring youth voice to their initiatives.

PHR 2/3 staff were involved with 18 organizations and coalitions in 21 counties that addressed adolescent injury prevention education on suicide prevention; PYD; youth connections to adults; youth engagement; self-harm prevention; bullying prevention; automobile safety; water safety; bike, ATV, and skateboard safety; promotion of the Friday Beat newsletter; promotion of the National Take Back Initiative – an initiative to properly dispose of unused medications; support and promotion of local youth-adult councils; and youth resiliency. Staff attended 47 meetings.

PHR 4/5N continued support of the evidence-based program Coaching Boys into Men (CBIM) to one Independent School District, providing training to approximately 32 athletes. CBIM is a Future's Without Violence program promoting respect and personal responsibility for young men (https://www.futureswithoutviolence.org/engaging-men/coaching-boys-into-men/). The program looks at a 12-week sport season with progressively more difficult conversations beginning with personal responsibility, including topics such as consent, when aggression crosses the line, and sexual reputation. The program promotes respect, integrity, and leadership. The program was introduced in FY17 to all school districts in PHR 4/5N. Initially seven schools responded, and PHR staff met with coaches. Three schools agreed to use the program and coaches were trained. Success was noted in a county with the coach reporting no athletes failing in either 1st or 2nd six-weeks, no athletes were sent to In-School-Suspension, and attendance increased from 88% to 92%.

PHR 4/5N partnered with four community groups and participated in the Last Ride/ATV Safety presentations/programs with approximately 639 children and 45 adults receiving the education. Staff conducted a total of 6 "*ASK About Suicide to Save a Life*" gatekeeper training presentations with 174 participants attending from five counties. Participants consisted of school staff, faith-based community organizations and nursing staff. New lifejacket stations were also erected and placed at seven new lake locations including marinas, state parks, resorts, and parks for swimming and boating. Three apartment complexes were given life jackets for loaner use as well as two day care centers. The previous 23 locations already in use continued to be maintained. These stations have infant, child, youth and adult size life jackets and a Throw, Don't Go personal flotation device (PFD). Stations included a sign-out sheet, proper fitting instructions for the life jackets, and a large sign with the state law and provisions approved by the DSHS Communications Department. The Throw Don't Go signs were designed in FY20 and added to eight new areas where swimming is prohibited. The PFDs were added to all new and existing life jacket loaner stations. DSHS prepared an interactive map to show the locations to be used on the PHR website and will soon include pin drop locations. Staff demonstrated a lifejacket loaner station at a tribal Pow-Wow.

PHR 7 hosted the PYD Training in November 2019. Fifteen participants included staff from five counties. PHR 9/10 provided TA and education on three topics that included drowning prevention (5 individuals), teen motor vehicle safety (13 individuals), and suicide prevention (27 individuals) to local community partners and physician offices. Suicide rates for youth in Texas are increasing and PHR 9/10 is following a similar pattern. Drowning has been a leading cause of injury death in adolescents ages 10 through 19 in PHR 9 where there are more lakes and swimming areas. Motor vehicle crashes were also one of the leading causes of unintentional injury death for youth in ages 10 through 19.

In FY20, MCH and PHRs continued to support the work of local Child Fatality Review Teams (CFRTs). Child Fatality Review is a public health strategy to understand child deaths through multidisciplinary review at the local level. The Texas process was created in 1995 by the Texas Legislature and is a statutorily defined multidisciplinary group of professional disciplines with unique perspectives on child safety. State Child Fatality Review Team (SCFRT) members are subject matter experts from law enforcement, the medical community, child protective services, child advocacy organizations, the court system, the behavioral health community, and other interested stakeholders. MCH continued to support the SCFRT and work with the Office of Injury Prevention (OIP) on injury prevention projects.

As of December 2019, there were 83 active, local CFRTs covering 211 of the 254 Texas counties resulting in 94% of Texas children residing in a county where child deaths are reviewed. Once COVID restrictions were in place, many teams struggled with regular meetings. Local CFRTs are volunteer-based and organized by county or multi-county geographic areas. Members collect information that corresponds to their disciplines and specific questions in the National Center for Fatality Review and Prevention database. Local CFRTs meet to share what each member knows about the specific child deaths being reviewed and identify risk factors specific to their communities. Reviews conclude with the question: “Was this death preventable?” The most recent year for which all local CFRTs completed their review of child fatality cases is 2016. In 2016, there were 3,858 child deaths in Texas and active local CFRTs reviewed 1,244 (approximately 32%) of the total child deaths.

MCH participated in the National Child Safety Learning Collaborative (CSLC) throughout FY20. The Texas CSLC team included the State Adolescent Health Coordinator, the MCH Unit Coordinator, MCH Regional Programs Coordinator, the Office of Injury Prevention, and PHR staff. The CSLC represents an unprecedented opportunity for states and jurisdictions to advance evidence-based strategies for injury and violence prevention. Through the CSLC, states and jurisdictions work to increase the adoption of evidence-based policies, programs, and practices at state and local levels. The Texas CSLC team is a part of the second cohort that began in May 2020 and continues through October 2021. The CSLC allows states to focus on at least one of four topics available. The Texas CSLC team focused on three topics which are as follows: Bullying Prevention, Motor Vehicle Traffic Safety, and Suicide and Self Harm Prevention. In FY20, MCH participated in one learning session, one state technical assistance call, and six topic-focused calls (two for each of the three topics).

Another mechanism to promote education on injury prevention through training, education, and resource sharing included the Texas Health Steps Online Provider Education (THS-OPE) modules. MCH provided feedback to the Health and Human Services Commission’s (HHSC) THS-OPE on adolescent-focused modules as needed. In FY20, the Injury Prevention and adolescent-focused THS-OPE modules – 1) Preventing Unintentional Injury, 2) Interpersonal Youth Violence, 3) Promoting Adolescent Health, and 4) High-Risk Behaviors in Young People: Screening and Intervention – were completed by 5,950 learners. MCH provided subject matter expertise for updates to the Managing Overweight and Obesity, Teen Consent, Youth Suicide Prevention, Promoting Adolescent Health, and Motivational Interviewing modules.

In an effort for MCH to increase the number of professionals that received adolescent injury prevention and reduction education, support, and community resources, MCH funded and collaborated with the Texas Office of Attorney General (OAG) on the CDC’s Rape Prevention and Education (RPE) Program. RPE addresses sexual violence, one of the main causes of intentional injury among adolescents and correlated to suicide ideation and suicide. RPE continued to identify common data points for funded rape crisis centers to aid in a state-level evaluation and analysis process. RPE is another example of MCH efforts to increase the number of programs using youth voice and approaching youth education with a PYD lens as well as an opportunity to engage 18 rape crisis centers on sexual violence prevention efforts. As the Principal Investigator on this CDC grant, the State Adolescent Health Coordinator worked with OAG, Texas Association Against Sexual Assault, and local rape crisis centers to implement primary prevention strategies to reduce sexual violence. MCH was awarded two supplemental funds from the CDC in FY20. One of the supplements focused on the impact of COVID-19 on implementation sites and the other supplement more broadly focused on supporting additional FY20 and FY21 activities. In FY20, RPE-funded rape crisis centers held 1,609 educational seminars with 26,867 participants, 503 training programs for professionals, and 491 internal and external workshops on the topics of primary prevention, consent, bystander intervention, and youth voice. Through these activities, RPE reached 38,264 participants in FY20.

MCH contracted with the Texas Juvenile Justice Department (TJJD) to support youth in the five TJJD secure detention sites. Most TJJD youth in detention have experienced significant childhood trauma. Unrelenting threats of violence and stress can hamper brain development and can make youth believe they are in constant danger. TJJD is implementing a Texas Model: TBRI (trust-based relational intervention)- focused strategy for youth development. TBRI® is designed for children from “hard places” such as abuse, neglect, or trauma. Because of their histories, it is often difficult for these children to trust the loving adults in their lives, which can result in perplexing behaviors. TBRI® offers practical tools for parents, caregivers, teachers, or anyone who works with children, to see the “whole child” in their care and help that child reach his/her highest potential. The goal of TJJD is to bring all youth in care to “secure attachment” with a caring trustworthy adult and build skills that allow them to develop secure attachment with other caring adults once they leave TJJD’s care.

In FY20, MCH funded equipment purchases in all five TJJD secure detention facilities to further the Texas TBRI® Model activities. TJJD utilized the equipment to set up team-building exercises and friendly competitive events between facilities. Due to the pandemic, TJJD was not able to use the activity kits to the full extent as expected upon purchasing them. As the conditions return to pre-pandemic routines, there will be an increase in the use of the activity kits, thus an increase in youth-staff connection and healing and ultimate create a youth-adult connection.

MCH supported the Children with Special Health Care Needs (CSHCN) Systems Development Group in several initiatives that target youth with special health care needs including the Medical Home Learning Collaborative (MHLC) and the Transition to Adult Learning Collaborative (TALC). MCH provided subject matter expertise and incorporate successful strategies into the Adolescent Health domain.

The MHLC met virtually every quarter to increase knowledge and share best practices on medical home for children and youth with special health care needs (CYSHCN). The TALC met quarterly to share knowledge, new resources, current initiatives, and implementation strategies to advance understanding of all aspects of transition, including moving from pediatric to adult health care. Members include parents/caregivers, providers, educators, social workers, representatives from community and managed care organizations, partners with academic centers, and state agency staff. Featured meeting topics addressed planning for improved transitions to adulthood in the areas of education, employment, housing, and long-term family and community support.

In FY20, MCH supported the work of PHR staff and CFRTs. The Texas Child Fatality Data and Recommendations Biennial Report was published in April 2020 as Required by Texas Family Code, Section 264.503(f). According to the report, in 2016, the Texas child death rate remained consistent with previous years. There were 3,858 child deaths (children ages 0 through 17) in Texas in 2016, and active local CFRTs reviewed 1,244 (approximately 32%) of the total child deaths. Since the 2018 Biennial Report, the local CFRT death certificate distribution process changed considerably at both the state and local level due to the requirement for DSHS to provide local CFRTs with electronic access to preliminary death certificates. Previously, death certificates were distributed by mail at an 18-to 24-month delay after the death occurred. The electronic death certificate distribution process evolved and improved during the past two years. The process started with teams primarily accessing the death certificate information from the NCFRP online case report system. After receiving local CFRT feedback regarding data needed from the death certificate to conduct a complete review, the electronic case distribution was expanded and improved. Local CFRTs currently receive a secure electronic spreadsheet with death certificate information. As of December 2019, local CFRTs received death certificate information through July 2019. The most recent year for which all local CFRTs have completed their review of child fatality cases is 2016. In 2020, according to 2016 death data on Texas children ages 0 through 17, there were 3,858 death certificates of which 1,243, or 32%, were reviewed by CFRTs. This is a decrease of five percentage points as compared to the 2013 Report baseline. Specific to adolescents, 341 out of 797 death certificates (43%) for adolescents ages 10 through 17 were reviewed by CFRTs.

The Panhandle CFRT reviews 100% of child deaths in the upper 26 counties of PHR 1. In FY20, a monthly meeting was attended by local and county community and health professionals. In addition to information sharing, members discussed topics such as the DSHS Health Alert, “Severe Pulmonary Illness Among Persons Reported Vaping”, and “Best Practices for Safe Sleep.” PHR 1 also provided pack-n-plays for infants who don’t have a safe place to sleep. Resources included safe sleep education and information on the Domestic Violence Coalition. The Texas Panhandle Suicide Prevention Coalition chair and the police department’s Crisis Intervention Team Coordinator came to a meeting to discuss CFRT activities on suicide awareness, prevention education, and post-vention.

PHR 2/3 has a total of 28 CFRTs within the 49 counties. These teams are a combination of single or multiple counties within the region. Twenty-one teams are in non-local health counties. PHR 2/3 staff provided an annual CFRT conference call to provide updates, successful community activities and events, and announce an opportunity to request funding assistance from the PHR with upcoming activities or events in the new fiscal year. The FY20 call was attended by 13 teams, and seven applications were approved at the end of the first quarter. Teams were encouraged to use their data to provide awareness-raising community activities or events.

Region 4/5N staff attended three CFRT meetings in FY20. They also met with county officials in two counties to re-start a CFRT in the area. Staff provided support and education on safe sleep, suicide prevention, drowning and water safety, and

motor vehicle accident prevention.

In PHR 6/5S, staff chaired or co-chaired five local CFRTs. Across the CFRTs, a total of 13 deaths were reviewed. The most reported deaths reviewed were safe sleep, child passenger safety (ages 0 through 9), and suicide. The number of deaths reviewed was lower than in previous years, but many CFRTs suspended meetings due to COVID-19.

In addition to serving as convener for CFRT teams, PHR staff also participated in reviews, supported leadership recruitment for teams, and participated in discussions on recommended interventions for trainings to local partners and hospitals such as safe sleep and injury prevention. PHR 9/10 staff participated in 6 CFRT meetings activities and reviewed 34 deaths in FY20.

NPM 7.2 Performance Analysis:
In FY20, MCH addressed NPM 7.2 through a multi-faceted approach utilizing various platforms including contracts, online education opportunities, Granicus, websites, projects, and partnerships to share injury prevention programs, strategies, and resources. Ongoing efforts were made to be aware of emerging trends in adolescent health, integrating social-emotional learning, and the impact of COVID-19 on adolescents to incorporate into MCH projects. Comparison of baseline data for each NPM 7.2 Objective with FY20 data showed that:

- In FY20, there were 753 youth involved in YAPs through the Community Partners – a four-fold increase from FY19.
- In FY20, the 28 TYAN Community Partners reported 31,907 youth and young adults that participated in YAP-affected programs and services – more than double of FY19.
- In FY20, 19 new Community Partners joined the nine Community Partners (baseline) recruited in FY19 – a 200% increase in one year.
- In FY20, there was a maintenance of 83 CFRTs.
- In 2020, according to 2016 death data on Texas children ages 0 through 17 years of age, there were 3,858 death certificates of which 1,243, or 32%, were reviewed by CFRTs. This is a decrease of 5 percentage points as compared to the 2013 Report baseline.
- In FY20, the Injury Prevention and adolescent-focused OPE modules: Preventing Unintentional Injury, Interpersonal Youth Violence, Promoting Adolescent Health, and High-Risk Behaviors in Young People: Screening and Intervention were completed by 5,950 learners.

Challenges / Opportunities:
FY20 brought challenges and opportunities for MCH adolescent health. COVID-19 halted all in-person events when the pandemic reached the state of Texas in March 2020. Virtual schooling and lack of social gatherings became the new "normal" for many adolescents, thus responding to this new format became a major priority for MCH and Adolescent Health contractors and programs.

Participating in the CSLC provided an opportunity for injury prevention programming for Texas. MCH focused on Bullying Prevention, Motor Vehicle Traffic Safety, and Suicide and Self Harm Prevention.

COVID-19 was a major challenge to the child fatality review process for FY20. As restrictions were put in place and staff were working virtually, teams within their respective agencies to determine the best way to proceed with virtual meetings.

SPM 4: Percent of adolescents and young adults (ages 18-24) who visited a doctor for a routine checkup in the past year
MCH identified an ongoing need to ensure that adolescents (ages 10 through 24) receive annual well visits as they move from family-supported, parent-directed health care into an individual, adult-centered relationship with their healthcare professional. Texas' 2018 Behavior Risk Surveillance Survey (BRFSS) showed that an estimated 63.5% of adults between the ages of 18 and 29 had an annual well visit. Although young adult well visits improved by approximately 5% from the 2017 survey, it was still a reduction of approximately 5% when comparing youth ages 12 through 17 with young adults ages 18 through 29. This supports other data sources like the Journal of Adolescent Health (http://www.jahonline.org/article/S1054-139X(16)30401-3/fulltext?rss=yes) that indicated that well visits for youth drops after age 18.

MCH led an innovative nutrition initiative to address the prevalence of overweight and obese children in Texas to promote the overall well-being of adolescents. The nutrition initiative kicked off in FY20 by participating in the Maternal and Child Health Workforce Development Center's 2020 Cohort (MCH WDC Cohort) program. The 7-month cohort involved work with the

Center to develop and implement a transformational change. The MCH WDC Cohort Texas team explored options for joining efforts across the life course by breaking down program silos and implementing a comprehensive initiative promoting nutrition and healthy eating behaviors. To accomplish these goals, the team decided to create a suite of presentations that incorporate parent/caregiver and individual/youth strategies. The intended outcome of this deliverable was to:

- Give parents, caregivers, and adolescents the tools to make healthy eating decisions;
- Encourage cross-domain collaboration;
- Enhance MCH workforce's knowledge of nutrition across the lifespan; and
- Increase collaboration between Central Office and PHRs.

The Texas MCH WDC Cohort team consisted of 12 members representing the following areas:

- Title V child health, adolescent health, and children and youth with special health care needs (CYSHCN) subject matter experts;
- A health disparity subject matter expert;
- Family partners for youth and CYSHCN;
- MCH PHR staff;
- A Performance Measurement Liaison;
- A MCH WDC Coach;
- A MCH WDC graduate student; and
- A senior sponsor from DSHS Executive Leadership

The State Child Health Coordinator co-led the Texas MCH WDC Cohort team.

In February 2020, a portion of the team attended a 4-day Learning Institute in North Carolina. This travel team clarified the project aim statement, practiced implementing new work processes and tools, and explored opportunities for technical assistance. Upon completion of the Learning Institute, the full team began meeting monthly to begin program design. In July 2020, the full team participated in a remote consultation before the conclusion of the cohort.

MCH funded several mechanisms to promote Adolescent Well Visits in FY20 including the development of an educational video and the Texas School Physical Activity and Nutrition (TXSPAN) project.

In FY19, MCH funded the Texas Department of Family and Protective Services' (DFPS) Prevention and Early Intervention division (PEI) to create a child health-related video for their parent education marketing campaign. The success of the video led to continued collaboration to produce another video in FY21. DFPS and MCH worked to plan another video in FY21 and determined the topic. The State Adolescent Health Coordinator took the lead on the project as the topic is related to positive relationships among youth in middle school.

In FY20, MCH continued to contract with the University of Texas Health Science Center at Houston (UTHealth) to support the activities of the Texas School Physical Activity and Nutrition (TXSPAN) project (https://sph.uth.edu/research/centers/dell/project.htm?project=3037edaa-201e-492a-b42f-f0208ccf8b29). TXSPAN is a statewide surveillance system which monitors trends in body mass index and health behaviors of children in 2nd, 4th, 8th, and 11th grades. The questionnaire administered in the project included questions about:

- Dietary behaviors
- Nutrition knowledge and attitudes
- Physical activity
- Social and environmental factors impacting health
- Body image
- Depression and other psychological impacts on health
- Sleep patterns
- Screen time

UTHealth recruited over 280 schools to participate in the project during FY20. An informational video produced in FY19 was

provided to the schools during the recruitment process (https://vimeo.com/onestory/review/364344483/a6bb6b137d). The video provided an overview of participant expectations and benefits. UTHealth reported increased success in recruitment of schools through the distribution of this video.

UTHealth planned to conclude the 5th cycle of data collection for the project in FY20. Most of the data collection typically occurs in late spring. Because of COVID-19, TXSPAN canceled all further data collection efforts for the fiscal year. By the time schools in Texas closed, TXSPAN's data sample did not meet requirements to be representative of all PHRs and a border versus non-border comparison. However, TXSPAN collected enough data to produce a representative snapshot of body weight and health trends at the state level. UTHealth administered 8,706 surveys across 227 public schools.

UTHealth and MCH convened regularly to discuss alternative and contingency plans due to COVID-19 delays. MCH pursued a contract renewal that would allow UTHealth to conduct another round of TXSPAN post-COVID-19 in FY21. This round of data collection would allow Texas to analyze child health behaviors pre- and post-pandemic. TXSPAN plans to complete data collection during the 2020-2021 school year, pending COVID-19 restrictions.

Although 2019-2020 data collection ceased, UTHealth continued data analysis and dissemination of the 2015-2016 TXSPAN data. In conjunction with MCH Epidemiology, UTHealth continued publication and presentation efforts. In FY20, TXSPAN had 36 publications with 15 manuscripts in progress. The 2015-2016 data was used in creating one-pagers used to educate policymakers on the importance of child health in Texas. In FY20, UTHealth created and released the following fact sheet topics:

- Child obesity crisis in Texas;
- Child nutrition;
- Child physical activity;
- Child screen time;
- Child sleep quality; and
- Child sugar-sweetened beverage consumption.

UTHealth also began analyzing data for upcoming fact sheet topics:

- Youth fast food consumption;
- Breakfast consumption; and
- Youth sports participation.

MCH continued to support and collaborate with the DSHS School Health program in the creation and distribution of the *Friday Beat*, an e-newsletter that is sent to over 7,900 school health stakeholders every Friday. The *Friday Beat* provided 217 unique articles, resources, and educational opportunities related to obesity prevention to 7,937 weekly users. FY20 *Friday Beat* resources and topics included:

- National Childhood Obesity Awareness Month
- Texas School Physical Activity & Nutrition Child Health Status Reports on various obesity-related topics
- School Nutrition Resources Toolkit
- How to involve families in physical activities in school
- Active People, Healthy Nation initiative
- Cookbook for schools and childcare centers
- Healthy meal finder tool
- How to stay healthy and active while at-home learning
- Staying active while social distancing

Further information about the *Friday Beat* can be found in NPM 7.2.

In FY20, a total of 27 Texas Health Steps' Online Provider Education (THS-OPE) modules related to adolescent health and well check visits were available. The module topics related to adolescent well checks included:

- Adolescent depression
- Adolescent substance use
- High-risk behaviors in adolescents
- Nutrition
- Promoting preventive check-ups
- Teen consent and confidentiality

MCH continued to support PHRs as they implemented activities to increase adolescent well visits in their communities. PHR 2/3 Public Health Nurses provided Oral Health Education to 238 elementary students at one Independent School District (ISD) and 25 elementary students in another ISD. The objectives to the training were to educate on the importance of oral hygiene and tooth decay prevention. Students were provided with toothbrushes, floss, timers, and educational material.

Performance Analysis:
In FY20, MCH began the first cross-domain initiative focusing on the priority needs of nutrition and disparities. The MCH WDC Cohort project enhanced workforce development of MCH, PHRs, and project partners. In FY21, MCH will have the opportunity to impact Texas adolescents through the implementation of the MCH WDC Cohort nutrition resource toolkit.

Although data collection was canceled halfway through the year, TXSPAN surveyed 8,706 students to get a representative sample response. The ability to collect data earlier in the school year was due to lead time written into the FY20 contract that allowed for an extended recruitment period. Based on this success, MCH plans to continue the same process for future contracts for TXSPAN.

The *Friday Beat* provided 217 unique articles, resources, and educational opportunities related to obesity prevention to 7,937 subscribers. Compared to FY19, the Friday Beat had an 18% increase in subscribers but 12% fewer obesity-related articles.

Challenges / Opportunities:
Because of COVID-19, some planned FY20 activities were impacted. To meet the needs of the population, MCH and contracted organizations adjusted plans accordingly. Many staff, contractors, and partners transitioned to virtual administration of education and programming. However, some components were unable to be done virtually.

Adolescent Health - Application Year

NPM 7: Rate of hospitalization for non-fatal injury per 100,000 children, ages 10 through 19.

The FY20 Needs Assessment, as in previous years, highlighted the need to prioritize injury prevention among adolescents, which the Centers for Disease Control and Prevention (CDC) defines as youth ages 10-18 and young adults ages 19-24. Based on National Performance Measures from the United States Department of Health and Human Services and state inpatient databases, Texas has had a consistently lower rate of adolescent hospitalization for injury than the rest of the U.S. However, unintentional injury has been, and continues to be, the leading cause of death among youth and young adults as well as the leading cause of non-fatal injury.

CDC Web-based Injury Statistics Query and Reporting System (WISQARS) data from 2018 shows that 16.5% of all injuries reported to the trauma system in Texas are of youth and young adults from falls and motor vehicle traffic accidents, which are both categorized as unintentional, non-fatal injuries.

A framework that proactively promotes protective factors in young people is Positive Youth Development (PYD). Maternal and Child Health (MCH) uses PYD as the foundation for engaging and serving youth in MCH strategies and initiatives. PYD involves youth as active agents, people that can improve their life by taking action on their own behavior, and engages every element of the community.

MCH funds several organizations to implement injury and violence prevention efforts to address NPM 7 including Texas A&M University (TAMU), Texas Juvenile Justice Department (TJJD), the Office of Attorney General (OAG) with a CDC grant, and the Texas Department of Family and Protective Services (DFPS).

To address injury prevention in FY22, TAMU will continue to administer the Texas Youth Action Network (TYAN) and expand on PYD work across the state. MCH began funding TYAN in FY18, building on the success of the Texas Healthy Adolescent Initiative from 2010-2018. TYAN promotes youth engagement and Youth-Adult Partnerships (YAPs) as effective strategies to improve youth-serving programs and organizations. TYAN's program engagement includes developing online resources for a general audience, conference presentations for youth-serving professionals, and online tools and advanced structured learning opportunities for interested individuals. TYAN also provides customized training and technical assistance to organizations willing to undertake a two-year commitment as a TYAN community partner. Community partners are organizations that formally join TYAN to create or expand YAPs in their community. TYAN provides training, technical assistance, and grant funding to community partners to help them establish or expand YAPs in their organization. TYAN will continue to implement these strategies during FY22.

TYAN will engage and recruit at least 16 organizations to be a part of the community partner learning cohorts in FY22. After changing their approach in FY20, TYAN exceeded recruitment expectations. Thus, in FY22, TYAN plans to approach engagement and recruitment of the community partners using the same strategies of exhibiting at conferences, networking through social media, referrals from Public Health Regions (PHRs) and current community partners, and appropriate communication with youth-serving organizations.

TYAN will continue evaluating the community partner YAPs in FY22. Effective YAPs have practices that provide youth opportunities to explore, take chances, safely learn from mistakes, and celebrate successes while being guided by caring, connected adults. In turn, youth have better resiliency-related positive youth development outcomes in areas like self-confidence, life skills, and core values and they are prepared to make better choices at all stages of life. TYAN collects evaluation data to measure the processes and assess the extent to which community partners are achieving the intended outcomes of the PYD framework within their YAPs. Adult and youth members are asked to

report on PYD-related behaviors before and after joining their YAP.

Knowing the importance of PYD and YAPs as a protective factor for injury prevention, TYAN will continue promoting these activities through the TYAN website, e-newsletters, and social media in FY22. All levels of program engagement involve the promotion of PYD and YAP, but this activity will be measured through online interactions with TYAN using the number of website visitors, number of social media followers, and the number of email subscribers. In FY22, TYAN will continue to disseminate a monthly newsletter to their subscribers, update their website with any new resources, announcements, and opportunities, and engage with followers through their social media posts.

In FY22, TYAN plans to continue disseminating adolescent health-focused online tools such as the Organizational Readiness Assessment for Youth- Adult Partnerships (ORAYAP) and Youth Development Training Series (YDTS) as well as the creation of an adolescent health data dashboard. The ORAYAP and YDTS were created in FY19. The ORAYAP is an assessment tool designed for youth-serving professionals to rate their organization's capacity to engage young people. Through the ORAYAP, organizations can assess their current youth engagement and identify areas of improvement to be a more youth-centered organization.

In FY20, TYAN funded a market research study that found that adolescent health champions and youth-serving organizations need data tools and information on health metrics to inform their programming. To address this gap, TYAN is developing an adolescent health dashboard in FY22. The dashboard will be a publicly available tool that showcases data at the county, regional, and state level. This activity will allow youth-serving professionals and stakeholders to access the best available adolescent health data in one location.

Another NPM 7 activity from TYAN includes presenting at youth-focused conferences throughout FY22. Conference presentations are intended to serve as a mechanism to spread awareness of TYAN and increase knowledge around PYD and YAPs. TYAN staff presented at two conferences in FY20 and three in FY21 due to COVID-19 canceling opportunities. TYAN instead sought out ways to connect with individuals and organizations virtually but found that, although virtual options give more flexibility, in-person conferences allow for deeper interactions between attendees and TYAN. In FY22, TYAN will try to attend at least four conferences to engage with youth-serving professionals and to identify opportunities with other youth-centered organizations.

Additionally, in FY20, MCH and TYAN identified a need to create a "training library" for PHRs on topics related to adolescent health. The library will be a source for PHRs to have access to updated trainings, research and materials to provide to the community as well as train internal staff. Since PHRs are considered the health experts within their communities, staff need to be as well-informed as possible on health issues, have access to evidence-based resources, and disseminate that information across the communities they serve.

MCH and TYAN will maintain efforts in FY22 to be up to date on emerging trends in adolescent health, integration of social-emotional learning, awareness of PYD, strategies to engage adolescents, connecting youth to PYD programs, and responding to adolescent health needs amidst COVID-19.

MCH has funded TJJD on a year-to-year basis since FY19 to create healthier environments for youth ages 12-18 living in residential facilities by increasing quality, positive activity opportunities. The COVID-19 pandemic resulted in increased stress, anxiety, and other mental health concerns among youth due to change in routines, break in continuity of learning, and health care, and loss of safety. To provide better support to youth in their residential facilities, TJJD identified the need to focus more on mental health regulation and established several calming rooms, spaces providing a supportive and relaxing environment, throughout their juvenile residential facilities in FY21. To support this shift, TJJD will use Title V funds to purchase sensory and calming supplies and equipment in FY22. The supplies and equipment may include items such as weighted blankets and stuffed animals, calming toys with tactile

sensory such as fidget tools, and activity kits for calming rooms and education spaces. MCH and TJJD expect to see increased participation of PYD activities as well as a decrease in self-reported risky behaviors. To measure success and reach of the activities, TJJD will send data on youth's participation in PYD activities, number of activities that support PYD (e.g., team building and youth group meetings), and self-reported metrics on PYD measures. MCH will meet with TJJD at least twice in FY22 to discuss TJJD youth needs and plan progress.

In FY22, MCH will continue to represent Texas as the Principal Investigator for the CDC's Rape Prevention and Education (RPE) grant. Year three of the five-year funding cycle began in February 2021. RPE addresses sexual violence, one of the main causes of intentional injury among adolescents and is correlated to suicide ideation and suicide. The activity is another example of MCH efforts to increase the number of programs using youth voice and approaching youth education with a PYD lens. RPE also provides an opportunity to engage 18 rape crisis centers on sexual violence prevention efforts through PYD. MCH contracts with OAG to implement community-based activities focused on PYD, healthy relationships, and the prevention of sexual violence. MCH works with OAG, Texas Association Against Sexual Assault, (TAASA), Texas A&M Health Science Center (TAMHSC), and local rape crisis centers to implement primary prevention strategies to reduce sexual violence. TAASA serves as the state sexual assault coalition and TAMU is the external evaluator.

During FY22, MCH, OAG, TAASA, and TAMHSC will provide technical assistance and training to 18 rape crisis centers implementing evidence-based and evidence-informed strategies as well as evaluate their efforts. Additionally, the state partners will meet twice a month as part of the Primary Prevention Programming Steering Committee. Ongoing activities include reviewing and improving the action plan, discussing effective implementation of the primary prevention focus areas, and tracking and evaluating the number of activities and participants that attend activities that the 18 RPE-funded sites host as part of their funding. The activities include educational seminars, training programs for professionals, and community-wide workshop topics on subjects such as primary prevention, consent, bystander intervention, PYD, and youth voice. RPE aims to end sexual violence by preventing it from happening, and, as with most primary prevention efforts, takes time to see the long-term outcomes. However, MCH and OAG track short-term outputs and outcomes of youth and adult reach through the RPE programming.

RPE was awarded two supplemental awards from the CDC for FY20 and FY21 related to COVID-19. The first award focused on the impact of the pandemic on implementation sites and the second award focused on supporting additional FY20 and FY21 activities. The additional funding supported training and technical assistance for the 18 RPE-funded rape crisis centers to adapt their primary prevention strategies for the virtual sphere as well as the development of two guidebooks. One guidebook focuses on adapting curriculum-based and community-level prevention programming to online implementation while the other guidebook focuses on keeping online trainings spaces engaging. Even though the supplemental funding ended in January 2021, RPE will continue using the guidebooks in FY22.

MCH will continue to fund Texas Department of Family Protective Services (DFPS). Since FY19, MCH has funded the Prevention and Early Intervention program at DFPS to create child- or adolescent-focused videos in English and Spanish. In FY21 and FY22, the videos will focus on youth and young adults. The topics are agreed upon by both agencies to align with their health priorities. In FY21, the topic focused on what it means to be a teen in the age of social media, the burden of social media on youth mental health, and associated risk such as disruption of proper mental functions and increased loneliness. This topic is especially timely amidst the pandemic. COVID-19 may affect the approach for focus groups and capturing footage, but DFPS is mitigating this issue with a more virtually friendly approach. The topic for FY22 has yet to be determined, but most likely will align with NPM 7. Success of this activity is measured using the reach of the video through tracking metrics by DFPS. MCH hopes to see an increase in parental awareness of issues affecting youth and young adults.

Due to the fiscal impact of COVID-19 on Texas' budget, all state agencies were asked to reduce their general revenue budget by 5%. After a thorough review of agency activities to protect core public health programs and key agency priorities, DSHS made the difficult decision to suspend the Medical Child Abuse Resources and Education System (MedCARES) Grant Program. MedCARES mainly focused on supporting direct client medical services, which does not align with DSHS's core public health mission or current guidance from HRSA's Maternal and Child Health Bureau around funding such services. MCH will conduct contract closeout procedures in FY22 and collaborate with Office of Injury Prevention (OIP) to identify supplemental injury prevention activities.

To address injury prevention and promote PYD, MCH leads Texas' efforts to support Child Fatality Review Teams (CFRTs), host adolescent health quarterly meetings, update adolescent health webpages, and disseminate adolescent health messaging through the agency's e-newsletter platform Granicus.

MCH will update DSHS adolescent health and CFRT websites, support regional activities, and develop education and resources for interested stakeholders. MCH will also promote webinars and technical assistance tools for injury prevention stakeholders and interested CFRT team members.

In FY22, MCH will continue providing technical assistance to local CFRT teams to increase quality and quantity of deaths reviewed and increase the number of counties covered by local CFRTs. MCH will work to determine the impact of the COVID-19 pandemic on local team operations by conducting a survey and will assist local teams as needed to reinstate local child fatality review.

The goal of the state CFRT is to provide review team coverage for all 254 Texas counties and increase the percentage of deaths reviewed. According to Texas' 2020 CFRT Report, local and regional CFRTs cover 211 of the 254 Texas counties resulting in 94% of Texas children residing in a county where child deaths are reviewed. MCH and PHRs will continue supporting the goal to cover all 254 Texas counties and will help where needed. PHR staff facilitate many of the CFRT teams. In FY22, the short-term goal will be to add or reinstate five more counties involved in CFRT activities.

CFRT staff will work to streamline the steps in death review facilitation. Electronic death certificates are currently delivered within six months of death. Local teams will continue to be trained to use an expedited review process for natural deaths to help teams prioritize reviews. Further, MCH will create one technical assistance training webinar related to death certificate distribution, child death review, and death review data entry in FY22. These process changes allow teams to gain timely access to data. Continuing education opportunities for local CFRTs will focus on improving the CFRT process in communities and address preventable deaths in Texas. This will require:

- Ongoing assessment of data needs, gaps, and opportunities;
- Continuous refinement of review tools, data systems, and training to aid in the reviews; and
- Review of pilot funding strategies to help in completion of data entry.

Resources will also include information on best practices in injury prevention programming. Located within the MCH Unit, the OIP continues to identify additional avenues to train medical examiners and justices of the peace.

The Adolescent Health Quarterly Meeting has been an ongoing activity since 2015. This group, with membership of more than 70 youth-serving professionals in Texas, shares information and updates about current projects and allows for potential opportunities for collaboration and coordination. FY20 saw the frequency of the group meeting decrease because of shifted priorities amidst COVID-19 and staff vacancies. In FY22, MCH plans to focus on injury prevention and reduction during at least one meeting with a potential presentation to members on up-to-date efforts and data on reducing injury among youth and young adults. This meeting is a health promotion and collaborative-based activity guided by evidence-based strategies and approaches informed by CDC technical packages.

MCH oversees 11 adolescent health-related webpages on the DSHS website. The webpages aim to increase knowledge about adolescent health-specific topics and PYD efforts as well as serve as a connecting opportunity to resources. Webpages include up-to-date adolescent health information, important phone numbers, resources, and related sites for adolescents and parents. In FY22, MCH plans to collaborate with OIP to include adolescent-specific injury prevention information on their webpage and link that information on the adolescent health webpage. The COVID-19 pandemic has shifted priorities for web content in FY21 and webpages will become more of a priority for FY22.

Another MCH activity supporting efforts to promote adolescent health, PYD, and the importance of youth participation in PYD programs is Granicus. Granicus delivers updates to subscribed users. At the start of FY21, the adolescent health distribution list had 10,281 subscribers. MCH will promote evidence-based strategies on injury prevention and reduction through intentional, targeted messaging by distributing messaging on injury prevention through adolescent health's Granicus at least three times throughout FY22 on protective and risk factors associated with injury prevention and reduction. The COVID-19 pandemic saw the isolation of (and potential lack of supportive environments for) youths and young adults affecting the risk for poor mental health - a concern for youth-serving professionals. Thus, MCH will continue to focus on targeted health promotion messaging on injury prevention and reduction.

To educate Texans on injury prevention and reduction, MCH supports the Texas PHRs, Texas Health Steps – Online Provider Education (THS-OPE), and *Friday Beat*.

MCH will support PHR staff in their endeavors to address unintentional injury and injury prevention in their communities. The PHRs focus on region-specific topics and activities. PHR staff plan to complete the following activities related to human and sex trafficking prevention in FY22:

- PHR 1 will conduct individual, parent, or guardian outreach by having educational resources available in the lobby or patient rooms on awareness and education on domestic minor sex trafficking prevention. Staff will provide awareness and education to health care providers or agencies who provide services to adolescents on domestic minor sex trafficking prevention by recognizing, referring, and reporting that someone might be trafficked.
- PHR 4/5N will promote child injury prevention related to human sex trafficking. Staff will conduct, track, and monitor the number of presentations, trainings, outreach events conducted regarding human sex trafficking prevention and awareness, location of events, number of participants, key partners, number of participants who can identify (3) grooming techniques used by human traffickers, and (3) characteristics of at-risk populations.
- PHR 7 will educate communities to recognize, report, and prevent human trafficking by continuing to use the Shared Hope Presentation, and will use a pre- and post-test to evaluate participants' understanding of the presentation. Education is planned for county judges, community centers, tattoo parlors, churches, libraries, schools, and hospital staff in Lampasas, Coryell, Burnet, Llano, Blanco, Robertson and Burleson counties. Each participant will receive a folder with print out material, cell phone pocket holders, and pens with the human trafficking hotline number on them for quick, accurate, and discretely provided referral information to anyone seeking information and resources about human trafficking including victims seeking to leave their captors. DSHS staff in these counties will continue to attend the Central Texas roundtable meetings as well as conferences and seminars to stay abreast of the latest trends related to human trafficking.
- PHR 9/10 will raise awareness of human trafficking prevention in the community. Staff will collaborate with and convene local partners in the fight against human trafficking. Staff will partner with coalitions or other interested partners in educating the local community to include parents and children. Staff will develop a clinic

process for identifying and referring identified human trafficking victims and individuals at risk to appropriate services.

PHR staff plan to complete the following activities related to motor and vehicle safety in FY22:

- PHR 7 will continue to partner with Texas Trails, Education and Motorized Management (TXTEAMM), AgriLife, and 4H to assist in safety awareness activities such as distributing handouts and TxDOT approved helmets and providing technical support. Staff plan to reach out to schools in those counties where all-terrain vehicle (ATV) rates are the highest to offer the safety awareness class at their school health fairs and at other events as requested by their community. They also plan to reach out to "Helmets of Love", a nonprofit organization that provides helmets to youth for bikes and All Terrain Vehicles (ATVs).
- Staff in PHR 8 will promote adolescent vehicle safety including having their field office team participate in one school or community event planning committee and provides technical assistance around evidence-based strategies for preventing motor vehicle crashes, give one presentation using evidence-based curriculum around motor vehicle safety per year, and provide adolescent injury prevention education, support, or community resources to at least one audience of CFRT members, commissioners, lawmakers, parents, educators, or providers.

Regional staff plan to complete the following activities related to suicide prevention in FY22:

- PHR 2/3 will assist school districts, in non-local health department counties, in obtaining resources on evidence-based suicide prevention programs, such as the Signs of Suicide (SOS) curriculum, through the local mental health authority or other available resources.
- PHR 4/5N will provide education and guidance to Save A Life Today (SALT) Coalition for suicide prevention outreach. Education and guidance may include sharing conference proceedings, research data, or prevention-related news and updates, with the intent that core group members will disseminate the information in their own counties.
- PHR 6/5S will partner with independent school districts or other organizations to provide suicide prevention trainings and to provide technical assistance with their suicide prevention policy or procedures reviews.
- PHR 9/10 will work with independent school districts, local coalitions, CFRTs, and other local partners to reduce the number of suicides and bullying by promoting evidence based PYD, suicide, and bullying prevention programs in middle and high school. Staff will survey school policies and identify gaps.
- PHR 11 will conduct five ASK About Suicide to Save a Life trainings to help equip their communities with gatekeeper skills. The goal of the trainings is to provide education regarding tools and resources available for suicide prevention.

Education will continue to be provided through THS-OPE Modules related to injury prevention and reduction for health care providers, teachers, regional staff, and other relevant youth-serving professionals. MCH will provide subject matter expertise for module reviews in FY22. Topics related to injury prevention include but are not limited to: Preventing Unintentional Injury, Interpersonal Youth Violence, Promoting Adolescent Health, and High-Risk Behaviors in Young People: Screening and Intervention. Additionally, the THS-OPE modules will be promoted and disseminated through Adolescent Health webpages, listservs, and Granicus. Success for this activity is measured in the number of learners completing each module as well as the reach from the various dissemination efforts.

Dissemination of and support for DSHS' *Friday Beat,* a weekly e-newsletter that is sent to over 7,900 school health stakeholders every Friday, will continue in FY22. The *Friday Beat* is developed based on CDC's Whole School, Whole Community, Whole Child approach for their health-related topic information distribution to school nurses and other youth-serving professionals. In FY22, MCH will recommend the importance of topics related to NPM 7 to the

school health staff. Additionally, MCH will continue to meet with school health staff on a quarterly basis to discuss collaboration opportunities and priorities.

In FY22, MCH will participate in national- and state-level activities such as the Children and Youth Behavioral Health Subcommittee (CYBHS), the National Network of State Adolescent Health Coordinators (NNSAHC), the Texas Medical Home Learning Collaborative, and the Transition to Adult Learning Collaborative to provide subject matter expertise and incorporate successful and evidence-based strategies in the adolescent health domain.

MCH will support the CYBHS as it relates to injury prevention, particularly in preventive mental and behavioral health strategies, community-based service systems, care coordination, and family-driven and youth-centered approaches. CYBHS is a subgroup of the Behavioral Health Advisory Committee, which serves as the primary advisory voice to Texas Health and Human Services Commission (HHSC) for issues related to mental health and substance use. The CYBHS provides recommendations on children and youth behavioral health topics and serves as the advisory body for the Texas System of Care, an HHSC framework to provide a spectrum of accessible, responsive, and effective services and supports. MCH will represent DSHS on the CYBHS during FY22 by attending quarterly subcommittee meetings, providing subject matter expertise, and collaborating on cross-sector initiatives.

MCH will continue to participate in the National Network of State Adolescent Health Coordinators (NNSAHC) on a bi-monthly basis during FY22. NNSAHC provides a space for collaboration and sharing of evidence-based practices and tips on any barriers or successes faced while implementing youth and young adult programs.

SPM 2: To reduce the prevalence of overweight and obesity in Texas children ages 10-21.

Amidst the COVID-19 pandemic, CDC reported strong and consistent evidence that shows children with underlying medical conditions such as overweight and obesity are at increased risk for severe illness compared to children without underlying medical conditions. This health risk is in addition to the associated increased lifetime risks of childhood obesity for adverse health outcomes including diabetes, heart disease, asthma, high blood pressure, depression, sleeping difficulties, and higher risk of being obese as an adult.

There are eight counties in Texas where 30% or more children experience food insecurity. Moreover, the 2019 Youth Risk Behavior Surveillance System (YRBSS) showed that less than 15% of students in grades 9-12 consume fruits and vegetables five or more times a day. Racial and ethnic differences in healthy eating habits among adolescents were highlighted in the 2016 Texas School Physical Activity and Nutrition survey; Black students were more likely to report eating foods with low nutrient value three or more times the previous day compared to White/Other and Hispanic students in similar grade levels.

The obesity epidemic is a multi-faceted problem that will require changes in social, economic, and built environments that take time. In FY22, MCH's efforts will focus on leading, funding, and supporting activities that support healthy eating and active living in a variety of settings. SPM 2 is a new performance measure for adolescent health during the 2021-2025 cycle, and activities continue to be reflected on for relevance, success, and feasibility. The effects of the pandemic on overweight and obesity in youth and young adults has yet to be fully examined, but with more families in economic duress, highlighting healthy eating and physical activity and how to adopt these behaviors regardless of socio-economic status is a priority.

To address the prevalence of overweight and obese youth and young adults in Texas, MCH leads multiple obesity prevention promotion activities. In FY22, MCH will continue to lead the Nutrition Toolkit Initiative, Adolescent Health quarterly meetings, Adolescent Health webpages, and Adolescent Health Granicus messaging.

The Nutrition Toolkit Initiative is an innovative nutrition education initiative that continues the work from the Children's

Healthy Weight Collaborative and the MCH Workforce Development Center's 2020 Cohort program. The aim of the initiative is to supply MCH staff in the PHRs with a go-to presentation resource on healthy eating – an evidence-based strategy for SPM 2. FY21 involved the creation and piloting of an overview toolkit focused on child, adolescent, and children with special health care needs (CSHCN) health. COVID-19 prolonged the initiative as most PHR staff were focused on direct services for COVID-19 and their bandwidth was limited. However, MCH was able to conduct a needs assessment survey in FY21 on PHR staff that illuminated the need for a specific resource on adolescent nutrition directed at adolescents as the target audience. Thus, FY22 will see the expansion of the initiative by adding another nutrition toolkit specifically focused on adolescent nutrition directed at adolescents. By partnering with obesity prevention, healthy eating, and health promotion subject matter experts, MCH will target youth and young adults in their eating habits to promote evidence-based nutrition recommendations and resources.

In FY22, MCH will promote obesity prevention and reduction strategies through intentional and targeted messaging through adolescent health promotional activities. Throughout the planned Adolescent Health quarterly meetings for FY22, MCH will focus on obesity prevention during at least one quarterly meeting with a potential presentation from subject matter experts of MCH-funded activities on obesity prevention and reduction. By engaging youth-serving professionals on SPM 2, MCH hopes to identify and act on opportunities for collaboration and coordination. For more information on the Adolescent Health quarterly meetings, see NPM 7.

To address SPM 2 in FY22, MCH plans to collaborate with the Obesity Prevention Program at DSHS to link information specific to adolescents and obesity prevention on the adolescent health webpage. Using the MCH web platform to promote SPM 2 will add an evidence-informed strategy for education and promotion of obesity prevention and reduction strategies. This activity will also highlight the new-to-adolescent health performance measure to youth-centered organizations and stakeholders. See NPM 7 for specifics on the Adolescent Health webpages.

As part of MCH's health promotion strategies in FY22, there are plans to distribute messaging on obesity prevention through the Adolescent Health Granicus, a listserv for youth-center organizations and public health professionals, at least three times throughout the year on different factors associated with overweight and obesity status in youth and young adults. This activity complements MCH health promotion strategies for a more evidence-informed approach to educating Texans on SPM 2. COVID-19 lowered the priority for Granicus messaging, but MCH plans to shift this activity to a higher priority in FY22. For more information on the Adolescent Health Granicus listserv, see NPM 7.

MCH funds the University of Texas Health Science Center School of Public Health in Austin (UTHealth) to implement the Texas School Physical Activity and Nutrition (TXSPAN) project. TXSPAN is a statewide surveillance system that monitors trends in body mass index, and health behaviors of children and youth in 2nd, 4th, 8th, and 11th grades. COVID-19 stalled data collection in FY20 and FY21 causing TXSPAN to postpone data collection in schools to FY22. A contingency plan is in place if schools do not allow research on their campuses in FY22 due to the pandemic. Activities that may overlap FY21 and FY22 related to data surveillance include ensuring Institutional Review Board approval, finalizing analyses from data collected during the 2019–2020 school year, and disseminating TXSPAN findings. TXSPAN will also review and update the survey and observation tools and adapt them for virtual and hybrid data collection approaches. Moreover, TXSPAN and MCH will work closely to include pandemic-related questions to allow for at-large comparison of health eating and physical activity behaviors between pre-pandemic and amidst-pandemic data.

In FY22, pending ability to go into schools due to COVID-19, TXSPAN will recruit districts and schools as well as prepare for data collection, including training contracted groups, research staff, field staff, school personnel, and UTHealth student volunteers. TXSPAN plans to conduct SPAN measurements at the individual level through parent

surveys of 2nd graders, student surveys of 4th, 8th, and 11th graders; and anthropometric measures of 2nd, 4th, 8th, and 11th graders. Data collection at the school level include administering the School Health Policy Survey, conducting the Healthy Signage Observation and Vending Machine Observation, and collection of Campus Improvement Plans. FY22 will also involve TXSPAN performing survey cleaning, dataset cleaning, data entry, and sending survey hard copies to Scantron to scan and create unique datasets by survey type.

In addition to data surveillance, TXSPAN also has several dissemination activities planned for FY22. Activities include but are not limited to updating infographics displaying TXSPAN data, updating the TXSPAN Data Explorer that allows health professionals to look through up-to-date health behavior data, and developing publications and presentations using TXSPAN data to disseminate in-person and virtually to a variety of audiences (e.g., public health professionals, parents, and other community stakeholders). Infographic and one-pager topics cover child and youth obesity, nutrition, physical activity, screen time, sleep quality, and sugar-sweetened beverage consumption data. Throughout FY22, TXSPAN will work to ensure these one-pagers are up to date. MCH will use these one-pagers as tools for data dissemination to and education of youth-centered organizations and public health professionals.

Partnering with the CSHCN domain to address SPM 2 is a priority for Adolescent Health in FY22. Children and adolescents with mental health conditions and physical disabilities are an important subpopulation of children who require focused attention in relation to obesity prevention. Participation of youth with disabilities in school and other social activities is lower than in the general population of youth. Thus, youth with special health care needs are less likely to be exposed to population-based obesity prevention strategies in schools or community organizations. Activities planned for FY22 to address this priority need are conducting a gap analysis of SPM 2 regarding children and youth with special health care needs and undergo a strategic planning session to ensure alignment and coordination of SPM 2 activities with the CSHCN domain.

To educate Texans on obesity prevention and reduction, MCH supports the Texas PHRs, THS-OPE, and *Friday Beat*.

In FY22, PHR staff will address overweight and obesity in youth within their communities. PHR staff will facilitate numerous awareness and education activities. Staff will participate in obesity prevention coalitions and provide subject matter expertise. Staff will also partner with local School Health Advisory Committees (SHACs) to provide technical assistance on implementation of evidence-based school health programs such as Coordinated Approaches to Child Health (CATCH), 5-2-1-0 Healthy Children, and Learn, Grow, Eat, Go!. To further support school health, staff will support the implementation of TXSPAN by facilitating recruitment of schools to participate in data collection. Finally, regional staff will promote obesity prevention resources, such as THS-OPE modules and WIC services, to clients.

Education will continue to be provided through THS-OPE Modules related to obesity prevention, nutrition, and physical activity to healthcare providers, teachers, regional staff, and other relevant professionals. MCH will provide subject matter expertise for module reviews in FY22. Modules related to SPM 2 include Management of Overweight and Obesity in Children and Adolescents and Diabetes Screening, Diagnosis and Management, Additionally, the THS-OPE modules will be promoted and disseminated through Adolescent Health webpage, listserv, and Granicus messaging.

In FY22, MCH will recommend the importance of topics related to SPM 2 to the school health staff. Activities include dissemination of, and support for, School Health staff's *Friday Beat* e-newsletter and quarterly meetings between MCH and School Health staff. For more information on *Friday Beat,* refer to NPM 7 above.

Children with Special Health Care Needs

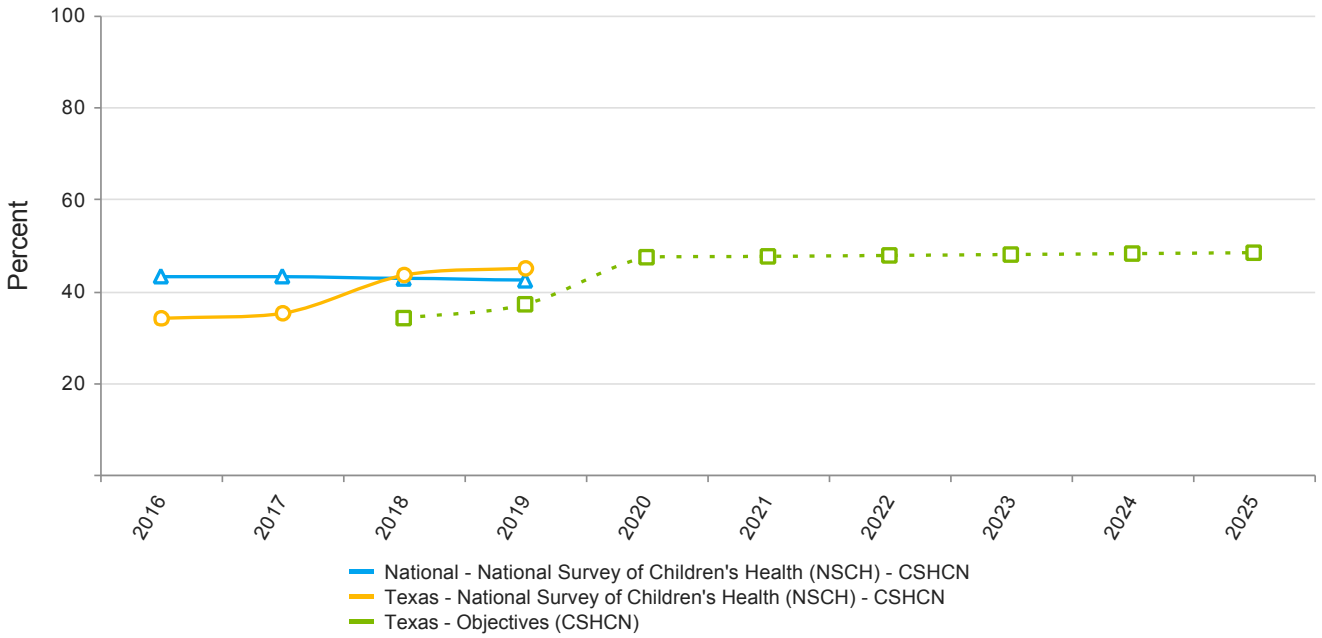
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	11.8 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	49.2 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	89.4 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	4.3 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			34.1	37.1	47.3
Annual Indicator		33.9	35.1	43.4	45.0
Numerator		443,280	417,948	538,344	578,913
Denominator		1,308,689	1,191,876	1,239,420	1,285,908
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	47.5	47.7	47.9	48.1	48.3	48.5

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Percent of families receiving professional care coordination for their child

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		37.5	38	38.5	39
Annual Indicator	35.7	38.1	36.4	27.8	27.8
Numerator	218	415	233	203	203
Denominator	610	1,090	640	730	730
Data Source	Texas 2016 CSHCN SP Outreach Survey	CYSHCN 2017 Outreach Survey	Annual CYSHCN Outreach Survey	Annual CYSHCN Outreach Survey	Annual CYSHCN Outreach Survey
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	39.5	40.0	40.5	41.0	41.5	42.0

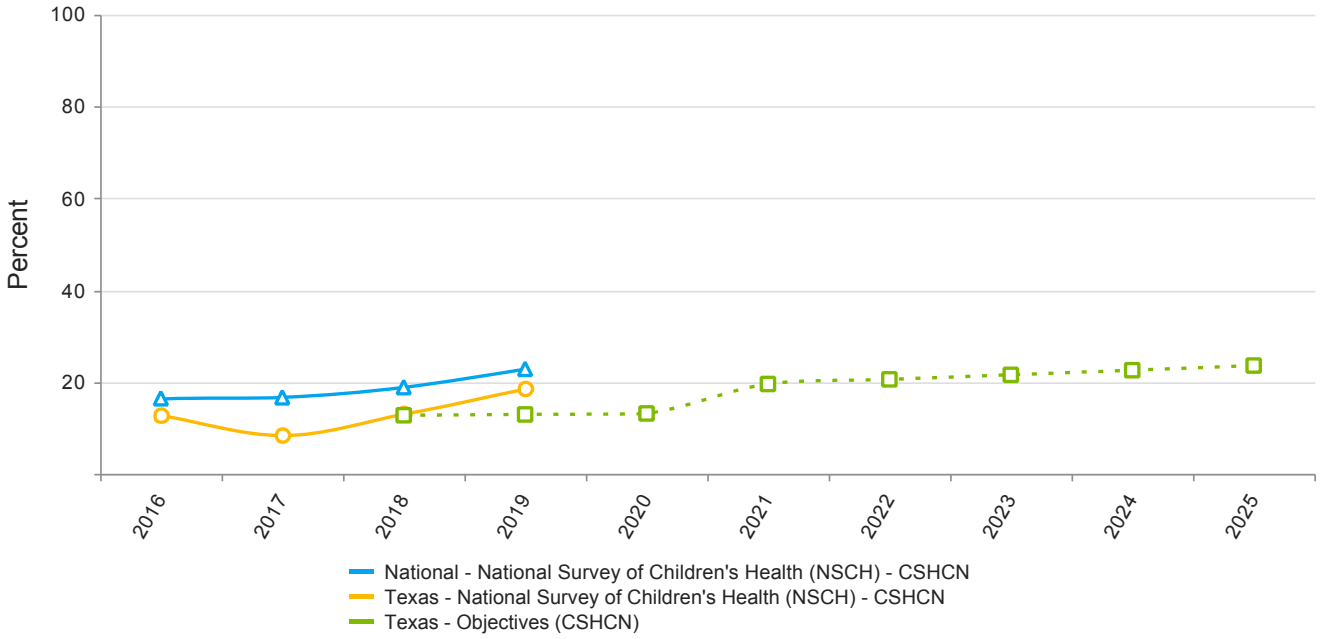
ESM 11.2 - Increase percent of families who have a plan for an emergency and/or disaster

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	68.0	69.0	70.0	71.0	72.0	73.0

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			12.8	13	13.2
Annual Indicator		12.6	8.5	13.0	18.6
Numerator		58,176	43,520	69,800	93,927
Denominator		461,518	512,065	537,747	504,239
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	19.6	20.6	21.6	22.6	23.6	24.6

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of families of transition age youth with special health care needs receiving professional help with their child's transition to adulthood

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		19.5	20	10	10.5
Annual Indicator	19.8	20.1	6.4	7	7
Numerator	46	69	40	15	15
Denominator	232	344	623	214	214
Data Source	Texas 2016 CSHCN Outreach Survey	Texas CYSHCN 2017 Outreach Survey	Annual CYSHCN Outreach Survey	Texas CYSHCN 2019 Outreach Survey	Texas CYSHCN 2019 Outreach Survey
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	11.0	11.5	12.0	12.5	13.0	13.5

ESM 12.2 - Decrease percent of families of transition-age youth who have not prepared for medical transition to adulthood

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	45.8	45.8
Numerator	98	98
Denominator	214	214
Data Source	CSHCN Outreach Survey	CSHCN Outreach Survey
Data Source Year	2019	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	46.8	47.8	48.8	49.8	50.8	51.8

State Performance Measures

SPM 1 - Percent of CYSHCN and their families who participate in social or recreational activities with families who have children with or without disabilities

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		37.5	69.1	70	71
Annual Indicator	37.5	68.1	68.9	68.9	68.9
Numerator	224	583	413	413	413
Denominator	598	856	599	599	599
Data Source	Annual CYSHCN Outreach Survey	CYSHCN 2017 Outreach Survey	CYSHCN Annual Outreach Survey	CYSHCN Annual Outreach Survey	CYSHCN Annual Outreach Survey
Data Source Year	2016	2017	2018	2018	2018
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	72.0	73.0	74.0	75.0	76.0	77.0

State Action Plan Table

State Action Plan Table (Texas) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Support comprehensive, family-centered, coordinated care within a medical home model for all Maternal and Child Health populations.	
NPM	
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	
Objectives	
By 2025, increase the percentage of CYSHCN and their families who are provided education and support about receiving care within a medical home by 2% above baseline (medical home services baseline FY15 = 5,754).	
By 2025, increase the percentage of providers of CYSHCN who are provided education about medical home by 5% above baseline (FY19 OPE participant baseline = 313).	
Strategies	
Strategy 1: Lead and Fund development of educational resources, trainings, and initiatives to share evidence-informed and best practice approaches to medical home and care coordination with families, health care providers, case managers, and other professionals serving CYSHCN and their families.	
Strategy 2: Fund community-based organizations and DSHS regional staff to assist CYSHCN and their families to learn about medical home services, and access primary care providers, develop emergency preparedness plans, and connect with needed resources/services.	
Strategy 3: Fund the CSHCN Services Program's health care benefit administered through HHSC to provide medically necessary services to eligible CYSHCN up to age 21.	
Strategy 4: Lead ongoing needs assessment and quality improvement activities to identify gaps and measure the experience of CYSHCN in accessing a medical home.	
Strategy 5: Partner and support state and national initiatives to promote family and provider education, and identify needs, gaps, and opportunities to strengthen systems to improve the quality of life and well-being of CYSHCN and their families.	
Strategy 6: Lead and partner on efforts to address social determinants of health and health disparities that CYSHCN and their families experience in accessing a medical home.	
ESMs	**Status**
ESM 11.1 - Percent of families receiving professional care coordination for their child	Active
ESM 11.2 - Increase percent of families who have a plan for an emergency and/or disaster	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

State Action Plan Table (Texas) - Children with Special Health Care Needs - Entry 2

Priority Need

Improve transition planning and support services for children, adolescents, and young adults, including those with special health care needs.

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Objectives

By 2025, increase the percentage of CYSHCN and their families who are provided education and support about transition from pediatric to adult health care by 2% above baseline. FY15 Transition Services Baseline = 3,809).

By 2025, increase the percentage of pediatric and adult providers who are provided education on transition from pediatric to adult health care by 2% above baseline. (FY19 OPE Participants Baseline = 1,084).

Strategies

Strategy 1: Lead development of educational resources, trainings, and initiatives such as the statewide Transition to Adulthood Learning Collaborative to share evidence-informed and best practices on transitioning to adulthood with families, youth and young adults, health care clinicians, case managers, educators, and other professionals serving CYSHCN and their families.

Strategy 2: Lead education and outreach efforts to help youth and young adults, families, health care clinicians, case managers, educators, and other professionals serving transition-age youth learn about the importance of implementation strategies and proactive planning for health care transition.

Strategy 3: Fund community-based organizations and DSHS regional staff to assist CYSHCN and their families to learn about and actively plan for the transition to adulthood.

Strategy 4: Lead ongoing needs assessment and quality improvement activities to identify gaps and measure the experience of YSHCN in planning for the transition to adulthood.

Strategy 5: Partner and support state and national initiatives to promote family and provider education, and identify needs, gaps, and opportunities to strengthen systems to improve the transition of CYSHCN to adult health care.

Strategy 6: Lead and partner on efforts to address social determinants of health and health disparities that CYSHCN and their families experience in transitioning to adulthood.

ESMs	Status
ESM 12.1 - Percent of families of transition age youth with special health care needs receiving professional help with their child’s transition to adulthood	Active
ESM 12.2 - Decrease percent of families of transition-age youth who have not prepared for medical transition to adulthood	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Texas) - Children with Special Health Care Needs - Entry 3

Priority Need

Increase family support and ensure integration of family engagement across all Maternal and Child Health programming.

SPM

SPM 1 - Percent of CYSHCN and their families who participate in social or recreational activities with families who have children with or without disabilities

Objectives

By 2025, increase the percentage of CYSHCN and their families who are provided family supports and community resources by 2%. (FY19 FSCR Services Baseline= 3,529).

By 2025, increase the percentage of providers of CYSHCN who are provided education and support on the provision of family supports and community resources by 2%. (FY17 FSCR Provider Services baseline = 1,777).

Strategies

Strategy 1: Lead development of educational resources and projects aimed at removing systemic barriers to improve the inclusion of CYSHCN and their families in community life and strategically advance family engagement.

Strategy 2: Lead advancement of family engagement efforts to promote inclusion of the family perspective in all MCH programs, awareness of the importance of meaningful family engagement at all levels, a family-centered approach to services, and development of family leaders.

Strategy 3: Fund community-based contractors and DSHS regional staff to help strengthen CYSHCN and their families and support their inclusion in community life by providing linkages for basic needs, facilitating parent to parent networking, hosting social and recreational activities, and offering respite for parents and caregivers.

Strategy 4: Lead needs assessment and quality improvement activities to identify gaps and measure the experience of CYSHCN and their families in being included in their communities.

Strategy 5: Partner and support state and national initiatives aimed at helping to ensure CYSHCN grow up in their families in the community, and identifying needs, gaps, and opportunities to strengthen systems to advance community inclusion.

Strategy 6: Lead and partner on efforts to address social determinants of health and health disparities that CYSHCN and their families experience in being included in their communities.

NPM 11: NPM Percent of children with and without special health care needs having a medical home.

According to 2018-2019 National Survey of Children's Health (NSCH) data, children and youth with special health care needs (CYSHCN) made up over 17% of children under the age of 18 in Texas. In the 2019 Title V Parental Outreach Survey sent out by the CSHCN Systems Development Group (CSHCN SDG), respondents reported that 61.8% of parents and guardians organized their child's care themselves, suggesting that a significant portion of this population was not receiving comprehensive care coordination from health care providers. The same data showed that more than half of respondents had a plan for a medical emergency (63.2%) and a natural or man-made disaster (53.1%). Still, a large portion of this population had not planned for emergencies.

The CSHCN SDG within the Maternal and Child Health Unit (MCH) partnered and supported multiple state and national initiatives to increase the percentage of CYSHCN families' knowledge about the medical home model and improve care coordination in FY20. Key family-focused activities included participation in the Health Resources and Services Administration (HRSA)-funded Collaborative Improvement and Innovation Network (CoIIN) to Advance Care for Children with Medical Complexities (CMC) project and serving on state and national workgroups.

Texas participated as one of ten state teams in the 4-year CMC CoIIN, which launched in 2018, to improve the quality of life for CMC, the well-being of CMC families, and increase the cost-effectiveness of care. The Children's Comprehensive Care Clinic at Dell Children's Medical Center (the Clinic), a dedicated practice serving only children with medical complexity, was the site for innovation in Texas. Nearly 400 clinic patients were part of the project's cohort. In addition to MCH and Clinic staff, the Texas team included families of children seen at the clinic, Texas Parent to Parent, practicing clinicians, Medicaid managed care organizations, the CEO of a Federally Qualified Health Center, health systems researchers, policy experts with the Dell Medical School at the University of Texas, Children's Hospital Association of Texas, the Texas Health and Human Services Commission (HHSC) Medicaid division, and other key stakeholders.

Specific aims of the Texas CMC CoIIN Team focused on:

- Meaningful engagement and support of CMC and their families to increase shared decision-making;
- Streamlining the multitude of required annual assessments for service eligibility to eliminate redundancies and inefficiencies;
- Utilizing technology to promote a shared care plan; and
- Improving efficiencies in accessing durable medical equipment, private duty nursing, therapies, and sub-specialty care at the Clinic.

Major FY20 Texas Team CMC CoIIN accomplishments included:

- Rapidly advancing clinic operations and family support in response to the pandemic. The clinic shifted family support services to an online platform and hosted virtual town halls, both in English and Spanish, to answer COVID-19 questions and dispel misinformation. The child life specialist at the Clinic engaged siblings through virtual activities.
- Piloting the Family Engagement in Systems Assessment Tool (FESAT) at the Clinic. Findings identified the need to expand the CMC CoIIN family workgroup to better represent the diversity of the Clinic population. In response, the family workgroup developed and began implementing an action plan to increase membership of families of color.
- Conducting 1:1 interviews with Clinic families, including Spanish-speaking families, to assess experience and satisfaction with Clinic services. Family workgroup leaders administered the surveys to solicit open, honest feedback.
- Collaborating with providers to establish a streamlined, integrated interdisciplinary virtual clinic visit.

The Mountain States Regional Genetics Network (the network), a multi-state HRSA-funded collaborative, focused on helping ensure that people with heritable disorders and their families have access to genetic expertise and quality care. The Texas team included family members, Texas Parent to Parent, nurses, genetic counselors, public health professionals, the state geneticist, MCH staff, and other interested stakeholders. Primary activities to expand awareness of genetic resources in Texas included:

- Developing and distributing COVID-19 information to families with children with genetic conditions;
- Exhibiting at the Texas Pediatric Society's (TPS) annual conference and advertising on the TPS website;
- Targeted advertising to families on Facebook; and,
- Expanding genetics content on Navigate Life Texas, a state-based website developed by and for families.

CSHCN SDG and the Executive Director of Texas Parent to Parent served on the legislatively mandated Texas Policy

Council for Children and Families (Council) in fiscal year (FY)20. The Council worked to improve the coordination, quality, efficiency, and outcomes of services provided to children with disabilities and their families through Texas' health, education, and human services systems. Most Council representatives were family members of youth and young adults with special health care needs. Legislation requires the Council to include at least one adolescent or young adult with a disability under the age of 26 receiving services from an HHSC agency. Additional members included community, faith, business, and other organizations providing services to children. The Council worked in FY20 to develop its biennial report, Recommendations for Improving Services for Children with Disabilities, for submission to the Texas Legislature and HHSC leadership in the fall of 2020. Medical home recommendations included strengthening emergency preparedness planning to ensure continued access to vital services during disasters or other large-scale events impacting families of CYSHCN; easing eligibility requirements for the state's Medicaid Buy-In program; and creating opportunities to enhance telemedicine in response to COVID-19.

CSHCN SDG funded community-based organizations and Public Health Region (PHR) case managers throughout Texas to help CYSHCN and their families in varying ways such as improving access to services and increasing the understanding of complex CYSHCN systems. The program also funded a health care benefits program for CYSHCN which was administered through HHSC.

CSHCN SDG awarded two types of contracts to community-based organizations for a 5-year grant cycle: Case Management (CASE) and Family Support and Community Resources (FSCR). CASE contractors worked in partnership with CYSHCN and their families to assess needs, develop service plans, provide linkages to state and local resources, and coordinate care. FSCR contractors helped CYSHCN and their families by providing a wide range of services and activities in response to community needs. Services and activities included respite assistance, educational workshops, recreational and fitness programs, parent to parent networking, and crisis prevention.

A new 5-year cycle for CASE and FSCR launched in FY20. CSHCN SDG selected 13 community-based organizations to contract through a competitive application process. One organization did not have a contract with CSHCN SDG in the previous cycle. Two contractors had CASE contracts only, five contractors had FSCR contracts only, and six contractors had both contract types. After finalizing funding awards, CSHCN SDG confirmed case management services were available in all regions of the state and identified two PHRs without FSCR contractors. To address the gaps, CSHCN SDG contacted health departments and hospital districts in both areas to gauge interest and solicit additional contractors. Subsequently, CSHCN SDG awarded contracts to three local health departments to ensure FSCR services would be provided in all eight PHRs. FSCR contractors now provide services in 136 of the 254 counties in Texas.

MCH also funded PHRs to provide case management services to families of CYSHCN, ensuring services were available in every county. PHR staff, in addition to the community-based CASE contractors, coordinated care for CYSHCN and their families. In FY20, CSHCN SDG contractors assisted 1,004 clients and PHR staff assisted 1,849 clients with comprehensive case management services.

In the first quarter of FY20, CSHCN SDG developed separate FSCR and CASE family experience surveys to better assess each contractor program. Previously, the survey was the same for both contracts. The new FSCR family experience survey gauged contractor responsiveness to family inquiries, respect for culture and traditions, quality of linkages to needed resources, facilitation of parent-to-parent connections, and support in helping families feel included in the community. Additionally, the CASE survey measured family satisfaction with service plan development, emergency preparedness planning, timeliness of follow-up, and shared decision-making for their child.

CSHCN SDG contractors distributed 4715 FSCR and 1004 CASE surveys to measure family experience and satisfaction with service delivery. To ensure distribution, CSHCN SDG sent each contractor printed surveys, return envelopes, and links to the online versions. The return rate was 16.7% for the FSCR survey and 8.3% for the CASE survey reflecting an improvement from the previous fiscal year (4.9% combined). Specific findings in FY20 identified that most families received:

- Accessible, family-centered, comprehensive services (92%)
- Coordinated services (88%)
- Culturally effective services (93%)
- Continuous services and overall satisfaction (95%)

To increase the survey response rate from FY19, CSHCN SDG informed contractors of return rates, satisfaction scores, and respondent comments quarterly in FY20. COVID-19 prevented CSHCN SDG from sending contractors additional printed surveys to distribute to families. Contractors who no longer had printed surveys had to revise ways to distribute surveys via text, email, and Quick Response (QR) codes. Many families lacked access to the Internet and technology which had a negative impact on the number of responses to the survey.

COVID-19 significantly impacted CASE and FSCR contractors in their ability to assist families. Contractors had to close offices temporarily and limit in-person interactions while transitioning to virtual platforms to connect with families and coordinate care. Providing services remotely presented challenges and unexpected opportunities. Contractors stated it was hard to follow through with goals and planning because families repeatedly canceled appointments due to additional

challenges with COVID-19. Families lacked technology capabilities, which made it difficult for contractors to get documents electronically signed. To assist with these new challenges, CSHCN SDG hosted bi-weekly COVID-19 huddles virtually for contractors to network, share ideas, and find solutions to the issues they faced. Web-based events provided the opportunity for contractors to reach a wider audience. More information on emergency funds and changes due to COVID-19 can be found under SPM 1.

According to World Atlas, Texas is the leading state in natural disaster frequency. Floods, wildfires, tornados, hurricanes, hailstorms, sinkholes, erosion, and drought all occur in Texas. CYSHCN and their families are particularly vulnerable and therefore emergency preparedness planning is a priority of CSHCN SDG. Community-based contractors are required to help families plan for emergencies.

In FY20, CSHCN SDG contractors helped 1,183 clients with emergency preparedness planning. Assistance included developing or updating current plans, organizing medical information electronically, and distributing emergency kits. The kits included a flashlight, fire extinguisher, and first aid supplies. Due to COVID-19, contractors adapted emergency preparedness information to include shelter-in-place information, which was previously not included, and plan to incorporate this information into future training programs. Contractors also helped families register with the State of Texas Emergency Assistance Registry (STEAR) to alert local preparedness planners and first responders of potential needs for additional assistance during an emergency. The FY20 CASE family experience survey results showed that of the 79% of respondents assisted with an emergency plan, 100% felt better prepared for an emergency or disaster after CASE helped establish a plan.

As COVID-19 began impacting communities, contractors also educated families on social distancing and mask wearing protocols. Contractors shared information about testing sites and encouraged families to follow the Centers for Disease Control and Prevention's (CDC) recommendations, referred communities to the DSHS COVID-19 website, and monitored local health department updates.

CSHCN SDG contractors promoted family education on medical home services by hosting conferences, workshops, and camps for youth with chronic health conditions throughout the year. Several contractors held in-person conferences in the first half of FY20. Due to the pandemic, spring and summer conferences changed to online platforms and one contractor hosted a virtual camp. Although these events were hosted online, families had opportunities to engage with health and wellness professionals and learn about available community resources. Featured topics included COVID-19 updates, mental health services, healthy cooking, personal hygiene, puberty, first aid training, domestic violence awareness, and an overview of the CSHCN Services Program administered by the Texas Health and Human Services Commission (HHSC).

Specific CSHCN SDG contractor-led activities are described below.

- Texas Parent to Parent, the statewide parent network, held two in-person regional parent conferences, prior to the pandemic, to empower parents in managing the issues and challenges of caring for CYSHCN. These regional conferences were a collaboration between Texas Parent to Parent, local parent groups, school districts, Education Service Centers, and others. A total of 80 parents, 18 professionals, and 1 self-advocate attended these events, which included 45 breakout sessions and 45 exhibits. Presentation topics covered children's mental health and the dangers of restraint and seclusion. Due to the pandemic, Texas Parent to Parent canceled its annual statewide conference and hosted a summer series of virtual workshops instead. A total of 320 parents and 48 professionals attended the series that included sessions on mental health and emergency preparedness amid the pandemic.
- Any Baby Can of San Antonio held numerous in-person events prior to the pandemic with 303 attendees participating. The contractor offered bi-weekly adaptive fitness classes; a workshop to help parents navigate the pre-teen, teen, and young adult years; and a 4-part series on autism, behavior supports, and reinforcements with visual strategies.
- Paso del Norte Child Development Center, located in El Paso, continued to offer a Leadership Academy for Families. The academy is a seven-week program provided in English and Spanish to parents, family members, and caregivers of CYSCHN as well as community members. Topics covered in the course included a history of disability, the special education process in Texas, advocacy, emergency preparedness, transitioning to adulthood, social services, assistive technology, and family dynamics. In FY20 Paso del Norte offered an academy specific to families whose children have autism and attention-deficit/hyperactivity disorder (ADHD). Due to COVID-19, classes went from in-person to virtual and each topic was split into 2 sessions.

The CSHCN Services Program (CSHCN SP) administered by HHSC received Title V funds to provide health care benefits to children younger than age 21 who have special health care needs and any individual with cystic fibrosis. In FY20 1,574 eligible clients received a benefit, of which 1,442 did not have any other health insurance coverage. There were 547 clients on the waitlist in FY20. There were 407 clients pulled from the waitlist that received a CSHCN SP benefit throughout the year. Beginning in FY20, CSHCN SDG met monthly with the HHSC CSHCN SP to stay informed on changes and activities in the health care benefits program.

CSHCN SDG facilitated the Medical Home Learning Collaborative (MHLC), which meets virtually every quarter to increase knowledge and share best practices on medical home. In FY20 the MHLC facilitated presentations on person-centered

planning, trauma-informed care for CYSHCN, assessing family-centeredness and family engagement, and managing autism in the medical home.

In 2018, CSHCN SDG surveyed certified community health workers (CHWs) in Texas to identify gaps in knowledge regarding services and supports available to families of CYSHCN. Results showed that CHWs were not informed on available resources or the unique needs and challenges of CYSHCN families. In FY20, CSHCN SDG developed an introductory training module to expand the capacity of CHWs to assist families of CYSHCN. The training aimed to ensure that CHWs will have greater knowledge and understanding of:

- Challenges and needs of CYSHCN and their families;
- Resources on health care funding options for CYSHCN in Texas; and
- How to advance community inclusion of CYSHCN and their families.

In FY20, CSHCN SDG distributed "What is a Medical Home", a brochure CSHCN SDG designed for health care providers and other professionals working with CYSHCN and their families. Due to the pandemic, distribution was down from previous years as events were canceled and staff, working remotely, were unable to mail resources to contractors. All materials remained available to download from the MCH CSHCN's website.

In FY20, MCH funded an academic institution and community-based organizations throughout the state to improve the quality of case management services and expand the knowledge base of providers on medical home.

CSHCN SDG contracted with the Texas Institute of Family and Child Wellbeing (TXIFCW) at the University of Texas School of Social Work to develop a practice model to ensure provision of high-quality, family-centered, and culturally sensitive case management services for CYSHCN and their families. The National Care Coordination Standards for CYSHCN served as a guiding foundation for the model. The project, launched in the beginning of FY20, will be implemented in three phases, each lasting approximately one year:

- Phase Ⅰ: Conduct an environmental scan and needs assessment
- Phase Ⅱ: Design the practice model and train case managers
- Phase Ⅲ: Continue technical assistance and program evaluation

As part of Phase 1, TXIFCW conducted an environmental scan to identify established standards and quality measures and examine how CYSHCN case management services are currently being implemented across Texas. For the needs assessment, TXIFCW collaborated with CSHCN SDG and MCH Epidemiology to develop and conduct stakeholder interviews to identify strengths and gaps in current case management practice. CSHCN SDG community-based contractors and PHR staff recruited stakeholders from all regions. The interviews included caregivers receiving CYSHCN case management services, case managers working with CYSHCN and their families, case management supervisors, DSHS staff, and community-based contractors. Interviews were initially planned as in-person focus groups but shifted to a remote format due to COVID-19. CSHCN SDG added questions to the interviews and surveys to ask about how COVID-19 affected services and supports for CYSHCN. TXIFCW also recruited participants for a Practice Model Advisory Group through CSHCN SDG community-based contractors and PHRs. TXIFCW plans to establish the group in FY21 to solicit input and expertise from CYSHCN case management staff, stakeholders, and families on the development of the case management practice model.

Throughout FY20, CSHCN SDG contractors provided education to providers on the importance of a medical home for CYSHCN, the medical impact on the daily lives of CYSHCN and their families, and on-site clinical care learning. Specific details of contractor activities are below.

- Texas Parent to Parent continued offering their Medical Education (MEd) program in FY20. The program was developed to give medical students and residents a deeper understanding of the experience of families who have a child with chronic health care needs. In FY20, 76 students and 107 residents participated in the MEd program. Participants attended a home visit, a school visit, and a communication skills interview. Due to the pandemic, fewer students participated than in previous years, in-person home visits were suspended, and the program was not offered in the 4th quarter.
- The CHOSeN Clinic, located in Houston, provided students the opportunity to visually learn about the primary care management of children and young adults with multiple disabilities in the medical home setting. The clinic offered the in-person clinical experience to social work interns, psychology interns, dental residents, and Leadership Education in Neurodevelopmental Disabilities (LEND) fellows. The clinic provided the learning experience to 24 full residency interns; 8 Internal Medicine and Pediatrics providers comprised of Fellows, residents and practicing physicians; 1 pediatric Genetics intern; 3 Child Neurology interns; 6 dental residents; and 30 LEND Fellows. Each day, 2-3 students participated in the program to obtain hands-on experience on how to manage care of the CSHCN population.

The Texas Primary Care Consortium Annual Summit, a partnership between the Texas Health Institute and the Texas Medical Home Initiative, included presentations on primary care, building a medical home, population health, meeting the needs of underserved communities, and more. CSHCN SDG served on the Steering Committee. In FY20, the Steering

Committee made the decision to postpone the conference due to COVID-19.

CSHCN SDG promoted Texas Health Steps' Online Provider Education (THS-OPE) modules on medical home. THS-OPE's award-winning online program offers free continuing education courses for primary care providers and other health professionals (https://www.txhealthsteps.com/). In FY20, 509 individuals completed "Building a Comprehensive and Effective Medical Home"; 923 individuals completed "First Dental Home"; and 3,608 providers completed "Culturally Effective Health Care".

- ADHD: Screening, Diagnosis, and Management
- Autism Spectrum Disorder: Screening, Diagnosis, and Management
- Texas Medicaid Services for Children

CSHCN SDG attended the quarterly STAR Kids Advisory Committee meetings to stay informed on developments in Texas' Medicaid managed care program for children with disabilities and special health care needs. The legislatively mandated STAR Kids program provides services for children with disabilities who have Medicaid coverage. The STAR Kids program requires a health home, care management, and comprehensive coordination of acute care and long-term service benefits. Several members of the CMC CoIIN team served on the STAR Kids Advisory Committee.

CSHCN SDG attended statewide meetings promoting primary and preventative health care. The Texas Pediatric Society is a professional nonprofit organization of physicians who care for children and Texas medical school students. The Texas Pediatric Society Annual Meeting was held in October 2019, where CSHCN SDG exhibited.

CSHCN SDG participated in the State Developmental Screening Workgroup (DSW). A goal of DSW for FY20 was to identify gaps in stakeholders represented in the group. Membership of the DSW expanded to include Special Supplemental Nutrition Program for Women, Infants, and Children; a Family Representative from Texas Parent to Parent; Easter Seals of Rio Grande Valley; Paso del Norte Children's Development Center; United Way of San Antonio & Bexar County; United Way for Greater Austin; Help Me Grow North Texas; and North Texas Area United Way. In FY20, the DSW:

- Explored opportunities for creating a statewide data system to house screening data and allow providers access to results;
- Conducted a statewide crosswalk of developmental screening and monitoring initiatives for project alignment and collaboration opportunities; and
- Agreed to support the state of Texas application to the Act Early Response, a COVID-19 project funded by the CDC and the Association of University Centers on Disabilities.

Performance Analysis: Increasing awareness and access to a medical home remained CSHCN SDG priorities. The MHLC, CMC CoIIN, Texas Primary Care Consortium, and other major state initiatives continued to help improve recognition and implementation of the medical home model. For the percentage of CYSHCN and their families who are provided education and support about receiving care within a medical home, the FY20 data point was 2,740 which is below the baseline established in FY15 (5,754). MCH will continue to identify opportunities through our partners and findings from the CYSHCN Outreach Survey. CSHCN SDG met and surpassed the goal to increase the percentage of providers of CYSHCN who are provided education and support on medical home. In FY20, 509 providers participated in the THS-OPE's medical home module, which is much higher than the baseline established in FY15 (313).

Challenges/ Opportunities: Limited staff capacity, constraints on families' challenges with sustainability, and the pandemic impacted collaboration with medical home initiatives statewide. MCH continues strategizing to increase involvement of clinical stakeholders with varying strengths, needs, interests, and expertise to expand supports for CYSHCN and their families. There is a significant opportunity to educate clinicians and other providers about supporting CYSHCN families within the medical home. The continuation of FY20 projects into FY21 will allow MCH to target specific health care professionals, such as case managers and CHWs. The STAR Kids Medicaid managed care program for CYSHCN requirements for improved care coordination.

NPM 12: Percent of children with and without special health care needs who received services necessary to transition to adult health care.

According to the 2018-2019 NSCH, 18.6% of CYSHCN in Texas ages 12 through 17 received the services necessary to transition to adult health care. This is a significant improvement from the 2016-2017 NSCH survey (8.5%) and beginning to approach the national average of 22.9%. In the 2019 Title V Parental Outreach Survey, 76% of respondents with transition-aged youth 12 through 17 did not feel prepared for their child's transition to adulthood. Texas continued raising awareness and conducting educational activities for families and professionals to increase the number of CYSHCN who receive services necessary to transition to adult health care.

The CSHCN SDG partnered on state and national initiatives in FY20 to increase the percentage of CYSHCN and their families knowledgeable about health care transition. Primary efforts focused on families included participating in the Big 5 States and the Policy Council for Children and Families.

In FY19, Texas established the Big 5 State Learning Collaborative with their counterparts in California, Florida, Illinois, and New York. Before the pandemic halted travel in FY20, the Title V CSHCN Director, the Title V MCH Director, and the MCH Unit Director met with Learning Collaborative representatives from other states in Albany, New York. During the meeting, the Learning Collaborative identified the need to collectively address challenges and barriers related to transition to adult health care that children with special needs experienced in large states.

CSHCN SDG and the Executive Director of Texas Parent to Parent served on the legislatively mandated Policy Council for Children and Families (Council). The Council works to improve the coordination, quality, efficiency, and outcomes of services provided to children with disabilities and their families through Texas' health, education, and human services systems. The majority of Council representatives are family members of youth and young adults with special health care needs. Additional members included community, faith, business, and other organizations serving children. The Council worked to develop recommendations for its biennial report to HHSC leadership and the 87th Texas Legislature for submission in the fall of 2021.

CSHCN SDG required CASE contractors to complete transition readiness assessments for all clients older than age 12. Case managers worked with families to identify and plan strategies for achieving transition goals related to adult health care, education, employment, independent living, and financial needs. In FY20, CSHCN SDG contractors provided 1,465 transition readiness services for CYSHCN.

MCH also funded PHR staff to provide case management services to families of CYSHCN through a statewide network of regional offices, ensuring services are available in every county. PHR staff conducted 860 encounters with clients to provide transition resources and 887 encounters to assist with permanency planning.

CSHCN SDG community-based contractors promoted transition readiness by hosting conferences, resource fairs, and workshops throughout the year. Featured presentation topics included making medical decisions, behavior supports, coping with transition after high school, employment, and the complexities of Social Security benefits. Featured CSHCN SDG contractor activities that focused on transition are described below.

- MCH funding supported Texas Parent to Parent's Pathways to Adulthood (PTA) workshops throughout Texas which introduced parents to transition planning. The workshops highlighted all major areas of transition: medical needs, education, legal issues, long term support services, personal support networks, and creative approaches to employment and housing. In-person PTA workshops were held during the first half of FY20. Due to COVID-19, the workshops changed to virtual events for the second half of FY20. A total of 329 parents and 180 professionals (e.g. medical professionals, education professionals, social workers, and transition specialists) attended the 8 in-person and 6 virtual PTA webinars.
- Due to COVID-19, Texas Parent to Parent canceled its annual statewide conference and hosted summer series of virtual workshops attended by 320 parents and 48 professionals. Transition-related sessions, translated into Spanish, addressed special education issues during the pandemic and planning for financial needs now and in the future.
- The Heart of Central Texas Independent Living Center in Temple promoted transition readiness by partnering with local high schools, Temple College, and the Texas Workforce Commission Vocational Rehabilitation staff to plan the inaugural Temple Area Possibilities Job Fair. The fair provided career information for students with disabilities in high school or students older than age 18 participating in post high school transition programs or attending college.
- West Texas Rehabilitation Center in Abilene partnered with Parent Resource Network's PEN Project, a parent training and information center serving Texas Parents with children and youth with disabilities, with an in-person workshop "Agents of Change: Preparing Youth with Disabilities for Transition into Adulthood." A panel of young adults shared their personal experiences during high school and after graduation.
- Any Baby Can of Austin canceled their annual summer camp due to COVID-19. Camp Grey Dove, a virtual camp, was held instead. The camp theme was Everyday Heroes and split participants, 41 children from 21 households, into small groups based on age. Any Baby Can of Austin sent each household the materials needed to participate in camp activities. The camp included sessions on transition, emergency preparedness, COVID-19, basic first aid, and provided opportunities for inclusion. One transition-focused session, "Confidence for Heroes", targeted transition-age youth and focused on developing confidence and independent living skills needed for transitioning to adulthood.
- Any Baby Can of Austin also held an online event "Special Health Care Needs Transition Age Youth and Parents: A conversation and Virtual Resource Fair" that 41 people attended. The event featured 8 organizations, resources, and services available in the contractor's 10-county service area. A Family Engagement Specialist from the University of Texas at Austin facilitated a panel of youth and parents. Two parents from Texas Parent to Parent participated in the panel.

MCH supported efforts to help families better prepare to transition from pediatric to adult health care by partnering with the school team and incorporating health into Individual Education Plans. The CSHCN SDG presented "Parents as Partners in Health Care Transition" to families, managed care service coordinators, transition specialists, and educators at a workshop hosted by the CSHCN SDG community-based contractor, Sharing Hands, located in Midland.

CSHCN SDG facilitated the statewide Transition to Adulthood Learning Collaborative (TALC). Members include parents, caregivers, providers, educators, social workers, representatives from community and managed care organizations, partners with academic centers, and state agency staff. TALC met quarterly to share knowledge, new resources, current initiatives, and implementation strategies to advance understanding of all aspects of transition, including moving from pediatric to adult health care. Featured meeting topics addressed planning for improved transitions to adulthood in the areas of education, employment, housing, and long-term family and community support.

CSHCN SDG hosted an in-person training for FSCR and CASE contractors. The training served as both professional development for contractor staff and time to communicate program requirements. Texas Parent to Parent gave a presentation to inform contractors how to help parents who have a CSHCN with various areas of transition. Topics included the challenges of transition, school years, Medicaid-based programs, social security benefits, legal rights at age 18, medical transition, youth working in the community, housing, and developing personal networks.

In FY20, CSHCN SDG distributed "What is Health Care Transition," a resource developed by the program in FY17. The informational brochure, available in English and Spanish, was created to help families and providers learn about health care transition and the importance of actively planning for the move to the adult system. CSHCN SDG also distributed "What is Transition" to health care providers and other professionals working with CYSHCN and their families. Due to the pandemic, distribution was down from previous years as events were canceled and staff, working remotely, were unable to mail resources to contractors. All materials remained available to download from the program's website.

CSHCN SDG served on the Advisory Board for the 20th Annual Chronic Illness and Disability Conference: Transition from Pediatric to Adult-based Care focused on skill preparation and health care transition planning for CYSHCN. The conference, hosted by Baylor College of Medicine and Texas Children's Hospital, featured presentations on legal and employment issues, youth and sibling perspectives of transition, and examples of successful transition programs. Texas Parent to Parent, with funding from MCH, provided scholarships for 3 youth and 30 parents to attend. Two CSHCN SDG staff attended. Additionally, CSHCN SDG participated on the Advisory Board for the 21st Annual Conference scheduled to be held virtually in October 2020.

The CSHCN SDG participated as a subject matter expert for updates to the Texas Health Steps Online Provider Education module "Transition Services for Children and Youth with Special Health Care Needs." CSHCN SDG promoted the module through its quarterly TALC meetings. CSHCN SDG also required all CASE and FSCR contractor staff who were funded by MCH to complete the course. A total of 1,146 individuals completed the module.

Prior to the start of the pandemic, CSHCN SDG gave the following presentations on health care transition:

- "Including Health in Transition Planning - Improving Outcomes for Students" at the Leander Independent School District's Community Symposium for the district's special educators and vocational rehabilitation staff.
- "Partnering with School Teams to Plan for Health Care Transition" for United Health Care's transition specialists supporting the STAR Kids managed care program.
- "Time for a Check Up: Integrating Health into Transition to Improve Post-School Outcomes" and "Volunteering for Victory: Creating Opportunities for Community Engagement and Building Skills for Success for Students with High Support Needs" for transition specialists, educators, students, and families at the Texas Transition Conference.

For the first time, CSHCN SDG exhibited at the Texas School Nurse Organization's annual conference. The event provided opportunities for networking and sharing ideas on how school nurses can advance health care transition planning with students. As a follow-up, the Texas School Nurse Organization in Education Service Center's Region 13 invited the CSHCN SDG to present "The School Nurse: Essential in Planning for a Healthy Transition to Adulthood."

Additional efforts in FY20 to increase understanding of the importance of planning for the transition from pediatric to adult care included:

- Exhibiting at the annual Partners in Prevention conference;
- Attending Association of University Centers on Disability meetings on health care transition;
- Attending Texas Parent to Parent's Parent Advisory Committee meetings to guide its new Central Texas Transition Center; and
- Attending quarterly meetings of the MCH Adolescent Health Workgroup.

Performance Analysis: Efforts to promote quality transition services, training, and technical assistance opportunities for families, contractors, service coordinators, social workers, educators, and other interested stakeholders continued. The

FY20 data point for the increase in percentage of CYSHCN and their families who are provided education and support about transition from pediatric to adult health care (Objective 1) is approximately 61.5% below the baseline. The data point for Objective 1 is below the baseline due to an overall decrease in the number of case management clients served by CSHCN SDG CASE contractors. The FY20 data point for tracking the increase in the percentage of pediatric and adult providers who are provided education and support on transition from pediatric to adult health care (Objective 2) is approximately 5.7% above the baseline (1,084) as 1,146 providers participated in the THS OPE module.

Challenges/Opportunities: Too few adult providers, insufficient payment for transition services, lack of understanding of the importance of planning, and provider reluctance to initiate conversations about health care transition contribute to poor outcomes for Texas youth. CSHCN SDG continues to forge strategic partnerships with educators to promote the inclusion of health care transition goals in school-based planning.

SPM 1: Percent of CYSHCN and their families who received the supports and services necessary to be included in their communities.

According to the 2019 Title V Parental Outreach Survey, 55% of respondents reported ever feeling isolated because of their child's disability, and more than a third of respondents did not feel a sense of belonging in their community. The same data showed that four out of five CYSHCN did not have access to inclusive day care or afterschool programs, and over 70% did not have access to inclusive preschool. Additionally, 26.2% of respondents reported needing respite care and not receiving it. In FY20, CSHCN SDG conducted and funded a variety of activities aimed to support the inclusion of CYSHCN and their families in Texas.

MCH led several projects aimed at removing systemic barriers to support the inclusion of CYSHCN families in community life and strategically advance family engagement. Key initiatives included developing a project to improve nutrition outcomes and reduce health disparities for CYSHCN and creating a new Family Engagement Specialist position focused on family engagement.

In FY20, MCH participated in the National Maternal and Child Health Workforce Development Center's (MCH WDC) 2020 Cohort. The Texas MCH WDC Cohort team included MCH child health, MCH adolescent health, CSHCN SDG, a health disparity subject matter expert, family partners for youth and CYSHCN, and a representative from PHRs. The 7-month learning opportunity involved collaborating with the Center to design and implement a health transformation challenge and strengthen workforce skills. To accomplish these goals, the team decided to create a series of presentations incorporating parent/caregiver and individual/youth nutrition and healthy eating strategies, including specific strategies for CYSHCN.

CSHCN SDG and the Executive Director of Texas Parent to Parent served on the legislatively mandated Policy Council for Children and Families (the Council). The Council works to improve the coordination, quality, efficiency, and outcomes of services provided to children with disabilities and their families through Texas' health, education, and human services systems. A majority of Council representatives are family members of youth and young adults with special health care needs. The Council worked to develop recommendations for its biennial report to HHSC leadership and the 87th Texas Legislature. Inclusion recommendations addressed unmet needs in accessing respite, mental health services, trauma-informed care, and crisis intervention services to help ensure children with disabilities grow up in families in their communities and not institutions.

In FY20, MCH began monthly professional development meetings aimed at increasing staff awareness and understanding of health disparities. The team strategized to identify ways to reduce health disparities throughout the MCH domains.

Title V leadership maximized an opportunity to advance family partnerships in all MCH population domains by creating a Family Engagement Specialist position within the Child and Adolescent Health Branch. The new role was designed to support and promote meaningful family engagement in all MCH programs to better address family needs, gaps in support, and emerging issues. Responsibilities included:

- Promoting inclusion of the family perspective in all MCH programs;
- Mobilizing partnerships with families, existing statewide parent and family support organizations, health care providers, policy makers, community stakeholders, and state agency staff to advance awareness of the importance of engaging with families at all levels;
- Assisting to establish and sustain a family-centered approach to services;
- Conducting outreach and consulting with external partners to increase family involvement; and
- Building capacity for family engagement and leadership.

CSHCN SDG contractors promoted community inclusion by offering CYSHCN and their family's opportunities to engage in social activities in their local neighborhoods. Contractors provided funding or helped families access reduced rates for tickets to community events, gardens, amusement parks, zoos, and museums. Prior to the pandemic, contractors led support groups and hosted sensory-friendly movie nights, holiday celebrations, “Parent’s Night Out” events, sporting activities, and dances.

Featured CSHCN SDG contractor activities that focused on inclusion are described below.

- Sharing Hands, located in Midland, partnered with local organizations to create opportunities for CYSHCN to participate in community sporting events. The contractor partnered with The Midland Soccer Association implement “TOPSoccer,” an inclusive program for youth of all abilities ages 5 through 19. Youth with disabilities were paired with a volunteer “buddy” to help get into position, focus, and follow the coach’s directions.
- Bryan’s House, located in Dallas, provided inclusive opportunities for CYSHCN and their families by connecting with the National Basketball Association (NBA). The NBA invited children with Down syndrome to be guests at a Dallas Mavericks game to raise awareness of the condition. The children received a VIP welcome on the court and met with the players. One player gave the contractor free tickets for a family of six to attend future home games.

The FSCR contractors provided respite for families. A total of 713 clients received a total of 22,124 hours of respite.

Due to COVID-19, some of the FSCR and CASE contractor activities were canceled which resulted in unused funds. Guidance from the DSHS Contract Management Section allowed contractors to divert unspent funds directly to families impacted by the pandemic. These 1-time emergency funds totaling $310,844 made it possible for families in crisis to pay for food, clothing, housing, utilities, furniture, transportation, phone, laundry, supplies for the home, medical supplies, and other basic needs. A total of 794 families received the emergency funds. Throughout the pandemic, case managers helped families access food pantries and food vouchers. Case managers also negotiated suspension of disconnection notices and fees with utility services, landlords, mortgage companies, and cell phone carriers.

The CSHCN SDG partnered on initiatives to increase the percentage of CYSHCN and their families able to access resources and services to support their active participation in community life by serving on multiple state councils.

The Title V CSHCN Director and program staff represented DSHS as voting members of the Texas Council for Developmental Disabilities (TCDD). TCDD, created by the Developmental Disabilities Assistance and Bill of Rights Act, was established to develop a comprehensive system of services and supports to help people with disabilities achieve their potential for independence. TCDD’s mission is to create change so that all people with disabilities are fully included in their communities and exercise control over their own lives. Representatives from disability organizations, University Centers for Excellence in Developmental Disabilities, and state agencies serve in governor-appointed positions together with self-advocates and family members. Quarterly meetings focused on state and federal policies and practices impacting people with disabilities.

In FY20, CSHCN SDG participated on the TCDD Project Development Committee which identifies unmet needs and makes recommendations to TCDD on grants to fund to meet those needs. The projects supported TCDD’s strategic state plan goals and addressed a variety of needs. Projects to advance opportunities for people with disabilities focused on competitive employment, higher education, health and fitness, positive behavioral interventions and supports, local advocacy networks, leadership training, strengthening communities, and cultural competence and sensitivity. CSHCN SDG participated in discussions regarding the development of TCDD’s FY22-FY26 state plan.

The Texas Early Learning Council (TELC) serves as Texas' state advisory council as required by the federal Improving Head Start for School Readiness Act of 2007. The Title V CSHCN Director was appointed to TELC in FY20. TELC utilizes its breadth of stakeholder representation to increase coordination and collaboration across state agencies and local program and service providers to improve the quality of, and access to, early childhood services across Texas. In FY20, TELC led a statewide birth-five needs assessment and strategic plan as part of Texas's Preschool Development Grant project.

The CSHCN SDG led efforts to increase the percentage of providers knowledgeable about the needs of CYSHCN families and effective ways to promote community inclusion.

FY20 began a new 5-year contract cycle for the CSHCN SDG community-based contractors. Early in FY20, CSHCN SDG hosted a 2-day in-person training for contractors to review contractual requirements, quarterly reports, state and national performance measures specific to CYSHCN, needs assessment activities, and provide technical assistance on financial reports. Contractors received travel reimbursement for transportation, lodging, and meals. The training provided participants the opportunity to network and better understand each other’s activities. Contractors learned about statewide support available to families through Texas Parent to Parent and the Sibshop facilitator trainings offered by Sharing Hands. The feedback from post-workshop surveys was positive. Contractors reported they found the sessions informative and helpful, and especially appreciated the opportunity to connect with each other.

CSHCN SDG partnered with Texas A&M AgriLife Extension and the TCDD to develop a Childcare Inclusion Workshop series. The team designed the workshop series to provide child care providers and professionals with the knowledge and

educational resources necessary to implement child care inclusion strategies for children with developmental and intellectual disabilities. The series consists of eight weekly online courses and webinars. AgriLife Extension and the TCDD plan to issue mini-credentials to those who complete the workshop.

Outdoor Learning Environment Texas is a statewide initiative that promotes healthful, nature-based outdoor spaces at early child care and education programs. A healthful outdoor environment helps preschool children be more physically active while they play, discover, and connect with nature. CSHCN SDG brought an inclusive lens to this initiative and advocated for intentional inclusion through appropriate language, outreach materials, and policy.

CSHCN SDG served on the Community Resources Coordination Group (CRCG) Statewide Workgroup and its Training and Technical Assistance Subcommittee. Located in 242 of 254 Texas counties, CRCGs are comprised of public and private agencies that partner with children, adults, and families who have complex, multi-agency needs. Each CRCG develops an individualized service plan to coordinate needed supports and resources. CSHCN SDG community-based contractors and DSHS PHR CSHCN case management staff participated in local CRCG meetings to help families in or near crisis identify and access needed services. The group met quarterly to inform and advance interagency coordination of activities. Workgroup members contributed to the implementation of the strategic plan, quarterly newsletter updates, and the following FY20 highlights:

- Reviewed and updated the website and informational resources in English and Spanish for individuals and families seeking services;
- Reviewed and updated the 2020 training plan for new CRCG leaders and members;
- Created a webinar series for CRCG members that included focused technical assistance on using telehealth platforms and hosting virtual meetings in response to the COVID-19 pandemic;
- Developed the biennial legislative report on local CRCG outcomes and systemic barriers;
- Strategized to address gaps in CRCG leadership due to the pandemic and recruit new leaders; and
- Developed and presented the CRCG of the Year recognition award.

CSHCN SDG attended the Texas Respite Advisory Committee (TRAC) meetings to monitor initiatives and identify respite opportunities for families of CYSHCN in the state. The TRAC was established by the HHSC Executive Commissioner to assist the agency in:

- Developing strategies to reduce barriers to accessing respite services;
- Improving the quality of respite services; and
- Providing training, education, and support to family caregivers.

Quarterly meetings were held in combination with the Aging and Disability Resource Center Advisory Committee to address shared interests and promote collaboration.

Performance Analysis: The 5-Year Needs Assessment and annual outreach surveys informed programmatic direction and confirmed that respite remains a vitally needed service. MCH staff and contractors continued efforts to improve access to community-based services and help families navigate their way through complex systems. The baselines for both objectives were established in FY17. Future annual reports will continue tracking the progress CSHCN SDG has made toward achieving these objectives.

Challenges/ Opportunities: COVID-19 significantly impacted inclusion efforts and access to respite throughout the state. Ongoing barriers to living successfully in the community for CYSHCN included negative attitudes towards people with disabilities, accessibility and access to adaptive technologies, absence of free or low-cost inclusive activities, inadequate supports and services for children with behavioral challenges, and lack of short-term community-based crisis services to prevent institutionalization. Respite was not readily available or affordable for many CYSHCN families. Program staff and contractor initiatives including parent networking, sibling support, and educational training/workshops helped strengthen families. Ongoing partnerships with external stakeholders will allow for development of future early childhood trainings focused on inclusion. The ability to provide emergency funds to families impacted by the pandemic allowed contractors to pivot to the needs of their communities.

Children with Special Health Care Needs - Application Year

NPM 11: NPM Percent of children with and without special health care needs having a medical home.

According to 2018-2019 National Survey of Children's Health (NSCH) data, children and youth with special health care needs (CYSHCN) make up over 17% of children age 18 and younger in Texas. The same data identified that 45% of CYSHCN in Texas receive care in a medical home, compared with 42.3% of CYSHCN nationwide. The Joint Principles of a Patient-Centered Medical Home describe a medical home as a place CYSHCN experience health care where the provider knows them well, care is comprehensive and continuous, and families are valued partners on the care team.

In the 2019 Title V Parental Outreach Survey, distributed by the Children with Special Health Care Needs Systems Development Group (CSHCN SDG), respondents reported that 61.8% of parents and guardians organized their child's care themselves. The same data showed that more than half of respondents had a plan for a medical emergency (63.2%) and a natural or man-made disaster (53.1%). Still, a large portion of this population had not planned for emergencies. In fiscal year (FY)22, CSHCN SDG will lead, fund, partner, and support efforts to improve care coordination for CYSHCN and their families, increase the percentage of CYSHCN having a medical home, and help families establish emergency plans.

The CSHCN SDG has led the statewide Medical Home Learning Collaborative (MHLC) since 2004 and will continue bringing together interested stakeholders (including providers and parents of CYSHCN) to increase knowledge, exchange resources, share best practices, and collaborate on efforts to improve access to a medical home. In FY22, CSHCN SDG will continue to survey MHLC participants following each quarterly meeting to ensure webinar topics and activities are meeting the members' needs. CSHCN SDG will keep members updated on current learning opportunities, new resources, recent publications, and other information pertinent to medical home through monthly communications. The program will structure meetings to promote collaboration and include active discussion on medical home innovation, best practices, and advancing optimum health outcomes for all Texans.

Also, CSHCN SDG will conduct outreach and consult with external partners to increase understanding and implementation of the medical home model for CYSHCN, families, and providers. Outreach activities will include ongoing development of educational resource materials, such as the "Every Child Deserves a Medical Home: A Guide for Families" brochure. Materials will be distributed to families, community-based contractors, clinicians, and partner organizations. CSHCN SDG will continue building a virtual presence through its website and DSHS social media platforms. The program will present on medical home best practices at local, regional, and state events and maximize opportunities to co-present with educators and family members. Efforts to increase membership on the medical home distribution list to expand outreach and build new partnerships will continue. CSHCN SDG will build on lessons learned during COVID-19 to connect with families, providers, and community stakeholders through virtual platforms.

The 2020 Title V Needs Assessment findings identified a state priority need to implement health disparity strategies throughout all maternal and child health populations. In 2021, CSHCN SDG developed a new initiative to identify communities experiencing health inequities and target interventions to strengthen services for underserved CYSHCN. The application will be open in FY22 and is scheduled to begin in FY23. DSHS will select an applicant demonstrating strong relationships with communities experiencing health inequities, extensive knowledge of culturally responsive practices, and a track record of program development and implementation.

CSHCN SDG identified the need to improve case management services in Texas by strengthening case managers' knowledge of family-centered, comprehensive case management for CYSHCN and their families. In FY22, CSHCN SDG will continue to fund the Texas Institute for Child and Family Wellbeing (TXICFW) to develop a standardized,

best practice approach and training curriculum for case managers across the state. The three-year project, which started in FY20, includes an assessment and development phase, a training phase, and a technical assistance and evaluation phase. The assessment and development phase was conducted remotely in FY20 because of COVID-19. In FY21, TXICFW continued the assessment and development phase, and began the training phase. In FY22, TXICFW will conduct training for case managers in regional and local health offices and provide ongoing technical assistance. DSHS and TXICFW will evaluate the feasibility of in-person training because of COVID-19 and adjust accordingly. Case managers and their supervisors will have access to an online learning community to ensure sustainability.

In FY22, TXICFW will complete outcome and process evaluations for the project that were developed alongside the practice model. As part of the evaluation plan, TXICFW will collect data from multiple sources including a survey of case managers to understand their perceptions of the effectiveness of the practice model and their retention of training concepts. The plan will include qualitative interviews with families and staff. TXICFW will also develop fidelity tools to understand the extent the practice model is followed by the case managers who participated in the training.

DSHS contracts with community-based organizations throughout Texas to provide gap-filling services to CYSHCN and their families who do not meet eligibility requirements for other programs. In FY22, CSHCN SDG will continue to fund eight organizations to provide case management (CM) and 14 organizations to provide family support and community resource (FSCR) services.

In FY22, contractors will work to advance medical home practices in their communities. Both CM and FSCR contractors will connect CYSHCN to primary care providers and specialists; help families access needed medication, medical supplies, and equipment; access services to meet basic needs; and educate families and professionals on the importance of the medical home. The CM contractors will provide comprehensive planning including a needs assessment, development of an individual service plan, ongoing assistance, and follow-up for families of CYSHCN. Some organizations will also manage medical equipment loans and recycling programs to reduce financial pressures on families.

Culturally responsive health care and care coordination system is a core component of the medical home. To help reduce health disparities and advance optimum health in their programs, CM and FSCR contractors are required to complete two outreach activities to underserved populations each quarter in FY22. Examples of qualifying outreach activities include:

- Meeting with an underserved population-serving organization
- Presenting/exhibiting at an underserved population event or conference
- Presenting on underserved population-specific disabilities or issues
- Partnering with underserved population-serving organizations to provide services to families
- Serving on a community board or group which targets activities to underserved populations

In FY22, CM and FSCR contractors will continue to partner with Federally Qualified Health Centers (FQHCs), local community organizations, and providers to increase CYSHCN access to health coverage, medical and dental services, primary and specialty care, medical transportation, medications, durable medical equipment, and other health-related needs. Contractors will continue collaborating with first responders, sharing resource information, and assisting with writing preparedness plans to help families of CYSHCN be ready in the event of a natural disaster, a need to shelter in place, and other emergencies.

In September 2021, CSHCN SDG will host a virtual training to keep contractors informed of public health priorities, review contract requirements, and provide technical assistance on DSHS' Maternal and Child Health (MCH) Title V

performance measures. The sessions will offer contractors opportunities to network with each other and exchange ideas for replicating successful activities. CSHCN SDG will review contract requirements addressing the CYSHCN-specific performance measures and state priority needs, including medical home, transition to adult health care, and community inclusion. This annual event will give contractors a better understanding of the MCH framework and how their activities contribute to advances for CYSHCN and their families.

CSHCN SDG requires CM and FSCR contractors to provide every family served at least one opportunity during the fiscal year to voluntarily complete a satisfaction survey. Families can complete either a paper or electronic version. Survey questions related to medical home will assess whether services are easily accessible, family-centered, comprehensive, continuous, and culturally effective. The CM contractor surveys have specific questions to assess family experience with service plan development, emergency preparedness planning, and timeliness of follow-up. To ensure data integrity, families will send completed surveys directly to CSHCN SDG for analysis. CSHCN SDG will share results with contractors to review areas of strength and those needing improvement.

DSHS Public Health Region (PHR) staff will collaborate with CM and FSCR contractors to ensure comprehensive care and responsive programming for families while ensuring services are not duplicated between PHR staff and the contractors. CSHCN SDG will provide PHR staff education on contractor activities in FY22 to help maximize partnership opportunities.

To increase the number of dentists with expertise in specialty care, CSHCN SDG will fund the University of Texas Health San Antonio School of Dentistry in FY22 to establish a Special Needs Dentistry Clinic (SNDC.) The clinic will be devoted exclusively to improve oral health for people with disabilities and special health care needs. The SNDC will be designed in close collaboration with public health agencies, community health organizations, and existing special health care resources. The operational plan will be developed after completing a needs assessment and will emphasize strategies that promote access to the SNDC, particularly for historically underserved populations. The SNDC will offer training that prepares future dentists and dental hygienists, school of dentistry faculty members, and private practitioners to serve the varying physical, mental, and sensory needs of CYSHCN. The clinic will also establish a SNDC Community Advisory Committee (SNDC-CAC) to provide guidance for the project. The SNDC-CAC will be comprised of patients, health care providers, parents, caregivers, self-advocates, and representatives of health organizations and facilities who are active in the community of San Antonio and surrounding regions. After the clinic is established, CSHCN SDG will explore opportunities to expand the training and share lessons learned from the project across the state.

CSHCN SDG will continue to partially fund the Health and Human Services Commission's (HHSC) CSHCN Services Program in FY22. The CSHCN Services Program's comprehensive health care benefits make it possible for CYSHCN across the state to access medically necessary health care. The program helps CYSHCN ages 20 and younger who meet eligibility criteria, and people of any age with cystic fibrosis, improve their health, well-being, and quality of life.

In FY22, CSHCN SDG will continue work on the advancing priorities of the Children with Medical Complexity (CMC) Collaborative Innovation and Improvement Network (CoIIN) project. Due to the success of the multi-state project, HRSA awarded supplemental funding for evaluation, sustainability and dissemination for an additional year. Texas team members include the Comprehensive Care Clinic (CCC) at Dell Children's Medical Group, TxP2P, Dell Medical School at the University of Texas, HHSC Medicaid, and Blue Cross Blue Shield of Texas (BCBSTX). BCBSTX supports children served in the clinic through Texas' STAR Kids Medicaid managed care program and will continue working to streamline redundant processes to reduce administrative burden. Dell Medical School researchers will contribute expertise in quality improvement to drive system changes.

The CMC CoIIN's overarching goals focus on improving the quality of life for CMC, the well-being of their families, and the cost-effectiveness of their care. These goals will remain project priorities in FY22. Telemedicine services, which expanded because of COVID-19, allowed for multiple sub-specialists, home health agencies, therapists, and equipment providers to attend a single appointment. Building on this advancement, the CCC will pilot a "whole child" visit designed to streamline assessments and develop a shared plan of care focused on what matters most to families. In FY21, the CMC CoIIN Family Workgroup developed outcome measures to assess family experience with the visits that will be incorporated into the FY22 post-visit survey. Assuring active, meaningful engagement, and empowerment of families who represent the diversity of the clinic population will be central to all project initiatives. In FY22, CSHCN SDG will support this project by:

- Helping advance the team's sustainability plan to help ensure continuing collaboration and progress to improve the quality of care for CMC and their families.
- Promoting ongoing, meaningful family engagement in all project initiatives.
- Participating in monthly team meetings and other project activities as requested.
- Contributing to the development of research papers, conference presentations, and posters.
- Identifying opportunities to scale project learnings to other initiatives including Texas' STAR Kids managed care program for CYSHCN.

CSHCN SDG will continue supporting several organizations that conduct activities aimed at increasing the percentage of CYSHCN who have a medical home including the Mountain States Regional Genetics Network, the Texas Primary Care Consortium, and Texas Health Steps.

The HRSA-funded Mountain States Regional Genetics Network (MSRGN) is one of seven regional networks helping to ensure that individuals with genetic disorders and their families have access to quality care and appropriate genetic expertise. MSRGN project priorities include:

- Offering educational activities for providers, families, and other stakeholders
- Developing and expanding educational resources for health professionals
- Developing educational resources for families and supporting family leaders to participate in the MSRGN and genetics care delivery system
- Facilitating the use of telehealth and telemedicine in the genetics health care delivery system
- Providing technical assistance, training, and support to providers on telehealth
- Facilitating implementation and expansion of telehealth in genetics service provision

In addition to CSHCN SDG staff, the MSRGN Texas team includes family members, geneticists, genetic counselors, and genetic student interns. One of Texas' two Act Early Ambassadors for the Center for Disease Control and Prevention's Learn the Signs Act Early initiative joined the team in FY21 and will bring expertise in early childhood intervention services. Texas team activities for FY22 will focus on identifying two clinics to serve as "genetic champions" to educate, equip, and empower pediatric and primary care providers to improve their ability to serve those impacted by pediatric genetic conditions. Additionally, the Texas team will continue building partnerships to increase awareness of and access to genetic services in the state through outreach and resource sharing to families, clinicians, and other professionals serving CYSHCN.

CSHCN SDG staff will serve on the steering committee of the Texas Primary Care Consortium (TPCC) in FY22. This statewide collaborative of diverse stakeholders seeks to ensure all Texans have access to high quality, timely, and person-centered primary care. TPCC hosts an annual statewide conference on primary care and the medical home, known as the "Texas Primary Care and Health Home Summit." The consortium will continue engaging additional stakeholders and examining the most effective methods to improve the health of all Texans.

CSHCN SDG will continue to provide subject matter expertise for updates to Texas Health Steps' medical home and other related modules. CSHCN SDG will also promote modules relevant to medical home through the Medical Home Learning Collaborative and other forums.

NPM 12: Percent of children with and without special health care needs who received services necessary to transition to adult health care.

According to the 2018 Clinical Report "Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home", youth, young adults, and family awareness of the importance of good health and continuity of care is vital for achieving goals in adulthood.

Findings of the 2018-2019 NSCH identified that 18.6% of CYSHCN in Texas ages 12 through 17 received the services necessary to transition to adult health care. This is a significant improvement from the 2016-2017 NSCH survey (8.5%) and beginning to approach the national average of 22.9%. In the 2019 Title V Parental Outreach Survey, 76% of respondents with transition-aged youth 12-17 did not feel prepared for their child's transition to adulthood. Respondents most often reported that they had not prepared for their child's transition in multiple areas including health care, postsecondary education, and addressing legal needs. Texas will continue raising awareness and conducting educational activities for families and professionals to increase the number of CYSHCN who receive services necessary to transition to adult health care.

CSHCN SDG will lead efforts to advance progress towards the seamless transition of young adults with special health care needs from pediatric to adult health care in FY22. CSHCN SDG will maximize opportunities to increase understanding of health care transition and promote active, intentional planning through education and resource sharing with youth, families, providers, educators, transition specialists, case managers, and others supporting CYSHCN and their families.

CSHCN SDG will continue building and strengthening relationships with families and professionals by leading the Transition to Adulthood Learning Collaborative (TALC) in FY22. Through the implementation of the TALC strategic plan, members will help drive improvements to advance awareness of health care transition and promote active planning in all areas of transition, including higher education, employment, and independent living. The TALC will convene via webinars and support a collaborative approach to transition planning by engaging parents, clinicians, educators, case managers, community-based organizations, and other key stakeholders in quarterly meetings. TALC will serve as a statewide forum for sharing knowledge, implementation strategies, resources, new publications, funding opportunities, updates on state and national transition initiatives, and upcoming transition-related events.

CSHCN SDG will continue funding TXICFW in FY22 to develop a family-centered, comprehensive case management model and training to increase the percentage of CSHCN who are receiving services necessary to transition to adult health care. This curriculum will be provided to all DSHS regional case management staff and will include specific training on partnering with families to prepare for their CYSHCN's transition to adulthood. The training will standardize elements of the case management and ensure that clients get the services they need. More information on the project can be found in NPM 11.

In FY22, CSHCN SDG-funded community-based organizations will promote health care transition and assist CYSHCN, ages 12 and older, and their families with the transition planning process. The CM contractors and PHR staff will work closely with youth and families to facilitate active preparation to transition from pediatric to adult-based health care by:

- Conducting readiness assessments
- Promoting health care self-management
- Increasing family understanding of age limit policies in both pediatric practices and children's hospitals
- Sharing resources
- Encouraging families to initiate conversations with clinicians to identify adult providers
- Providing linkages to adult services

Contractors will distribute transition resources through online forums such as electronic newsletters and social media. CSHCN SDG will continue to require contractors to actively engage families in meaningful ways to ensure the family perspective is incorporated into transition program development. CSHCN SDG will continue encouraging contractors to invite families to serve on the organization's advisory board and respond to family experience surveys.

In FY22, CM and FSCR contractors will continue collaborating with youth and families to plan and host transition fairs and workshops. Contractors will offer in-person events and adhere to COVID-19 safety guidelines for public meetings. Many transition trainings will continue to be offered virtually to maximize opportunities to engage families unable to attend in person. A hybrid approach of both online and in-person trainings will help address attendance barriers and reach a wider audience.

In addition to focusing on the transition to adult health care, CM contractors and PHR staff will help families prepare for legal changes at age 18 and help youth and their families plan for higher education, vocational training, employment, and independent living. Case managers will meet with youth, young adults, and their families to identify priority transition goals using the family need assessment tool and develop an individual service plan. FSCR contractors will also work to increase the number of adolescents, both with and without special health care needs, to develop skills to prepare for transition to adulthood.

CSHCN SDG requires contractors to offer two transition workshops each fiscal year to help youth develop knowledge and skills to transition to adulthood. One workshop must focus on health care transition planning or building health care self-management skills. The other workshop may include broader transition-related topics such as higher education, vocational and employment skills, and independent living. Contractors will offer all youth ages 12 to 21, and their families, the opportunity to attend both workshops.

The annual Baylor College of Medicine's Chronic Illness and Disability Conference: Transition from Pediatric to Adult-based Care will be held virtually in October 2021. CSHCN SDG staff will participate on the conference advisory board planning committee and attend the conference. The national conference brings together young adults, parents, physicians, and other health care professionals to learn from national thought leaders about how to better facilitate the successful transition from pediatric to adult-based care.

CSHCN SDG staff, together with Texas Parent to Parent (TxP2P), the Texas Center for Disability Studies, and Title V colleagues in Minnesota, New Mexico, North Carolina, and Wisconsin will continue to partner on a grass roots initiative to advance health care transition planning in schools. Federal and state legislation requires schools to address transition services in the Individual Education Plan (IEP) together with students and parents. With families already engaged in the process, including "health" in the IEP is a natural fit. Good health is the foundation for success in all other areas of transition - higher education, employment, and independent living. In FY22, the multi-state collaborative will continue to exchange resources and further develop outreach strategies to engage families, teachers, transition specialists, and school nurses to advance health care transition planning in school. Got Transition is a key collaborator in this effort and will offer guidance and expertise.

Texas Health Steps' web-based, self-paced provider training modules offer free continuing education credits for primary care providers and other health professionals. The courses offer information on Texas Medicaid and provide guidance on clinical, legal, regulatory, and practice management issues. CSHCN SDG will continue to provide subject matter expertise for updates to Texas Health Steps modules that address transition to adulthood. CSHCN SDG will also promote the transition-related modules through the Transition to Adulthood Learning Collaborative and other forums.

The CSHCN SDG contractor, TxP2P, received grant funding in 2019 from the Texas Council of Developmental Disabilities (TCDD) to establish the Parent Transition Center of Central Texas. The Center provides 1:1 transition planning consultation and support to families. To meet grant requirements, TxP2P established a Project Advisory Committee (PAC) to guide development of the new initiative. The PAC also offers guidance on Texas Network Connections, a TxP2P project to expand personal support networks in the state. Personal networks help reduce isolation and strengthen the safety net for children and adults with disabilities. In FY22, CSHCN SDG staff will attend PAC meetings, share resources, and offer subject matter expertise on transition and planning for the future.

The Adolescent Health Learning Collaborative, led by the state adolescent health coordinator, meets quarterly to bring together youth-serving professionals to share program updates, new resources, learning opportunities, and strengthen partnerships. In FY22, CSHCN SDG will attend group meetings, contribute resources, and identify collaborative opportunities to improve the health of youth and young adults.

SPM 1: Percent of CYSHCN and their families who received the supports and services necessary to be included in their communities.

The Americans with Disabilities Act (ADA), signed into law in 1990, conveys America's commitment to ensuring that people with disabilities are fully integrated and included in all aspects of daily life. All families and children benefit from a sense of belonging in their communities. For CYSHCN, inclusion provides equal access to community activities and offers benefits of friendships, peer models, and teaching others to accept differences.

CSHCN SDG surveyed certified community health workers (CHWs) in Texas to identify gaps in knowledge regarding services and supports available to families of CYSHCN. Results showed that CHWs were not informed on the unique needs and challenges of CYSHCN families, or available resources to support them. In response, CSHCN SDG developed an introductory training module to expand the capacity of CHWs in Texas to assist families of CYSHCN. This free, online training will continue to be promoted, evaluated, and updated as appropriate in FY22. CSHCN SDG will continue to survey CHWs to assess their knowledge, interests, and educational needs in working with families of CYSHCN. If indicated, CSHCN SDG will create additional learning opportunities for CHWs in Texas.

In FY22, CSHCN SDG will continue leading a nutrition initiative, which joins efforts across the life course by breaking down program silos and promoting healthy eating behaviors across domains. This initiative aims to integrate best practice principles and family voices in the project. To accomplish this mission, the team created a series of presentations incorporating caregiver, adolescent, and individual nutrition and healthy eating strategies, including ones specific to CYSHCN.

CSHCN SDG will establish a new Family Engagement Learning Collaborative (FELC) in FY22 to ensure the family voice is central to programmatic direction and policy decisions. The FELC will give families a forum to have meaningful opportunities to impact program policies, procedures, and initiatives while learning about quality improvement and public health work. The FELC will initially focus on families of CYSHCN and young adults with disabilities. The intention is to expand the initiative to include all Title V population domains in the future. The FELC

will be a platform for exchanging resource information, education, and raising awareness of programs and services.

CSHCN SDG will continue to fund community-based organizations to implement respite programs and host community activities for families and CYSHCN in FY22. These activities aim to strengthen community connections and reduce barriers to inclusion for CYSHCN and their families. Specific services available to CYSHCN and their families vary by contractor and community needs.

The FSCR contractors provide home- and center-based respite to give parents and caregivers a break from daily responsibilities and stressors. Some center-based respite contractors employ nurses making it possible for children with medical complexity to participate.

The FSCR contractors will continue hosting family and sibling support groups, social and recreational activities such as a sensory-friendly movie night, and other local events to strengthen family bonds and advance community inclusion. To expand opportunities for CYSHCN to build friendships with their peers without disabilities, contractors will offer camps throughout the year and provide scholarship funds when able, so more children can participate.

The CM contractors and DSHS regional staff assist families with accessing needed resources including insurance coverage, health care, specialized therapies, durable medical equipment, counseling, behavior specialists, respite, and long-term services and supports. These efforts, along with linking families to critical resources to meet basic needs such as food, housing, clothing, and transportation, will continue in the FY22. Helping to ensure CYSHCN remain living at home with their families is a CSHCN SDG priority.

Case management staff will assist school-age CYSHCN by helping parents prepare for IEP meetings. When requested by families, case managers will attend IEP meetings to support CYSHCN with accessing the general education curriculum and other school-based services. Meaningful inclusion at school offers all students opportunities to learn from each other, be more accepting of differences, and build lasting friendships.

COVID-19 amplified the financial hardships many families of CYSHCN experience. Parents may have lost jobs or experienced reduced work hours, leaving many struggling to meet basic needs. In response, CSHCN SDG allocated additional FY22 funding for CM and FSCR contractors to give financial help to families. The funds may be used for food, clothing, utilities, furniture, transportation, phone, laundry, supplies for the home, medical supplies, medical equipment, and other basic needs. Contractors are responsible for developing internal policies and procedures to identify and prioritize families in their area and ensure that funds are distributed to families within the 12-month timeframe.

In FY22, the Title V CSHCN director and program staff will continue to represent MCH Title V as voting members of the TCDD, which strongly advocates for the full, meaningful inclusion of individuals with disabilities in their communities. In FY22, staff will continue to participate on the TCDD Project Development Committee. The TCDD Project Development Committee provides expertise and recommendations on the grants the council funds throughout Texas. The grants address a variety of needs and areas of focus— including competitive employment, education, health and fitness, positive behavioral interventions and supports, local advocacy networks, leadership training, strengthening communities, and cultural competence and sensitivity. CSHCN SDG staff will also participate in discussions regarding the implementation of the TCDD FY22- FY26 state plan.

The Title V CSHCN director will represent DSHS on the federally mandated Texas Early Learning Council (TELC) in FY22. The goal of the TELC is to improve the quality of and access to early childhood services throughout Texas. The TELC is comprised of cross-sector stakeholders who work to increase coordination and collaboration among state agencies and local entities. TELC will continue to assess the impact of COVID-19 on Texas' early childhood services

and identify solutions.

CSHCN SDG will continue to collaborate with statewide partners to plan an online series about inclusive care for children with intellectual and developmental disabilities. The purpose of the Child Care Inclusion Workshop Series is to increase knowledge, resources, and understanding for child care providers and other professionals working with CYSHCN and their families in a child care setting. Once a week for eight weeks, participants will take an online training module and attend a live webinar developed and presented by faculty, state, and local service providers, experienced child care providers, and parent advocates.
The Policy Council for Children and Families (PCCF), a legislatively mandated statewide workgroup, strives to improve the coordination, quality, efficiency, and outcomes of services provided to children with disabilities and their families through the state's health, education, and human services systems. PCCF formulates and submits recommendations on system improvements to the executive commissioner of HHSC and the Texas Legislature. In FY22, CSHCN SDG staff will represent DSHS as an ex-officio member to the council and provide subject matter expertise on transition to adult health care, medical home, and community inclusion.

Community Resource Coordination Groups (CRCGs) are county-based interagency groups comprised of public and private agencies that convene voluntarily and play a vital role in helping CYSHCN with complex needs, which cannot be met by a single agency. In FY22, CSHCN SDG staff will remain active on the CRCG Statewide Workgroup which serves as the point of contact for local CRCGs to report concerns and focuses on assuring access to needed supports for youth at risk of or experiencing a crisis. In FY21, three sub-committees merged into one to better align with the strategic plan. CSHCN SDG staff will serve on this newly formed sub-committee. Both CSHCN SDG CM and FSCR contractors will support their local CRCGs by attending staffing meetings and sharing critical resources to help keep children at home in FY22.

The Texas Respite Advisory Committee, established by the Texas Legislature, assists HHSC to:

- Develop strategies to reduce barriers to accessing respite.
- Improve the quality of respite services.
- Provide training, education, and support to family caregivers.

In FY22, CSHCN SDG will support the TRAC by attending meetings and monitoring statewide respite initiatives to identify opportunities to improve access for families of CYSHCN to quality, affordable respite services.

Outdoor Learning Environments Texas (OLE! Texas) is a statewide initiative that seeks to address obesity by improving outdoor spaces at child care centers. CSHCN SDG will continue to support OLE! Texas in FY22 by serving on the leadership committee. OLE! Texas will convene and support local coalitions to assist early childhood education centers with the process of developing and constructing a high-quality outdoor learning environment. The OLE! Texas leadership committee will also develop a network of trained landscape and design professionals to design outdoor spaces featuring best practices.

The Texas Developmental Screening Workgroup (DSW) is a group of stakeholders who collaborate on increasing developmental screenings and enhancing quality service referral mechanisms statewide. CSHCN SDG will continue to participate in bimonthly workgroup meetings. In FY22, workgroup members will participate in the identification of relevant initiatives to partner with, dissemination of screening resources to providers and families, and generation of standard language and definitions across sectors and applicable data sets where possible. In FY21, the DSW began exploring opportunities for creating a statewide hub to house developmental screening data that would provide a means for sharing screening results across community settings. The DSW will continue exploration of this effort in FY22 through identification of potential platforms and generating recommendations for implementation.

Cross-Cutting/Systems Building

Cross-Cutting/Systems Builiding - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

III.F. Public Input

Stakeholders are notified of public comment opportunities through announcements sent to the MCH and CSHCN GovDelivery lists maintained by MCHS. Announcements are sent to the three CSHCN distribution lists, including CSHCN Services Program, CSHCN Medical Home, and the CSHCN Transition list. MCHS also maintains the Maternal and Child Health and Adolescent Health lists. Recipients of the notifications included providers, consumers, HHS system staff, hospitals, and other MCH partners. During public comment opportunities, Title V consults with the MCHU Information Specialist who specializes in communications and assists with strategically developing materials, media posts, and ensuring that all communications meet agency accessibility standards.

MCHS maintains email addresses (TitleV@dshs.texas.gov and cshcn@dshs.texas.gov) for obtaining ongoing public and partner questions and feedback on MCH priorities. The DSHS MCH website contains regularly updated information about Title V, related programs, and resource materials for public use. Additional Title V MCH Block Grant Applications and Five-Year Needs Assessments are also linked on the site for reference. Respondents typically represent hospitals, academia, state government, community, non-profit, schools, and violence prevention stakeholders. Texas continues to identify and employ new methods aimed at increasing in the response rate during the public comment opportunities.

DSHS offers stakeholders continuing opportunities to receive updated information via emails through subscription to a variety of MCH-related topic GovDelivery distribution lists, including maternal and child health, adolescent health, children with special health care needs, medical home, transition, Healthy Texas Babies, Zika, and Community Health Worker training and certification. These email distribution lists serve as the basis for ongoing and future communication with partners, families, providers, consumers, and other stakeholders interested and impacted by MCH issues. GovDelivery is frequently used by MCHS to quickly disseminate critical updates and information to the public and interested stakeholders. DSHS employs a number of methods to obtain input and feedback from the public throughout the year. MCHS meets regularly with MCH partners and stakeholders throughout the HHS system and DSHS. MCHS hosts ongoing partner meetings for key MCH colleagues to share updates and explore opportunities for collaboration. Participants include partners from multiple programs including Oral Health, Newborn Screening, Birth Defects Epidemiology and Surveillance, Obesity Prevention, Tobacco Prevention and Control, Mental Health and Substance Abuse, Home Visiting, Early Childhood Intervention, Medicaid, and School Health.

Additionally, discussion time is allotted during Title V quarterly contractor and DSHS Public Health Regional staff conference calls to share information about best practices and challenges in serving MCH populations. MCHS meets with DSHS regional staff engaged in the planning and provision of Title V population-based activities through conference calls, webinars, in-person meetings and trainings focused on Title V topics. MCHS also meets with DSHS Regional Medical Directors to provide periodic updates related to Title V activities and discuss regional Title V population-based activities planning and implementation.

MCHS regularly involves the Texas Family Delegate as well as Texas Parent to Parent colleagues in the development and review of content. Families who are served by MCHS have the opportunity to respond to surveys regarding the services that they receive through the program. MCHS conducts CSHCN surveys and focus groups of providers and families to gather ongoing feedback to inform programming. DSHS staff regularly convene and attend formal and informal advisory workgroups, steering committees, councils, task forces, and other groups to address emerging issues and work on collaborative initiatives related to MCH populations throughout the year.

Participants (including parents and family members) on various committees related to population health domains also serve as resources throughout the year, and assist with identifying priorities and guiding programming planning efforts. Many of these group provided timely and valuable feedback that informed changes to programming and operations during the early stages of the COVID-19 pandemic. As part of the ongoing Needs Assessment process, MCHS will host multiple hosted stakeholder webinars to share progress on state Title V efforts and seek feedback

from MCH partners.

III.G. Technical Assistance

Texas values the ongoing provision of technical assistance and educational resources from HRSA. Learning opportunities that include peer networking can enhance the MCH workforce and generate improved quality of programming. The following topics represent continued areas of interest in Texas:

COVID-19 Maternal and Child Health data and updates related to the populations served by Title V. Resources, tools, and peer networking opportunities would be useful as states navigate changes due to COVID-19.

Ongoing Needs Assessment Peer sharing opportunities and resources for both the ongoing annual needs assessments and the statewide five-year needs assessment, designed for both epidemiology and program staff.

Community Inclusion Resources or tools focusing on Community Inclusion efforts for CSHCN would assist with developing and implementing evidence-based and evidence-informed programming.

National Performance Measures Continued facilitation of peer networking opportunities focused on implementation of national performance measures would be useful for Texas MCH staff and colleagues.

State Performance Measures Technical assistance and facilitation of peer networking opportunities related to the five Texas SPMs (child and adolescent obesity prevention, infant mortality, community inclusion, maternal health and safety, and maternal morbidity) would be beneficial.

Maternal and Child Health Disparities The continued provision of learning opportunities to operationalize activities to address health disparities and the community-level drivers would be welcomed.

Life Course and Integrated Care DSHS will continue to seek guidance regarding ongoing efforts to integrate physical, mental, and behavioral health systems for MCH populations and continued development of community health worker programs to address MCH needs.

"Very Large State" Grouping Texas appreciated the opportunity to connect and discuss grant block efforts with other comparably-sized states at recent Technical Assistance meetings. This method of grouping states is extremely valuable for networking and idea sharing among MCH colleagues.

Provider Engagement MCHS continues to explore methods for conducting provider outreach to increase partnerships and gather feedback as part of ongoing needs assessment activities. Seeking guidance in how to best showcase the work of the Texas Title V program in a way that is meaningful to health care providers.

Workforce Development Continued assistance with statewide workforce development would be useful in order to enhance regional MCH capacity and improve efficiency in implementation of activities throughout the Public Health Regions in Texas.

Family Partnership/Engagement Guidance and resources to integrate family partnerships across all MCH domains. Specifically geared toward Very Large States with diverse populations.

Stakeholder Feedback Guidance on best-practices and methods for capturing meaningful and ongoing stakeholder and MCH partner feedback throughout the block grant cycle.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - IV. Title V - Medicaid MOU.PDF

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - V. Supporting Document 1_Glossary.pdf

Supporting Document #02 - V. Supporting Document 2_Legislative Reports.pdf

Supporting Document #03 - V. Supporting Document 3_TexasAIM Update and Other Resources.pdf

Supporting Document #04 - V. Supporting Document 4_TCHMB Presentation.pdf

Supporting Document #05 - V. Supporting Document 5_Epi Posters and Presentations.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - VI. Organizational Chart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Texas

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 35,734,420	
A. Preventive and Primary Care for Children	$ 15,565,952	(43.5%)
B. Children with Special Health Care Needs	$ 13,647,520	(38.1%)
C. Title V Administrative Costs	$ 3,475,000	(9.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 32,688,472	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 40,208,728	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 40,208,728	
A. Your State's FY 1989 Maintenance of Effort Amount $ 40,208,728		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 75,943,148	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 4,711,238	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 80,654,386	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 160,020
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 2,655,427
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 97,963
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 304,111
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Violent Death Registry	$ 780,508
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 553,209

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 33,958,965		$ 35,146,149	
A. Preventive and Primary Care for Children	$ 15,326,549	(45.1%)	$ 13,891,250	(39.5%)
B. Children with Special Health Care Needs	$ 13,261,101	(39.1%)	$ 13,639,521	(38.8%)
C. Title V Administrative Costs	$ 2,200,000	(6.5%)	$ 2,743,058	(7.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 30,787,650		$ 30,273,829	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 40,208,728		$ 40,208,728	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 40,208,728		$ 40,208,728	
A. Your State's FY 1989 Maintenance of Effort Amount $ 40,208,728				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 74,167,693		$ 75,354,877	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 4,139,691		$ 3,630,896	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 78,307,384		$ 78,985,773	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 150,000	$ 141,375
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 2,100,000	$ 2,428,634
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	$ 0	$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 97,963	$ 62,419
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Violent Death Registry	$ 761,508	$ 310,176
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000	$ 182,569
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 148,000	$ 133,575
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Children's Oral Care Access Program		$ 30,523
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees		$ 83,801
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Zika Health Care Services Program	$ 632,220	$ 257,824

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**

Field Note:
The value in Line 1C, Title V Administrative Costs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted due to an increase in federal allocation in FY21, per FY21 NOAs received. The FY22 budgeted amount reflects this increase in federal funding, and the administrative costs remain under the 10% threshold.

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Texas

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 2,173,234	$ 3,864,667
2. Infants < 1 year	$ 872,714	$ 1,007,653
3. Children 1 through 21 Years	$ 15,565,952	$ 13,891,250
4. CSHCN	$ 13,647,520	$ 13,639,521
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 32,259,420	$ 32,403,091

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 10,700,110	$ 9,371,892
2. Infants < 1 year	$ 1,167,225	$ 1,721,313
3. Children 1 through 21 Years	$ 3,959,631	$ 7,256,885
4. CSHCN	$ 20,585,589	$ 20,826,796
5. All Others	$ 3,796,173	$ 1,031,842
Non-Federal Total of Individuals Served	$ 40,208,728	$ 40,208,728
Federal State MCH Block Grant Partnership Total	$ 72,468,148	$ 72,611,819

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: This amount reflects a $400,000 adjustment to include Maternal Safety initiatives and Maternal Mortality and Morbidity Review Committee data collection efforts. Due to COVID, spending in this category was delayed.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: This amount reflects an increase of $323,342 to increase supports for CSHCN.	

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Texas

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 8,318,087	$ 12,585,796
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 14,500	$ 3,217,184
B. Preventive and Primary Care Services for Children	$ 4,865,000	$ 3,376,283
C. Services for CSHCN	$ 3,438,587	$ 5,992,329
2. Enabling Services	$ 3,819,084	$ 929,429
3. Public Health Services and Systems	$ 23,597,249	$ 21,630,924
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 7,151,730
Physician/Office Services		$ 1,276,334
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 1,375,277
Dental Care (Does Not Include Orthodontic Services)		$ 1,885,288
Durable Medical Equipment and Supplies		$ 215,130
Laboratory Services		$ 180,601
Other		
Home Health		$ 14,234
Counseling, supplies, & radiology		$ 410,048
Low-Protein Foods		$ 77,154
Direct Services Line 4 Expended Total		$ 12,585,796
Federal Total	$ 35,734,420	$ 35,146,149

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 17,706,915	$ 17,809,751
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 751,158	$ 1,061,628
B. Preventive and Primary Care Services for Children	$ 650,000	$ 661,254
C. Services for CSHCN	$ 16,305,757	$ 16,086,869
2. Enabling Services	$ 2,328,937	$ 3,218,781
3. Public Health Services and Systems	$ 20,172,876	$ 19,180,196
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 8,692,842
Physician/Office Services		$ 1,553,044
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 5,277,233
Dental Care (Does Not Include Orthodontic Services)		$ 715,618
Durable Medical Equipment and Supplies		$ 825,499
Laboratory Services		$ 409,919
Other		
Low-Protein Foods		$ 115,730
Home Health		$ 54,621
Counseling, case management, radiology, & supplies		$ 165,245
Direct Services Line 4 Expended Total		$ 17,809,751
Non-Federal Total	$ 40,208,728	$ 40,208,728

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Texas

Total Births by Occurrence: 372,570 **Data Source Year: 2020**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	369,413 (99.2%)	15,673	434	434 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Cystic Fibrosis
Glutaric Acidemia Type I	Holocarboxylase Synthase Deficiency	Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency
Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Primary Congenital Hypothyroidism
Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences
ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Newborn hearing screening	363,155 (97.5%)	13,691	2,382	678 (28.5%)
Secondary RUSP Conditions	369,413 (99.2%)	244	123	123 (100.0%)

3. Screening Programs for Older Children & Women

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Vision Screening	1,830,165	183,126	153,548	51,698
Hearing Screening	1,798,165	40,608	31,097	9,765
Spinal Screening	370,874	12,271	12,271	4,452

4. Long-Term Follow-Up

Long-term follow-up of newborns diagnosed with a screened condition is not mandatory in Texas. The Newborn Screening Program staff members contact clinicians in Texas to request long-term follow-up information to monitor a child for: continuity of care, hospitalizations/crisis information, and compliance with medications. Clinicians are not mandated to respond to the Department's requests. For some conditions, children are monitored up to 18 years of age. Children and families are referred to case management services that are available through Medicaid and Title V. The program is exploring options to improve long-term tracking; however, there is currently no automated tracking system to capture, store, and report these data.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Newborn hearing screening - Total Number Referred For Treatment**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The discrepancy in the number of confirmed cases and the number referred for treatment is due to lack of documentation about whether certain confirmed cases were referred for treatment. Providers often make referrals without recording the referral in the Texas Early Hearing Detection & Intervention (TEDHI) database. DSHS continues to work on reducing this rate of loss to follow-up/lack of documentation.	
2.	**Field Name:**	**Secondary RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: All secondary RUSP conditions screened for in Texas are included in this measure. These conditions include: Carnitine acylcarnitine translocase deficiency; 2,4 Dienoyl-CoA reductase deficiency; 2-Methl-3-hydroxybutyric aciduria; 2-Methylbutyrylglycinuria; 2-Methylbutyrylglycinuria; Argininemia; Benign hyperphenylalaninemia; Biopterin defect in cofactor biosynthesis; Biopterin defect in cofactor regeneration; Carnitine palmitoyltransferase type I; Carnitine palmitoyltransferase type II; Citrullinemia type II; Glutaric acidemia type II; Hypermethioninemia; Isobutyrylglycinuria; Malonic acidemia; Medium short chain L-3-hydroxyacl-CoA dehydogenase deficiency; Medium chain ketoacyl-CoA thiolase deficiency, Methylmalonic academia; Short Chain acyl-CoA dehydrogenases deficiency; Tyrosinemia type II; Tyrosinemia type III; T-cell related lymphocyte deficiencies; and other various hemoglobinopathies.	
3.	**Field Name:**	**Secondary RUSP Conditions - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens for several secondary RUSP conditions were included with the number for several core RUSP conditions. It was not possible to determine the exact number of presumptive positive screens for these conditions; therefore, for these secondary RUSP conditions, the number of presumptive positive screens was set to 0. Thus, the total number of presumptive positive screens for all secondary RUSP conditions is likely an underestimate. Secondary RUSP conditions for which it was not possible to determine the exact number of presumptive positive screens included: 2-Methl-3-hydroxybutyric aciduria; 2-Methylbutyrylglycinuria; 3-Methylglutaconic aciduria; Benign hyperphenylalaninemia; Biopterin defect in cofactor biosynthesis; Biopterin defect in cofactor regeneration; Citrullinemia type II, Hypermethioninemia; Medium chain ketoacyl-CoA thiolase deficiency; Methylmalonic acidemia (Cbl C and D forms); and T-cell related lymphocyte deficiencies.	

4.	**Field Name:**	**Secondary RUSP Conditions - Total Number Confirmed Cases**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**

Field Note:
The number shown is an aggregate total, which includes the number of confirmed cases for all secondary RUSP conditions screened for in Texas. These conditions include: Carnitine acylcarnitine translocase deficiency; 2,4 Dienoyl-CoA reductase deficiency; 2-Methl-3-hydroxybutyric aciduria; 2-Methylbutyrylglycinuria; 2-Methylbutyrylglycinuria; Argininemia; Benign hyperphenylalaninemia; Biopterin defect in cofactor biosynthesis; Biopterin defect in cofactor regeneration; Carnitine palmitoyltransferase type I; Carnitine palmitoyltransferase type II; Citrullinemia type II; Glutaric acidemia type II; Hypermethioninemia; Isobutyrylglycinuria; Malonic acidemia; Medium short chain L-3-hydroxyacl-CoA dehydogenase deficiency; Medium chain ketoacyl-CoA thiolase deficiency, Methylmalonic academia; Short Chain acyl-CoA dehydrogenases deficiency; Tyrosinemia type II; Tyrosinemia type III; T-cell related lymphocyte deficiencies; and other various hemoglobinopathies.

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Texas

Annual Report Year 2020

Form 5a – Count of Individuals Served by Title V (Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	92,891	51.0	0.0	42.0	7.0	0.0
2. Infants < 1 Year of Age	93,578	51.0	0.0	42.0	7.0	0.0
3. Children 1 through 21 Years of Age	103,460	32.0	0.0	52.0	16.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	11,329	41.0	0.0	54.0	5.0	0.0
4. Others	90,420	9.0	0.0	71.0	20.0	0.0
Total	380,349					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	377,599	No	374,100	100.0	374,100	92,891
2. Infants < 1 Year of Age	386,178	No	372,570	100.0	372,570	93,578
3. Children 1 through 21 Years of Age	8,619,532	No	8,781,114	27.7	2,432,369	103,460
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,565,537	No	1,602,458	28.8	461,508	11,329
4. Others	19,998,543	No	20,094,040	7.5	1,507,053	90,420

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**
	Field Note: Programs and services for pregnant women include Information for Parents of Newborns, Genetics Fee-for-Service, Parent's Guide to Raising Healthy Happy Children, and MCH Fee-for-Service. It is estimated that half of the Information for Parents of Newborns and Parent's Guide to Raising Happy Healthy Children were provided to pregnant women during a prenatal care visit. In addition, it is estimated that 50% of the individuals who received the Information for Parents of Newborns were enrolled in Medicaid and would have also received the Parent's Guide to Raising Happy Healthy Children. Therefore, the number of individuals who were provided the Information for Parents of Newborns was reduced by 50%. Primary source of coverage for pregnant women was estimated using 2020 birth data.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**
	Field Note: Programs and services for infants include Information for Parents of Newborns, Lactation Support Center, Parent's Guide to Raising Healthy Happy Children, and MCH Fee-for-Service. It is estimated that half of the Information for Parents of Newborns and Parent's Guide to Raising Happy Healthy Children were provided after delivery. In addition, it is estimated that 50% of the individuals who received the Information for Parents of Newborns were enrolled in Medicaid and would have also received the Parent's Guide to Raising Happy Healthy Children. Therefore, the number of infants served by the Information for Parents of Newborns was reduced by 50%. Primary source of coverage for infants was estimated using 2020 birth data.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Programs and services for children include Oral Health Program, School Health, Genetics Fee-for-Service, MCH Fee-for-Service, inpatient and outpatient MedCARES consultations and exams, and all CSHCN services detailed in 3a. Primary source of coverage for children was estimated using 2017 American Community Survey data.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Programs and services for children with special healthcare needs include CSHCN Health Care Benefits, CSHCN Systems Development, and CSHCN Regional Case Management. Primary source of coverage for CSHCN was estimated using 2016-2017 National Survey of Children's Health data.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**

Field Note:
Programs and services for other populations include COVID-19 isolation support services, Information for Parents of Newborns and the Parent's Guide to Raising Healthy Happy Children.

The Form 5a Reference Data for Others Column (B) Title XIX % was 8%,but the row percents did not add up to 100% and created a validation error. Others Column B was changed to 9% to pass validation checks.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**

Field Note:
Programs and services for pregnant women include Information for Parents of Newborns, Genetics Fee-for-Service, Parent's Guide to Raising Healthy Happy Children, MCH Fee-for-Service, Healthy Texas Babies, Every Ounce Counts, and Texas Ten Step. It is estimated all pregnant women residing in the state of Texas were served by Title V through the Information for Parents of Newborns, because prenatal care providers and delivery hospitals are required to provide these educational materials to all pregnant women in Texas. The denominator was estimated from Texas 2018 provisional birth and fetal death files.

2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**

Field Note:
Programs and services for infants include Information for Parents of Newborns, Lactation Support Center, Parent's Guide to Raising Healthy Happy Children, MCH Fee-for-Service, GovDelivery, Newborn Screening, Genetics Fee-for-Service, Texas Collaborative for Healthy Mothers and Babies, and Healthy Texas Babies. It is estimated all infants born in the state of Texas were served by Title V through universal Newborn Screening and through the Information for Parents of Newborns, because prenatal care providers and delivery hospitals are required to provide these educational materials to all pregnant women in Texas. The denominator was estimated from Texas 2018 provisional birth files.

3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
Programs and services for children include School Health, MEDCARES, Genetics Fee-for-Service, MCH Fee-for-Service, Rape Prevention and Education, School Screening, GovDelivery, Project LAUNCH, Texas Health Steps Online Provider Education, Youth Engagement Project, and the Texas Healthy Adolescent Initiative. Since school vision and hearing screening are mandatory for students in the same grades, the larger of the two numbers was used, rather than adding the two numbers together, to prevent duplication. Since participants at RPE workshops all received RPE informational units, the number of informational units distributed was used, rather than adding the two numbers together, to prevent duplication. The denominator was estimated from Texas Demographic Center 2018 Projections for 2020 population.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**

	Field Note: Programs and services for children with special healthcare needs include CSHCN Health Care Benefits, CSHCN Systems Development, and CSHCN Regional Case Management. The denominator was estimated by multiplying the percent CSHCN in Texas from NSCH 2018-2019 data by Texas Demographic Center 2018 Projections for 2020 population. The numerator was calculated by adding the estimated number of CSHCN served by children programs to the number of CSHCN only served by CSHCN programs, assuming that CSHCN were served by children programs at the same rate as other children.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Programs and services for other populations include Healthy Texas Babies, MedCARES, Suicide Prevention, Community Health Workers, GovDelivery, Regional Population Based Services, and TexasZika.org, the Texas Collaborative for Healthy Mothers and Babies conference, the Youth Engagement Project, smoke-free policy toolkits, Texas Mother-Friendly worksites, Zika Printed Materials. Since TexasZika.org links to the order form for Zika Printed Materials, the larger of the two numbers was used, rather than adding the two numbers together, to prevent duplication. The denominator was estimated from Texas Demographic Center 2018 Projections for 2020 population.	

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Texas

Annual Report Year 2020

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	374,100	119,485	46,604	179,594	618	18,864	574	5,294	3,067
Title V Served	3,045	193	147	2,394	10	38	12	0	251
Eligible for Title XIX	184,633	31,103	26,746	110,875	346	3,199	277	5,435	6,652
2. Total Infants in State	428,414	125,951	50,027	217,697	1,040	19,090	961	8,913	4,735
Title V Served	372,570	119,065	46,279	178,991	614	18,823	569	5,283	2,946
Eligible for Title XIX	218,473	15,892	16,203	71,047	132	1,642	129	8,591	104,837

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: CHS Provisional 2020 Natality File and CHS Provisional 2020 Fetal Mortality File	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Title V MCH FFS Program	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Data Quality Team, Center for Analytics & Decision Support, HHSC	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Texas Demographic Center 2018 Projections for 2020 Population. State population data do not contain all race categories. Therefore, race-specific numbers for columns E,G,H, and I were estimated based on racial distribution in Texas 2020 provisional birth files.	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: CHS Provisional 2020 Natality File	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Data Quality Team, Center for Analytics & Decision Support, HHSC	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Texas

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(877) 541-7905	(877) 541-7905
2. State MCH Toll-Free "Hotline" Name	2-1-1 Texas	2-1-1 Texas
3. Name of Contact Person for State MCH "Hotline"	James Valdenegro	James Valdenegro
4. Contact Person's Telephone Number	(512) 483-5101	(512) 483-5101
5. Number of Calls Received on the State MCH "Hotline"		25,511

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	https://dshs.texas.gov/mch/	https://dshs.texas.gov/mch/
4. Number of Hits to the State Title V Program Website		107,700
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

The methodology for capturing the "Number of Hits to the State Title V Program Website" has been updated, and now includes unique pageviews for all pages linked to the main DSHS MCH website (/mch/default.shtm). Previously, annual report data was provided only on the pageviews to the landing page and did not reflect the use of the full DSHS MCH website.

Form 8
State MCH and CSHCN Directors Contact Information

State: Texas

1. Title V Maternal and Child Health (MCH) Director	
Name	Jeremy Triplett
Title	Maternal and Child Health Section Director
Address 1	Texas Department of State Health Services
Address 2	PO Box 149347 MC1922
City/State/Zip	Austin / TX / 78714
Telephone	(512) 776-2567
Extension	
Email	Jeremy.Triplett@dshs.texas.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Audrey Young
Title	Child and Adolescent Health Branch Manager
Address 1	Texas Department of State Health Services
Address 2	PO Box 149347 MC1922
City/State/Zip	Austin / TX / 78714
Telephone	(512) 776-7727
Extension	
Email	Audrey.Young@dshs.texas.gov

3. State Family or Youth Leader (Optional)	
Name	Kim Beam
Title	MCH Regional Programs Administrator
Address 1	Texas Department of State Health Services
Address 2	5425 Polk St Ste 220
City/State/Zip	Houston / TX / 77023
Telephone	(713) 767-3018
Extension	
Email	Kim.Beam@dshs.texas.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Texas

Application Year 2022

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Implement health equity strategies across all maternal and child health populations.	New
2.	Improve nutrition across the life course.	New
3.	Improve the cognitive, behavioral, physical, and mental health and development of all Maternal and Child Health populations.	New
4.	Increase family support and ensure integration of family engagement across all Maternal and Child Health programming.	New
5.	Support health education and resources for families and providers.	New
6.	Promote safe, stable, nurturing environments to reduce violence and the risk of injury.	New
7.	Improve transition planning and support services for children, adolescents, and young adults, including those with special health care needs.	New
8.	Support comprehensive, family-centered, coordinated care within a medical home model for all Maternal and Child Health populations.	New
9.	Improve maternal and infant health outcomes through enhanced health and safety efforts.	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Implement health equity strategies across all maternal and child health populations.	New
2.	Improve nutrition across the life course.	New
3.	Improve the cognitive, behavioral, physical, and mental health and development of all Maternal and Child Health populations.	New
4.	Increase family support and ensure integration of family engagement across all Maternal and Child Health programming.	New
5.	Support health education and resources for families and providers.	New
6.	Promote safe, stable, nurturing environments to reduce violence and the risk of injury.	New
7.	Improve transition planning and support services for children, adolescents, and young adults, including those with special health care needs.	New
8.	Support comprehensive, family-centered, coordinated care within a medical home model for all Maternal and Child Health populations.	New
9.	Improve maternal and infant health outcomes through enhanced health and safety efforts.	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Texas

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	69.1 %	0.1 %	256,108	370,573
2018	69.3 %	0.1 %	257,744	372,122
2017	68.2 %	0.1 %	256,625	376,319
2016	67.0 %	0.1 %	262,351	391,547
2015	67.6 %	0.1 %	266,459	394,080
2014	67.0 %	0.1 %	260,851	389,181
2013	63.8 %	0.1 %	241,058	378,036
2012	63.6 %	0.1 %	240,223	377,709
2011	63.6 %	0.1 %	237,738	373,760
2010	61.5 %	0.1 %	235,032	382,030
2009	59.5 %	0.1 %	235,316	395,746

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	66.2	1.4	2,381	359,829
2017	62.9	1.4	2,185	347,392
2016	66.1	1.4	2,426	366,770
2015	67.8	1.6	1,884	277,754
2014	70.8	1.4	2,583	364,789
2013	69.6	1.4	2,454	352,667
2012	64.7	1.4	2,280	352,348
2011	69.3	1.4	2,443	352,357
2010	65.8	1.4	2,357	358,162
2009	64.8	1.3	2,408	371,716
2008	59.9	1.3	2,215	369,699

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2019	20.4	1.0	396	1,939,938
2014_2018	21.7	1.1	426	1,962,105

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	8.4 %	0.1 %	31,802	377,443
2018	8.5 %	0.1 %	32,037	378,489
2017	8.4 %	0.0 %	32,162	381,740
2016	8.4 %	0.0 %	33,445	397,655
2015	8.2 %	0.0 %	33,275	403,460
2014	8.2 %	0.0 %	32,744	399,625
2013	8.3 %	0.0 %	32,159	387,204
2012	8.3 %	0.0 %	31,607	382,636
2011	8.5 %	0.1 %	32,018	377,333
2010	8.4 %	0.0 %	32,486	385,982
2009	8.5 %	0.0 %	34,137	401,831

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	11.0 %	0.1 %	41,634	377,554
2018	10.8 %	0.1 %	40,799	378,529
2017	10.6 %	0.1 %	40,403	381,803
2016	10.4 %	0.1 %	41,388	397,672
2015	10.2 %	0.1 %	41,019	403,443
2014	10.3 %	0.1 %	41,345	399,607
2013	10.4 %	0.1 %	40,340	387,192
2012	10.5 %	0.1 %	40,179	382,584
2011	10.7 %	0.1 %	40,378	377,299
2010	10.9 %	0.1 %	42,117	385,985
2009	11.1 %	0.1 %	44,514	401,804

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	31.2 %	0.1 %	117,629	377,554
2018	30.4 %	0.1 %	115,107	378,529
2017	29.9 %	0.1 %	114,234	381,803
2016	28.7 %	0.1 %	114,229	397,672
2015	28.2 %	0.1 %	113,841	403,443
2014	28.1 %	0.1 %	112,228	399,607
2013	28.4 %	0.1 %	109,907	387,192
2012	28.4 %	0.1 %	108,785	382,584
2011	30.6 %	0.1 %	115,438	377,299
2010	33.5 %	0.1 %	129,310	385,985
2009	34.4 %	0.1 %	138,380	401,804

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	3.0 %			
2015/Q3-2016/Q2	3.0 %			
2015/Q2-2016/Q1	4.0 %			
2015/Q1-2015/Q4	4.0 %			
2014/Q4-2015/Q3	3.0 %			
2014/Q3-2015/Q2	4.0 %			
2014/Q2-2015/Q1	4.0 %			
2014/Q1-2014/Q4	5.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	6.0 %			
2013/Q2-2014/Q1	7.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	5.2	0.1	1,987	379,489
2017	5.5	0.1	2,107	382,968
2016	5.3	0.1	2,126	398,994
2015	5.5	0.1	2,224	404,687
2014	5.5	0.1	2,219	400,770
2013	5.8	0.1	2,238	388,356
2012	5.3	0.1	2,039	383,628
2011	5.4	0.1	2,048	378,377
2010	5.7	0.1	2,196	387,141
2009	5.5	0.1	2,223	403,039

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	5.5	0.1	2,075	378,624
2017	5.9	0.1	2,236	382,050
2016	5.7	0.1	2,277	398,047
2015	5.7	0.1	2,305	403,618
2014	5.8	0.1	2,337	399,766
2013	5.8	0.1	2,255	387,340
2012	5.8	0.1	2,231	382,727
2011	5.7	0.1	2,135	377,445
2010	6.1	0.1	2,373	386,118
2009	6.0	0.1	2,403	401,977

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	3.6	0.1	1,376	378,624
2017	3.9	0.1	1,505	382,050
2016	3.7	0.1	1,491	398,047
2015	3.7	0.1	1,504	403,618
2014	3.9	0.1	1,560	399,766
2013	3.9	0.1	1,515	387,340
2012	3.7	0.1	1,418	382,727
2011	3.7	0.1	1,412	377,445
2010	3.9	0.1	1,511	386,118
2009	3.8	0.1	1,517	401,977

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2018	1.8	0.1	699	378,624
2017	1.9	0.1	731	382,050
2016	2.0	0.1	786	398,047
2015	2.0	0.1	801	403,618
2014	1.9	0.1	777	399,766
2013	1.9	0.1	740	387,340
2012	2.1	0.1	813	382,727
2011	1.9	0.1	723	377,445
2010	2.2	0.1	862	386,118
2009	2.2	0.1	886	401,977

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	177.5	6.9	672	378,624
2017	181.4	6.9	693	382,050
2016	171.8	6.6	684	398,047
2015	173.4	6.6	700	403,618
2014	185.6	6.8	742	399,766
2013	194.4	7.1	753	387,340
2012	180.3	6.9	690	382,727
2011	193.4	7.2	730	377,445
2010	216.3	7.5	835	386,118
2009	189.3	6.9	761	401,977

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	90.1	4.9	341	378,624
2017	89.0	4.8	340	382,050
2016	91.9	4.8	366	398,047
2015	98.1	4.9	396	403,618
2014	95.8	4.9	383	399,766
2013	81.6	4.6	316	387,340
2012	89.9	4.9	344	382,727
2011	88.0	4.8	332	377,445
2010	100.0	5.1	386	386,118
2009	97.0	4.9	390	401,977

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	7.8 %	0.8 %	29,980	383,681
2015	7.7 %	0.9 %	30,111	393,018
2010	6.1 %	0.7 %	23,091	376,121
2009	5.7 %	0.7 %	22,301	391,349

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	2.2	0.1	807	358,842
2017	2.5	0.1	879	350,174
2016	2.4	0.1	885	369,425
2015	2.3	0.1	637	279,769
2014	2.4	0.1	898	367,636
2013	2.1	0.1	737	357,128
2012	1.9	0.1	671	355,636
2011	1.7	0.1	593	355,132
2010	1.6	0.1	562	360,845
2009	1.4	0.1	531	374,532
2008	1.3	0.1	469	369,884

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	11.6 %	1.4 %	806,541	6,957,161
2017_2018	14.7 %	2.0 %	1,031,152	7,024,994
2016_2017	14.8 %	2.0 %	1,006,928	6,783,766
2016	12.0 %	1.8 %	789,875	6,578,612

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	17.9	0.7	658	3,676,663
2018	18.4	0.7	677	3,681,208
2017	17.8	0.7	653	3,669,611
2016	19.4	0.7	709	3,651,591
2015	19.1	0.7	689	3,612,971
2014	17.9	0.7	642	3,579,427
2013	19.2	0.7	682	3,554,644
2012	19.0	0.7	672	3,530,799
2011	20.0	0.8	703	3,517,075
2010	18.8	0.7	653	3,476,861
2009	21.0	0.8	720	3,432,311

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	34.4	0.9	1,430	4,156,116
2018	32.1	0.9	1,324	4,123,762
2017	34.7	0.9	1,413	4,069,972
2016	33.0	0.9	1,318	3,999,650
2015	30.8	0.9	1,216	3,954,010
2014	31.3	0.9	1,221	3,895,675
2013	31.1	0.9	1,196	3,850,226
2012	30.5	0.9	1,164	3,818,176
2011	31.4	0.9	1,194	3,801,868
2010	32.6	0.9	1,228	3,765,007
2009	36.9	1.0	1,373	3,725,761

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	12.9	0.5	783	6,090,236
2016_2018	12.6	0.5	759	6,007,832
2015_2017	13.2	0.5	781	5,915,788
2014_2016	13.3	0.5	773	5,815,991
2013_2015	14.1	0.5	806	5,732,499
2012_2014	14.2	0.5	803	5,672,021
2011_2013	14.3	0.5	809	5,649,938
2010_2012	14.7	0.5	829	5,645,966
2009_2011	16.0	0.5	902	5,640,714
2008_2010	17.9	0.6	1,004	5,604,251
2007_2009	19.4	0.6	1,074	5,537,596

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	12.3	0.5	750	6,090,236
2016_2018	12.0	0.5	720	6,007,832
2015_2017	11.1	0.4	659	5,915,788
2014_2016	9.8	0.4	570	5,815,991
2013_2015	9.0	0.4	515	5,732,499
2012_2014	8.7	0.4	493	5,672,021
2011_2013	8.4	0.4	476	5,649,938
2010_2012	8.0	0.4	454	5,645,966
2009_2011	8.1	0.4	459	5,640,714
2008_2010	7.7	0.4	430	5,604,251
2007_2009	7.6	0.4	423	5,537,596

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	17.4 %	1.4 %	1,285,908	7,380,413
2017_2018	16.9 %	1.7 %	1,239,420	7,318,545
2016_2017	16.5 %	1.6 %	1,191,876	7,233,647
2016	18.2 %	1.9 %	1,308,689	7,192,337

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	11.8 %	2.5 %	152,193	1,285,908
2017_2018	11.4 %	2.6 %	141,284	1,239,420
2016_2017	10.3 %	2.1 %	123,302	1,191,876
2016	12.5 %	2.8 %	163,813	1,308,689

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	3.3 %	0.8 %	203,247	6,092,408
2017_2018	2.6 %	0.8 %	163,265	6,172,662
2016_2017	2.2 %	0.8 %	130,706	6,078,197
2016	1.5 %	0.5 %	91,752	5,954,974

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	8.6 %	1.1 %	525,765	6,107,861
2017_2018	8.5 %	1.3 %	521,763	6,153,968
2016_2017	9.0 %	1.3 %	541,358	5,990,024
2016	10.0 %	1.4 %	582,475	5,849,961

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	49.2 %	6.1 %	407,796	828,399
2017_2018	46.6 %	6.8 %	317,139	680,793
2016_2017	45.5 %	7.0 %	254,057	557,806
2016	51.9 %	7.0 %	323,935	623,702

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	89.4 %	1.4 %	6,589,309	7,374,516
2017_2018	86.9 %	1.8 %	6,354,741	7,312,648
2016_2017	85.7 %	1.9 %	6,188,859	7,219,939
2016	86.3 %	2.0 %	6,182,812	7,164,921

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	15.9 %	0.1 %	36,402	228,987
2016	14.6 %	0.1 %	39,165	268,787
2014	14.9 %	0.1 %	45,667	307,498
2012	15.9 %	0.1 %	53,384	336,178
2010	16.9 %	0.1 %	61,237	361,823
2008	16.9 %	0.1 %	53,507	317,047

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	16.9 %	1.1 %	236,511	1,403,375
2017	18.6 %	1.2 %	246,856	1,325,374
2013	15.7 %	0.9 %	204,039	1,302,698
2011	15.6 %	0.9 %	199,398	1,280,539
2009	13.2 %	0.8 %	162,684	1,229,339
2007	15.5 %	1.0 %	172,938	1,114,648
2005	13.7 %	0.8 %	154,582	1,129,791

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	17.3 %	2.4 %	547,671	3,169,345
2017_2018	15.5 %	2.5 %	485,715	3,134,822
2016_2017	18.5 %	2.8 %	543,359	2,931,799
2016	21.3 %	3.4 %	599,096	2,812,232

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	12.3 %	0.2 %	910,596	7,394,731
2018	10.6 %	0.2 %	786,651	7,399,171
2017	10.1 %	0.2 %	746,757	7,361,228
2016	9.2 %	0.2 %	671,604	7,286,776
2015	9.4 %	0.2 %	674,608	7,202,412
2014	11.2 %	0.2 %	793,938	7,108,828
2013	12.5 %	0.2 %	882,240	7,036,198
2012	12.3 %	0.3 %	858,409	6,973,857
2011	13.3 %	0.3 %	927,982	6,956,614
2010	14.7 %	0.2 %	1,012,831	6,889,245
2009	16.3 %	0.3 %	1,125,242	6,887,732

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	67.7 %	1.7 %	275,000	406,000
2015	66.0 %	1.7 %	275,000	417,000
2014	68.1 %	1.7 %	281,000	413,000
2013	64.7 %	1.9 %	262,000	405,000
2012	69.4 %	2.0 %	276,000	398,000
2011	66.3 %	2.5 %	262,000	395,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	62.8 %	1.1 %	4,350,672	6,927,822
2018_2019	61.8 %	1.0 %	4,261,985	6,899,765
2017_2018	58.0 %	1.0 %	3,962,677	6,827,976
2016_2017	60.4 %	1.4 %	4,047,990	6,707,523
2015_2016	62.1 %	1.6 %	4,060,188	6,543,413
2014_2015	64.4 %	1.6 %	4,172,377	6,481,865
2013_2014	62.5 %	1.5 %	4,059,583	6,490,711
2012_2013	56.2 %	1.8 %	3,689,653	6,564,471
2011_2012	52.5 %	1.3 %	3,356,150	6,393,154
2010_2011	46.4 %	1.8 %	2,962,117	6,383,872
2009_2010	45.5 %	1.6 %	2,569,769	5,647,843

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	65.1 %	1.8 %	1,352,700	2,078,930
2018	59.9 %	1.8 %	1,233,627	2,058,117
2017	57.8 %	1.7 %	1,175,478	2,034,276
2016	49.3 %	1.9 %	991,127	2,009,750
2015	50.6 %	1.8 %	999,475	1,977,148

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	84.8 %	1.4 %	1,762,717	2,078,930
2018	83.4 %	1.4 %	1,717,163	2,058,117
2017	83.2 %	1.3 %	1,692,826	2,034,276
2016	85.0 %	1.4 %	1,708,200	2,009,750
2015	85.1 %	1.3 %	1,682,016	1,977,148
2014	88.3 %	1.6 %	1,721,139	1,950,300
2013	86.1 %	1.8 %	1,633,445	1,897,340
2012	82.5 %	1.7 %	1,523,370	1,845,560
2011	80.7 %	1.7 %	1,470,745	1,821,756
2010	71.9 %	2.2 %	1,264,426	1,758,928
2009	57.2 %	2.6 %	1,006,302	1,759,508

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	85.9 %	1.3 %	1,786,588	2,078,930
2018	86.7 %	1.2 %	1,783,652	2,058,117
2017	85.1 %	1.3 %	1,731,922	2,034,276
2016	85.5 %	1.4 %	1,718,380	2,009,750
2015	89.6 %	1.1 %	1,770,550	1,977,148
2014	88.6 %	1.5 %	1,728,470	1,950,300
2013	87.7 %	1.8 %	1,663,003	1,897,340
2012	84.6 %	1.7 %	1,560,639	1,845,560
2011	79.1 %	2.0 %	1,440,229	1,821,756
2010	65.4 %	2.4 %	1,150,610	1,758,928
2009	51.0 %	2.7 %	897,164	1,759,508

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	24.0	0.2	24,109	1,004,804
2018	25.3	0.2	25,089	993,348
2017	27.6	0.2	26,971	978,094
2016	31.0	0.2	29,765	961,221
2015	34.6	0.2	32,687	945,429
2014	37.7	0.2	35,063	928,988
2013	40.9	0.2	37,525	918,337
2012	44.3	0.2	40,451	912,193
2011	46.9	0.2	42,748	911,145
2010	52.2	0.2	47,751	914,011
2009	57.9	0.3	52,656	909,426

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	15.1 %	1.1 %	57,537	381,067
2015	14.7 %	1.2 %	57,607	391,165

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	4.3 %	1.0 %	318,045	7,347,000
2017_2018	4.5 %	1.3 %	326,942	7,283,816
2016_2017	4.6 %	1.3 %	329,959	7,192,232
2016	4.0 %	1.0 %	285,465	7,118,440

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Texas

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	79.1	82.7	83.4	86.2	87.4
Annual Indicator	81.9	83.1	85.0	83.9	85.9
Numerator	302,196	305,258	339,365	306,509	308,498
Denominator	368,965	367,465	399,450	365,530	359,027
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	88.6	89.8	91.0	92.2	93.4	94.6

Field Level Notes for Form 10 NPMs:

None

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	17.8	22.4	26	27.4	28.8
Annual Indicator	21.0	24.6	24.1	24.1	23.9
Numerator	75,605	88,501	93,997	84,785	82,687
Denominator	360,397	359,467	390,543	351,763	346,287
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	30.2	31.6	33.0	34.4	35.8	37.2

Field Level Notes for Form 10 NPMs:

None

NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	67.9	69.9	71.9	73.9	77.9
Annual Indicator	66.0	71.2	73.3	73.3	73.3
Numerator	240,305	273,155	277,214	277,214	277,214
Denominator	364,373	383,419	378,111	378,111	378,111
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2010	2015	2016	2016	2016

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	67.9	69.9	71.9	73.9	77.9
Annual Indicator	69.4			77.7	74.2
Numerator	263,609			282,659	265,154
Denominator	379,932			363,606	357,195
Data Source	PRAMS			PRAMS	PRAMS
Data Source Year	2014			2017	2019
Provisional or Final ?	Final			Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	78.9	79.9	80.9	81.9	82.9	83.9

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Although 2009 and 2010 are the latest federally available PRAMS data for Texas, 2013 and 2014 Texas PRAMS results (not federally-available) for this NPM were 72.2% (CI: 69.0-75.3) and 69.4% (CI: 66.1-72.7), respectively.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: The 2013 and 2014 Texas PRAMS results (not federally-available) for this NPM were 72.2% (CI: 69.0-75.3) and 69.4% (CI: 66.1-72.7), respectively.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The 2017 Texas PRAMS results (not federally-available) for this NPM was 77.7% (CI: 75.5-80.0).	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The 2019 Texas PRAMS results (not federally-available) for this NPM was 74.2% (CI: 71.3-77.1).	

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		29.6	30.4
Annual Indicator	28.8	28.8	28.8
Numerator	102,501	102,501	102,501
Denominator	356,249	356,249	356,249
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2016	2016

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			29.6	30.4
Annual Indicator	27.6		30.2	32.8
Numerator	102,501		103,958	111,212
Denominator	370,983		344,288	338,553
Data Source	PRAMS		PRAMS	PRAMS
Data Source Year	2016		2017	2019
Provisional or Final ?	Final		Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	33.1	33.5	33.8	34.1	34.4	34.8

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Based on 2016 PRAMS data received Summer 2018. Includes mothers reporting that their baby always or often sleeps alone, usually in a crib, bassinet, or pack and play, and not usually in a standard bed, couch, sofa, armchair, car seat, or swing.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The 2017 Texas PRAMS results (not federally-available) for this NPM is 30.2% (CI: 27.7-32.7).	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The 2019 Texas PRAMS results (not federally-available) for this NPM was 32.8% (CI: 29.7-36.0).	

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		40.8	41.3
Annual Indicator	40.5	40.5	40.5
Numerator	143,846	143,846	143,846
Denominator	355,525	355,525	355,525
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2016	2016

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			40.8	41.3
Annual Indicator	39.8		41	47.2
Numerator	143,846		141,045	161,328
Denominator	361,249		343,877	341,873
Data Source	PRAMS		PRAMS	PRAMS
Data Source Year	2016		2017	2019
Provisional or Final ?	Provisional		Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	47.7	48.1	48.6	49.1	49.6	50.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Based on 2016 PRAMS data received Summer 2018. Includes mothers reporting that their baby does not usually sleep with blankets, toys, cushions, pillows, or crib bumper pads.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The 2017 Texas PRAMS results (not federally-available) for this NPM were 41.0% (CI: 38.3-43.7).	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The 2019 Texas PRAMS results (not federally-available) for this NPM was 47.2% (CI: 43.9-50.5).	

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			34.4	36.6	38.8
Annual Indicator		34.1	35.2	38.2	46.4
Numerator		295,528	306,220	349,190	420,111
Denominator		867,587	868,865	915,008	905,526
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	46.9	47.3	47.8	48.3	48.7	49.2

Field Level Notes for Form 10 NPMs:

None

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	132	122	107.7	100.9	97.9
Annual Indicator	125.3	111.7	102.9	98.3	96.1
Numerator	4,981	3,372	4,175	4,003	3,914
Denominator	3,974,223	3,017,993	4,057,490	4,072,971	4,071,873
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	95.9	93.9	91.9	89.9	88.9	87.9

Field Level Notes for Form 10 NPMs:

None

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	219.3	188.9	181.4	173.9	166.4
Annual Indicator	194.7	188.8	190.6	184.1	176.0
Numerator	7,599	5,595	7,624	7,492	7,256
Denominator	3,902,181	2,963,378	3,999,650	4,069,972	4,123,762
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	158.9	151.4	143.9	136.4	133.4	131.9

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			34.1	37.1	47.3
Annual Indicator		33.9	35.1	43.4	45.0
Numerator		443,280	417,948	538,344	578,913
Denominator		1,308,689	1,191,876	1,239,420	1,285,908
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	47.5	47.7	47.9	48.1	48.3	48.5

Field Level Notes for Form 10 NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			12.8	13	13.2
Annual Indicator		12.6	8.5	13.0	18.6
Numerator		58,176	43,520	69,800	93,927
Denominator		461,518	512,065	537,747	504,239
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	19.6	20.6	21.6	22.6	23.6	24.6

Field Level Notes for Form 10 NPMs:

None

NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	4.3	3.5	3.3	2.9	2.6
Annual Indicator	3.6	3.3	3.0	2.7	2.4
Numerator	14,521	12,978	11,394	10,239	9,206
Denominator	403,518	397,971	381,948	378,549	377,097
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	2.3	2.2	2.1	2.0	1.9	1.8

Field Level Notes for Form 10 NPMs:

None

NPM 14.2 - Percent of children, ages 0 through 17, who live in households where someone smokes - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			12	11.5	11
Annual Indicator		12.5	12.5	13.1	14.6
Numerator		883,263	892,707	945,028	1,056,499
Denominator		7,040,867	7,126,660	7,195,034	7,225,038
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	10.5	10.0	9.5	9.0	8.5	8.0

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Texas

SPM 1 - Percent of CYSHCN and their families who participate in social or recreational activities with families who have children with or without disabilities

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		37.5	69.1	70	71
Annual Indicator	37.5	68.1	68.9	68.9	68.9
Numerator	224	583	413	413	413
Denominator	598	856	599	599	599
Data Source	Annual CYSHCN Outreach Survey	CYSHCN 2017 Outreach Survey	CYSHCN Annual Outreach Survey	CYSHCN Annual Outreach Survey	CYSHCN Annual Outreach Survey
Data Source Year	2016	2017	2018	2018	2018
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	72.0	73.0	74.0	75.0	76.0	77.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Changed the performance measure to evaluate the usage of services. The previous measure asked about the useage and awareness.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The FY19 CSHCN survey did not have a question on the utilization of recreational activities comparable to previous survey years. Consequently, FY18 data are reported for FY19. The CSHCN survey is getting revised in FY20 to provide comparable data to previous years.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The 2018 CSHCN survey did not have a question on the utilization of recreational activities comparable to previous survey years. The biennial survey was revised in 2021 and will be available for reporting data compare to previous years in the FY22 application.	

SPM 2 - Percent of overweight and obesity in Texas children ages 2-21.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		27.8	27.1	26.4	40.2
Annual Indicator	28.5	28	28	40.7	40.7
Numerator	113,597	88,319	88,319	139,579	139,579
Denominator	398,359	315,808	315,808	343,339	343,339
Data Source	Texas WIC client data	2017 Texas WIC Client data	2017 Texas WIC Client data	Texas SPAN	Texas SPAN
Data Source Year	2016	2017	2017	2015-2016	2015-2016
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.2	39.8	39.4	39.0	38.6	38.2

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Other secondary measures for this SPM include: 1) Percent of infants born to mothers with pre-pregnancy BMI in the overweight/obese range (provisional 2016 data): 52.0% 2) Percent of children with BMI in the overweight/obese range (2016): 39.4% 3) Percent of adolescents with BMI in the overweight/obese range (2013): 30.3% 4) Percent of adults with BMI in the overweight/obese range (2015): 68.7%	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 2017 data only includes Jan 2017-Jul 2017 due to changes in data systems; Secondary measure: Percent of children with BMI in the overweight/obese range (2016) 39.4%	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: WIC client data is currently unable to be reported due to database issues, but the systems are expected to be fixed by the fall. The 2018 indicator is currently the 2017 indicator, but will be updated as soon as newer data become available.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: SPM 2 reporting changed from WIC client data to the statistically valid Texas School Physical Activity and Nutrition Survey (SPAN). The estimate for Texas children in grade 8 in 2015-2016 who were overweight or obese is 40.7% (95% CI: 36.2 - 45.1%).	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: SPAN survey cohort data was not updated in 2020 or 2021. The estimate for Texas children in grade 8 in 2015-2016 who were overweight or obese is 40.7% (95% CI: 36.2 - 45.1%).	

SPM 3 - Infant Mortality Disparities: Ratio of Black to White infant mortality rate

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		2.1	2.1	2.1	2
Annual Indicator	2.2	2.3	2.4	2.4	2.3
Numerator	10.9	10.7	10.8	11.9	11.5
Denominator	4.9	4.7	4.5	5	5.1
Data Source	Texas natality and mortality data	DSHS Center For Health Statistics	Texas natality and mortality data	Texas natality and mortality data	Texas birth file (natality data) and death file (m
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2.0	2.0	2.0	2.0	2.0	2.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Indicator information for the secondary measure for this SPM is below: 1) Ratio of black to white feto-infant mortality (2014): 1.82	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Data source details: 2017 Texas birth file (natality data) and death file (mortality data), DSHS Center For Health Statistics. Indicator for secondary measure: 3.a Ratio of black to white feto-infant mortality (2014): 1.82	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data source details: 2018 Texas birth file (natality data) and death file (mortality data), DSHS Center For Health Statistics.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data source details: 2019 Texas birth file (natality data) and death file (mortality data), DSHS Center For Health Statistics.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data source details: 2020 Texas birth file (natality data) and death file (mortality data), DSHS Center For Health Statistics.	

SPM 4 - Maternal Morbidity Disparities: Ratio of Black to White severe maternal morbidity rate.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	2	1.8
Numerator	299.4	275
Denominator	146.3	149
Data Source	Texas Hospital Inpatient Public Use Data Files	Texas Hospital Inpatient Public Use Data Files
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.9	1.8	1.7	1.6	1.5	1.4

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data source details: 2018 Texas Hospital Inpatient Public Use Data Files, DSHS Center For Health Statistics. The numerator is the severe maternal morbidity rate for delivery hospitalizations among Black women in Texas. The denominator is the severe maternal morbidity rate for delivery hospitalizations among White women in Texas.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data source details: 2019 Texas Hospital Inpatient Public Use Data Files, DSHS Center For Health Statistics. The numerator is the severe maternal morbidity rate for delivery hospitalizations among Black women in Texas. The denominator is the severe maternal morbidity rate for delivery hospitalizations among White women in Texas.	

SPM 5 - Percent of women of childbearing age who self-rate their health status as excellent, very good, or good

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			86	86.1
Annual Indicator			87.5	82.9
Numerator			4,780,630	4,597,793
Denominator			5,461,979	5,546,052
Data Source			Texas Behavioral Risk Factor Surveillance System	Texas Behavioral Risk Factor Surveillance System (
Data Source Year			2018	2017
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	86.2	86.3	86.4	86.5	86.5	86.5

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The denominator is the Texas Demographic Center projection for Texans ages 18-44. The numerator is the weighted BRFSS percent applied to the population projection.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The denominator is the Texas Demographic Center population projection for Texans ages 18-44. The numerator is the weighted BRFSS percent applied to the population projection.	

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 4 - Percent of young adults (ages 18-24) who visited a doctor for a routine checkup in the past year

Measure Status:	Active				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		57.6	58	58.1	58.2
Annual Indicator	49.2	57.9	53.2	62.3	61.2
Numerator	1,421,277	1,701,728	1,550,070	1,837,648	1,824,973
Denominator	2,888,775	2,939,082	2,911,785	2,947,920	2,980,352
Data Source	Texas Behavioral Risk Factor Surveillance System (	2016 Texas Behavioral Risk Factor Surveillance Sys	Texas Behavioral Risk Factor Surveillance System	Texas Behavioral Risk Factor Surveillance System	Texas Behavioral Risk Factor Surveillance System
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Denominator data source is the Texas Demographic Center 2014 Projections for 2016 Population (provisional data). Denominator and numerator information will be updated once final 2016 estimates are available.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Denominator data source is the Texas Demographic Center Projections for 2017 Population (provisional data). Denominator and numerator information will be updated once final 2017 estimates are available.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: The denominator is the Texas Demographic Center population projection for Texans ages 18-24. The numerator is the percent of young adults who visited a doctor for a routine checkup from BRFSS applied to the population projection.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The denominator is the Texas Demographic Center population projection for Texans ages 18-24. The numerator is the percent of young adults who visited a doctor for a routine checkup from BRFSS applied to the population projection.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The denominator is the Texas Demographic Center population projection for Texans ages 18-24. The numerator is the percent of young adults who visited a doctor for a routine checkup from BRFSS applied to the population projection.	

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Texas

ESM 4.1 - Percent of births occurring in hospitals with policies consistent with the WHO/UNICEF Ten Steps to Successful Breastfeeding and recognized by the Texas Ten Step designation.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
2.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
3.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
4.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
5.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	

ESM 4.2 - Estimated minimum number of Texas workers employed at a worksite with a written and communicated worksite lactation support policy and recognized by the Texas Mother-Friendly designation

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
2.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
3.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
4.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
5.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	

ESM 4.3 - Number of after-hours calls to Texas' lactation support hotline

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
2.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
3.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
4.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
5.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	

ESM 5.1 - Number of health professionals who received Texas HHS CE credits on SUID prevention or safe sleep practices in the past year

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
2.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
3.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
4.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
5.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	

ESM 6.1 - Number of Texas Health Steps Online Provider Education (OPE) users completing developmental screening modules

Measure Status:	Active				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			6,750	13,005	13,655
Annual Indicator	6,429	18,552	12,386	17,632	9,223
Numerator					
Denominator					
Data Source	Texas Health Steps Online Provider Education (OPE)	Texas Health Steps Online Provider Education (OPE)	Texas Health Steps Online Provider Education (OPE)	Texas Health Steps Online Provider Education (OPE)	Texas Health Steps Online Provider Education (OPE)
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	14,337.0	15,053.0	15,805.0	16,595.0	17,425.0	18,296.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Two modules (Screening for Austism Spectrum Disorder; Using Developmental Screening Tools) were not available to providers during 2020, Pandemic

ESM 6.2 - Number of developmental screenings provided in the Healthy Child Care Texas Grant

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	482	438
Numerator		
Denominator		
Data Source	Healthy Child Care Texas	Healthy Child Care Texas
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	250.0	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

None

ESM 6.3 - Percent of families participating in Help Me Grow Texas (HMGTX) who receive a developmental screening

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: This effort began in FY21. Data will be provided in the FY23/FY21 Application.	
2.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
4.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
5.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	
6.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives will established in the FY23/FY21 application. This figure serves as a placeholder.	

ESM 7.1.1 - Number of School Health Friday Beat newsletters per fiscal year with at least one injury prevention resource provided

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			25	25	25
Annual Indicator	40	45	48	42	43
Numerator					
Denominator					
Data Source	DSHS School Health Program	DSHS School Health Program	DSHS School Health Program	DSHS School Health Program	DSHS School Health Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	25.0	45.0	45.0	45.0	45.0

Field Level Notes for Form 10 ESMs:

None

ESM 7.1.2 - Number of individuals trained on injury prevention through the Medical Child Abuse Resources and Education System (MEDCARES) grant

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	4,806	21,652
Numerator		
Denominator		
Data Source	Medical Child Abuse Resources and Education System	Medical Child Abuse Resources and Education System
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	22,000.0	22,500.0	23,000.0	23,500.0	24,000.0	25,000.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Texas was only able to use data collected from June-Aug 2019.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: September 2019-August 2020;	

ESM 7.2.1 - Number of Texas Health Steps Online Provider Education (OPE) users completing injury prevention modules.

Measure Status:	Active				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		12,893	13,538	26,276	27,589
Annual Indicator	12,279	18,514	25,025	29,139	28,948
Numerator					
Denominator					
Data Source	Texas Health Steps Online Provider Education (OPE)	Texas Health Steps Online Provider Education (OPE)	Texas Health Steps Online Provider Education (OPE)	Texas Health Steps Online Provider Education (OPE)	Texas Health Steps Online Provider Education (OPE)
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	28,968.0	30,416.0	31,936.0	33,532.0	35,209.0	36,969.0

Field Level Notes for Form 10 ESMs:

None

ESM 7.2.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		68	70	70	79
Annual Indicator	0	78.9	78.9	76.3	76.3
Numerator			1,605	997,819	997,819
Denominator			2,035	1,307,757	1,307,757
Data Source	YRBS	Texas YRBS	Texas YRBS	Texas YRBS	Texas YRBS
Data Source Year	2016	2017	2017	2019	2019
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	79.5	79.5	80.0	80.0	80.5	80.5

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: No YRBSS data was collected for this ESM in 2016. Placeholder of "0" was entered in indicator field as data was not collected in 2016.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The 2019 indicator numerator and denominator are reported as the weighted YRBS estimates to align with the ESM documentation. The Source is the 2018 Texas Youth Risk Behavior Survey. The 2019 indicator is 76.3% (95% CI: 72.9 - 79.4%).	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: No YRBSS data was collected for this ESM in 2020.	

ESM 11.1 - Percent of families receiving professional care coordination for their child

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		37.5	38	38.5	39
Annual Indicator	35.7	38.1	36.4	27.8	27.8
Numerator	218	415	233	203	203
Denominator	610	1,090	640	730	730
Data Source	Texas 2016 CSHCN SP Outreach Survey	CYSHCN 2017 Outreach Survey	Annual CYSHCN Outreach Survey	Annual CYSHCN Outreach Survey	Annual CYSHCN Outreach Survey
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	39.5	40.0	40.5	41.0	41.5	42.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Numerator listed as: Number of CYSHCN families surveyed who indicated they received professional care coordination for their child Denominator as: Total number of CYSHCN families surveyed	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Numerator listed as: Number of CYSHCN families surveyed who indicated they received professional care coordination for their child Denominator as: Total number of CYSHCN families surveyed	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: No CYSHCN data was collected for this ESM in 2020.	

ESM 11.2 - Increase percent of families who have a plan for an emergency and/or disaster

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	68.0	69.0	70.0	71.0	72.0	73.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.1 - Percent of families of transition age youth with special health care needs receiving professional help with their child's transition to adulthood

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		19.5	20	10	10.5
Annual Indicator	19.8	20.1	6.4	7	7
Numerator	46	69	40	15	15
Denominator	232	344	623	214	214
Data Source	Texas 2016 CSHCN Outreach Survey	Texas CYSHCN 2017 Outreach Survey	Annual CYSHCN Outreach Survey	Texas CYSHCN 2019 Outreach Survey	Texas CYSHCN 2019 Outreach Survey
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	11.0	11.5	12.0	12.5	13.0	13.5

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: The 2018 indicator changed from 2017 due to differences in the way the total CSHCN population was calculated. An increase in the denominator decreased the indicator for the percent of children receiving professional help. The calculation change more accurately reflects documentation for the denominator used in prior years.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: No CYSHCN data was collected for this ESM in 2020.	

ESM 12.2 - Decrease percent of families of transition-age youth who have not prepared for medical transition to adulthood

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	45.8	45.8
Numerator	98	98
Denominator	214	214
Data Source	CSHCN Outreach Survey	CSHCN Outreach Survey
Data Source Year	2019	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	46.8	47.8	48.8	49.8	50.8	51.8

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
No CYSHCN data was collected for this ESM in 2020.

ESM 14.1.1 - Number of health organizations engaged in a DSHS maternal or infant health improvement effort involving integration of tobacco/e-cigarette screening, education and referral.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	10.0	40.0	40.0	80.0	200.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.1 - Number of materials distributed to household members and caregivers intended to raise awareness about the risk of infant and child exposure to tobacco.

Measure Status:	Active			
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			220,000	220,500
Annual Indicator			0	123,455
Numerator				
Denominator				
Data Source			Pending	DSHS MCH Published Materials
Data Source Year			2019	2020
Provisional or Final ?			Provisional	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	221,000.0	221,500.0	222,000.0	222,000.0	222,000.0	220,000.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: This ESM will continue into the next Block Grant cycle, however, due to tobacco programming changes and COVID-19-related delays, Texas Title V is still working to confirm objectives and identify all relevant materials to include in the count. The FY19 indicator data and annual objectives are placeholders, and will be finalized in FY21 and updated/noted in the FY22/FY20 Block Grant application.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The indicator includes the number of distributed and downloaded materials for two legislatively mandated materials coordinated through DSHS MCH: "Information for Parents of Newborns", and "Parents Guide to Raising Happy Healthy Children." Indicator is lower than anticipated due to COVID challenges with distribution. MCH still exploring additional resources to include in the data source.	

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 4.1 - Breastfeeding support assessment findings available

Measure Status:	**Active**				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		Yes	0	0	0
Annual Indicator	Yes	Yes	Yes	Yes	Yes
Numerator					
Denominator					
Data Source	Texas WIC Infant Feeding Practices Survey	Texas WIC Infant Feeding Practices Survey Report	Texas WIC Infant Feeding Practices Survey Report	Texas WIC Infant Feeding Practices Survey Report	Texas WIC Infant Feeding Practices Survey Report
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 4.3 - Number of Texas birthing facilities that receive information and technical assistance to facilitate integration of the WHO/UNICEF Ten Steps to Successful Breastfeeding

Measure Status:	**Active**				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		140	145	150	155
Annual Indicator	143	143	148	153	151
Numerator					
Denominator					
Data Source	DSHS Texas Ten Step Program	Infant Feeding Workgroup Star Achiever Database	Infant Feeding Workgroup Star Achiever Database	Infant Feeding Workgroup Star Achiever Database	Infant Feeding Workgroup Star Achiever Database
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Data Source: Infant Feeding Workgroup Star Achiever Database (Texas Ten Step Hospitals + Star Achiever + National Initiatives; unduplicated)	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Number decreased due to closure of OB units.	

2016-2020: ESM 4.4 - Number of employers who receive information and technical assistance on Mother-Friendly breastfeeding support policies

Measure Status:	**Active**				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		400	400	400	400
Annual Indicator	458	613	339	522	284
Numerator					
Denominator					
Data Source	DSHS Mother Friendly Worksite Program	Mother Friendly Worksite -TASP Annual Report	Mother Friendly Worksite -TASP Annual Report	Mother Friendly Worksite -TASP Annual Report	Mother Friendly Worksite -TASP Annual Report
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Outreach efforts were impacted by COVID.

2016-2020: ESM 4.5 - DSHS Infant Feeding Position Statement reviewed, revised and updated in FY2019

Measure Status:	Active			
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	No	0	0	0
Annual Indicator	No	No	No	No
Numerator				
Denominator				
Data Source	HTMB Programs	HTMB Programs	HTMB Programs	HTMB Programs
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 5.1 - Interagency Safe Sleep Messaging Strategic Communication Plan available in 2017

Measure Status:	**Active**				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		No	0	0	0
Annual Indicator	No	No	Yes	No	No
Numerator					
Denominator					
Data Source	Safe Sleep Messaging Interagency Workgroup	HTMB Programs	HTMB Programs	HTMB Programs	HTMB Programs
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
In development in 2016. Draft will be complete in 2017. Released planned for 2018.

2016-2020: ESM 5.2 - Complete community assessments and infant mortality prevention strategic plans in Healthy Texas Mothers and Babies (HTMB) Coalition communities

Measure Status:	**Active**			
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	No	0	0	0
Annual Indicator	No	Yes	Yes	No
Numerator				
Denominator				
Data Source	HTMB Programs	Contractor Reports	Contractor Reports	Contractor Reports
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 6.2 - Number of additional individuals trained in early childhood developmental screening and referral in the Texas LAUNCH communities

Measure Status:	**Active**				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		300	100	73	0
Annual Indicator	27	354	123	2,232	0
Numerator					
Denominator					
Data Source	Project LAUNCH	Project LAUNCH	Project LAUNCH	Project LAUNCH	Project LAUNCH
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Project LAUNCH concluded in 2019.

2016-2020: ESM 7.1.2 - Percent of child deaths reviewed by Child Fatality Review Teams (CFRT)

Measure Status:	**Active**				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		37	37.5	38	38.5
Annual Indicator	0	32	32.3	32.2	29.3
Numerator			1,209	1,244	1,131
Denominator			3,739	3,858	3,859
Data Source	Child Fatality Review Teams and Vital Statistics	Child Fatality Review Teams and Vital Statistics	Child Fatality Review Teams and Vital Statistics	Child Fatality Review Teams and Vital Statistics	Child Fatality Review Teams and Vital Statistics
Data Source Year	2014	2015	2015	2016	2017
Provisional or Final ?	Provisional	Final	Final	Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Final data will be available in FY18. Placeholder indicator has entered until final data are available.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Child fatality data for 2016 and 2017 will be will be available in FY20.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data used for FY2020 is provisional and from FY17.	

2016-2020: ESM 7.1.3 - Train Child Fatality Review (CFR) teams on injury prevention

Measure Status:	**Active**				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		Yes	0	0	0
Annual Indicator	No	Yes	No	Yes	No
Numerator					
Denominator					
Data Source	Texas DSHS	Texas DSHS	MCH Program	Texas DSHS	Texas DSHS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Partners in Prevention Conference.

2016-2020: ESM 11.4 - Increase medical home provider education

Measure Status:	Active			
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective		712	762	812
Annual Indicator	1,012	821	676	509
Numerator				
Denominator				
Data Source	Texas Health Steps OPE module database	Texas Health Steps OPE module database	Texas Health Steps OPE module database	Texas Health Steps OPE module database
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
COVID19 affected 2020 indicator.

2016-2020: ESM 11.5 - Meet with clinical champions for provider engagement

Measure Status:	Active			
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	No	0	0	0
Annual Indicator	No	Yes	No	No
Numerator				
Denominator				
Data Source	MCH Children with Special Health Care Needs (CSHCN	MCH Children with Special Health Care Needs (CSHCN	MCH Children with Special Health Care Needs (CSHCN	MCH Children with Special Health Care Needs (CSHCN
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
This is not listed in the data spreadsheet

2016-2020: ESM 11.6 - Create a provider engagement strategic plan

Measure Status:	Active			
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	No	0	0	0
Annual Indicator	No	No	No	No
Numerator				
Denominator				
Data Source	DSHS CSHCN SDG	DSHS CSHCN SDG	DSHS CSHCN SDG	DSHS CSHCN SDG
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 12.3 - Distribution of CYSHCN Outreach Survey

Measure Status:	**Active**				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		Yes	0	0	0
Annual Indicator	Yes	Yes	No	Yes	No
Numerator					
Denominator					
Data Source	DSHS CSHCN Systems Development Group	CYSHCN 2017 Outreach Survey	Annual CYSHCN Outreach Survey	Annual CYSHCN Outreach Survey	Annual CYSHCN Outreach Survey
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
The survey was not distributed in FY20 due to five-year Needs Assessment efforts conducted during this time.

2016-2020: ESM 12.4 - Increase in transition provider education

Measure Status:	Active			
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective		906	956	1,006
Annual Indicator	856	1,130	1,900	1,146
Numerator				
Denominator				
Data Source	Online Provider Education (OPE) Data	Online Provider Education (OPE) Data	Online Provider Education (OPE) Data	Online Provider Education (OPE) Data
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 14.1.1 - Number of health professionals trained on tobacco prevention and cessation interventions as it relates to risks associated with maternal and infant exposure to tobacco.

Measure Status:	Active			
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			0	0
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			Online Provider Education (OPE) Data	Online Provider Education (OPE) Data
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
2,811 people completed OPE that includes information on tobacco and maternal or infant health outcomes. This ESM is retiring and being replaced by another ESM for 14.1.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Texas

SPM 1 - Percent of CYSHCN and their families who participate in social or recreational activities with families who have children with or without disabilities
Population Domain(s) – Children with Special Health Care Needs

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To improve awareness and utilization of resources, including respite, by CYSHCN and their families, to promote community integration.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of CYSHCN families surveyed indicating they participate in social or recreational activities with families who have children with or without disabilities</td></tr>
<tr><td>Denominator:</td><td>Total number of CYSHCN families surveyed per state fiscal year</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Annual CYSHCN Outreach Survey
Responses to the CYSHCN Outreach Survey will be collected on an annual basis. The survey will be mailed out and disbursed electronically to families served by the Health and Human Services Commission’s CSHCN Services Program and Maternal and Child Health community-based contractors in both English and Spanish formats. The survey will be promoted through email communication, newsletters and webpages. Baseline data obtained from the FY16 CYSHCN Outreach Survey indicates only 37.4% of families surveyed were aware of local services and utilized them. This percentage increased to 68.1% in the FY17 CYSHCN Outreach Survey. Data from the 2018 CYSHCN Outreach Survey showed that 69% of respondents participate in social or recreational activities with families of children with disabilities or families of children without disabilities.

Data Issues:
Challenges associated with surveying a convenience sample of youth and families include the potential to under-represent subsets of CYSHCN families in Texas according to geographical location, language spoken, and race/ethnicity. Maternal and Child Health seeks to address these challenges by utilizing key groups of stakeholders to increase awareness of the survey and providing both online and paper access to the survey in English and Spanish. Geographical data is also gathered in order to examine areas of need for additional ongoing needs assessment activities including focus group interviews.</td></tr>
<tr><td>Significance:</td><td>The NS-CSHCN 2009/10 identified that nearly one quarter of CYSHCN nationally did not receive at least one of the services they needed. While services may be available, a lack of awareness of resources by both families and providers and a lack of communication of available resources impeded access. According to the Title V Five-Year Needs Assessment, parents noted a lack of programs and facilities that can accommodate their children and stressed a need for more inclusive community resources.</td></tr>
</table>

The majority of family members of CYSHCN participating in focus groups reported feeling alone and isolated within their communities. Parents expressed the desire for more community education about CYSHCN to promote awareness and inclusion. In the 2018 CYSHCN Outreach Survey, 74% of parents indicated the need for respite care. Nearly 15% of parents who want respite indicated that they have never used respite care services. Barriers included lack of money to pay for respite care and difficulty finding providers.

Successful outreach efforts promoting family to family networking, utilization of respite, and access to support groups, education and other community-based services will lead to increased inclusion and strengthened families. Access to needed resources helps assure that children grow up in families and participate in their communities with a strong sense of belonging.

SPM 2 - Percent of overweight and obesity in Texas children ages 2-21.
Population Domain(s) – Child Health, Adolescent Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To reduce the prevalence of overweight and obesity in Texas children ages 2-21.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of 8th graders surveyed with BMI in overweight or obese category</td></tr>
<tr><td>Denominator:</td><td>Total number of 8th graders surveyed</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Texas School Physical Activity and Nutrition (SPAN) Survey

The School Physical Activity and Nutrition (SPAN) Project is a Texas-wide surveillance system which monitors trends in body mass index (BMI) of school-aged children in the 2nd, 4th, 8th, and 11th grades within racial/ethnic, gender, and geographic subpopulations. SPAN survey data have been collected in Texas at five time points using a cross-sectional questionnaire (years 2000-2002, 2004-2005, 2009-2011, 2015-2016, 2019-2020). In addition to monitoring the prevalence of school-aged children with overweight and obesity in Texas, SPAN identifies factors in Texas students that may underlie obesity, including dietary behaviors. nutrition knowledge and attitudes, and physical activity.

Data Issues: Due to the structure of the survey, the grade levels are unable to be combined. The decision was made to focus on 8th grade, as it is within both Child and Adolescent domain age ranges.</td></tr>
<tr><td>Significance:</td><td>Obesity is a major public health concern in Texas. Texas has the seventh highest obesity rate for youth and the 14th highest adult obesity rate in the U.S. according to The State of Obesity report. Over 600,000 Texas youth have obesity. Additionally, racial disparities exist in the rate of childhood obesity in the state as identified in the 2015-2016 round of the SPAN survey. State trends demonstrate that childhood obesity is getting worse overtime. Obesity is associated with increased lifetime risks for adverse health outcomes, including: diabetes, heart disease, asthma, high blood pressure, depression, sleeping difficulties, and higher risk of being obese as an adult (Daniels, 2009; Singh et al., 2008). Additionally, childhood obesity is costly, resulting in extra health care costs. A child with obesity has $12,900 more in medical costs than a child with normal weight (Finkelstein et al., 2014). Educational attainment is associated with lifetime earnings. Obesity in childhood is associated with poorer educational outcomes, including: lower GPA, lower reading scores, lower math score, and more school absences (Carey et al., 2015; Shore et al., 2008; Geier et al., 2012).

Tracking trends across time through the SPAN survey will ensure an adequate understanding of gaps and areas of focus for state and local entities to address.</td></tr>
</table>

SPM 3 - Infant Mortality Disparities: Ratio of Black to White infant mortality rate
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Reduce Black infant mortality rates in order to reduce racial disparities between Black and White infant mortality.
Definition:	<table><tr><td>**Unit Type:**</td><td>Ratio</td></tr><tr><td>**Unit Number:**</td><td>1</td></tr><tr><td>**Numerator:**</td><td>Rate of Black infant mortality among Texas residents in a specific calendar year.</td></tr><tr><td>**Denominator:**</td><td>Rate of White infant mortality among Texas residents in a specific calendar year.</td></tr></table>
Data Sources and Data Issues:	Data Source: Texas birth file (natality data) and death file (mortality data), DSHS Center for Health Statistics Birth data are derived from a subset of variables collected on the Texas Certificate of Live Birth. Death data are derived from a subset of variables collected on the Texas Certificate of Death. As a secondary analysis, we also plan to calculate the ratio of Black to White feto-infant mortality, using live birth, fetal death, and birth cohort linked birth infant death. Results for this additional measure will be provided in the Notes section in future years, as available. Data Issues: Birth and death data used for this report are likely to be provisional data, and as such, are subject to change. Death data are reported using race/ethnicity of the infant. Birth data are reported using race/ethnicity of the mother.
Significance:	The racial and ethnic disparities between Black women and other populations must be addressed. According to the March of Dimes, in 2010, the overall US infant mortality rate was 6.1 infant deaths per 1,000 live births. The infant mortality rate for black women (11.5 per 1,000) was 2.2 times greater than that for white women (5.2). This racial gap has widened from 1960 to 2011, as infant mortality rates have declined. In 2013, the Black infant mortality rate in Texas was 12.0 infant deaths per 1,000 live births, while for all other racial/ethnic groups, the infant mortality rate was already below the Healthy People 2020 goal of 6.0 per 1,000.

SPM 4 - Maternal Morbidity Disparities: Ratio of Black to White severe maternal morbidity rate.
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Reduce Black severe maternal morbidity (SMM) rates to reduce racial disparities in severe maternal morbidity and increase health equity between Black and White women.
Definition:	**Unit Type:** Ratio **Unit Number:** 1 **Numerator:** Rate of Black SMM among Texas residents in a specific calendar year **Denominator:** Rate of White SMM among Texas residents in a specific calendar year
Data Sources and Data Issues:	Data Source: SMM identified with the CDC SMM Index of indicators [1] using the Texas Health Care Information Collection (THCIC) hospital discharge data and International Classification of Diseases (ICD) diagnosis and procedure codes Data Issues: THCIC is requesting a waiver for hospitals during COVID-19. In the short-term, this may contribute to a delay in availability of data. Data issues identified in the literature include: Rare pregnancy complications are likely to be under-reported [2]. The CDC SMM Index likely overestimate cases of SMM compared with cases identified with medical record abstraction [3] and case review [4]. Inclusion of codes for transfusion-only cases, many of which may involve transfusion of only 1-2 units such as for preexisting anemia, may be a significant source of false-positive cases [5]. Some cases of SMM may be identified through hospital case review but not be identified by the CDC SMM Index [6]. *See references in Section V. Supporting Document #1.
Significance:	The racial and ethnic disparities in health outcomes between Black women and other populations must be addressed. SMM has been defined as the “unintended outcomes of the process of labor and delivery that result in significant short-term or long-term consequences to a woman’s health” [7]. Rates of SMM, while remaining relatively stable in Texas from 2009-2018 [8], are increasing in the United States [9]. Non-Hispanic Black women are disproportionality impacted by SMM with rates of SMM approximately 100 percent higher among Black than White women, with no reduction in the Black-White disparity over time [11,12]. Like maternal mortality, Much of SMM is considered to be highly preventable and, when not ameliorated, may result in maternal death [12]. *See references in Section V. Supporting Document #1.

SPM 5 - Percent of women of childbearing age who self-rate their health status as excellent, very good, or good
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To improve the self-reported health status of women of reproductive age through programming that improves systems and provides resources to promote well-being and prevent poor health outcomes.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Estimated number of females in Texas, ages 18-44, who reported their general health status was excellent, very good, or good. **Denominator:** Total number of females ages 18-44 in Texas during a specific calendar year.
Data Sources and Data Issues:	Data Source: Texas Behavioral Risk Factor Surveillance System (BRFSS), Core Item The Texas BRFSS is a telephone-based survey that collects data from Texas adults regarding health-risk related behaviors, chronic health conditions, and use of preventive services. BRFSS sample results are thought to be representative of the total adult population. This measure is based on self-assessment only and does not include an objective health component. Data Issues: All data collected by BRFSS are self-reported. Furthermore, response rates to the BRFSS are lower than ideal and declining, a limitation that it shares with all telephone surveys. BRFSS findings are intended for population surveillance and have only limited generalizability to specific geographic subgroups such as counties or cities. Additionally, in Texas, Spanish Speaking respondents are consistently underrepresented in phone surveys, and Texas has a low rate of cooperation (less than sixty percent).
Significance:	A woman's health in the preconception and interconception periods affects her health, safety and wellbeing throughout her life course, including outcomes of any future pregnancies and subsequent maternal, infant and child health. Women in Texas have experienced rising rates of obesity, diabetes, hypertension, and substance abuse disorder as well as low rates of health insurance coverage and access to care. Evidence of poor preconception health is shown in high rates in Texas of unintended pregnancy, preterm birth, maternal morbidity, and maternal mortality. Self-reported health status has the capacity to account for the multiple factors that impact a woman's preconception and interconception health. Self-reported health status is a measure of health-related quality of life and is recognized as an indicator of a population's overall well-being. This measure is a Council of State and Territorial Epidemiologists (CSTE) Core State Preconception Health Indicator. According to the CSTE indicator detail sheet, this indicator is highly correlated with various adverse health outcomes, and lower ratings of this subjective measure have consistently been associated with "increased mortality, incident adverse health events, health care utilization and illness severity, even after medical risk factors have been accounted for."

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 4 - Percent of young adults (ages 18-24) who visited a doctor for a routine checkup in the past year
Population Domain(s) – Adolescent Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percentage of adolescents and young adults who report visiting a doctor for a routine checkup, in order to provide prevention, early detection, and intervention of potential chronic health issues.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Estimated number of young adults in Texas, ages 18-24, who reported that they had visited a doctor for a routine checkup in the past year</td></tr>
<tr><td>Denominator:</td><td>Total number of young adults ages 18-24 in Texas during a specific calendar year</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>Associated HP2020 objective: Increase the proportion of adolescents who have had a wellness checkup in the past 12 months (AH-1)</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Texas Behavioral Risk Factor Surveillance System (BRFSS)
The Texas BRFSS is a telephone-based survey that collects data from Texas adults regarding health-risk related behaviors, chronic health conditions, and use of preventive services. BRFSS sample results are thought to be representative of the total adult population.

As a secondary analysis, we also plan to calculate the percent of adolescents (ages 12-18) who had a routine checkup in the past year, using YRBS estimates. Baseline data for this secondary analysis will not be available until 1-2 years from now, but we will provide results in the Notes section in future years, as available.

Data Issues:
All data collected by BRFSS are self-reported. Furthermore, response rates to the BRFSS are lower than ideal and declining, a limitation that it shares with all telephone surveys. BRFSS findings are intended for population surveillance and have only limited generalizability to specific geographic subgroups such as counties or cities. The same limitations apply to YRBS data.</td></tr>
<tr><td>Significance:</td><td>Adolescents and young adults (ages 10-24) make up 21% of the United States population. Health behaviors established during these developmental and transitional periods will influence not only these young people’s current health status, but their risk for developing chronic diseases as adults. Young adults in particular have unique health issues; they have a higher prevalence of mortality, substance use, and sexually transmitted infections than do adolescents, and are less likely to have health care coverage than any other age group. In order to address potential health risk factors in adolescents and young adults, initial steps need to be taken to identify these factors, refer patients to the appropriate services, and provide educational guidance to mitigate the health impact.</td></tr>
</table>

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Texas

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Texas

ESM 4.1 - Percent of births occurring in hospitals with policies consistent with the WHO/UNICEF Ten Steps to Successful Breastfeeding and recognized by the Texas Ten Step designation.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the proportion of births occurring in facilities taking steps to provide recommended support for lactating mothers and their babies
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Estimated number of births occurring in hospitals that are designated by the HHSC Texas Ten Step Program **Denominator:** NA
Data Sources and Data Issues:	Data Source: Hospital's self-reported number of annual births; Texas Ten Step designation listing (HHSC Texas Ten Step Program) Data Issues: None anticipated
Evidence-based/informed strategy:	The U.S. Surgeon General's Call to Action to Support Breastfeeding calls for health care to ensure that maternity practices are fully supportive of breastfeeding, and to develop systems to guarantee continuity of skilled lactation support between hospitals and health care settings in the community. Evidence-based guidelines for quality maternity practices, including the Ten Steps to Successful Breastfeeding and related practices, are well-established and widely promoted by health authorities but are inconsistently implemented. The Ten Steps are an evidence-based bundle of practices shown to improve infant feeding outcomes across all races, ethnicities and income levels, to increase continuity and, ultimately, to result in improved short- and long-term maternal and infant health outcomes.
Significance:	CDC breastfeeding policy or environmental support indicators focus on increasing the state score on the Maternity Practices in Infant Nutrition and Care (mPINC) survey and increasing proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies. This is measured by the number of births occurring in facilities that have achieved the Baby Friendly Hospital designation by demonstrating full implementation of the Ten Steps. The Baby Friendly Hospital Initiative is an international WHO/UNICEF program that is administered in the United States by Baby-Friendly USA. Another key metric is reducing the proportion of breastfed newborns who receive formula supplementation within the first 2 days of life.

ESM 4.2 - Estimated minimum number of Texas workers employed at a worksite with a written and communicated worksite lactation support policy and recognized by the Texas Mother-Friendly designation
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To reduce work-related barriers to breastfeeding initiation, continuation, and exclusivity by providing employers with information and assistance on recommended practices for establishment of worksite lactation support policies and environments</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>25,000</td></tr>
<tr><td>Numerator:</td><td>Estimated minimum total number of Texas workers employed at a worksite with a written and communicated worksite lactation support policy and recognized by the Texas Mother-Friendly designation</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Texas Mother-Friendly Worksite applications. The current online application asks employers to report a range of number of employees employed at a business by choosing one of the following options from a dropdown list:
1-5
6-10
11-24
25-50
51-99
100-499
500-2499
2500-24,999
25000+
Data Issues: Range-based reporting restricts the ability to fully count the number of employees at a business to the lowest number in the range. This will result in under-estimating the number of employees reached by Mother-Friendly policies. Efforts will be made over the next three years to revise the online application system to include an actual count of fulltime equivalent positions at a worksite.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The U.S. Surgeon General calls for employers to have high-quality employee lactation support programs and to work toward other efforts, such as paid maternity leave, to reduce breastfeeding barriers for working mothers. Employment barriers to breastfeeding, including early return to work, lack of support in the workplace and difficulties with pumping when separated, remain the biggest barriers for breastfeeding initiation, duration and exclusivity.</td></tr>
<tr><td>Significance:</td><td>A previous statewide assessment showed many Texas employers did not perceive a need for formal support of breastfeeding and did not hear of the need from employees. Many working mothers reported fear (e.g. job insecurity) of asking employers for basic worksite lactation supports. Mothers report barriers to finding clean, private spaces and taking lactation breaks enough to maintain milk supply. Women reported that a written worksite policy providing flexible scheduling and access to clean, private space for lactation breaks, such as recommended by the Texas Mother-Friendly Worksite Program, would enable them to confidently approach their employer for these basic supports and would help with balance of</td></tr>
</table>

work commitments and personal breastfeeding goals.

Supportive worksite policies and practices increase a mother's ability to establish and maintain lactation even when separated from her infant and can improve infant feeding outcomes while also benefiting the employers through cost savings of up to $3 for every $1 invested by employers. Savings are realized through increased employee retention, loyalty and productivity, reduced absenteeism, and reduced health care costs. Texas women have limited access to supportive workplace policies and programs that allow them to continue to breastfeed after returning to work. Many employers are now required by law to provide basic lactation support in the workplace.

ESM 4.3 - Number of after-hours calls to Texas' lactation support hotline
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase access to skilled lactation support through provision of 24/7 access to breastfeeding counselors and skilled clinical lactation specialists who provide information, counseling and referrals related to infant feeding for Texas families and
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Total annual number of calls received by the Texas Lactation Support Hotline after-hours service **Denominator:**
Data Sources and Data Issues:	Data Source: Monthly after hour hotline call logs The Texas Lactation Support Hotline provides callers with information, tele-consult services for lactation support, and referrals to local WIC services. The line provides access to international Board-Certified Lactation Consultants for any calls requiring lactation support or clinical lactation expertise. Calls received during daytime hours (typically 8 a.m.-4:30 p.m. on non-holiday weekdays) are fielded by WIC staff and funded by the Texas WIC Program. MCH funds coverage of the hotline during the remaining hours through a subcontract with a national lactation tele-consult service to ensure 24-hour per day, 7-day per week coverage. Data Issues: None anticipated
Evidence-based/informed strategy:	As reported in the MCH/HHSC Texas WIC Infant Feeding Practices Survey, Texas mothers cite problems with breastfeeding including sore nipples, engorged breasts, mastitis, leaking milk, pain, difficulty with infants' ability to latch, and concerns about insufficient milk supply. Research demonstrates that professional assistance with these problems increase the likelihood that women will continue to breastfeed and, when the problems are successfully resolved, are more likely to choose to breastfeed with subsequent children.
Significance:	The U.S. Surgeon General's Call to Action to Support Breastfeeding calls for assurance of access to "to trained individuals with established relationships in the health care community who are flexible enough to meet mothers' needs outside of traditional work hours and locations, and provide consistent information", including access to services provided by International Board Certified Lactation Consultants.

ESM 5.1 - Number of health professionals who received Texas HHS CE credits on SUID prevention or safe sleep practices in the past year
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase statewide access to coordinated, consistent, evidence-based public health information about recommended practices related to safe sleep environments and risk reduction for sleep-related infant deaths</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>100,000</td></tr>
<tr><td>Numerator:</td><td>Total annual number of health care and health professionals who complete education and receive Texas HHS CE credits on SUID prevention or safe sleep practices</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Texas HHS continuing education logs for enduring and/or live events on SUID prevention and infant sleep safety (e.g. Texas Health Steps Online Provider Education, MCH events).
Data Issues: None anticipated</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Sleep-related infant death (SUID, including SIDS) is the leading cause of postneonatal death and the third leading cause of infant death overall, after birth defects and preterm-related complications. About half of all Texas SUIDs in 2012 were attributed to SIDS. SIDS/SUID rates were much higher for infants born to Black mothers than other racial/ethnic groups. In 2016, the AAP reaffirmed their policy in the publication SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment, which provides an evidence-based, comprehensive approach to sleep safety and risk reduction for all sleep-related infant deaths, including SIDS. A comprehensive, evidence-based, communication-focused risk-reduction approach is also promoted through national MCH and public health efforts including the National Action Partnership to Promote Safe Sleep.</td></tr>
<tr><td>Significance:</td><td>The AAP recommends that “health care professionals, staff in newborn nurseries and NICUs, and child care providers should endorse and model the SIDS risk-reduction recommendations from birth,” and the National Action Plan to Increase Safe Infant Sleep includes actions to mobilize and train health care professionals and community programs to provide consistent and accurate information and modeling.</td></tr>
</table>

ESM 6.1 - Number of Texas Health Steps Online Provider Education (OPE) users completing developmental screening modules
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	To increase the number of providers accessing education on early childhood developmental screening guidelines.
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Number of individual users completing one or more Texas Health Steps Online Provider Education (OPE) developmental screening modules per fiscal year. **Denominator:**
Data Sources and Data Issues:	Data Source: Texas Health Steps Online Provider Education (OPE) website data Texas Health Steps OPE course data will be utilized to measure provider trainings on developmental screening for children. Texas Health Steps OPE is an award-winning online program offering free continuing education modules for primary care providers and other health professionals. These modules offer updated clinical, regulatory, and best practice guidelines for a range of preventive health, oral health, mental health, and case management topics. Completion of at least one of the following developmental screening modules will be assessed for this measure: 1. ADHD: Diagnosis and Management 2. Autism Spectrum Disorder: Screening, Diagnosis, and Management 3. Behavioral Health: Screening and Intervention 4. Developmental Surveillance and Screening: Birth through 6 Years 5. Hearing and Vision Screening 6. Newborn Hearing Screening 7. Newborn Screening 8. Screening for Autism Spectrum Disorder 9. Using Developmental Screening Tools Data Issues: Texas Health Steps OPE modules offered may be subject to change, which could impact analysis of trends over time.
Significance:	In 2010 and 2014, the American Academy of Pediatrics (AAP) reaffirmed its 2006 Policy Statement “Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening.” The policy states that early identification of developmental disorders is critical to the well-being of children and their families. However, up to half of American children with developmental delay did not have the delay identified by the time they enter kindergarten. A Healthy People 2020 goals is to increase the proportion of parents who receive information from a health professional when they have a concern about their child’s learning, development, or behavior (EMC-2.4). According to the 2017/18 NSCH, a quarter (25.9%) of Texas parents of children age 0 to 5 years were asked if they had concerns about their child’s learning, development, or behavior by a doctor or other health care provider. Increasing providers’ understanding of the importance of developmental screening guidelines will ensure more providers are screening children when recommended/required and are referring parents to resources and additional assessment tools to follow their children’s developmental progress.

ESM 6.2 - Number of developmental screenings provided in the Healthy Child Care Texas Grant
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of children receiving a developmental screening in the Healthy Child Care Texas grant.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>3,000</td></tr>
<tr><td>Numerator:</td><td>Number of developmental screenings provided in the Healthy Texas Child Care grant.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Healthy Child Care Texas trainings

The Healthy Child Care Texas (HCCT) grant promotes optimal health, safety, nutrition, and development of children in out-of-home child care programs. Child Care Health Consultants (CCHCs) provider trainings to childcare centers on administration of physical, social, and emotional developmental screenings. CCHCs will train center directors on administration of the Ages and Stages Developmental Screening tool. Grant funding for these trainings will be available from FY20-FY22.

Data Issues: Covid-19 may impact the number of trainings conducted over the next two years.</td></tr>
<tr><td>Significance:</td><td>The American Academy of Pediatrics recommends that all children be screened for developmental disabilities and delays at well-child doctor visits at 9 months, 18 months, and 24 or 30 months. Research has shown that early intervention treatment services can greatly improve a child’s development. However, many children with developmental disabilities/delays are not identified before age 10, by which time significant delays might already have occurred and opportunities for treatment might have been missed. One of the Healthy People 2020 goals is to increase the proportion of parents who receive information from their doctors or other health professionals when they have a concern about their child’s learning, development, or behavior (EMC-2.4). According to the 2017/18 NSCH, a quarter (25.9%) of Texas parents of children age 0 to 5 years were asked if they had concerns about their child’s learning, development, or behavior by a doctor or other health care provider.

Increasing individuals trained in the Healthy Child Care grant on developmental screening tools will ensure more communication and resources are provided to parents on the importance of developmental screenings and the need to follow their children’s developmental progress.</td></tr>
</table>

ESM 6.3 - Percent of families participating in Help Me Grow Texas (HMGTX) who receive a developmental screening
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percent of families participating in Help Me Grow Texas (HMGTX) who receive a developmental screening.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of developmental screenings provided in the Help Me Grow.</td></tr>
<tr><td>Denominator:</td><td>The total number of eligible children participating in Help Me Grow Texas.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Quarterly contractor reports on Help Me Grow Texas developmental screenings. Covid-19 may impact the number of screenings conducted over the next two years. This effort began in FY21, and denominator and numerator counts will be determined in FY22. Annual objectives will established in the FY23/FY21 application.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>One of the Healthy People 2020 goals is to increase the proportion of parents who receive information from their doctors or other health professionals when they have a concern about their child’s learning, development, or behavior (EMC-2.4). According to the 2017/18 NSCH, a quarter (25.9%) of Texas parents of children age 0 to 5 years were asked if they had concerns about their child’s learning, development, or behavior by a doctor or other health care provider. Increasing the percent of families participating in Help Me Grow Texas (HMGTX) who receive a developmental screening will ensure more communication and resources are provided to parents on the importance of developmental screenings and the need to follow their children’s developmental progress.</td></tr>
<tr><td>Significance:</td><td>The American Academy of Pediatrics recommends that all children be screened for developmental disabilities and delays at well-child doctor visits at 9 months, 18 months, and 24 or 30 months. Research has shown that early intervention treatment services can greatly improve a child’s development. However, many children with developmental disabilities/delays are not identified before age 10, by which time significant delays might already have occurred and opportunities for treatment might have been missed.</td></tr>
</table>

ESM 7.1.1 - Number of School Health Friday Beat newsletters per fiscal year with at least one injury prevention resource provided
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	To have at least one injury prevention resource in each issue of the Friday Beat, to educate teachers, school administrators, and other interested individuals on injury prevention topics.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of School Health Friday Beat bi-weekly newsletter issues per year that include at least one injury prevention resource. **Denominator:**
Data Sources and Data Issues:	Source: DSHS School Health MCHS is working with School Health to try to ensure that every issue of the Friday Beat newsletter includes at least one injury prevention resource. Approximately 25 newsletter issues will be written/distributed each year (issues are published every other week). The Friday Beat newsletter goes out each week to over 2,500 followers through their distribution list. School Health will provide MCHS with the numbers and topics of the injury prevention resources they include in their bi-weekly Friday Beat issues.
Significance:	Unintentional injury is the leading cause of death and disability among children and adolescents, both in Texas and the United States as a whole. School is one environment in which children spend a significant portion of their day, so this environment could definitely have an impact on injury risk. Both fatal and nonfatal childhood injuries are very costly; in addition to the burden of death and disability, childhood injuries can result in substantial economic costs, including medical costs for the child and lost work days for caregivers. In order to impact the number of injury-related hospital admissions per population ages birth to 19 years, teachers, school administrators, nurses, and other interested individuals need to increase their knowledge of the potential risks impacting this population at school, in the community, and at home, and be provided strategies to reduce the risk. This measure will ensure that injury prevention resources are included in each issue of the School Health Friday Beat newsletter.

ESM 7.1.2 - Number of individuals trained on injury prevention through the Medical Child Abuse Resources and Education System (MEDCARES) grant
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Provide trainings to individuals on injury prevention best practices and intervention methods to best inform future injury prevention strategies.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>30,000</td></tr>
<tr><td>Numerator:</td><td>Number of individuals trained in injury prevention best practices and intervention methods in the MEDCARES grant.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Medical Child Abuse Resources and Education System (MEDCARES)

MEDCARES is a grant program that improves services related to the prevention, assessment, diagnosis, and treatment of child abuse and neglect in hospital or academic health care settings through funding, collaboration, and outcome reporting, in addition to providing direct services.

Data Issues: MEDCARES is a legislatively mandated program and activities are contingent on legislation and being appropriated funds. This number is also could be duplicated due to the same individual attending multiple trainings. Covid-19 may impact the number of trainings conducted over the next two years.</td></tr>
<tr><td>Significance:</td><td>Unintentional injury is the leading cause of death and disability among children, both in Texas and the United States as a whole. Many aspects of the environment in which children live (physical, social, cultural, economic, etc.) have impacts on injury risk. Both fatal and nonfatal childhood injuries are very costly; in addition to the
burden of death and disability, childhood injuries can result in substantial economic costs, including medical costs for the child and lost work days for caregivers. In order to impact the number of injury-related hospital admissions per population ages birth to 9 years, those who work with children at risk need to increase their knowledge of the potential risks impacting this population. MEDCARES providers will lead trainings to educate them on injury prevention best practices and intervention methods to best inform future injury prevention strategies and interventions.</td></tr>
</table>

ESM 7.2.1 - Number of Texas Health Steps Online Provider Education (OPE) users completing injury prevention modules.
NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	To increase the number of providers taking OPE modules, so providers are better able to educate parents and children on injury prevention strategies and resources, in order to prevent injuries and reduce their consequences.
Definition:	**Unit Type:** Count **Unit Number:** 50,000 **Numerator:** Number of individual users completing one or more Texas Health Steps Online Provider Education (OPE) injury prevention modules per year **Denominator:**
Data Sources and Data Issues:	Data Source: DSHS Texas Health Steps Online Provider Education (THS-OPE) website data. THS-OPE module data will be utilized to measure the number of providers taking trainings on injury prevention. THS-OPE is an award-winning online program offering free continuing education modules for primary care providers and other health professionals. These modules offer updated clinical, regulatory, and best practice guidelines for a range of preventive health, oral health, mental health, and case management topics. Completion of at least one of the following injury prevention modules will be assessed for this measure: 1) Addressing Adverse Childhood Experiences through Trauma-Informed Care 2) Adolescent Substance Use 3) Behavioral Health: Screening and Intervention 4) Childhood and Adolescent Depression 5) Concussion: Diagnosis, Treatment, and Prevention 6) Culturally Effective Health Care 7) High-Risk Behaviors in Young People: Screening and Intervention 8) Interpersonal Youth Violence 9) Motivational Interviewing 10) Preventing Unintentional Injury 11) Promoting Adolescent Health 12) Recognizing, Reporting, and Preventing Child Abuse 13) Teen Consent and Confidentiality 14) Trauma-Informed Care for Children in Foster Care Data Issues: THS-OPE modules offered may be subject to change, which could impact analysis of trends over time. Specific data on the methods by which many of the adolescent injuries took place is limited.
Significance:	Unintentional injury is the leading cause of death and disability among children and adolescents, both in Texas and the United States as a whole. Many aspects of the environment in which children live (physical, social, cultural, economic, etc.) have impacts on injury risk. Both fatal and nonfatal childhood injuries are very costly. In addition to the burden of death and disability, childhood injuries can result in substantial economic costs, including medical costs for the child and lost work days for caregivers. To impact the number of injury-related hospital admissions per population ages birth to 19 years, parents and professionals

	need to increase their knowledge of the potential risks impacting this population and strategies available to reduce this risk. Providers need tools to approach adolescents about injury risks and consequences in a manner that will yield the highest benefit. This measure will examine the number of individuals who completed injury prevention-related THS-OPE modules.

ESM 7.2.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19
NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	Increase the percentage of youth reporting a connection to at least one caring adult, as a measure of positive youth development (PYD) and a protective factor against injury.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Estimated number of youth in Texas (grades 9-12) reporting a connection to at least one caring adult during a specific year. **Denominator:** Total number of youth (grades 9-12) in Texas during a specific year
Data Sources and Data Issues:	Data Source: Texas Youth Risk Behavior Surveillance System (YRBSS). Texas YRBSS is a school-based survey of representative samples of 9th through 12th grade students in Texas. The survey monitors priority health risk behaviors that contribute to the leading causes of death, disability, and social problems among youth and adults. The YRBSS survey is conducted every two years. Starting with 2017 YRBSS data, this estimate will be the percentage of youth who reported that they either ate dinner at home with parents or guardians 4 of the last 7 days or they felt comfortable seeking help from an adult other than their parents if they had an important question affecting their life. Data Issues: All data collected by YRBSS are self-reported and subject to self-reporting bias. Furthermore, response rates to the YRBSS are lower than ideal and have seen a decline since 2011. YRBSS findings are intended for population surveillance and have only limited generalizability to specific geographic subgroups such as counties or cities. In 2019, Texas YRBSS worked with CDC to utilize available data for results to be considered representative of youth across the state, so 2019 YRBSS data is the baseline to estimate annual objectives. There is also the potential that future YRBSS may not collect information about whether youth ate dinner at home with parents/guardians 4 of the last 7 days due to the states question selection process.
Significance:	Research shows that adolescents who have positive connections to at least one adult in their life have increased protective factors and are less likely to participate in risky behaviors that can lead to injury and death. PYD focuses on the development of relationships with caring adults, supportive relationships with parents, supportive peer networks, promoting positive connections to school, supportive communities, and opportunities to experiment in healthy ways.

ESM 11.1 - Percent of families receiving professional care coordination for their child
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Assess care coordination to evaluate the assistance families receive with medical home services and inform efforts to support provision of medical home services for CYSHCN.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of CYSHCN families surveyed who indicated they received professional care coordination for their child</td></tr>
<tr><td>Denominator:</td><td>Total number of CYSHCN families surveyed</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: CYSHCN Outreach Survey

Responses to the CYSHCN Outreach Survey are collected on a biennial basis. The survey is mailed out and dispersed electronically to families served by the HHSC CSHCN health care benefits program and MCHS contractors in both English and Spanish formats. The survey will be promoted through email communication, newsletters, and webpages. According to results of the 2019 CYSHCN Outreach Survey as part of the 2020 Title V Five Year Needs Assessment, 203 of 730 survey respondents (27.8%) indicated they received professional help from someone at the child’s doctor’s office, a case manager or social worker, or someone at the child’s school with care coordination services.

Data Issues: Challenges associated with surveying a convenience sample include the potential to underrepresent subsets of the CYSHCN population in Texas according to geographical location or language spoken. The CYSHCN Outreach Survey seeks to combat these challenges by providing both online and paper access to the survey in English and Spanish. Geographical data is also gathered in order to examine relevant needs assessment activities.</td></tr>
<tr><td>Significance:</td><td>The 2002 AAP Policy Statement on Medical Home defined care within a medical home as accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. The Joint Principles of the Patient Centered Medical Home defined these characteristics through seven principles including care coordination across all elements of the complex health care system and community.
The National Survey of Children’s Health (NSCH) 2016/18 identified that 43.4% of Texas CYSHCN met all criteria for the medical home outcome, and less than one third received any help with arranging or coordinating care. Findings from the Title V Five Year Needs Assessment support that coordination of care is a challenge. The 2019 CYSHCN Outreach Survey, gathered as part of the Title V 2020 Needs Assessment, showed 61.8% of respondents reported that they coordinate their child’s care themselves. Survey data also showed that 27.8% of respondents received professional help from someone at the child’s doctor’s office, a case manager or social worker, or someone at the child’s school with care coordination services. Successful provider education, outreach, and promotion of medical home best practices will lead to increased implementation skills related to providing quality care coordination for CYSHCN and families.</td></tr>
</table>

ESM 11.2 - Increase percent of families who have a plan for an emergency and/or disaster
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percent of families who have a plan for an emergency and/or disaster.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of CYSHCN families surveyed who indicated they have a plan for an emergency and/or disaster.</td></tr>
<tr><td>Denominator:</td><td>Total number of CYSHCN families surveyed.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: CYSHCN Outreach Survey

Responses to the CYSHCN Outreach Survey are collected on a biennial basis. The survey is mailed out and dispersed electronically to families served by the HHSC CSHCN health care benefits program and MCHS contractors in both English and Spanish formats. According to survey results from the 2019 CYSHCN Outreach Survey as part of the 2020 Title V Five Year Needs Assessment, 371 of 557 survey respondents (66.6%) indicated that they had a plan for a natural or man-made disaster or medical emergency.

Data Issues: Challenges associated with surveying a convenience sample include the potential to underrepresent subsets of the CYSHCN population in Texas according to geographical location or language spoken. The CYSHCN Outreach Survey seeks to combat these challenges by providing both online and paper access to the survey in English and Spanish. Geographical data is also gathered in order to examine relevant needs assessment activities.</td></tr>
<tr><td>Significance:</td><td>The 2002 AAP Policy Statement on Medical Home defined care within a medical home as accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. The Joint Principles of the Patient Centered Medical Home defined these characteristics through seven principles including care coordination across all elements of the complex health care system and community.

The AAP acknowledges that CYSHCN have unique physical, mental, behavioral, developmental, communication, therapeutic, and social needs that must be addressed in all aspects of disaster preparedness and recommends providers encourage the development of written preparedness plans.

In order to increase the percent of families who have a plan for an emergency/disaster, MCHS promotes emergency preparedness to families and professionals through web-based communications, conference exhibiting, trainings, webinars, meetings, and presentations.</td></tr>
</table>

ESM 12.1 - Percent of families of transition age youth with special health care needs receiving professional help with their child's transition to adulthood
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Assess the provision of transition services to evaluate provider education, outreach and promotion of best practices, and to inform efforts to support providers and families.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of families of transition-aged youth with special health care needs (12 years+) surveyed who indicated they received professional help with transition services</td></tr>
<tr><td>Denominator:</td><td>Total number of families of transition-aged youth with special health care needs (12 years+) surveyed</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: CYSHCN Outreach Survey

Responses to the CYSHCN Outreach Survey will be collected on a biennial basis. The survey will be mailed out and dispersed electronically to families served by HHSC CSHCN health care benefits and MCHS contractors in both English and Spanish formats. The survey will be promoted through email communication, newsletters, and webpages. According to the 2019 CYSHCN Outreach Survey as part of the 2020 Title V Five Year Needs Assessment, 15 of 214 respondents with transition-aged youth (7.0%) indicated they received professional help with four or more of the seven areas of transition services.

Data Issues: Challenges associated with surveying a convenience sample include the potential to underrepresent subsets of the CYSHCN population in Texas according to geographical location or language spoken. The CYSHCN Outreach Survey seeks to combat these challenges by providing both online and paper access to the survey in English and Spanish.

Geographical data is also gathered in order to examine areas of need for additional ongoing needs assessment activities including focus groups and interviews.</td></tr>
<tr><td>Significance:</td><td>The AAP outlined guidelines to promote successful transition from pediatric to adult health care in a 2011 Clinical Report. The Got Transition Six Core Elements operationalized the components of health care transition support by establishing evidence-based tools for use by providers and families.

According to the 2017-2018 NSCH, 87.0% percent of the Texas CSHCN population did not receive the services necessary to transition to adult health care compared to 81.1 percent of CSHCN in the United States. In the Title V CSHCN Parental Outreach Survey, 75% of respondents said that they did not feel prepared for their child's transition. Only 7.0% of respondents prepared for transition in at least four out of seven transition areas with a professional. Most respondents who indicated that they had prepared for their child's transition had done so by themselves.</td></tr>
</table>

The percent of families of transition-age youth who indicate they received professional help with transition services for their child is derived from the CYSHCN Outreach Survey. Data collected reflects the number of survey respondents who indicate that a professional helped them with four or more of the following areas of transition needs: medical, educational, independent living, financial, social, employment, and legal.

Successful provider education, outreach, and promotion of best practices, including Got Transition's Six Core Elements, will lead to increased knowledge, attitudes, and implementation skills for providing transition support. Successful family education, outreach, and support will lead to increased demand for quality transition services.

ESM 12.2 - Decrease percent of families of transition-age youth who have not prepared for medical transition to adulthood
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Decrease percent of families of transition-age youth who have not prepared for medical transition to adulthood.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of families of transition-aged youth with special health care needs (12 years+) surveyed who indicated they have not prepared for transition to adult health care.</td></tr>
<tr><td>Denominator:</td><td>Total number of families of transition-aged youth with special health care needs (12 years+) surveyed.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: CYSHCN Outreach Survey

Responses to the CYSHCN Outreach Survey will be collected on an biennial basis. The survey will be mailed out and dispersed electronically to families served by the HHSC CSHCN health care benefits program and MCHS contractors in both English and Spanish formats. According to the 2019 CYSHCN Outreach Survey as part of the 2020 Title V Five Year Needs Assessment, 98 of 214 respondents with transition-aged youth (45.8%) indicated they have not prepared for medical needs as an adult.

Data Issues: Challenges associated with surveying a convenience sample include the potential to underrepresent subsets of the CYSHCN population in Texas according to geographical location or language spoken. The CYSHCN Outreach Survey seeks to combat these challenges by providing both online and paper access to the survey in English and Spanish.</td></tr>
<tr><td>Significance:</td><td>The AAP outlined guidelines to promote successful transition from pediatric to adult health care in a 2011 Clinical Report. The Got Transition Six Core Elements operationalized the components of health care transition support by establishing evidence-based tools for use by providers and families. In the 2019 CYSHCN Outreach Survey, a quarter of respondents (25.1%) felt prepared for their child to transition to adult medical care. Furthermore, 98 of 214 respondents with transition-aged youth (45.8%) indicated they have not prepared for medical needs as an adult.

Provider education, outreach, and promotion of best practices, including Got Transition’s Six Core Elements, will lead to increased knowledge, attitudes, and implementation skills for providing transition support. Family education, outreach, and support will lead to increased planning for transition to adult health care.</td></tr>
</table>

ESM 14.1.1 - Number of health organizations engaged in a DSHS maternal or infant health improvement effort involving integration of tobacco/e-cigarette screening, education and referral.
NPM 14.1 – Percent of women who smoke during pregnancy

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the proportion of women during pregnancy, childbirth and the puerperium in health care organizations providing recommended screening, education and referral for women who smoke during pregnancy</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>200</td></tr>
<tr><td>Numerator:</td><td>Number of health organizations receiving information, technical assistance, and/or support for maternal and/or infant health care improvement annually through DSHS MCH programs to increase practices supportive of smoking cessation among women of chil</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: DSHS HTMB Program data, including but not limited to data from the TexasAIM Program and the High-Risk Maternal Care Coordination Services Pilot
Data Issues: None anticipated</td></tr>
<tr><td>Significance:</td><td>The American College of Obstetricians and Gynecologists document the importance of education, assessment, screening, and intervention for tobacco and nicotine use during pregnancy and in the interpregnancy period for reducing the percent of women who smoke during pregnancy and maintaining smoking cessation. Behavioral pharmacotherapy interventions, such as recommended by the U.S. Preventive Services Task Force , have demonstrated efficacy for smoking cessation. Screening for tobacco and nicotine use and providing resources and interventions for smoking cessation should be incorporated into routine maternal care as well as targeted care for women at risk of maternal morbidity, such as women with opioid use disorder.
Guerby, P., Garabedian, C., Berveiller, P., Legendre, G., Grangé, G., & Berlin, I. (2020). Tobacco and Nicotine Cessation During Pregnancy. Obstetrics and gynecology, 136(2), 428–429. https://doi.org/10.1097/AOG.0000000000004033
American College of Obstetricians and Gynecologists, & Society for Maternal-Fetal Medicine (2019). Obstetric Care Consensus No. 8: Interpregnancy Care. Obstetrics and gynecology, 133(1), e51–e72. https://doi.org/10.1097/AOG.0000000000003025
Siu AL. Behavioral and pharmacotherapy interventions for tobacco smoking cessation in adults, including pregnant women: U.S. Preventive Services Task Force Recommendation Statement. U.S. Preventive Services Task Force. Ann Intern Med 2015;163:622–34.
Krans, E. E., Campopiano, M., Cleveland, L. M., Goodman, D., Kilday, D., Kendig, S., Leffert, L. R., Main, E. K., Mitchell, K. T., O'Gurek, D. T., D'Oria, R., McDaniel, D., & Terplan, M. (2019). National Partnership for Maternal Safety: Consensus Bundle on Obstetric Care for Women With Opioid Use Disorder. Obstetrics and gynecology, 134(2), 365–375. https://doi.org/10.1097/AOG.0000000000003381</td></tr>
</table>

ESM 14.2.1 - Number of materials distributed to household members and caregivers intended to raise awareness about the risk of infant and child exposure to tobacco.
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To improve health outcomes of children (0-17) through distribution of promotional materials and information to household members and caregivers that increase awareness, knowledge, and skill in reducing use of an exposure to tobacco.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>500,000</td></tr>
<tr><td>Numerator:</td><td>Number of materials distributed to household members and caregivers intended to raise awareness about the risk of infant and child exposure to tobacco per state fiscal year</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: DSHS Maternal and Child Health Section (MCHS)

Annual total number of materials distributed associated with tobacco control from the programs:
- Pamphlet for Parents of Newborns
During the 2005 regular legislative session, legislators pass SB 316, which 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. DSHS makes this pamphlet available online and for distribution from HHSC Warehouse in English and Spanish. DSHS reports on the number of pamphlet ordered from the warehouse each FY.

- Parent’s Guide to Raising Happy Healthy Children
As per HB 1240 enacted by the 81st Legislative Session the resource guide provides information relating to the development, health, and safety of a child from birth to five. This developmental resource guide is only available free of charge to prenatal care providers, including hospitals, birthing centers, physician, nurse midwives, and midwives, who provide prenatal care or deliver an infant of a pregnant woman enrolled in Medicaid. DSHS makes this pamphlet available online and for distribution in English and Spanish. DSHS reports on the number of guides ordered each Fiscal Year.

Data Issues: None anticipated.</td></tr>
<tr><td>Significance:</td><td>Exposure to secondhand smoke causes increased risk of sudden infant death syndrome (SIDS), acute respiratory infections, middle ear issues, and more severe and frequent asthma attacks. There is no safe level of exposure to secondhand smoke. As of 2016, the Centers for Disease Control and Prevention reports that Texas is one of the better performing states for maternal smoking, largely due to the high number of births to Hispanic women who are less likely to smoke. However, there is geographic disparity in this behavior with the higher rates of maternal smoking in the north and east of the state.

The Community Guide recommends, as part of a comprehensive tobacco control program, information and technical assistance be provided to support evidence-based practices. Due to the breadth of stakeholders involved in these efforts a process measure to assess diffusion of information among the target population is appropriate.</td></tr>
</table>

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 4.1 - Breastfeeding support assessment findings available
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase availability of data to inform public health strategies for breastfeeding support.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Text</td></tr>
<tr><td>Unit Number:</td><td>Yes/No</td></tr>
<tr><td>Numerator:</td><td>Yes: One or more reports of assessment findings related to breastfeeding support is produced and made available to the public via the DSHS website annually.
No: No reports of assessment findings related to breastfeeding support are produced and made</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: DSHS website
DSHS has multiple breastfeeding assessment sources, including WIC programmatic data, the Behavioral Risk Factor Surveillance System, the Pregnancy Risk Assessment Monitoring System, the Texas Hospital Association Survey, the Texas birth certificate, the Newborn Screening Demographic Form, the biennial Texas WIC Infant Feeding Practices Survey, and targeted qualitative studies of knowledge, attitudes, behaviors, and experiences. DSHS has funded research related to breastfeeding experiences and practices in hospitals, worksites, public, and child care settings, as well as a Baby-Friendly Hospital cost-analysis.

Data Issues: None anticipated.</td></tr>
<tr><td>Significance:</td><td>One of the Healthy People 2020 objectives (MICH-21) focuses on increasing the proportion of infants who are breastfed. In addition, the U.S. Surgeon General’s Call to Action to Support Breastfeeding calls for action in research and surveillance to strengthen capacity for conducting research on breastfeeding, and to develop a monitoring system to improve tracking of breastfeeding rates as well as policies and environmental factors known to affect breastfeeding. Assessment activities provide rich information to inform the strategic direction of breastfeeding programming and to evaluate the impact of programmatic efforts, allowing for ongoing monitoring and quality improvement.</td></tr>
</table>

2016-2020: ESM 4.3 - Number of Texas birthing facilities that receive information and technical assistance to facilitate integration of the WHO/UNICEF Ten Steps to Successful Breastfeeding
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the proportion of births occurring in facilities providing recommended support for lactating mothers and their babies.
Definition:	**Unit Type:** Count **Unit Number:** 500 **Numerator:** Number of Texas birthing facilities receiving information and technical assistance annually through the DSHS continuum of Ten Step Initiatives to increase practices supportive of breastfeeding. **Denominator:**
Data Sources and Data Issues:	Data Source: DSHS Infant Feeding Workgroup DSHS provides a continuum of Ten Step initiatives to support birthing facilities in implementing maternity care practices supportive of breastfeeding. These efforts include: - Engaging administrative and clinical decision makers in Ten Step improvement through the Right from the Start awareness campaign and through one-day hospital breastfeeding summits. - Providing a robust slate of online and in-person education offerings and resources - Recognizing facilities' incremental achievement with Texas Ten Step designation if at least 85% of DSHS Texas Ten Step criteria are addressed in policy, including designation as a Texas Mother Friendly Worksite. All Texas Baby-Friendly Hospitals, to date, are engaged in the TTS Program through which they continue to receive ongoing support for improvement in and implementation of the Ten Steps. - Accelerating integration of the Ten Steps and to support continuity of care from the hospital to the community through the Texas Ten Step Star Achiever Initiative. The initiative offers a learning collaborative, training, community partner meetings, ongoing technical assistance, and tools for facilities to improve policies and processes that impact breastfeeding outcomes. - Coordinating with national partners to support Texas birthing facilities that participate in national collaborative breastfeeding improvement initiatives, currently including facilities recruited for the W.K. Kellogg Foundation's Communities and Hospitals Advancing Maternity Practices (CHAMPS) initiative to reduce disparities in breastfeeding, and facilities that were recruited for the CDC/Abt Associates Enhance Maternity Practices (EMPower) for Breastfeeding initiative, the CDC's newest collaborative to increase the number of birthing facilities that are designated as Baby-Friendly. Data Issues: None anticipated.
Significance:	The U.S. Surgeon General's Call to Action to Support Breastfeeding calls for health care to ensure that maternity practices are fully supportive of breastfeeding, and to develop systems to guarantee continuity of skilled lactation support between hospitals and health care settings in the community. Evidence-based guidelines for quality maternity practices, including the Ten Steps to Successful Breastfeeding and related practices, are well-established and widely promoted by health authorities but are inconsistently implemented.

	The Ten Steps are an evidence-based bundle of practices shown to improve infant feeding outcomes across all races, ethnicities and income levels, to increase continuity and, ultimately, to result in improved short- and long-term maternal and infant health outcomes. One of the Healthy People 2020 objectives (MICH-24) focuses on increasing the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies. This is measured by the number of births occurring in facilities that have achieved the Baby Friendly Hospital designation by demonstrating full implementation of the Ten Steps. The Baby Friendly Hospital Initiative is an international WHO/UNICEF program that is administered in the United States by Baby-Friendly USA. Other Healthy people 2020 objectives associated with this measure include increasing the proportion of infants who are breastfed (MICH-21) and reducing the proportion of breastfed newborns who receive formula supplementation within the first 2 days of life (MICH-23).

2016-2020: ESM 4.4 - Number of employers who receive information and technical assistance on Mother-Friendly breastfeeding support policies
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To reduce work-related barriers to breastfeeding initiation, continuation, and exclusivity by providing employers with information and assistance on recommended practices for establishment of worksite lactation support policies and environments.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of Texas employers receiving information and technical assistance annually through the Texas Mother-Friendly Worksite Technical Assistance and Support Program **Denominator:**
Data Sources and Data Issues:	Data Source: MFW-TASP quarterly reports Data from the DSHS Mother-Friendly Worksite Technical Assistance and Support Program (MFW-TASP) are used for this ESM. The DSHS Mother-Friendly Worksite Program provides information, technical assistance, tools, resources and recognition to encourage and support employers to establish and maintain comprehensive, high-quality lactation support programs for employees who are separated from their infants during the workday. This program tracks the number of worksites that receive technical assistance, the type of assistance provided, and the number of these worksites that meet or exceed minimum program criteria and become designated as Texas Mother-Friendly Worksites. Data Issues: None anticipated
Significance:	Healthy People 2020 objective MICH-22 is to increase the proportion of employers with worksite lactation support programs. The U.S. Surgeon General calls for employers to have high-quality employee lactation support programs and to work toward other efforts to reduce breastfeeding barriers for working mothers. Employment barriers to breastfeeding, including early return to work, lack of support in the workplace and difficulties with pumping when separated, remain the biggest barriers for breastfeeding initiation, duration and exclusivity. A recent statewide assessment showed many Texas employers did not perceive a need for formal support of breastfeeding and did not hear of the need from employees. Many working mothers reported fear (e.g. job insecurity) of asking employers for basic worksite lactation supports. Mothers report barriers to finding clean, private spaces and taking lactation breaks sufficient to maintain milk supply. Women reported that a written worksite policy providing flexible scheduling and access to clean, private space for lactation breaks, such as recommended by the Texas Mother-Friendly Worksite Program, would enable them to confidently approach their employer for these basic supports and would help balance work commitments and personal breastfeeding goals. Supportive worksite policies and practices increase a mother's ability to establish and maintain lactation even when separated from her infant and can improve infant feeding

	outcomes while also benefiting employers through cost savings of up to $3 for every $1 invested by employers. Savings are realized through increased employee retention, loyalty and productivity, reduced absenteeism, and reduced health care costs. Texas women have limited access to supportive workplace policies and programs that allow them to continue to breastfeed after returning to work. Many employers are now required by law to provide basic lactation support in the workplace.

2016-2020: ESM 4.5 - DSHS Infant Feeding Position Statement reviewed, revised and updated in FY2019
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To provide up-to-date, evidence-informed direction for DSHS programs about infant nutrition and feeding and to make explicit to interested partners and stakeholders the public health importance of breastfeeding and the DSHS position on infant feeding
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** Yes: The DSHS Position Statement on Infant Feeding is reviewed and updated in FY2019 No: The DSHS Position Statement on Infant Feeding is not reviewed and updated in FY2019 **Denominator:**
Data Sources and Data Issues:	Data Source: DSHS Infant Feeding Workgroup All breastfeeding support activities are coordinated through the DSHS Infant Feeding Workgroup (IFW). The IFW seeks to address the determinants and barriers to breastfeeding within a comprehensive strategic action framework for the coordination, integration, and evaluation of breastfeeding support messaging, programs, and policies. DSHS has developed and leveraged strategic, data-informed planning, intensive cross-program coordination, and an integrated system of partnerships to systematically increase breastfeeding support and move the needle on breastfeeding outcomes. The IFW will complete a review of current scientific knowledge and needs assessment findings to revise the DSHS Position Statement on Infant Feeding. The statement was last revised in 2010, and this version of the statement is currently available online at http://dshs.texas.gov/wichd/lactate/position.shtm. Data Issues: None anticipated
Significance:	Breastfeeding is a public health priority. Suboptimal breastfeeding is associated with poor maternal and child health and developmental outcomes, including increased risk of acute and chronic morbidities, increased risk of infant death, and premature maternal and child deaths due to increased risk of several chronic diseases. Suboptimal breastfeeding results in an estimated annual loss in the U.S. of >$17 billion in excess maternal and child health care costs and lost productivity. While the vast majority of Texas mothers choose to breastfeed, fewer than half will breastfeed for as long as they want to. The U.S. Surgeon General's Call to Action to Support Breastfeeding calls for action in public health infrastructure to improve leadership on the promotion and support of breastfeeding. DSHS offers a comprehensive program of breastfeeding support, closely aligned with the U.S. Surgeon General's Call to Action to Support Breastfeeding, to address barriers to breastfeeding across sectors including health care, employment, and the community. In addition, one of the Healthy People 2020 objectives focuses on increasing the proportion of infants who are breastfed (MICH-21). An explicitly communicated position on infant feeding provides an explanation, justification, and recommended course of action to DSHS programs and other interested stakeholders to facilitate clarity, consistency, alignment and synergy in DSHS' approach to matters related to infant nutrition and feeding.

2016-2020: ESM 5.1 - Interagency Safe Sleep Messaging Strategic Communication Plan available in 2017
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To increase statewide access to coordinated, consistent, comprehensive, and evidence-based public health messaging and programming about recommended practices related to safe sleep environments and risk reduction for sleep-related infant deaths.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** Yes: An Interagency Safe Sleep Messaging Strategic Communication Plan —including goals, SMART objectives, and a five-year action plan – is developed, reviewed, and approved by DSHS leadership in FY17. No: A strategic plan is not developed, reviewed, **Denominator:**
Data Sources and Data Issues:	Data Source: Interagency Safe Sleep Messaging Strategic Communication Plan The DSHS/DFPS Safe Sleep Messaging Interagency Workgroup (SSMIW) is working to develop a strategic communication plan to ensure delivery of an effective, accurate and unified public health message across HHS programs serving infants and families about recommended practices related to sleep safety and risk reduction for sleep-related deaths. The plan, which will be finalized in FY2017 and will provide a road map for future activities, should include: - identification of primary and secondary audiences (including internal and external audiences); - key communication strategies to deliver unified messages for each target audience; - recommendations for activities, trainings, curricula, messages, materials, and other communications including alignment of existing messages as appropriate; - prioritized activities and key partnerships to develop or strengthen; - a dissemination and implementation action plan; and - an evaluation strategy. Data Issues: None anticipated
Significance:	Sleep-related infant death (SUID, including SIDS) is the leading cause of postneonatal death and the third leading cause of infant death, after birth defects and preterm-related complications. About half of all Texas SUIDs in 2012 were attributed to SIDS. SIDS/SUID rates were much higher for infants born to Black mothers than other racial/ethnic groups. In 2015, the AAP reaffirmed their policy in the publication SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment, which provides an evidence-based, comprehensive approach to sleep safety and risk reduction for all sleep-related infant deaths, including SIDS. A comprehensive, evidence-based, communication-focused risk-reduction approach is also promoted through national MCH and public health efforts including the Safe Sleep Learning Network of the COIIN, the NAPPSS project, and the ASTHO Safe Sleep Roundtable. A scan of messages from HHS System agency programs related to maternal and infant care revealed lack of consistency and comprehensiveness in messaging when compared to the AAP policy recommendations. The SSMIW was convened to ensure development of effective, accurate, coordinated, and unified public health messaging and programming about sleep safety and risk reduction for sleep related deaths.

2016-2020: ESM 5.2 - Complete community assessments and infant mortality prevention strategic plans in Healthy Texas Mothers and Babies (HTMB) Coalition communities
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To complete community assessments and infant mortality prevention strategic plans in HTMB Coalition communities with excess sleep-related infant deaths.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Text</td></tr>
<tr><td>Unit Number:</td><td>Yes/No</td></tr>
<tr><td>Numerator:</td><td>Yes: 4 local community assessments and infant mortality prevention plans are completed per year through FY2019
No: Less than 4 assessments and plans are completed per year</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: HTMB Evaluation Reports

HTMB currently supports four (4) Community Coalitions (HTMB-CCs) and an additional 4 will be recruited in FY2018 to strengthen local perinatal infrastructure, assess community needs and priorities, and develop, implement and evaluate initiatives within their communities to reduce disparities in preterm birth and feto-infant morbidity and mortality.

DSHS expects to identify a HTMB Technical Assistance Contractor (HTMB-TAC) in early FY18 to support HTMB-CCs with local community health assessment to include:
• Operational definition of the community of interest;
• Target population demographics, geographic data, socio-economic data, maternal, fetal and infant health and mortality data, racial/ethnic disparities, and community health status information;
• Rapid assessment of relevant community perinatal knowledge, attitudes and practices;
• Gaps, barriers and strengths of local health services and provider characteristics;
• Partners' organizational capacity, levels of commitment, and operational strengths and potential areas of contribution to CC goals;
• Opportunities to engage new and non-traditional partners; and
• Current locally implemented strategies and interventions relevant to infant mortality.

The HTMB-TAC will support each HTMB-CC in developing a strategic plan to address excess feto-infant mortality. The 4 currently contracted HTMB-CCs are expected to draft assessments and plans in FY2018. The additional 4 HTMB-CCs will begin assessment and planning processes in FY2018 that are anticipated to continue into FY2019.

Data issues:
Achievement is contingent on successful and timely development and execution of contracts; no issues are anticipated.</td></tr>
<tr><td>Significance:</td><td>Disparities in feto-infant mortality persist across the state. HTMB-CCs are recruited from geographic areas identified through PPOR mapping to have excess deaths in one or more PPOR when compared to a state reference group. Currently participating HTMB-CCs, and organizations to be recruited for development of additional HTMB-CCs are based within</td></tr>
</table>

areas previously determined to have excess deaths in the Infant Period of Risk (POR). This POR includes deaths occurring among infants in the postneonatal period (between 28 days and 1 year) and born weighing >1500 grams. While not all deaths that occur in the Infant POR are sleep-related, SIDS is the leading cause of postneonatal infant death.
Risk for sleep-related deaths—including SIDS, ill-defined deaths, and accidental suffocation and strangulation in bed—may be decreased by decreasing intrinsic and extrinsic risks, as discussed in a recent commentary by Moon RY and Hauck FR—SIDS Risk: It's More Than Just the Sleep Environment (Pediatrics.2016;137(1): e20153665). Recommendations to address known modifiable risks are described in the AAP TASK FORCE ON SUDDEN INFANT DEATH SYNDROME's Policy Statement—SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment (Pediatrics. 2016;138(5):e20162938) and the rationale for the recommendations is provided in the Task Force's corresponding Technical Report (Moon RY et al. Pediatrics. 2016;138(5):e20162940). DSHS will work with HTMB-CCs to assess community needs related to feto-infant mortality and to develop locally-relevant strategic plans to address identified priorities. DSHS anticipates that some HTMB-CCs will identify priorities related to sleep-related death and will develop strategies to address intrinsic and extrinsic risks for these deaths. Ongoing customized technical assistance, capacity building, training and evaluation support will be provided to HTMB CCs for optimal coordination, synergy, collaboration and impact.

2016-2020: ESM 6.2 - Number of additional individuals trained in early childhood developmental screening and referral in the Texas LAUNCH communities
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of individuals trained in early childhood developmental screening and referral in the Texas LAUNCH communities. The 2016 baseline is 2 individuals.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>3,000</td></tr>
<tr><td>Numerator:</td><td>Number of individuals trained in early childhood screening and referral in the Texas LAUNCH communities of El Paso, Fort Worth and San Antonio through Texas LAUNCH efforts.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Texas LAUNCH community trainings
The Texas LAUNCH communities are were selected through a competitive RFP. These communities will be training individuals on the Ages to Stages developmental screening tools. Grant funding for these trainings will be available from 2016-2019.

Data Issues:
The Texas LAUNCH communities are just getting up and running and have not yet developed their data collection and training plans. TVMCH will need to ensure that all LAUNCH communities are providing the same trainings with the same tools, and are collecting data through the same mechanisms.</td></tr>
<tr><td>Significance:</td><td>The American Academy of Pediatrics recommends that all children be screened for developmental disabilities and delays at well-child doctor visits at 9 months, 18 months, and 24-30 months. Research has shown that early intervention treatment services can greatly improve a child’s development. However, many children with developmental disabilities/delays are not identified before age 10, by which time significant delays might already have occurred and opportunities for treatment might have been missed. One of the Healthy People 2020 goals is to increase the proportion of parents who receive information from their doctors or other health professionals when they have a concern about their child’s learning, development, or behavior (EMC-2.4).

Increasing individuals trained in the Texas LAUNCH communities on developmental screening tools will ensure more communication and resources are provided to parents on the importance of developmental screenings and the need to follow their children’s developmental progress.</td></tr>
</table>

2016-2020: ESM 7.1.2 - Percent of child deaths reviewed by Child Fatality Review Teams (CFRT)
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	Increase the percentage of child death reviews completed by Child Fatality Review Teams.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of child deaths reviewed by Child Fatality Review Teams (CFRT) per calendar year</td></tr><tr><td>**Denominator:**</td><td>Total number of child deaths in Texas per calendar year</td></tr></table>
Data Sources and Data Issues:	Data Source: DSHS Maternal and Child Health Section (MCHS) CFRT data Data Issues: CFRTs are volunteers, so teams may not be entering data consistently. MCHS will provide training to teams in order to establish fidelity across the counties covered.
Significance:	Unintentional injury is the leading cause of death and disability among children and adolescents, both in Texas and the United States as a whole. Many aspects of the environment in which children live (physical, social, cultural, economic, etc.) have impacts on injury risk. Both fatal and nonfatal childhood injuries are very costly; in addition to the burden of death and disability, childhood injuries can result in substantial economic costs, including medical costs for the child and lost work days for caregivers. In order to impact the number of injury-related hospital admissions per population ages birth to 19 years, regional CFR teams need to increase their knowledge of the potential risks impacting this population. Texas will lead CFR team trainings in the fall of 2016 to educate them on injury prevention best practices and intervention methods as well as on the collection, assessment and documentation of child death reporting to best inform future injury prevention strategies and interventions. Due to these trainings and the introduction of paid coordinators in two communities, an increase in the percentage of child deaths reviewed is expected in the coming years.

2016-2020: ESM 7.1.3 - Train Child Fatality Review (CFR) teams on injury prevention
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Provide trainings to regional CFR teams in the fall of 2016 on injury prevention best practices and intervention methods, as well as on the collection and documentation of child death information, to best inform future injury prevention strategies.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Text</td></tr>
<tr><td>Unit Number:</td><td>Yes/No</td></tr>
<tr><td>Numerator:</td><td>Yes: CFR teams were trained on injury prevention in the fall of 2016.
No: CFR teams were not trained on injury prevention in the fall of 2016.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: DSHS Maternal and Child Health Section (MCHS).
TVMCH will be leading trainings for regional CFR teams.

Data Issues: None anticipated.</td></tr>
<tr><td>Significance:</td><td>Unintentional injury is the leading cause of death and disability among children and adolescents, both in Texas and the United States as a whole. Many aspects of the environment in which children live (physical, social, cultural, economic, etc.) have impacts on injury risk. Both fatal and nonfatal childhood injuries are very costly; in addition to the burden of death and disability, childhood injuries can result in substantial economic costs, including medical costs for the child and lost work days for caregivers. In order to impact the number of injury-related hospital admissions per population ages birth to 19 years, regional CFR teams need to increase their knowledge of the potential risks impacting this population. Texas will lead CFR team trainings in the fall of 2016 to educate them on injury prevention best practices and intervention methods, as well as on the collection, assessment and documentation of child death reporting to best inform future injury prevention strategies and interventions.</td></tr>
</table>

2016-2020: ESM 11.4 - Increase medical home provider education
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To increase the number of providers educated on the Texas Health Steps Medical Home Online Provider Education (OPE) module.
Definition:	**Unit Type:** Count **Unit Number:** 7,000 **Numerator:** Unduplicated number of users who completed the Texas Health Steps Medical Home Online Provider Education (OPE) module each fiscal year **Denominator:**
Data Sources and Data Issues:	Data Source: Texas Health Steps OPE module database State fiscal year data will be collected for the Medical Home Texas Health Steps (THSteps) OPE module “Building a Comprehensive and Effective Medical Home.” The goal of this module is to equip THSteps providers and others to build comprehensive and effective medical homes that serve children and adolescents with and without special health care needs, regardless of their racial, ethnic, socioeconomic and health status. Raw data are available annually and can be sorted by type of provider and date of module completion. Sorting module users by month will allow MCHS to detect increases in module use following targeted provider outreach efforts like conference exhibiting or presentations. Data Issues: Content updates are regularly scheduled for all THSteps OPE modules. The Medical Home module updates might impact trend analysis.
Significance:	The 2002 AAP Policy Statement on Medical Home defined care within a medical home as accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. The Joint Principles of the Patient Centered Medical home defined these characteristics through seven principles including, care coordination across all elements of the complex health care system and community. The NSCH 2017/18 identified that 43.4% of Texas CYSHCN met all criteria for the medical home outcome, and less than one third received any help with arranging or coordinating care. In order to increase provider knowledge, MCHS promotes THSteps OPE modules to targeted audiences through web-based communications, conference exhibiting, trainings, webinars, meetings, and presentations. After completing the activities of the medical home module, users will be able to: 1. Interpret the definition of a medical home. 2. Create a medical home approach for a child with special health-care needs. 3. Integrate preventive service components into care delivery. 4. Manage one practice tool for developing and sustaining a medical home. 5. Organize a comprehensive care plan to support a patient’s individualized care in the medical home.

	6. Employ a systematic practice change to improve access and delivery of care. 7. Specify how specialists and subspecialists can support coordination of care. Changes in provider knowledge of the medical home model, in combination with support and technical assistance from TVMCH, will lead to increased provider implementation of medical home best practices and improved outcomes for CYSHCN and their families.

2016-2020: ESM 11.5 - Meet with clinical champions for provider engagement
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To host a meeting of a group of clinical Maternal and Child Health partners committed to increasing the number of physicians and other providers engaged in MCHS activities for CYSHCN in each fiscal year.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** Yes: A group of clinical Maternal and Child Health partners have been recruited and a meeting of this group has occurred in the fiscal year No: A meeting of the group of clinical Maternal and Child partners has not occurred in the fiscal year **Denominator:**
Data Sources and Data Issues:	Data Source: MCHS Children with Special Health Care Needs (CSHCN) Systems Development Group (SDG) Led by the Maternal and Child Health CSHCN Director, the SDG will recruit clinical partners who are interested in improving MCHS engagement of physicians and other providers across the state. Data Issues: Competing priorities of clinicians may impact the amount of time group members are able to allocate to meetings.
Significance:	The National Center for Medical Home Implementation (NCMHI) recommends “state programs such as Title V can provide technical assistance and support to medical practices implementing the medical home model.” The NCMHI also suggests “clinical practices build relationships and partnerships with state departments of public health and/or other state agencies and programs.” Additionally, The National Center for Health Care Transition, Got Transition, recommends a quality improvement approach for clinicians to implement the Six Core Elements of Health Care Transition 2.0 framework. MCHS offers education, technical assistance and support to clinicians who provide health care transition services. In order to develop programmatic activities targeting physicians and other providers, MCHS developed and distributed a survey to gather information on education and support needs. Due to a low response rate in FY15-FY17, the survey was discontinued. Creating a group of clinical partners will help us to focus on physician and provider outreach and engagement in other ways. Successful outreach to physicians and other providers will also lead to improved physician knowledge and attitudes toward providing medical home and transition services for CYSHCN in Texas. Engagement may lead to participation in education or quality improvement activities, technical assistance, data sharing, and utilization of best practice frameworks.

2016-2020: ESM 11.6 - Create a provider engagement strategic plan
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To collaborate with a group of clinical Maternal and Child Health partners to develop a strategic plan to increase the number of physicians and other providers engaged in MCHS activities by 2020.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** Yes: A strategic plan for provider engagement was created by 2020. No: A strategic plan for provider engagement was not created by 2020. **Denominator:**
Data Sources and Data Issues:	Data Source: MCHS Systems Development Group (SDG) Led by the Title V CSHCN Director, the SDG will recruit clinical partners who are interested in improving MCHS engagement of physicians and other providers across the state. This group will work together to develop a strategic plan for ongoing provider engagement. Data Issues: Provider engagement may be difficult to standardize across Texas due to regional variations in the health care system.
Significance:	The National Center for Medical Home Implementation (NCMHI) recommends “state programs such as Title V can provide technical assistance and support to medical practices implementing the medical home model.” The NCMHI also suggests “clinical practices build relationships and partnerships with state departments of public health and/or other state agencies and programs.” Additionally, The National Center for Health Care Transition, Got Transition, recommends a quality improvement approach for clinicians to implement the Six Core Elements of Health Care Transition 2.0 framework. TVMCH offers education, technical assistance and support to clinicians who provide health care transition services. In order to develop programmatic activities targeting physicians and other providers, TVMCH developed and distributed a survey to gather information on education and support needs. Due to a low response rate in FY15-FY17, the survey was discontinued. Creating a strategic plan with providers will help us to increase their engagement in MCH programs and activities. Successful outreach to physicians and other providers will also lead to improved physician knowledge and attitudes toward providing medical home and transition services for CYSHCN in Texas. Engagement may lead to participation in education or quality improvement activities, technical assistance, data sharing, and utilization of best practice frameworks.

2016-2020: ESM 12.3 - Distribution of CYSHCN Outreach Survey
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To engage young adults with special health care needs and families of CYSHCN in continued needs assessment.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Text</td></tr>
<tr><td>Unit Number:</td><td>Yes/No</td></tr>
<tr><td>Numerator:</td><td>Yes: The CYSHCN Outreach Survey was distributed and responses collected during the fiscal year.
No: The CYSHCN Outreach Survey was not distributed or responses were not collected during the fiscal year.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: CYSHCN Outreach Survey
Responses to the CYSHCN Outreach Survey will be collected every other year. The survey will be mailed out and dispersed electronically to families served by the HHSC CSHCN health care benefits program and MCHS contractors in both English and Spanish formats. The survey will be promoted through email communication, newsletters, and webpages. Baseline data obtained from the FY16 CYSHCN Outreach Survey indicates 19.4% of respondents had a professional help them prepare for transition to adult health care in four or more areas of transition. Survey respondents indicated the top need in preparing for the transition to adult health care was help and guidance from a person who is an expert in transition planning (52.3%).

Data Issues:
Challenges associated with surveying a convenience sample include the potential to underrepresent subsets of the CYSHCN population in Texas according to geographical location or language spoken. The CYSHCN Outreach Survey seeks to combat these challenges by providing both online and paper access to the survey in English and Spanish. Geographical data is also gathered in order to examine areas of need for additional ongoing needs assessment activities including focus groups and interviews.</td></tr>
<tr><td>Significance:</td><td>The CYSHCN Outreach Survey was developed by MCHS to build upon the Title V Five Year Needs Assessment and to provide a consistent source of data relating to the needs of youth with special health care needs and families of CYSHCN in Texas. Information gathered will be utilized to develop targeted programming to improve the wellbeing of CYSHCN in Texas across the six core system outcomes.

Input from youth and family members will inform statewide quality improvement related to family-centered care. Inclusion of the parent perspective in programming for CYSHCN acknowledges parent’s expertise and understanding of their child’s personal strengths and needs. Information obtained from the CSHCN Outreach Survey will drive continued expansion of family/professional partnerships throughout the state.

The CYSHCN Outreach Survey includes a measure of self-reported age in order to gather responses from youth and young adults with special health care needs over age 18. MCHS</td></tr>
</table>

	aims to engage individuals who recently transitioned or are in the midst of transitioning from pediatric to adult health care. Responses from this population will assist Title V in increasing the youth-friendliness of resources and services. In addition to transition and medical home, the CYSHCN Outreach Survey asks questions of young adults with special health care needs and families of children and youth with special health care needs related to respite care and community inclusion. The 2016 CYSHCN Community Outreach Survey established baseline data for SPM 1. Analysis of survey results will inform separate focus groups for youth and young adults with special health care needs, and families of CYSHCN. The combination of survey and focus groups will be repeated annually in order to monitor progress towards improving community inclusion, medical home, and transition outcomes throughout Texas.

2016-2020: ESM 12.4 - Increase in transition provider education
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of providers educated on health care transition best practices.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>7,000</td></tr>
<tr><td>Numerator:</td><td>Unduplicated number of users who completed the Texas Health Steps Transition Online Provider Education (OPE) module each fiscal year</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Texas Health Steps OPE module database

State fiscal year data will be collected for the Texas Health Steps (THSteps) OPE module “Transition Services for Children and Youth with Special Health-Care Needs”. The goal of this module is to equip Texas Health Steps providers and others to employ transition services for children, adolescents, and young adults with chronic health conditions or disabilities at key transition points.

Raw data are available annually and can be sorted by type of provider and date of module completion. Sorting module users by month will allow MCHS to detect increases in module use following targeted provider outreach efforts like conference exhibiting or presentations.

Data Issues: Content updates are regularly scheduled for all THSteps OPE modules. The transition module updates might impact trend analysis.</td></tr>
<tr><td>Significance:</td><td>The AAP outlined guidelines to promote successful transition from pediatric to adult health care in a 2011 Clinical Report. The Got Transition Six Core Elements operationalized the components of health care transition support by establishing evidence-based tools for use by primary care and specialty care providers.

According to the NSCH 2017/18, 13.0% of Texas children received the services necessary to make the transition to adult health care, compared to 18.9% nationally. In the 2019 CYSHCN Outreach Survey, a quarter of respondents (25.1%) felt prepared for their child to transition to adult health care. Further, 45.8% of respondents indicated that they had not prepared for transition to adult medical care. Most respondents who indicated that they had prepared for their child’s transition had done so by themselves.

Respondents in Five Year Needs Assessment stakeholder meetings noted that few doctors have the passion or willingness to take on the primary care role and coordinate the many specialists usually seen by young adults whose medical needs are complex. Many adult providers cite lack of training as a barrier to providing care to young adults with special health care needs.

In order to increase provider knowledge, MCHS promotes THSteps OPE modules to targeted audiences through web-based communications, conference exhibiting, trainings, webinars,</td></tr>
</table>

	meetings and presentations. After completing the activities of this module providers will be able to: 1. Formulate a strategy to address the health, education, and social needs of children and youth with special health-care needs at key transition points. 2. Differentiate and integrate the functions of health-care professionals involved in transition assistance for youth with special health-care needs. 3. Apply legal requirements and best practices for aiding the transition of children and youth with special health-care needs.

2016-2020: ESM 14.1.1 - Number of health professionals trained on tobacco prevention and cessation interventions as it relates to risks associated with maternal and infant exposure to tobacco.
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	To increase the number of health professionals trained in tobacco prevention and cessation interventions to enhance their understanding and skill in providing tobacco cessation counseling and intervention to women of reproductive age and their partne
Definition:	**Unit Type:** Count **Unit Number:** 0 **Numerator:** Number of health professionals trained on tobacco risks and cessation interventions as it relates to risks associated to maternal and infant exposure to tobacco per state fiscal year. **Denominator:**
Data Sources and Data Issues:	Data source: DSHS Maternal and Child Health Section (MCHS) and Tobacco Prevention & Control Branch (TPCB). State fiscal year data for number of health professionals trained will be collected from the following program: 1. OPE Module: Preconception and Prenatal Health: Identifying and Intervening in High-Risk Behaviors The goal of this module is to equip Texas Health Steps providers and other health-care professionals to improve the preconception and prenatal health of women in Texas. Target audience is primary care providers and other health professionals who treat adolescent and adult female patients who may become pregnant again or for the first time. This module discusses the risks of tobacco use and smoking during pregnancy, provides examples of smoking cessation interventions, and provides listed resources for smoking cessation. 2. CHW Trainings. Trainings will address the needs of maternal and child health by expanding the number of CHWs that are educated about the hazards of tobacco to maternal and child health populations in order to better serve their communities and educate women about the hazards of tobacco and cessation support. 3. NAPPSS-IIN - In early 2018 DSHS was chosen to represent Texas as one of five pilot states in the National Action Partnership to Promote Safe Sleep Improvement and Innovation Network (NAPPSS-IIN). DSHS will provide outreach and technical assistance to the selected pilot hospital to support the creation, testing and implementation of the NAPPSS-IIN safe infant sleep and breastfeeding care bundle. One critical element of the bundle is health care professional (provider) training to increase knowledge and skills around policies and practices for optimal safe sleep and breastfeeding; smoking prevention and intervention will be part of this training. Healthy Texas Babies Community Coalitions: DSHS support 8 perinatal community coalitions across the state to engage local stakeholders and communities in evidence-based interventions
Significance:	Tobacco use is one of the most preventable risk factors of poor birth outcomes. Smoking during pregnancy increases the risks of spontaneous abortion, ectopic pregnancy, cancers, stillbirth, premature birth, stunted growth, cleft palate, low birth weight, and sudden infant death syndrome (SIDS). As of 2016, the Centers for Disease Control and Prevention reports that Texas is one of the better performing states for maternal smoking, largely due to the higher number of births to Hispanic women who are less likely to smoke. However, there is geographic disparity in this behavior with higher rates of maternal smoking in the north and east of the state.

Form 11
Other State Data

State: Texas

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Texas

Annual Report Year 2020

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Quarterly	2		• Medicaid • Fetal Death
2) Vital Records Death	Yes	Yes	Quarterly	2	Yes	• Medicaid • Fetal Death
3) Medicaid	Yes	Yes	Monthly	1	Yes	• Vital Records Death • Fetal Death • PRAMS
4) WIC	Yes	Yes	Monthly	1	Yes	• PRAMS
5) Newborn Bloodspot Screening	Yes	Yes	Monthly	3	Yes	• PRAMS
6) Newborn Hearing Screening	Yes	No	Annually	3	No	
7) Hospital Discharge	Yes	Yes	Quarterly	9	Yes	• Medicaid
8) PRAMS or PRAMS-like	Yes	Yes	Annually	7	Yes	• Medicaid • WIC

Form Notes for Form 12:

None

Field Level Notes for Form 12:

Data Source Name:	**1) Vital Records Birth**
	Field Note: Accumulative annual provisional vital events records are provided quarterly. Statistically locked vital event files are provided when completed by the DSHS Center for Health Statistics. Vital event records (birth, death, and fetal death) are linked to Medicaid administrative records in support of efforts to address maternal mortality.
Data Source Name:	**2) Vital Records Death**
	Field Note: Accumulative annual provisional vital events records are provided quarterly. Statistically locked vital event files are provided when completed by the DSHS Center for Health Statistics. Vital event records (birth, death, and fetal death) are linked to Medicaid administrative records in support of efforts to address maternal mortality.
Data Source Name:	**3) Medicaid**
	Field Note: The MCH Epi program maintains access to Medicaid data for use in PRAMS data collection and analysis. Additionally, an MOU between MCH Epi and Texas' HHSC Center for Analytics and Decision Support allows for linking of vital event records to Medicaid and CHIP administrative records to support activities related to maternal mortality.
Data Source Name:	**4) WIC**
	Field Note: The MCH Epi program maintains access to WIC data for use in PRAMS data collection and analysis.
Data Source Name:	**5) Newborn Bloodspot Screening**
	Field Note: The MCH Epi program maintains access to newborn bloodspot screening data for use in PRAMS data collection and analysis.
Data Source Name:	**6) Newborn Hearing Screening**
	Field Note: MCH Epi has access to annual provisional newborn hearing screening data for reporting of program reach in the Title V Block Grant.
Data Source Name:	**7) Hospital Discharge**

	Field Note: Hospital discharge data are provided in two formats- a public use data file and a research data file with identifiers. The research data file is provided to MCH Epi for use in support of efforts to address maternal mortality. Hospital discharge records are linked to Medicaid administrative records in support of efforts to address maternal mortality.
Data Source Name:	**8) PRAMS or PRAMS-like**
	Field Note: PRAMS is a joint surveillance research project between the Centers for Disease Control and Prevention and DSHS. The Texas PRAMS project is housed specifically in MCH Epi within Texas DSHS