Maternal and Child Health Services Title V Block Grant

Texas

FY 2018 Application/ FY 2016 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

TEXAS
Health and Human Services

Texas Department of State Health Services

John Hellerstedt, M.D.
Commissioner

July 17, 2017

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 Family and Community Health Services for the Texas Department of State Health Services, I hereby submit this letter to apply for the Maternal and Child Health Services Title V Block Grant funds for federal fiscal year 2018. The online application has been completed in accordance with this year's grant guidance.

Should you have questions or need additional information, please contact Manda Hall, MD, Medical Director, Title V and Maternal and Child Health at 512-776-7373 or me at 512-776-2567. Thank you for your consideration and review of the Texas Maternal and Child Health Services Title V Block Grant Application for FY 2018 and Annual Report for FY 2016.

Sincerely,

Evelyn Delgado, Associate Commissioner
Family and Community Health Services

Attachment

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I.B. Face Sheet

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

I.C. Assurances and Certifications

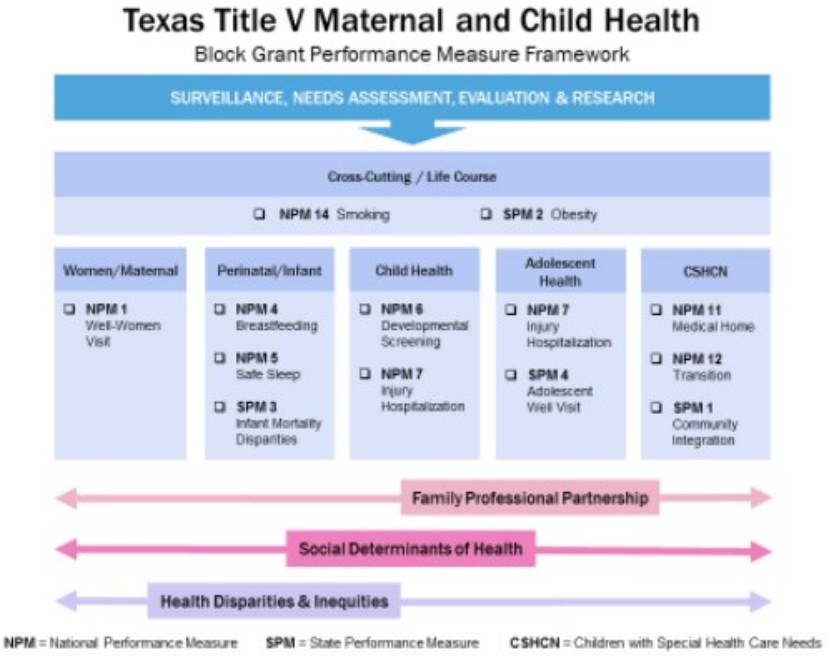
The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

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 care needs (CYSHCN) and their families. State priorities to support this vision reflect the specific needs identified through a comprehensive five-year needs assessment (NA) process which included collaboration and engagement of MCH stakeholders, including families. The NA revealed significant disparities across multiple indicators and populations in the state which informed the selection of state priority needs that became the foundation for Texas' performance measures. Priorities selected in 2015 were a continuation or a broadening of those selected in 2010, and relate to improvements in infrastructure, quality, and coordination of care to strengthen community-based systems of care for children and youth with special health care needs and population-based services for MCH populations. 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. Through the selection of National Performance Measures (NPMs), Texas is focusing on well-woman care, breastfeeding, safe sleep, developmental screening, injury prevention, medical home and transition for children with special health care needs, and maternal and household smoking. State priorities also informed the State Performance Measures (SPMs) which include community integration for CYSHCN, obesity across the life course, infant mortality disparities, and quality components of adolescent care. As evidenced by the Texas Block Grant Performance Measure Framework, family-professional partnerships, Social Determinants of Health, and health disparities and inequities remain a focus and key priorities of all areas of Title V programming and serve as the foundation of efforts to move the needle for all of MCH populations in Texas.



Maternal and Women's Health

With increasing focus on severe maternal morbidity and maternal mortality, findings from the NA provide areas of challenge and opportunity within maternal and women's health. Less than two-thirds of Texas Women of Childbearing Age (WCBA) had a routine checkup in the past year, and the rate of women giving birth who received adequate prenatal care fell below the Healthy People 2020 recommendation of 77.6% of pregnant women receiving early and adequate prenatal care. Rates of hypertension, diabetes and obesity are increasing, and only Hispanic women met the HP2020 abstinence from smoking during pregnancy target of 98.6%. Almost half of women who reported not wanting to become pregnant used contraceptives, and over half of all pregnancies in Texas are unintended.

The Texas Department of State Health Services (DSHS) has made progress in building infrastructure and capacity to promote prenatal care, health, and wellness among WBCA through the efforts of women's health programming and other statewide initiatives, such as the Maternal Mortality and Morbidity Task Force (MMMTF) and Healthy Texas Babies (HTB). Through the work of MMMTF, recommendations have been made related to issues impacting

maternal health outcomes including access to interconception health services, provider and community awareness of health inequities, screening and referral practices for behavioral health services; and improving the quality of maternal death data, reporting and investigation. Through HTB, Texas is supporting the development of the infrastructure for the state's perinatal quality collaborative, the Texas Collaborative for Healthy Mothers and Babies; supporting the spread of the Preconception Peer Educators program throughout Texas Historically Black Colleges and Universities; educational outreach to WCBA, men, healthcare providers and other stakeholders through the Someday Starts Now public awareness campaign and health care provider education; and the support of statewide community perinatal coalitions.

Perinatal/Infant Health

Considerable progress has been made over the past five years, through collaboration and integration, to develop, implement and evaluate a comprehensive program to address known barriers to and increase support for breastfeeding. Texas has created a strong foundation to promote breastfeeding due to the correlation it has with preventing many acute and chronic diseases, obesity and SIDS. 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 continue 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.

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 to ensure consistent implementation of unified, comprehensive, evidence-informed public health information about sleep safety and risk reduction for sleep related deaths. DSHS has drafted a strategic communication plan that is informed by recommendations, guidelines, strategies and approaches from the American Academy of Pediatrics, the national Safe to Sleep campaign, and the National Action Partnership to Promote Safe Sleep. DSHS has also drafted communication guidelines for agency health communications (a strategy developed through participation in the Infant Mortality CoIIN Safe Sleep Learning Network). The strategic communication plan and guidelines are currently under review for finalization.

Although Texas has made progress in reducing infant mortality, data continues to show disparities between Black and White birth outcomes. In response to the state's priority need to reduce health disparities for maternal and child health populations, 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.

Title V supports the Newborn Screening Unit, which screens for 53 health conditions that can cause serious problems such as developmental delays, major illness or even death. All Texas babies are screened via blood spot testing, in addition to point-of-service screens for hearing loss, and critical congenital heart defects. The NBS Program continues to meet its annual objective of 100% follow up and case management of identified presumptive positives.

The Perinatal Advisory Council (PAC) developed and recommended criteria to inform the neonatal levels of care designation rule that became effective in June of 2016. The designation for neonatal level of care is an eligibility requirement for Medicaid reimbursement beginning September 1, 2018. The PAC is now developing recommendations for the maternal levels of care rules.

Child Health

DSHS continues to expand efforts to reduce child injury, one of the leading causes of death for children one to fourteen years of age in Texas. DSHS has strong collaborations with numerous stakeholders including other state agencies that will enhance injury prevention efforts. DSHS and DFPS formed a collaboration to create a strategic plan to reduce child deaths due to maltreatment. Two causes of injury that are being addressed through regional projects and statewide partnerships are hyperthermia and pedestrian back over deaths.

DSHS hosted the statewide Child Injury Prevention Conference in conjunction with Child Fatality Review Team (CFRT) trainings. Participants provided recommendations for DSHS programming, strategies to share with other stakeholders, and a plan to reduce injuries that result in hospitalization. Texas will continue strengthening the CFRT review processes and increase infrastructure to monitor child fatalities. DSHS will work with Texas Medical Child Abuse Resources and Education System programs to expand prevention and education activities to provide education to Child Advocacy Centers, schools and community partners on recognizing and reporting child abuse.

According to the National Survey of Children's Health (NSCH) 2011/12, only 30.4% of Texas children aged 10 months to 5 years received a standardized screening for developmental or behavioral problems. Further, through qualitative data collected during the NA process, parents reported a lack access to providers to assess their child's

development. DSHS implements the State Project LAUNCH Expansion grant from the Substance Abuse and Mental Health Services Administration to improve early childhood systems (ages 0 to 8), strengthen parenting competencies and improve children's developmental and behavioral outcomes. Through Project LAUNCH, communities develop systems and infrastructure to implement services to children with developmental needs in health disparate areas.

Adolescent Health

By utilizing Positive Youth Development (PYD) as a foundation for activities, DSHS will continue to focus on injury prevention. PYD helps youth acquire the personal assets, or protective factors, needed to become healthy and productive adults. 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 prevention including current efforts to collect data on, and develop a plan for, communities with multiple risk factors as it pertains to suicide or "suicide by violence". Through injury prevention efforts, including an Injury Prevention Conference and CFRT trainings, DSHS works to promote collaboration and best practice sharing among injury prevention professionals to reduce injuries and hospitalizations.

Data from the Adolescent and Young Adult CoIIN identified adolescent well visits, particularly for young adults, as a need for Texas youth. In addition, obesity continues to be an issue for adolescents. Based on available data and input from stakeholders, obesity and adolescent well visits have been selected as SPMs. DSHS will lead statewide initiatives and partner 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

The CSHCN Systems Development Group (SDG) supports family-centered, community-based strategies for improving the quality of life for children with special health care needs and their families. Central themes emerging during the NA process included concerns with access, education and coordination of resources and services. The CSHCN SDG developed priority statements for CYSHCN and their families for FY16 through FY20:

- Promotion of community integration
- Continued advancement of medical home services
- Increased access to and improved care coordination
- Increased medical home capacity
- Promotion of appropriate services to transition to adulthood
- Improved access to community-based services to support families, including respite
- Supporting CYSHCN and their families across the life course
- Enhance family/professional partnerships within systems serving CYSHCN

Challenges identified through the NA include timely access to resources and early intervention services. Families and stakeholders identified that to improve well-being, family-professional partnerships needed to be developed early and services needed to be based on the unique needs of the family and provided continuously. Individual needs, including transition planning and family support services, can be addressed more effectively within a medical home. DSHS addresses these needs through the funding of a comprehensive health care benefits program, case management provided by community-based contractors and regional staff, the provision of family support and community resource services, and the development of new initiatives to increase provider knowledge and capacity. Participation and facilitation of statewide initiatives including leadership of the Texas Title V Transition and Medical Home Workgroups, and quality improvement projects contributes to success in moving the needle forward for CYSHCN and their families in Texas.

Cross-cutting/Life Course

Results of the NA showed women who smoked had more than a three-fold increase in the odds of their infant's death being classified as SIDS than women who did not smoke. Focus group participants and stakeholders expressed a need for increased education at the patient and provider levels to help adopt and promote healthy behaviors and navigate the health care system.

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 CHW training, and other platforms. DSHS will expand components of the HTB SSN campaign to incorporate smoking cessation messaging, including promoting cessation resources throughout the website.

Smoking cessation efforts will be incorporated as part of SIDS/safe sleep outreach efforts. DSHS will work with partners to increase coordination across sectors to address risk factors for children with asthma, including secondhand smoke and other harmful exposures.

Obesity is at the heart of many health issues in Texas across the lifespan. Obesity prevention and interventions have the potential to greatly reduce disease burden and improve the overall health of Texans across the lifespan by reducing the prevalence of many chronic diseases, such as hypertension and diabetes. Obesity has long-term health and behavioral effects for children, adolescents, and adults. The contributing factors to obesity are so widespread that it has become a proxy for the overall health and well-being of the state, much like infant mortality. No single prevention/intervention effort will reduce obesity. DSHS has success stories with obesity reduction among low-income children within the WIC program and will build on those stories across the lifespan. Expansion and increased use of SPAN data to inform population-based and targeted prevention/intervention for obesity reduction will be critical for success. DSHS will continue to build upon activities begun in FY 17 to impact obesity across the lifespan.

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/.

II. Components of the Application/Annual Report

II.A. Overview of the State

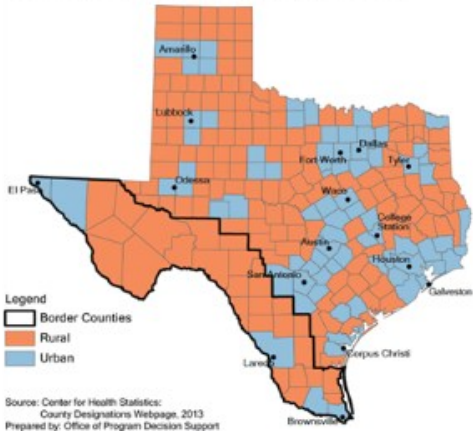
Texas is a vast state, with regional differences in geography, population size, and demographic and socioeconomic characteristics. This section provides an overview of these variations and the existing challenges related to health care availability and access, as well as cultural literacy and effectiveness 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% of the total U.S. land area. The land area of Texas is equal to the land area of all six New England states and Ohio, New York, Pennsylvania, and North Carolina combined. Texas has a larger land area than any single country completely contained in Europe including France and the Ukraine. The longest straight-line distance in Texas is 801 miles from the northwest corner of the Panhandle to the extreme southern tip of Texas on the Rio Grande below Brownsville. With the large north-south expanse of Texas, Dalhart, in the northwestern corner of the state, is closer to the state capitals of Kansas (430 miles), Colorado (310 miles), New Mexico (200 miles), Oklahoma (275 miles), and Wyoming (390 miles) than it is to Austin (470 miles), its own state capital. The greatest east- west distance is 773 miles from the extreme east-ward bend in the Sabine River in Newton County to the extreme western bulge of the Rio Grande just above El Paso. This east-west expanse is so large that El Paso, in the western corner of the state, is closer to San Diego, California (630 miles) than to Beaumont (740 miles), near the Louisiana state line; Beaumont, in turn, is closer to Jacksonville, Florida (680 miles) than it is to El Paso.

The geography of Texas is as varied as it is large. Texas includes 254 counties that are classified as either rural or urban (Figure 2.1), with 88.8% 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, especially those living in rural counties, must travel to receive health care services can be a significant challenge to accessing and receiving those services.

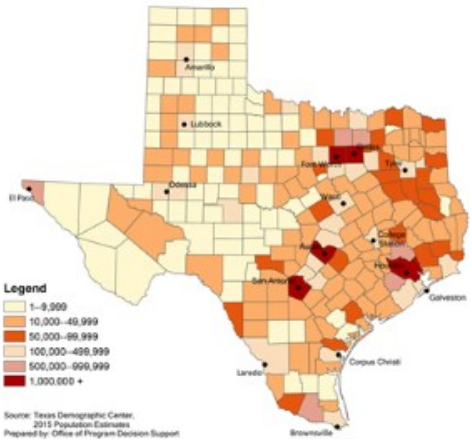
Figure 2.1
2013 Rural, Urban, and Border County Designations in Texas



Population

Just as the Texas geography is varied, so is the distribution of its population (Figure 2.2). Differences in race/ethnic composition, along with the high percentage of foreign-born residents, present particular cultural literacy and effectiveness challenges when it comes to meeting maternal and child health needs.

Figure 2.2
Texas Total Population by County, 2015

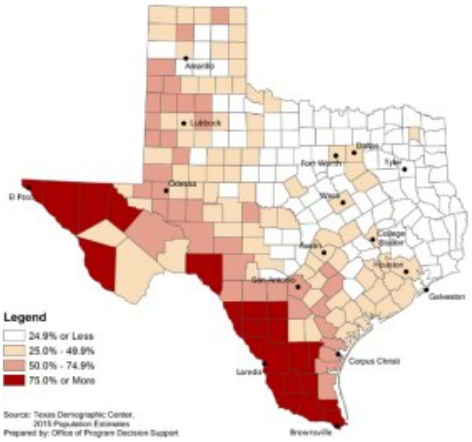


Texas also has the second-largest population in the U.S. (behind California), with an estimated population of over 27 million in 2015. Texas has been one of the fastest-growing states in the nation since 2010, according to U. S. Census annual estimates. There has been a 9.2% increase in the Texas population from 2010 to 2015. The Texas Demographic Center predicts that the population in Texas will exceed 31 million people by using a zero migration scenario and exceed 50 million people by using a full 2000-2010 migration scenario by 2050. The majority of Texans live in the northeast, east, central, south, and gulf coast regions of the state (Figure 2.2).

Race/Ethnicity

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 2015, six major cities in Texas were located in counties where over 50% of the population were Hispanic: San Antonio, Corpus Christi, Brownsville, Laredo, El Paso, and Odessa (Figure 2.3). Hispanics made up more than 80% of the population in the counties containing the cities of Brownsville, Laredo, and El Paso.

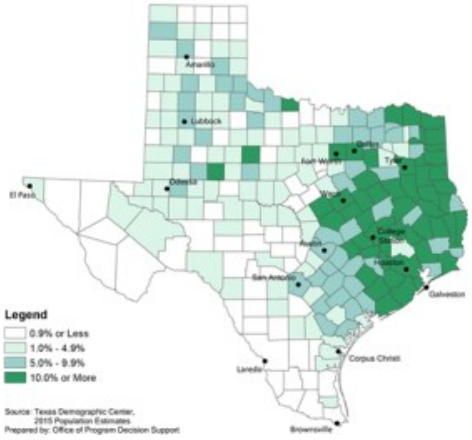
Figure 2.3
Percent of Population that are Hispanic, by County, 2015



Regional concentrations of the black population in Texas (Figure 2.4) were quite different from that of the Hispanic population. Counties with the highest proportions of black populations in 2015 were largely concentrated in the

northeastern, eastern, and north gulf-coast regions of the state. Blacks made up more than 17% of the population in the counties containing the cities of Dallas, Houston, and Tyler. The black population along the Texas-Mexico border was estimated to be slightly above 29,000 in 2015. When excluding El Paso, the total black population was only 8,200 (less than 1% of the population) in the remaining border counties.

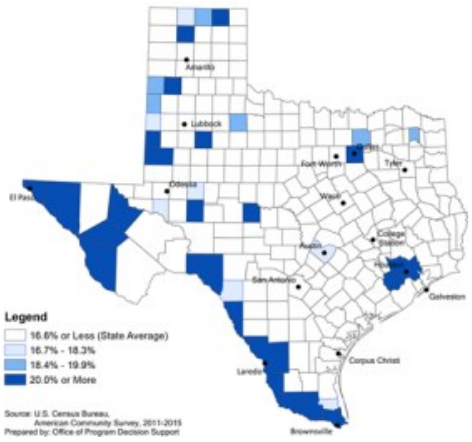
Figure 2.4
Percent of Population that are Black, by County, 2015



Foreign-Born

Texas had a higher percentage of foreign-born residents (16.6%) compared to the nationwide average (13.2%) in 2011-2015. More than 65% of foreign-born residents in Texas were not United States citizens. Over 70% of foreign-born Texas residents were born in Latin American countries – almost 19 percentage points more than the national average. Therefore, it is not too surprising that 35% of Texans spoke a language other than English at home in 2011-2015. About 30% of Texans spoke Spanish at home, compared with 13% of U.S. residents. Within four metropolitan statistical areas in Texas (Laredo, McAllen-Edinburg-Mission, Brownsville-Harlingen, and El Paso), 72% to 92% of persons spoke a language other than English at home, with the vast majority speaking Spanish. Texas border counties had high percentages of foreign-born residents in 2011-2015, as did several other counties in west and northwest Texas (Figure 2.5). 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 DSHS Community Health Worker (CHW) program has increased the number of certified CHWs to address the need for cultural literacy and effectiveness.

Figure 2.5
Percent of Population who are Foreign Born, 2011-2015



Age

According to 2011-2015 American Community Survey data, Texas has the third youngest population in the United States, with a median age of 34.1 years, behind Alaska (median age 33.4 years) and Utah (median age 30.1 years). Texas was second only to California in the number of births occurring in the state in 2011-2015, and accounted for almost 10% of all births in the nation.

In 2015, Texas was tied for the second-largest proportion of the population being children younger than 18 years old (26.3%) in the nation. About 7.2% of the Texas population were younger than 5 years old, 14.6% were 5 to 14 years old, and 4.5% were 15 to 17 years old. Texans younger than 22 years of age accounted for 32.2% of the total population in 2015. Border counties in South Texas had high percentages of individuals younger than 22 years old, as did several counties in the Texas Panhandle (Figure 2.6).

Women comprised half of the total population in Texas in 2015. However, women between 18 and 44 years of age accounted for 18.7% of the total population (Figure 2.7). 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 2.6
Percent of Population Younger than 22 Years, 2015

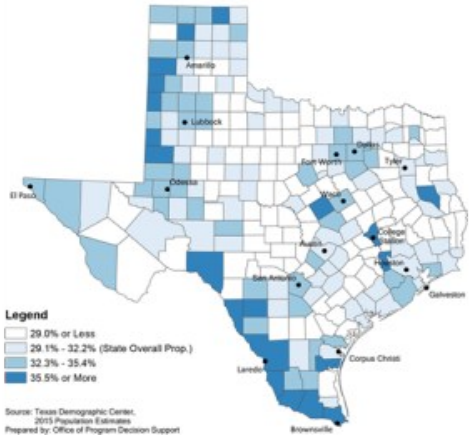
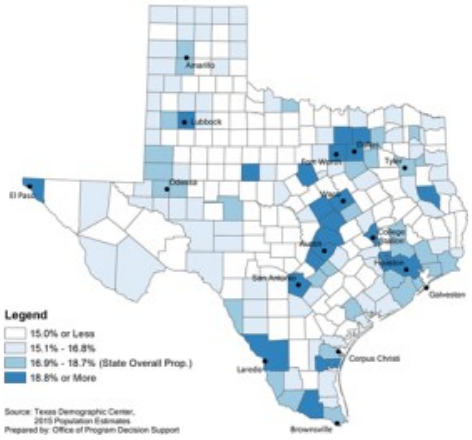


Figure 2.7
Percent of Population Who Are 18-44 Years Old and Female, 2015



In addition, the 2009/10 National Survey of Children with Special Health Care Needs (NS-CSHCN) estimated that

13.4% of Texas children ages 0-17 (versus 15.1% nationally) had a special health care need. Of those children identified as Children and Youth with Special Health Care Needs (CYSHCN) within Texas, 37.0% were Hispanics and 14.8% were Blacks. About one-third of the Hispanic CYSHCN spoke Spanish as the primary household language.

Socioeconomic Characteristics

Socioeconomic characteristics such as income and poverty, education, unemployment, and crime are added challenges for meeting the health needs of mothers, children, and families in Texas. The presence of these factors in a community are important risks for the life course of the individuals within that community.

Income and Poverty

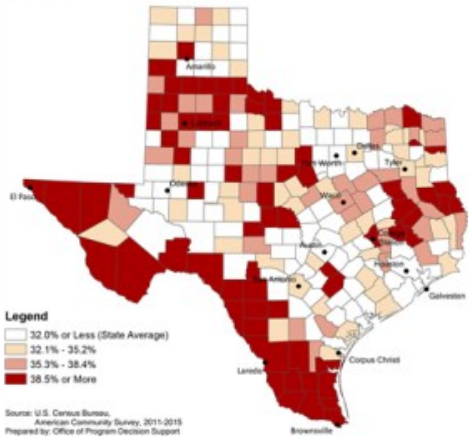
Income inequalities exist within different areas in Texas, and largely reflect gender and race/ethnic differences. In 2011-2015, the median household income in Texas was $53,207, which was slightly lower than the national median household income of $53,889.

To determine who lives in poverty, the U.S. Census Bureau uses a set of 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 U.S. and do not vary geographically; however, they are updated each year to account for inflation.

According to 2011-2015 U.S. Census Bureau American Community Survey five-year estimates, Texas as a whole had a higher proportion (38.0%) of people living below 200 percent of the Federal Poverty Level (FPL) than the national average of 34.3%.

Among the adult population aged 18 and older in Texas, counties with a large proportion of adults living below 200 percent FPL in 2011-2015 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 2.8).

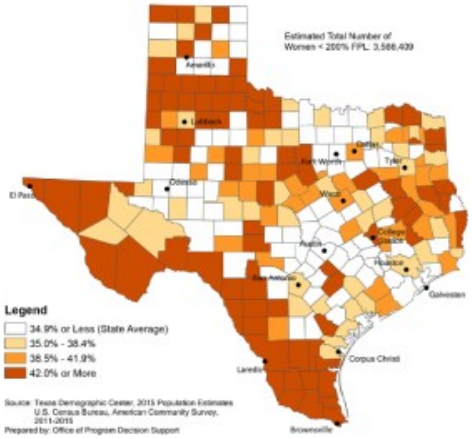
Figure 2.8
Percent of Adult Population Below 200% Federal Poverty Level, 2011-2015



It was estimated that about 34.9% (3.6 million) of the adult female population lived below 200 percent FPL in Texas in 2011-2015. Counties in the Texas-Mexico border region had high rates of women living below 200 percent FPL, as did several counties in rural East Texas, west of Fort Worth, and between Lubbock and Amarillo in the Panhandle (Figure 2.9). The fastest growing major metropolitan areas – Austin, Houston, and San Antonio – had a relatively low

proportion of women living below 200 percent FPL.

Figure 2.9
Estimated Percent of Adult Female Population Below 200% Federal Poverty Level, 2011-2015



Poverty, lack of health care coverage, and limited access to providers are root causes of many health disparities in Texas. In 2011-2015, Texas had a greater proportion of children younger than 5 years of age living in poverty (below 100 percent FPL) than the nation as a whole (27.4% vs. 24.5%). Also, 24.7% of children younger than 18 years old lived below 100 percent FPL in Texas, compared to 21.7% in the nation (US Census Bureau, American Community Survey, 2011-2015). On the other hand, the 2009/10 NS-CSHCN showed that 22.3% of the CYSHCN younger than 18 years old lived in poverty in Texas, which was comparable to the national rate of 22.5%.

In 2011-2015, about one-third of Texas counties had more than 33.0% of their children younger than 5 years of age living below 100 percent FPL (Figure 2.10). The highest poverty rates among young children were seen in the rural areas of Texas, as well as those counties around the cities of Brownsville, Laredo, Amarillo, and Tyler. About one-fourth of the counties in Texas had more than 29.7% of their children younger than 18 years of age living below 100 percent FPL (Figure 2.11). Many of the counties with the highest poverty rates for this age group were located in south Texas, east Texas, and the Panhandle.

Figure 2.10
Percent of Children Younger than 5 Years Old Below 100% Federal Poverty Level, 2011-2015

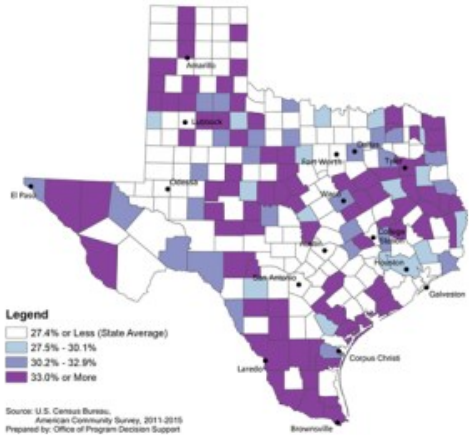
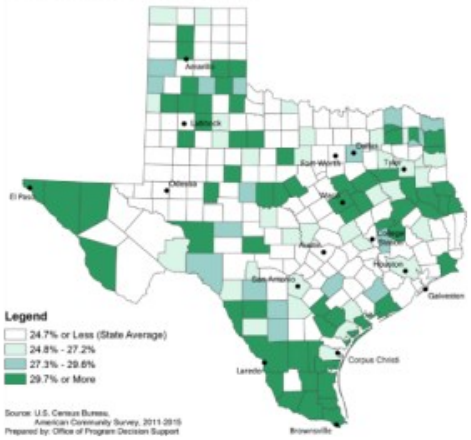


Figure 2.11
Percent of Children Younger than 18 Years Old Below 100% Federal Poverty Level, 2011-2015



Education

Lower educational attainment is associated with poverty, and is consequently related to poor health outcomes. Among those 25 years and older, a greater percentage of both men (18.7%) and women (17.5%) in Texas had less than a high school education in 2011-2015, compared to men (14.1%) and women (12.7%) nationwide. Approximately a quarter of Texas residents aged 25 and older had a high school diploma or equivalent as their highest level of educational attainment, and 27.6% had a bachelor's degree or higher. These rates were 2-3 percentage points lower than the corresponding national rates.

Educational attainment levels are not evenly distributed throughout the state. There were five counties where the educational attainment of a bachelor's degree or higher was 40%-50% among individuals 25 years of age and older: Denton and Collin counties outside of Dallas, Fort Bend county outside of Houston, Kendall county in the Texas Hill Country (northwest of San Antonio), and Travis county in central Texas (part of the Austin-Round Rock metropolitan statistical area). Counties where less than 10% of the people aged 25 years and older had a bachelor's degree or higher were largely clustered in south Texas, northwest Texas, and east Texas.

Unemployment

While Texas had a higher percentage of adults without a high school diploma compared to the nation as a whole, it had a lower rate of unemployment (7.0%) than was seen nationwide (8.3%) in 2011-2015. Even among persons aged 25-64 without a high school diploma, Texas had a lower rate of unemployment (8.2%) compared to the national average for this educational attainment group (12.6%). As was seen nationwide, the Texas unemployment rate decreased as education level increased. The unemployment rate in Texas was as low as 3.2% among those with a bachelor's degree or higher in 2011-2015.

Although Texas as a whole had a relatively low unemployment rate, 102 Texas counties had an unemployment rate higher than the state average and 32 counties had an unemployment rate of 10% or higher in 2011-2015. Texas counties with higher unemployment rates were predominantly located in east Texas, south Texas, along the Texas-Mexico border, and in several rural areas in northwest Texas.

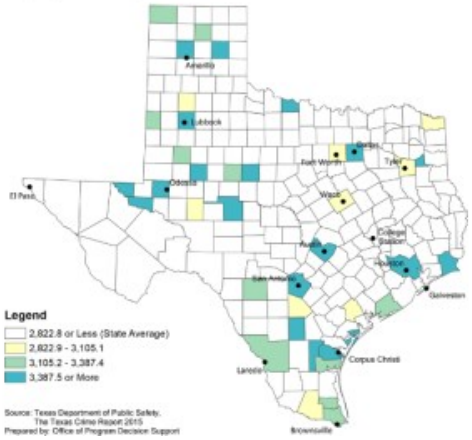
Crime

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, creating unstable living environments. By assessing communities where crimes occur, it is possible to identify areas at high risk and help prevent adverse

consequences. In 2015, Texas' crime rate was 3,233.3 crimes per 100,000 persons, a decrease of 4.7% from the previous year.

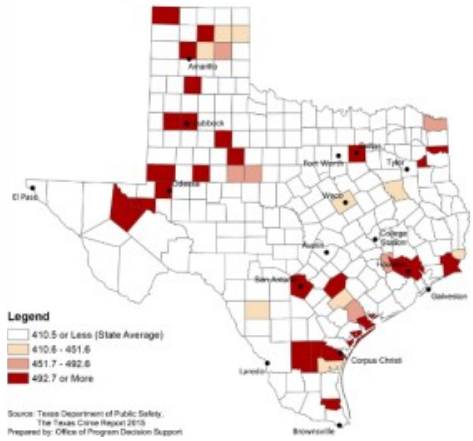
Texas crime statistics describe two major categories of crime: property crimes and violent crimes. Property crimes consist of burglary, larceny, and motor vehicle theft. The 2015 property crime rate was 2,822.8 crimes per 100,000 Texans, a decrease of 5.5% when compared to the rate for 2014. The highest property crime rates in 2015 were primarily localized within and surrounding the larger cities of Texas (Figure 2.12).

Figure 2.12
Property Crime Rate per 100,000, Texas 2015



Violent crimes include murder, rape, robbery, and aggravated assault. The violent crime rate was 410.5 crimes per 100,000 Texans, a 1.6% increase from the rate reported in 2014. The highest violent crime rates in 2015 were primarily concentrated near the larger cities of the panhandle: Odessa, Lubbock, and Amarillo (Figure 2.13). Houston, Dallas, San Antonio, Corpus Christi and surrounding areas also had a high concentration of violent crimes.

Figure 2.13
Violent Crime Rate per 100,000, Texas 2015



Violence within Texas families has also been recognized as a growing threat to the safety of Texans. The Uniform Crime Report indicated 194,872 family violence incidents in Texas in 2015, a 4.9% increase when compared to 2014. Although the largest percentage of family violence was between other family members (44.3%), family violence also occurred among spouses/couples (39.3%) and within parent-child relationships (16.1%). Females were more likely to be victims in family violence. Of the victims whose gender was known, 28% were male and 72% were female. The 20-24 age group had the highest number of victims in family violence.

Mobility/Migration

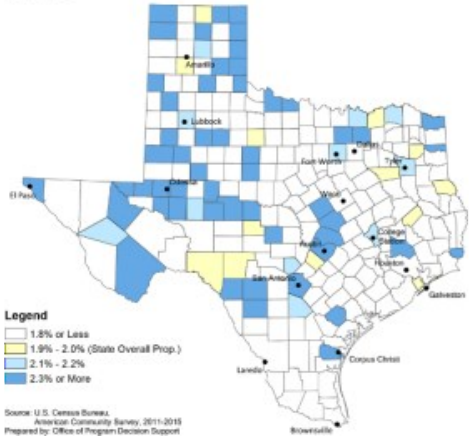
Moving or relocating is one of life's most stressful events, and can impact individual health and well-being. The Texas School Survey of Substance Use shows that students in grades 7 to 12 living in their current school district for three years or less are more likely to use illicit drugs than those living there more than three years.

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 2014 and 2015. The population in these four metropolitan areas increased by more than 400,000 people in a year.

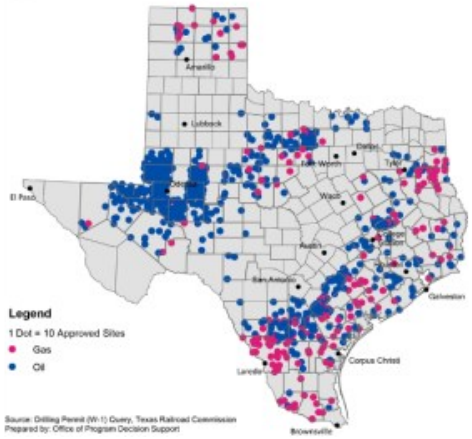
Among these four fastest-growing areas in Texas, about 2% to 3% of the population consists of people who moved to the area from out of state (out-of-state migration). Some rural counties also had high levels of out-of-state migration in 2011-2015, particularly in the parts of the state bordering Oklahoma and the Panhandle, as well as in west Texas (Figure 2.14). The majority of Texas counties, however, had little to no new residents from other states.

Figure 2.14
Percent of Population that Moved from Another State to Texas, 2011-2015



The oil and gas industry is concentrated in three areas of the state (Figure 2.15). Many counties with a large number of active oil or gas wells in 2014-2015 also had high out-of-state migration. The jobs created from the oil and gas industry may be notably contributing to the migration of people into these areas.

Figure 2.15
Approved Oil and Gas Sites, July 2014 - June 2015



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 had among the highest rates of within-county relocations over a one-year period. 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.

Within-county mobility in Texas may also be associated with poverty and household type. Within-county mobility over a one-year period is positively correlated with a poverty rate below 100 percent FPL (r=0.33), such that census tracts with higher rates of poverty tend to also be census tracts with higher within-county mobility. Similarly, census tracts with higher rates of female-headed households tend to be census tracts with higher within-county mobility (r=0.21).

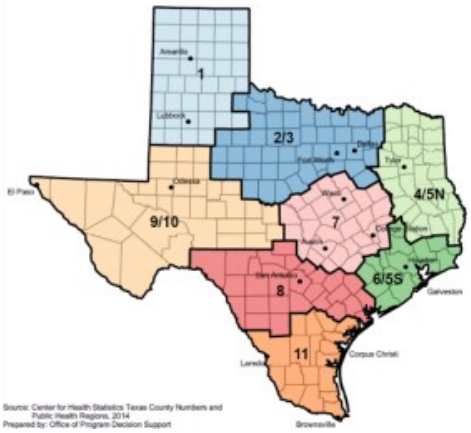
Between-county mobility, however, is negatively correlated with the rate of female headship. Census tracts with higher rates of female-headed households tend to have lower between-county mobility (r=-0.20).

Health Care Coverage and Access

Health insurance and access to health care are fundamental to the health of Texans. A major finding that emerged from the Title V stakeholder meetings was that limited access to health care was a widespread concern. For CYSHCN, lack of financial support or no health insurance was a top reason parents said they could not receive care for their children.

Each of the 254 Texas counties is assigned to one of 11 public health regions. However, for administrative purposes, there are eight Health Service Regions (HSRs) (Figure 2.16). Region 1 (HSR 1) is administered from a regional office in Lubbock. Regions 2 and 3 (HSR 2/3) are administered from a regional office in Arlington. Region 4 and the northern part of Region 5 (HSR 4/5N) are administered from a regional office in Tyler, and Region 6 and the southern part of Region 5 (HSR 6/5S) are administered from a regional office in Houston. Three counties in public health region 5 are in HSR 6/5S: Hardin, Jefferson, and Orange. The rest are in HSR 4/5N. Region 7 (HSR 7) is administered from a regional office in Temple, Region 8 (HSR 8) is administered from an office in San Antonio, Regions 9 and 10 (HSR 9/10) are administered from an office in El Paso, and Region 11 (HSR 11) is administered from an office in Harlingen.

Figure 2.16
Texas Health Service Regions



Health Insurance

Texas led the nation in the proportion of the population without health care coverage in 2011-2015, with 20.6% uninsured (US Census Bureau, American Community Survey, 2011-2015). The national average was 13.0%. In terms of race/ethnicity, higher rates of uninsured were observed among Hispanics (31.9%), Blacks (18.3%), and Whites (11.8%) in Texas, compared with national rates (Hispanics = 25.8%; Blacks = 15.3%; Whites = 9.0%).

Texas also 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, 8.5% of children younger than 6 years old were uninsured, compared to 5.2% in the nation, and 30.4% of Texas women aged 18 to 44 were uninsured, compared to 18.7% nationwide. Furthermore, 32.9% of Texans living below 200 percent FPL were uninsured, compared to 22.5% of the nation as a whole. In addition, the 2009/10 NS-CSHCN data showed that 15.6% of CYSHCN in Texas had been without health insurance at some point during the past year prior to the survey, compared to 9.3% nationally.

Counties with high proportions of uninsured children younger than 6 years of age were concentrated in west Texas between Odessa and San Antonio, and in the Panhandle (Figure 2.17). The Texas-Mexico border regions and several counties outside Lubbock and Waco had high proportions of women aged 18 to 44 without health insurance (Figure 2.18).

Figure 2.17
Percent of Children Younger than 6 Years without Health Insurance, 2011-2015

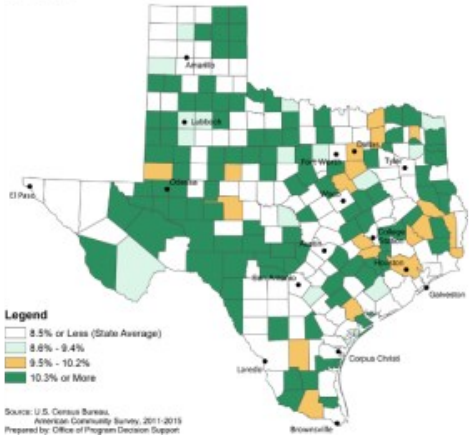
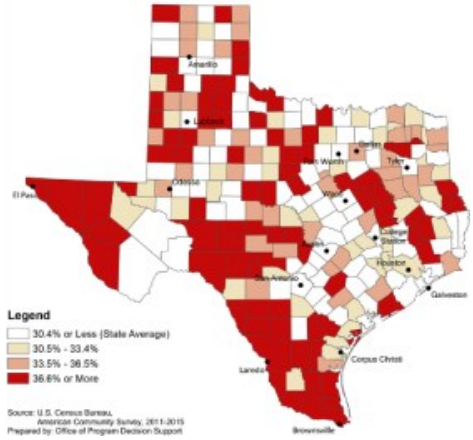


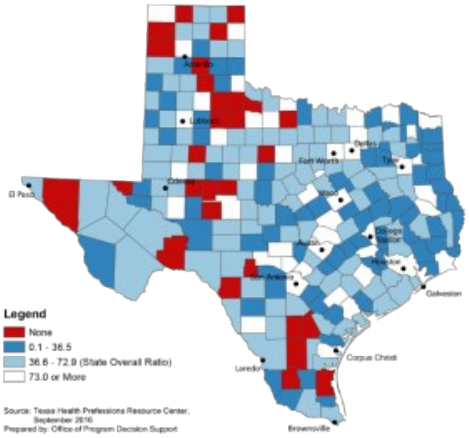
Figure 2.18
Percent of Females (18-44 Years) without Health Insurance, 2011-2015



Access to Health Care

Given the size of the state and the vast distances between points of care for health services in rural areas, access to care in Texas can be a challenge. There were 20,578 primary care physicians (72.9 per 100,000 population) in Texas in 2016, which was an increase from 18,834 primary care physicians (70.6 per 100,000 population) in 2013. Twenty-nine counties still had no primary care physicians in 2016 (Figure 2.19).

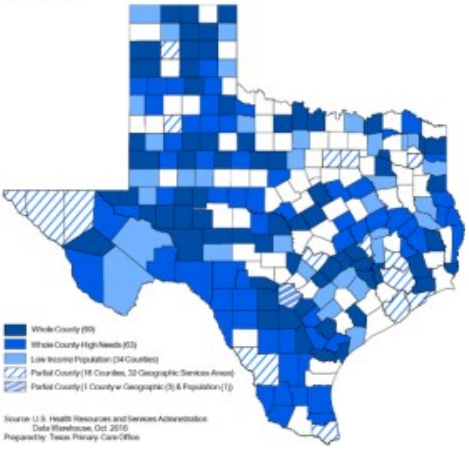
Figure 2.19
Number of Primary Health Care Physicians per 100,000 Population, September 2016



The total number of obstetricians (OB) and/or gynecologists (GYN) increased from 2,483 in 2013 to 2,594 in 2016. However, the density of OB/GYNs in Texas decreased from 18.5 OB/GYNs per 100,000 females in 2013 to 18.3 per 100,000 females in 2016. A total of 148 counties had no OB/GYN in 2016 and 51 counties did not have a local dentist.

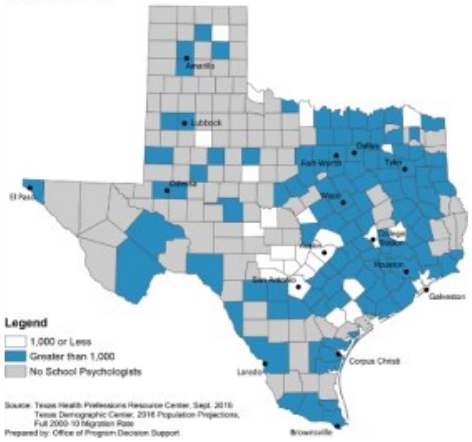
The Health Professional Shortage Area (HPSA) designation employs a ratio of population to primary care physicians to determine whether or not an area has a shortage of physicians. The ratio threshold is 3,500:1 and is reduced to 3,000:1 in areas with high needs, such as at least 20% of population below 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, but in some urban areas, access is limited because many providers do not accept Medicaid or patients are not enrolled in Medicaid and unable to pay out-of-pocket. Most counties in Texas are designated as either a whole-county or partial-county HPSA. Only 71 Texas counties were not designated as a geographic or population HPSA as of Oct. 2016 (Figure 2.20).

Figure 2.20
Texas Primary Care Health Professional Shortage Areas, October 2016



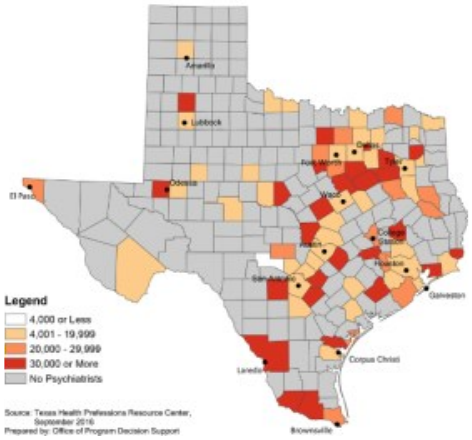
Parents who responded to the Title V Community Outreach Survey indicated that finding a mental or behavioral health professional was very or extremely difficult, especially finding those that treat children. The National Association for School Psychologists recommends a student-to-provider ratio of 1,000:1. County-level data for specific student enrollment are not available, but based on population aged 6-18, the only two counties with a large child population meeting this ratio are those in which Austin and San Antonio are located (Travis and Bexar counties; Figure 2.21).

Figure 2.21
Ratio of Children (6-18 Years) to School Psychologists, September 2016



Psychiatrist shortage is also a concern. The HPSA cut-offs for designating an area with a mental health shortage is 30,000 population to 1 psychiatrist, and 20,000 population to 1 psychiatrist in areas with high needs. Some studies suggest that a ratio of more than 4,000 population to 1 psychiatrist likely adversely impacts the availability of mental health care; as of September 2016, only one county in Texas had a ratio below this 4,000:1 threshold (Figure 2.22). Several counties surrounding major cities, however, met one of the two HPSA cut-offs.

Figure 2.22
Ratio of Population to Psychiatrist, September 2016



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. There are almost no child and adolescent psychiatrists in the state practicing outside of major cities in Texas.

Emerging Issues

The positioning of MCHS program staff at both the state and regional levels allows a broad and local approach in addressing current and emerging issues. Zika virus infection is a highly significant public health concern and challenge, and protecting pregnant women and unborn children against Zika is a central public health goal for Texas. Ongoing planning, education and awareness through the website TexasZika.org, a comprehensive media campaign, mosquito surveillance and control, human surveillance/testing, and assurance of appropriate linkage to services and supports remain key areas of focus in Texas' Zika response . Other emerging issues affecting multiple MCH populations include the increase in opioid use, including during pregnancy and the resultant uptick in births complicated by Neonatal Abstinence Syndrome (NAS). Working with partners in Behavioral Health Services at HHSC and initiatives focusing on interconception care, MCHS is working to increase education and understanding around this issue.

Senate Bill 200, 84th Legislature, 2015, directed the Executive Commissioner of the Health and Human Services Commission (HHSC) to submit a transition plan that outlined the restructuring of the health and human services delivery system to promote accountability, reduce fragmentation, and streamline operations across the 5 agencies that comprise the HHS system to benefit the people served. On March 31, 2016, that plan was presented to the Transition Legislative Oversight Committee on the Transformation of the Health and Human Services System (HHS System).

Based on the Committee's guidance, the transition plan was further streamlined into two phases. The first phase, which took place on September 1, 2016, was a smooth one for the employees and public alike. The main changes of this phase included client service programs transferring from DSHS to HHSC, administrative services at HHSC were consolidated, and prevention and early intervention services transferred from DSHS to DFPS.

The second phase, which took place on September 1, 2017, restructured the Department of State Health Services to focus on its core public health mission. Within this restructure, Women, Infants, and Children (WIC) transferred to HHSC from DSHS. Within DSHS, the Family Community Health Services (FCHS) Division changed to the Community Health Improvement (CHI) Division and the Title V Maternal and Child Health (TVMCH) Section was changed to the Maternal and Child Health Section (MCHS). The Office for Program Decision Support (OPDS) was changed to Maternal and Child Health Epidemiology (MCHE) and is now housed within MCHS. CHI was restructured to enhance promotion of community health by improving maternal and child health; reducing chronic disease, tobacco use, and injury; ensuring healthy environments; operating non-infectious disease registries; and conducting surveillance/epidemiology on those diseases and conditions. Please see the updated DSHS and CHI organizational charts in Section V, Supporting Document 5.

Updates are regularly posted to the HHSC website and the public is given an opportunity to be placed on a distribution list to receive emails with updates. More information about the HHSC transformation can be found here: http://www.hhsc.state.tx.us/hhs-transformation/index.shtml.

Authority and State Public Health Agency Priorities

Serving as the state's public health agency, DSHS is responsible for the administration of programs funded through the Title V MCH Services Block Grant. DSHS' mission is to improve the health and wellbeing of all Texans. Within the Community Health Services Division, MCHS administers the Title V Block Grant. Through the work of the CSHCN SDG, MCHS provides services to support community-based, family-centered coordinated systems of care for CYSHCN and their families.

DSHS began operations in its current structure as a result of the passage of House Bill 2292 during the 78th

Legislative Session, 2003. This legislation established a clear directive to transform the delivery of health and human services in Texas and resulted in the consolidation of 12 agencies into a network of four new departments under the leadership of HHSC. The goal of this new structure was to improve services, increase efficiency, and enhance accountability among the state's health and human service agencies. To advance these goals, Senate Bill 200, 84th Legislature, 2015, directed the HHSC Executive Commissioner to further restructure the health and human services delivery system. This has resulted in the combination of three of the five health and human agencies: HHSC, DARS, and DADS. Public health functions will remain at DSHS.

As client service programs have transferred to HHSC, DSHS continues to consolidate its focus to public health. As such, MCH will continue to remain a state health priority, with Title V-funded population health programs and initiatives playing a pivotal role in achieving agency-wide objectives, including reducing obesity across the lifespan, decreasing the use of tobacco, reducing preventable infectious disease, increasing behavioral health screening and prevention, growing the exclusive practice of breastfeeding, and reducing preventable injury. Information pertaining to the provision of services to MCH populations in Texas includes:

Medical Child Abuse Resources and Education Systems (MEDCARES)	The MEDCARES grant program was established by Senate Bill 2080, 81st Texas Legislature, to help develop and support regional initiatives to improve the assessment, diagnosis, and treatment of child abuse and neglect.
Birth Defects Monitoring	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 programs purpose is to identify, investigate, and monitor birth defects cases in Texas. The program is required to provide information to identify the risk factors and causes of birth defects, support the development of strategies to prevent birth defects, and maintain data in a central registry.
Child Passenger Safety	Legislation requires children younger than 8 years old, unless they are 4 feet 9 inches in height, to be properly restrained in a child passenger safety seat while riding in an operating vehicle.
Child Fatality Review	Child Fatality Review Teams (CFRT) are authorized under Texas Family Code SS264.501-264.515. The State Committee is a multi-disciplinary group of professionals selected from across the state with a membership reflecting the geographical, cultural, racial, and ethnic diversity of the state that works to understand the causes and incidence of child deaths in Texas; identify procedures within the representative agencies to reduce the number of preventable child deaths; and increase public awareness and make recommendations to the governor and legislature for effective changes in law, policy, and practices.
Sudden Infant Death Syndrome (SIDS)	Texas law requires that the death of a child 12 months old or younger be reported to the Justice of the Peace, medical examiner, or other proper official if the child dies suddenly or is found dead and the cause is unknown. If SIDS is determined as the cause of death, the law directs DSHS to reimburse the county a fixed sum for the cost of the autopsy. Texas Health and Safety Code Title 8, Chapter 673.
Community Health Worker Training and Certification	Texas Health and Safety Code Chapter 48 provides authority to DSHS to establish and operate a certification program for community health workers (CHWs). The statute also establishes an advisory committee that advises DSHS and HHSC on the implementation of standards and requirements related to the training and regulation of CHWs. The advisory committee also provides provide advice and recommendations related to CHW employment and funding of CHW services.
People First Language	The 82nd Texas Legislature passed House Bill 1481 which added the Person First Respectful Language Initiative to the Texas Government Code. The legislation established preferred terminology requiring the use of wording which places the person before the disability.
Resource Pamphlet And Resource Guide Provided To Parents Of Newborn Children	H.B. No. 1240 Sections 161.501 and 161.502, Health and Safety Code requires a resource guide be provided by hospitals, birthing centers, physicians, nurse-midwives, and midwives who provide prenatal care during gestation or at delivery to pregnant women on Medicaid.
CYSHCN	The CSHCN SP is authorized under Chapter 35, Texas Health and Safety Code (HSC) which states that the program shall provide 1) early identification; 2) diagnosis and evaluation; 3) rehabilitation services; 4) development and improvement of standards and services; 5) case management services; 6) other family support services; and 7) access to health benefits plan coverage under Section 35.0031. CSHCN SP rules for these services are in Title 25 of the Texas Administrative Code (TAC), Chapter 38.
Newborn Hearing Screening Program	The program is authorized under Chapter 47, HSC to oversee the point-of-care hearing screening required for all newborns in the state. The goal of newborn hearing screening and early detection of hearing loss is to maximize linguistic competence and literacy development. Program rules in 25 TAC, Chapter 37.
Breastfeeding	Health and Safety Code 165. Breastfeeding mandates the right to breastfeed, the Business Designation as Mother-Friendly, and Services Provided By State Agencies.
The Maternal Mortality and Morbidity Task Force	Senate Bill (S.B.) 495, 83rd Texas Legislature, Regular Session, 2013, amended Chapter 34, Texas Health and Safety Code, to establish the Maternal Mortality and Morbidity Task Force (task force) to: study and review cases of pregnancy-related deaths, and trends in severe maternal morbidity; determine the feasibility of the task force studying cases of severe maternal morbidity; and make recommendations to help reduce the incidence of pregnancy-related deaths and severe maternal morbidity in Texas.

II.B. Five Year Needs Assessment Summary and Updates

FY 2018 Application/FY 2016 Annual Report Update

Healthy Texas Babies (HTB) Databook

The HTB Databook is an overview of infant mortality and morbidity in the state and in select communities. It is an activity and product of Maternal and Child Health Epidemiology (MCHE) at DSHS. The 2016 HTB Databook, which included a perinatal periods of risk analysis, was presented and distributed at the TCHMB annual meeting in December (Section V. Supporting Document 1). Attendees included health care professionals on infant mortality and maternal health, as well as regional medical staff, staff in regional WIC offices, regional March of Dimes staff, and community based groups funded through the HTB initiative. The HTB Databook was presented to 150 Texas early childhood stakeholders and staff at the Texas Home Visiting Community IMPACT Meeting in February 2017. It has been estimated that more than 250 stakeholders receive the HTB Databook each year. In alignment with Title V performance measures, trends of two infant health practices, breastfeeding and safe sleep, were added to the 2016 HTB Databook.

Pregnancy Risk Assessment Monitoring System

Data collection for Texas PRAMS has been ongoing since 2002, with 3,511 women selected for the 2016 survey. The CDC will be providing the weighted 2016 PRAMS survey dataset in 2018. Data collection for the 2017 birth year began in April 2017, and the 2017 PRAMS survey dataset will be provided in 2019. The 2017 birth year survey utilized new PRAMS survey questions developed by CDC plus three supplemental questions on prescription drug use. The 2014 PRAMS Databook was made publicly available in February, 2017. For the 2014 PRAMS Databook, the reporting of results is displayed in various charts and graphs, which is a more user-friendly format. Texas PRAMS data continue 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. Two surveillance dashboards using PRAMS data were also created (*Pre-pregnancy Obesity in Texas* and *Prenatal Oral Health Care*) to drive and inform MCH policy development. Analysis of PRAMS data was not only critical for the HTB Databook and dashboards, but also played a key role in the development of a joint strategic plan between DSHS and the DFPS. As a result of this strategic plan, MCHS and MCHE are implementing a pilot survey on father involvement and maternal social support, and data collecting will begin during the 2017 birth year. The Texas PRAMS Team worked with academic partners, representatives from DFPS Prevention and Early Intervention, the Office of Attorney General's Child Support Division, and MCHS to develop survey questions. Data obtained from this pilot survey will help the Texas PRAMS Team choose supplemental questions to include in future years of the PRAMS survey. Renewal for the second year of the CDC five-year cooperative agreement was submitted to CDC in 2017, and the award was received in May 2017. Mothers reporting postpartum depressive symptoms were more likely to have both partner-related and financial stressors, but less likely to go to the dentist during pregnancy, visit a health care professional for a postpartum checkup, or use postpartum birth control. The findings suggest the need for health care professionals to monitor the moods and actions of mothers during pregnancy, to provide early interventions for mothers experiencing postpartum depressive symptoms related to life stressors, and to emphasize constructive maternal health practices.

Regional Analysis of Maternal and Infant Health in Texas

There is a need to identify and evaluate health related needs in each of the HSRs in Texas, with a focus on assessing maternal and infant health disparities, as well as relevant risk and protective factors. The findings will help inform the

evidence-based practices, the Healthy Texas Babies initiative, and the strategy for building and implementing regional coalitions, whose mission will then be to design and implement public health interventions to meet the maternal and infant health needs identified. To this end, a regional analysis of maternal and infant health in Texas will be conducted and completed by April 2018. Analysis of the latest population-level data will be integrated with available community outreach survey results and focus group findings. The analysis will include an overview of geographic characteristics and birth demographics, followed by region-specific analysis of infant mortality and morbidity, perinatal periods of risk, access to health care, maternal risk factors (smoking, obesity, diabetes, hypertension, substance use including prevalence of Neonatal Abstinence Syndrome/opioid use, and physical abuse), and infant health practices. Geographic mapping at the county level for obtainable indicators will also be performed to gain a better understanding of a particular region and the state as a whole.

Birth Defects Surveillance

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) and has been in operation since 1994. Statewide data became available in 1999. Highly-trained regional staff visits medical facilities regularly where they have the authority to review logs, hospital discharge lists, and other records to find babies with birth defects (structural malformations or chromosomal disorders). If the record indicates that the infant or fetus has a birth defect 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 1st 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 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. Due to the growing interest in microcephaly and the association of this condition with the Zika virus, the Birth Defects Epidemiology and Surveillance Branch recently implemented rapid ascertainment of microcephaly and related conditions that have been linked to Zika virus, and is attempting real-time surveillance for congenital Zika infection. The Branch is also planning activities related to the referral and ascertainment of outcomes of children with these conditions. In FY2016, the Birth Defects, Epidemiology, and Surveillance Branch at DSHS entered nearly over 27,000 cases of birth defects (i.e., individuals affected by one or more birth defects) into the web-based abstraction system (Maven) during that year. By the end of FY2016, the Registry had nearly completed the 2014 delivery year.

CSHCN Data Analysis & Surveillance

Due to a lack of recent NSCH or NS-CSHCN data, the CYSHCN Community Outreach Survey and discussion groups were held during FY2016 and FY2017 to monitor progress towards improving community integration, medical home, and transition outcomes. The 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 transition, care coordination, community integration, respite care and emergency preparedness. English and Spanish versions are distributed by mail and online and responses are tracked by zip code in order to ensure representation of subsets of the CYSHCN population in Texas. Information from the survey and discussion groups is utilized by MCHS to develop programming to improve the wellbeing of CYSHCN in Texas across the six core system outcomes.

During FY2016, MCHS developed the Medical Home and Transition Physician Survey for distribution in FY17 to assess physicians' baseline knowledge of best practices. The Physician Survey was designed to inform provider education and outreach programming. Although MCHS conducted outreach to key groups of stakeholders throughout FY2017, a low response rate was obtained. Revisions to the Physician Survey sought to increase the

response rate during FY2017 by splitting content into smaller surveys, yet a statistically valid sample could still not be obtained. Responses gathered using audience response systems during interactive presentations, while successful, were unable to stand alone as usable data without survey data. In FY2018 MCHS will focus on assessing its CSHCN-related provider engagement efforts through the formation of a champion workgroup to assist in the development of a strategic plan for engaging providers.

Maternal Mortality and Morbidity Task Force (MMMTF) Data Analysis & Surveillance

Senate Bill 495, 83rd Legislature, 2013, established the MMMTF to study maternal mortality (i.e., deaths that result from pregnancy) and severe maternal morbidity (i.e., the most severe complications that result from pregnancy), and to review specific cases. To this end, MCHE conducted analyses of trends and disparities in maternal mortality and severe maternal morbidity using statewide vital event and hospital discharge data, the findings from which were reported in the 2016 (second) Joint Biennial Report for the Legislature by DSHS and the Task Force was published in July, 2016 (Section V. Supporting Document 3). Findings thus far from the Task Force's review of maternal death cases in 2012 were also presented, as were recommendations for addressing the findings. Soon after this report was published, MCHE responded to numerous legislative and media inquiries regarding an article by MacDorman, et al. appearing in the September 2016 issue of *Obstetrics & Gynecology*, which showed a sharp increase in maternal mortality in Texas between 2010 and 2012, with the greatest single-year increase occurring between 2010 and 2011. MCHE and MCHS staff were then invited to comment on the MacDorman et al. (2016) article, and did so in a commentary on maternal mortality in Texas published in December 2016 in the *American Journal of Perinatology* (Section V. Supporting Document 2). While maternal mortality increased sharply from 2010 to 2011, the percent change or the magnitude of the increase in the maternal mortality rate in Texas differs depending on the statistical methods used to compute and display it. Methodologic challenges in identifying maternal death were also discussed, as well as chronic disease risk factors (pre-pregnancy obesity, diabetes, and hypertension) and causes of maternal death in Texas. Lastly, several state efforts currently underway to address the Task Force's recommendations concerning maternal mortality in Texas were described. Especially noteworthy is our progress in securing additional staffing resources to expand case review capacity. In January 2017, DSHS was able to hire two contractors, who have begun to redact case patient records so that a DSHS nurse can then abstract/summarize each case for Task Force review. Work on securing a contract with a state university is underway, which will also significantly increase case review capacity by having nursing students abstract/summarize maternal death cases (with university and DSHS nurse supervision and quality monitoring). The Task Force is currently focusing on completing reviews of all 2012 maternal death cases involving drug overdose as cause of death, with the aim of producing a white paper on the role of behavioral health in preventing maternal mortality in Texas. Lastly, an epidemiologic investigation by MCHE staff is planned using a new in-depth verification method for identifying maternal deaths, and from which an updated maternal mortality rate (MMR) estimate for 2012 can be computed.

Oral Health Needs Assessment & Surveillance

The Oral Health Program (OHP) at DSHS strives to identify the oral health needs of Texans. In 2016, MCHE conducted several needs assessment and surveillance activities for OHP. Analysis of 3rd grade sealant prevalence data from the Basic Screening Survey (BSS) was conducted, and updates were made to the electronic data collection forms and reports for the 2016 preventive dental services (PDS) surveillance data. A dashboard was also developed to compare PDS data for years 2015 and 2016, while also developing an on-going county level data report for the University of Texas-San Antonio Health Science Center to support the HRSA Workforce Grant. MCHE also worked to create a new methodology for sampling children in schools for PDS. Lastly, to improve oral health surveillance capacity, oral health questions within the School Physical Activity and Nutrition Survey (SPAN) were expanded to parents of children in grade 2, and to children in grades 4, 8, and 11.

Reduction of Early Elective Deliveries (EEDs): Positive Implications for Texas Medicaid

The high prevalence EEDs is a public health concern that poses increased risk for maternal and infant complications. These complications increase healthcare spending, including spending in the Texas Medicaid program. To address this problem, the Commissioner appointed a workgroup with representatives from multiple state agencies to consider different policy interventions. One of the outcomes was the HTB initiative, developed and supported by MCHS. HTB focused on reducing EEDs through education and outreach according to recommendations for evidence-based care by the American Congress of Obstetricians and Gynecologists. Another workgroup outcome by HHSC was the implementation of a state policy in 2011 that changed Medicaid reimbursement policy to no longer cover EEDs. Moreover, to better evaluate the effectiveness of these strategic efforts, DSHS and HHSC recently coordinated on a legislative report concerning EEDs in Texas. MCHS staff assisted with the design, planning, editing, and review of this legislative report (as required by House Bill 1, 84th Texas Legislature, Special Provision 45). Overall, the new EED estimation method produced slightly lower EED rates than the methods previously used in Texas. However, both the new and old calculation methods produced similar trends over time; they all showed that EED rates in Texas declined in 2011 (the year that Medicaid policy denied payment of EEDs). Indeed, a recent study by Dahlen et al. (2017) found that EED rates in Texas fell by up to 14% after this Medicaid policy change. Mothers of non-Hispanic white race/ethnicity, those with private insurance, and mothers who had at least one previous cesarean section all had higher EED rates.

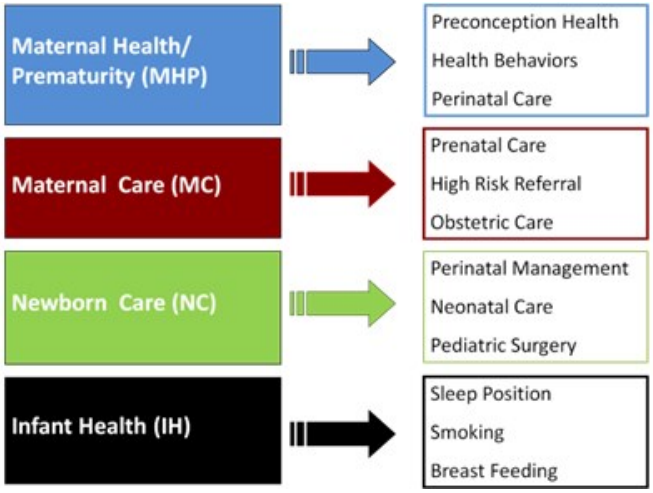
Organizational Structure Updates

Per Senate Bill 200, 84th Legislature, 2015, Texas HHSC began transitioning to a new structure. On September 1, 2017, DSHS restructured to focus on its core public health mission. Organizational charts are located in Section V.

FY 2017 Application/FY 2015 Annual Report Update

Results from the Title V Five-Year NA showed that although Texas has made significant progress in reducing infant mortality, disparities persist between Black and White women in infant mortality and feto-infant mortality. To better understand these disparities, a perinatal periods of risk analysis (PPOR) was recently conducted, including an examination of the risk of feto-infant mortality during the different perinatal periods. Based on birth weight and age of death, fetal and infant deaths occurring during 2009-2012 were partitioned into four corresponding points of intervention in the health care continuum (see Figure 2.2). These four points have different risk factors and causes of death, and hence, different opportunities for intervention.

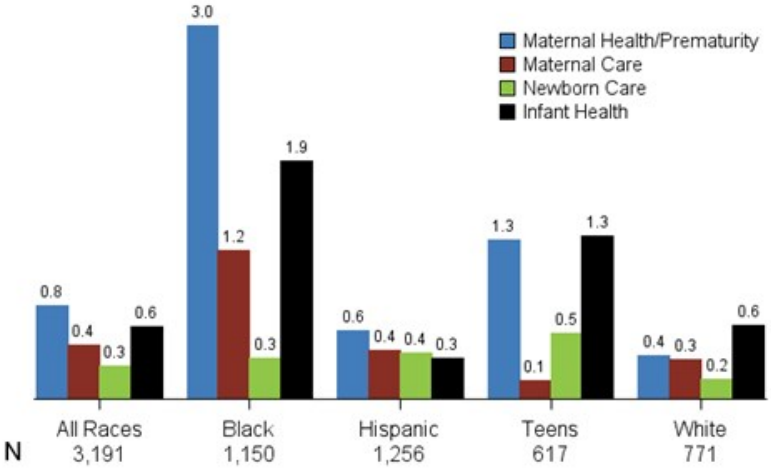
Figure 2.2: PPOR Periods: Points of Intervention



From: Peck, M. G., Sappenfield, W. M., & Skala, J. (2010). Perinatal periods of risk: A community approach for using data to improve women and infants' health. *Maternal & Child Health Journal, 14(*6), 864-874. doi:10.1007/s10995-010-0626-3

Texas and sub-populations were compared to a state-level reference group generally known to have better feto-infant mortality outcomes (i.e., non-Hispanic White women who are at least 20 years of age and have 13+ years of education). The excess feto-infant mortality rate (F-IMR) is the difference between the exposure group (Black, White, Hispanic, teen) and the reference group. The excess F-IMR was: 6.5 for Blacks; 1.4 for Whites; 1.7 for Hispanics; and 3.3 for teens Figure 2 shows excess feto-infant mortality rates in each of the periods of risk for all races and specific sub-populations.

Figure 2: Excess Feto-infant Mortality Rates by Race/Ethnicity, Texas



Black women had the highest excess F-IMR for 3 of the 4 risk periods, with 56 % of Black fetal and infant deaths being potentially preventable. Moreover, 47 % of these overall excess deaths occurred in the MHP risk period, with an excess F-IMR

8.5 times that of Whites. For teens, 80 % of excess deaths occurred in the MH and IH risk periods (40 % each). In the IH risk period, the rate of excess feto-infant mortality among Blacks was 3.2 times that of Whites and 5.8 times that of Hispanics.

These findings suggest the need for targeted interventions for Black and Hispanic women and teens during the MHP period, when they are most at risk of experiencing a feto-infant death. Interventions are also needed that target Black women during the MC and IH POR, as are efforts targeting teens and White women to reduce the risk of feto-infant mortality during the Infant Health period.

Primary Care Needs Assessment

An overview of the state was completed to assess the need for primary care in Texas, and Title V conducts ongoing needs assessment activities and surveillance to inform programming for MCH populations. A Primary Care NA was submitted in March 2016 to HRSA on behalf of the Texas Primary Care Office at DSHS, and is attached for reference in Section V. Within this Needs Assessment, the Texas population is described using the most recent data available, including demographic and socioeconomic characteristics. General health issues and outcomes in Texas are also highlighted, many of which are also areas of concern for maternal and child health, including oral health, mental health, infant mortality, low birth weight, diabetes, and hypertension. Three crucial health risk behaviors—obesity, smoking, and teen births—are included as well. Preventive services received in mammography screening and immunizations are also assessed to help identify potential causes of unmet health needs and disparities among Texans. The health care workforce capacity is discussed, as are shortage areas in the context of the medically underserved population and potentially preventable hospitalizations.

Children with Special Health Care Needs Outreach Surveys and Focus Groups

The Annual *CYSHCN Community Outreach Survey* includes questions relating to respite care, emergency preparedness, transition, care coordination, insurance needs and community integration. The survey is distributed in English and Spanish, by mail and online, and responses are tracked by zip code in order to ensure representation of subsets of the CYSHCN in Texas. Annual parent and youth/young adult focus groups will provide additional information on specific barriers and challenges. The annual, web-based *Medical Home and Transition Physician Survey* assesses understanding, implementation skills, and barriers relating to medical home and transition best practices. Follow-up physician focus groups will be held at meetings for medical and health professional organizations. Data from annual surveys is utilized by the CSHCN SP to develop targeted programming to improve the wellbeing of CYSHCN in Texas across the six core system outcomes and state priority needs.

Healthy Texas Babies Databook

The Healthy Texas Babies (HTB) Databook is an overview of infant mortality and morbidity in the state and in select communities. It is an activity and product of the Office of Program Decision Support (OPDS) at DSHS. The HTB Databook is written for the Texas Collaborative for Healthy Mothers and Babies (TCHMB), which is the perinatal collaborative in Texas. The 2015 HTB Databook was distributed in November to maternal and infant health care professionals including regional medical staff, staff in regional Women, Infant and Children offices, regional March of Dimes staff, and community based groups funded through the Healthy Texas Babies initiative. It is disseminated via the DSHS website and presented at the annual TCHMB meeting for stakeholder feedback. An estimated 250 stakeholders receive the HTB Databook each year. The purpose of the HTB Databook is to provide the data necessary to help develop and shape policies and programs focused on reducing maternal health risks and infant mortality. Tthe Databook has also helped with identifying and developing partnerships with key stakeholders and organizations invested in improving maternal and infant health. A copy of the 2015 HTB Databook is attached for reference in Section V.

Pregnancy Risk Assessment Monitoring System (PRAMS)

In Texas, PRAMS provides the most comprehensive population-based data on maternal health during and after pregnancy. The PRAMS survey asks questions (via mail, web, or telephone) of recent mothers and on health topics, such as access to prenatal care, pregnancy intention, alcohol use, smoking, knowledge of the importance of folic acid, multivitamin use, type of insurance, intimate partner violence, postpartum depression, breastfeeding, infant sleep position, and smoke exposure. Data collection for Texas PRAMS has been ongoing since 2002, with 2,481 women selected for the 2015 survey. The Centers for Disease Control and Prevention (CDC) will be providing the weighted 2015 PRAMS survey dataset in 2017. Data collection for the 2016 birth year began in April 2016, and the 2016 PRAMS survey dataset will be provided in 2018. The 2016 birth year survey utilized new PRAMS survey questions developed by CDC. The 2012 PRAMS Databook wase made publicly available in May, 2016. For the 2012 PRAMS Databook, the reporting of results is being compiled differently than in previous Databooks; data is displayed

in various charts and graphs, which is a more user-friendly format. The Databook is being developed using Tableau software and is interactive, allowing users to re-arrange figures and download the reported data in Excel files. Texas PRAMS data continue to be used by DSHS and several 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. Analysis of PRAMS data was not only critical for the HTB Databook, but also played a key role in the development of a joint strategic plan between DSHS and the DFPS. As a result,Title V is implementing a pilot survey on father involvement and maternal social support that will be launched during the 2016 birth year. The Texas PRAMS Team worked with academic partners, representatives from DFPS Prevention and Early Intervention, the Office of Attorney General's Child Support Division, and Title V to develop survey questions. Data obtained from this pilot survey will help the Texas PRAMS Team choose supplemental questions to include in future years of the PRAMS survey. While attempts are made to increase the response rate to the PRAMS survey in Texas, the results can be generalized to the population of women who are residents of Texas per the CDC formulaic weighting of the survey sample. Results from PRAMS are compared with those from other surveys for validation beyond what CDC provides.The award for the CDC five-year cooperative agreement was was received in June, 2016.

Maternal Mortality and Morbidity Task Force Data Analysis and Data Collection System

The Maternal Mortality and Morbidity Task Force (MMMTF), established by Senate Bill 495 during the 83rd Texas Legislative Regular Session, is mandated to study cases of maternal mortality (i.e., deaths that result from pregnancy) and trends in severe maternal morbidity (the most severe complications that result from pregnancy), and make recommendations for prevention. Title V continued to support MMMTF with the development of the task force infrastructure, data analysis, development of a data collection system, records request, redaction and abstraction, and meeting logistics in 2015 and 2016. In 2015, a trend analysis was conducted, which provided MMMTF with a comparison of the 2012 maternal death cohort with the most recent statewide data on overdose deaths and maternal Medicaid status. Autopsies, police death investigations, and delivery hospital medical records were requested. Records were redacted of identifiable information, abstracted into case reports and provided to MMMTF for their review. Development of the data collection system has also begun. In 2016, abstraction forms were created and used to abstract 8 cases. A report on severe maternal morbidity trends in the state was presented, which informed the task force on the current rates of hypertension, diabetes, obesity and opioid use, as well as the incidence of hospitalizations due to hemorrhage and behavioral health issues during pregnancy. Title V staff facilitated writing the MMMTF Report to the Texas Legislature in 2016, including findings from statewide trend analysis and case reviews, and recommendations to prevent maternal mortality and severe maternal morbidity in Texas.

Texas Child Fatality Review Team Biennial Report

In an effort 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 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. In 2015, local teams reviewed 1,503 (40.2 %) of the 3,741 child deaths that occurred in 2012, and 1,384 (37.0 %) of the 3,742 child deaths that occurred in 2013; the majority of those reviewed were unexplained infant mortalities or non-natural child deaths. Data trends for child deaths occurring in 2012 and 2013 were then published in a biennial report (see attachment in Section V.), with a focus on the leading causes of preventable child deaths, including those involving motor vehicle crashes, drowning, homicides, suicides, and sleep-related deaths.

School Physical Activity and Nutrition Survey

The School Physical Activity and Nutrition (SPAN) survey is a surveillance system that monitors the prevalence of, and secular trends in, overweight and obesity in school children in Texas. The survey identifies factors in Texas students that may be associated with obesity. Information from SPAN assists in the development of targeted programs and policies to address overweight and obesity among Texas youth. SPAN 2015-2016 is the fourth time the state-wide project will be conducted. In preparation, OPDS worked with the University of Texas Health Science Center (UTHSC) and the Office of Border Health on survey logistics, including oversampling along the border. The final data is projected to be available in March, 2017.

Texas Statewide Sexual Assault Prevalence Study

In FY14-15, Title V funded a statewide telephone survey to present the descriptive findings on sexual assault prevalence, health and well-being in Texas, including the victim's relationship to the perpetrator, involvement of alcohol, reporting of sexual

assault to police and the impact of sexual assault on victims' health. Results from this survey will inform programmatic decisions going forward.

Other Surveillance

Title V resources are utilized to fund questions for YRBS and BRFSS. In addition, the state breastfeeding coordinator serves as the primary investigator on the WIC infant Feeding Practices Survey with data analytic support from OPDS.

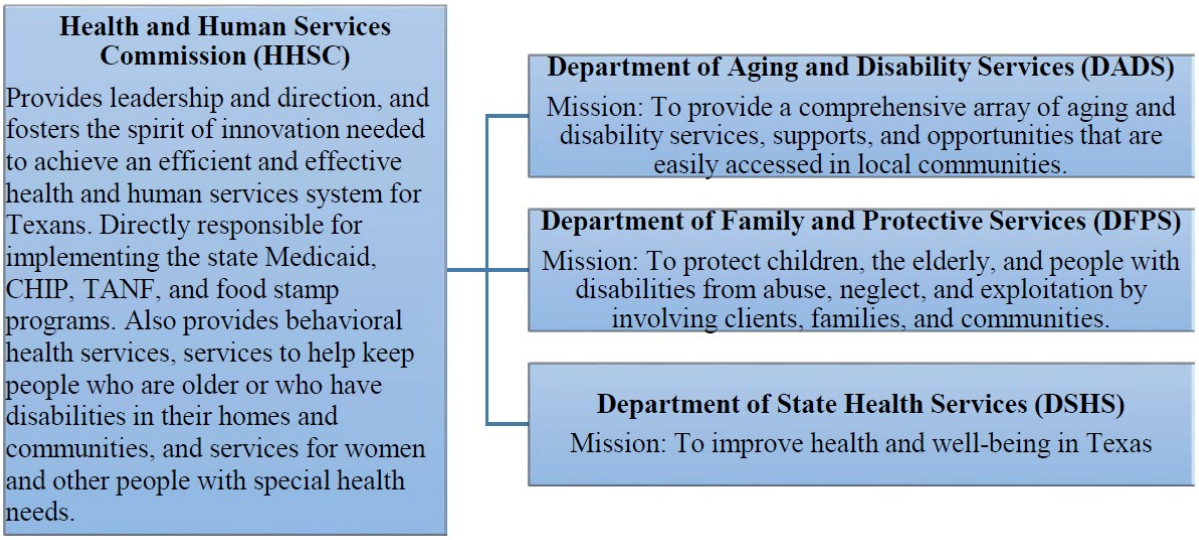
Organizational Structure Updates

Dr. John Hellerstedt, MD joined DSHS as the new commissioner on January 1, 2016. Dr. Hellerstedt is a graduate of the University of Pittsburgh medical school and completed his residency at the University of Texas-San Antonio Health Science Center. Most recently he served as the chief medical officer for the Seton Family of Hospitals, and previously served as medical director for the Medicaid and Children's Health Insurance Program Division within the HHS System. Dr. Hellerstedt served as vice president of medical affairs for Dell Children's Medical Center of Central Texas. He has also been in private practice as a pediatrician.

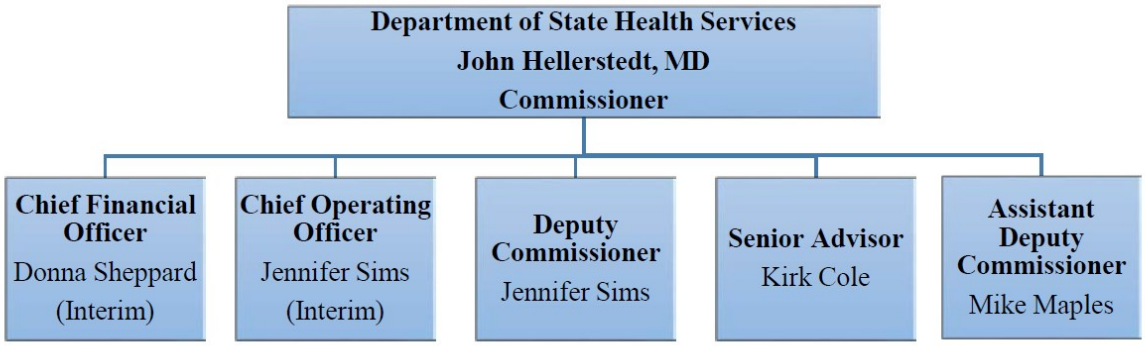
Governor Greg Abbott selected Charles Smith for the role of Executive Commissioner of HHSC effective June 1, 2016. Smith is recognized as a leader in personnel management, analytics, innovation, organization, streamlining processes and increasing the efficiency and effectiveness of operations. He has overseen the areas of Medicaid and CHIP, procurement and contracting, health policy, social services, women's health services, mental health coordination, medical transportation, and veteran services at HHSC. Smith is a graduate of Texas Tech University.

Cecile Erwin Young was promoted from Chief of Staff at HHSC to serve as the new Chief Deputy Executive Commissioner. She has thirty years of state government experience in Texas. From 2007 to 2011 she served as Associate Commissioner for Health Coordination and Consumer Services at HHSC and returned as chief of staff in January 2015. In her career in state government, she has served four governors, an attorney general and a state representative.

Updates to Figure 49 are as depicted:



Updates to Figure 50 are as depicted:



Updates to Figure 52 are as depicted:

Five-Year Needs Assessment Summary
(as submitted with the FY 2016 Application/FY 2014 Annual Report)

II.B.1. Process

DSHS assessed current status and needs of the MCH population in Texas, using existing data analysis, community outreach surveys and qualitative focus group and stakeholder data. Goals included stakeholder representation from all Texas regions to provide insight to opportunities and challenges identified through epidemiologic research (Fig.1).

Figure 1. Needs Assessment Process

Analysis of existing data sources was guided by the life course perspective, the recognition of CYSHCN as part of the community, and the complexity and diversity of the MCH population. Data sources included numerous state and national surveillance systems and surveys, such as census, public safety, vital statistics, BRFSS, YRBSS, and PRAMS.

DSHS surveyed parents and community members in English and Spanish about their community's needs and strengths. The Title V Community Outreach Survey (1,987 responses) focused on provider access, community engagement and community health concerns. The CYSHCN Outreach Survey (923 responses including 312 in Spanish) assessed transition services, care coordination, respite care needs, emergency preparedness, and health insurance needs.

Focus groups and stakeholder meetings provided qualitative data to complement community outreach surveys. DSHS held focus groups in every HSR, including groups for the general population and for parents of CYSHCN.

Table 1 describes the general population focus groups (132 participants), including two men-only groups held in areas impacted by the Texas oil/gas boom to focus on work, fatherhood, and environmental issues.

Table 1. Focus group locations and target demographics for the general population

Location		Demographics		Language
Amarillo	Small urban/rural	Women 19-22	White/Mixed	English
Brownsville	Small urban/rural	Women 19-22	Hispanic	Spanish
Fort Worth	Large urban	Women 25-35	Black/Mixed	English
Houston	Large urban	Women 25-35	Black	English
Killeen	Small urban/rural	Women 25-35	Mixed	English
Nacogdoches	Rural	Women 25-35	Black	English
San Angelo	Small urban/rural	Men 25-35	Mixed	English
San Antonio	Large urban	Men 25-35	Hispanic/Mixed	Spanish

DSHS held 11 focus groups for parents of CYSHCN, including Spanish-speaking groups in El Paso, Dallas and Laredo. Of the 102 participants, 44% were Spanish-dominant.

DSHS held stakeholder meetings with professionals, providers and local health administrators in each HSR. Most were in English, with bilingual sessions in El Paso and Laredo. Of the 128 participants, 41% work with CYSHCN and their families.

II.B.2. Findings

II.B.2.a. MCH Population Needs

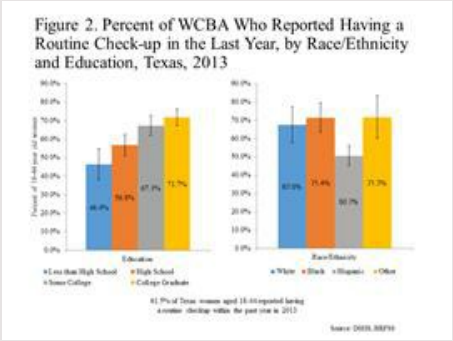
Maternal/Women's Health

Women's Health

This section describes the overall health status of women who may become pregnant now or in the future (preconception). The first few weeks post-conception are critical for fetal development so efforts to prevent, detect and treat health conditions should begin before conception. Health promotion, screening and management for women of childbearing age (WCBA), those 18-44 years old, are important risk reduction strategies for poor pregnancy/birth outcomes while also improving overall population health.

The Texas State Data Center estimates 5.2 million WCBA live in Texas in 2015. The majority were Hispanic (43.5%) or White (36.9%), while 12.4% were Black and 7.3% another race/ethnicity.

The proportion of WCBA who reported a routine checkup within the past year ranged from 54.9% in 2011 to 61.5% in 2013. Education level and race/ethnicity affect these rates (Fig 2).

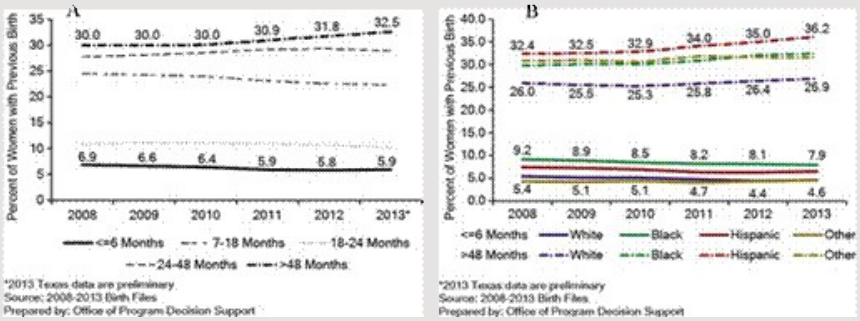


Focus group participants reported concerns with access to care; coordination and collaboration of care; and a focus on the whole person across the life course.

Birth Spacing

Interpregnancy intervals (IPIs) with spacing <18 months are associated with negative birth outcomes, with spacing 0-18 months showing an inverse dose-dependent like relation with negative birth outcomes. [i] Since 2008, the prevalence of short IPIs has decreased and the prevalence of IPIs > 48 months has increased (Fig 3).

Figure 3. A) Distribution of Interpregnancy Intervals, Texas, 2008-2013. B) Interpregnancy Intervals ≤6 Months or >48 Months by Race/Ethnicity among Multiparous Women Having a Live Birth in 2013, Texas.

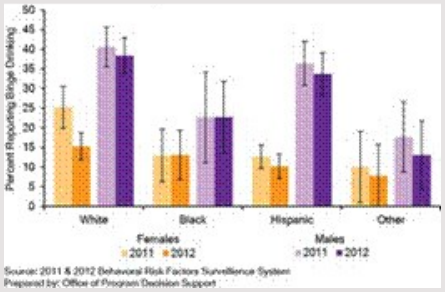


Texas BRFSS 2009-10 data showed 76% of sexually active, heterosexual WCBA were actively avoiding becoming pregnant. About 17% of WCBA had a tubal ligation or hysterectomy to avoid getting pregnant, while 5.6% of WCBA reported using less effective methods like rhythm or withdrawal.

Substance Use

Prenatal exposure to alcohol is one of the leading causes of preventable birth defects and intellectual disabilities.[ii] The rates for drinking and for binge drinking (Fig 4) among WCBA are lower than those of men in the same age range.

Figure 4. Binge Drinking Rates by Sex and Ethnicity, Texas, 2011, 2012

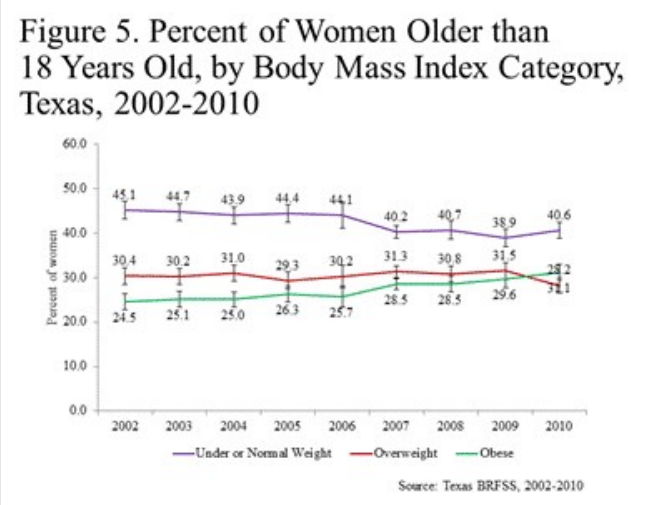


Recreational drug use has been associated with poor birth outcomes and can contribute to poor health/well-being. Prescription drugs are often easy to access, inexpensive and falsely believed to be safer than illicit drugs.[iii] In 2010-11, 3.1% of Texas WCBA reported nonmedical use of prescription drugs in the past month, and 7% in the past year.

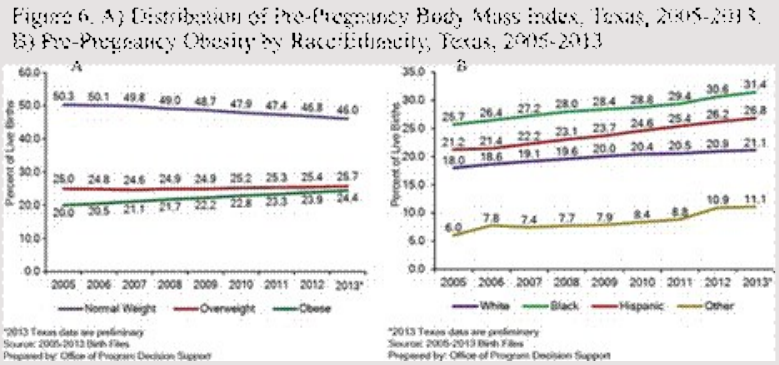
Overweight and Obesity

Obesity contributes to numerous illnesses including diabetes, hypertension, heart disease, cancer and infertility. Obesity is also associated with unfavorable perinatal health outcomes like neural tube defects, labor/delivery complications, fetal/neonatal death and maternal complications like gestational diabetes and preeclampsia. Texas BRFSS reports that in 2006 the proportion of obese women rose steadily to 31.1% in 2010 (Fig 5). More Texas women are overweight/obese than normal

weight, and this gap appears to be widening.



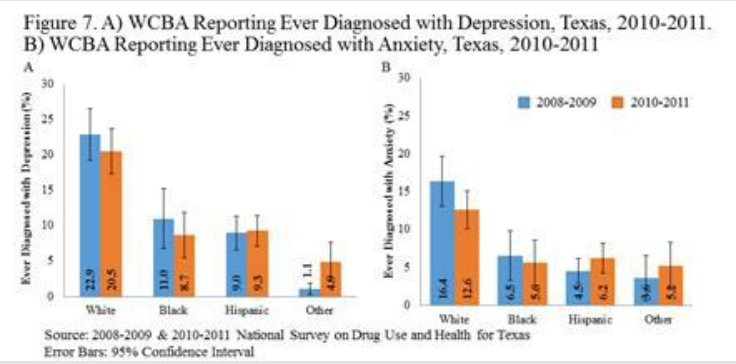
Pre-pregnancy obesity has increased by 22% since 2005 (Fig 6A). Rates have increased in every racial/ethnic group, though the overall rate for each group varies greatly (Fig 6B).



Participants in focus groups and stakeholder meetings consistently identified obesity among their top health care concerns. Most focus group participants understood healthy eating, could describe healthy meals and did most of their shopping at grocery stores. Participants identified time, fatigue and cost as barriers to healthy eating. DSHS incorporates obesity prevention messages in its health outreach efforts and leads multiple statewide initiatives, such as breastfeeding support, nutrition services, the SPAN survey, and worksite wellness programs to address obesity throughout the life course. DSHS continues to build partnerships to develop the infrastructure to support sustainable changes in this area.

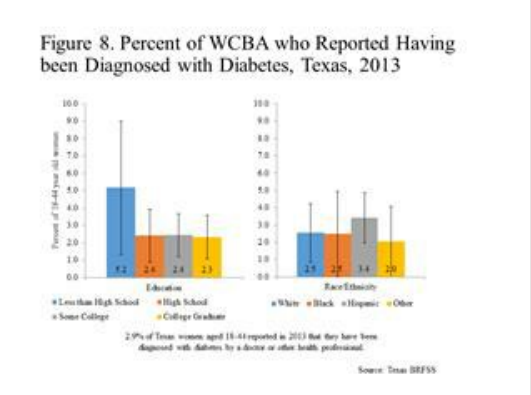
Mental Health

NSDUH 2010-11 data indicate the rate of lifetime depression for women was over twice that of men. About 13.7% of Texas WCBA had been diagnosed with depression in their lifetime and 8% with anxiety. Rates vary by race/ethnicity (Fig 7). These data reflect diagnoses and not true prevalence, which is obscured by confounding variables like access to care and care-seeking behavior.

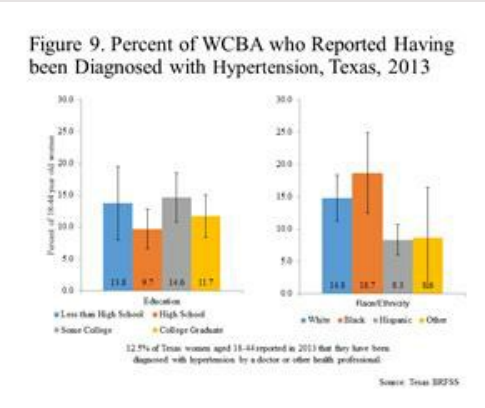


Chronic Conditions

Diabetes control before/during pregnancy is critical to reduce risk of congenital malformations, pregnancy loss and perinatal mortality [iv]. In 2013, 2.9% of WCBA reported a diabetes diagnosis; rates vary by education and race/ethnicity (Fig 8).



Chronic hypertension may complicate pregnancies by leading to (pre)eclampsia, central nervous system or kidney damage, placental complications, fetal demise and other poor outcomes.[v] About 11% of all feto-infant deaths are to a hypertensive mother. In 2013, 12.5% of WCBA reported a hypertension diagnosis, but rates vary by education level and race/ethnicity (Fig 9).

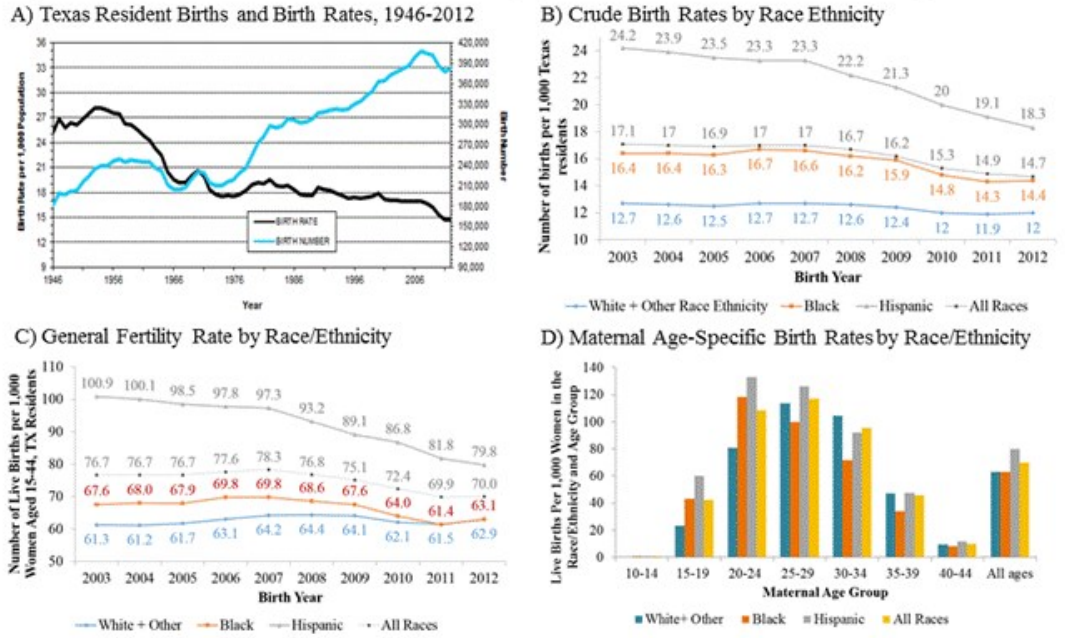


MaternalHealth

Birth and Fertility Rate

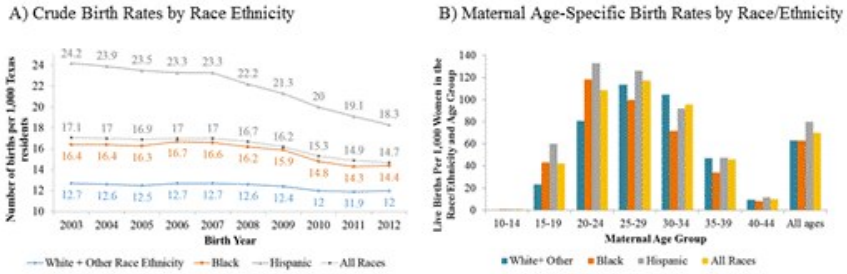
While the total number of Texas births increased exponentially over the past 40 years, the birth rate has steadily declined (Fig 10A. Age-specific birth rates were highest among women ages 25-29 overall, but among women ages 20-24 for Hispanics and Blacks (Fig 10B). Since 2009, the peak in age distribution shifted from 22-24 to 27-29 year olds, and births among 11-19 year olds declined.

Figure 10. Historical and current birth demographic data, Texas Residents, through 2012.



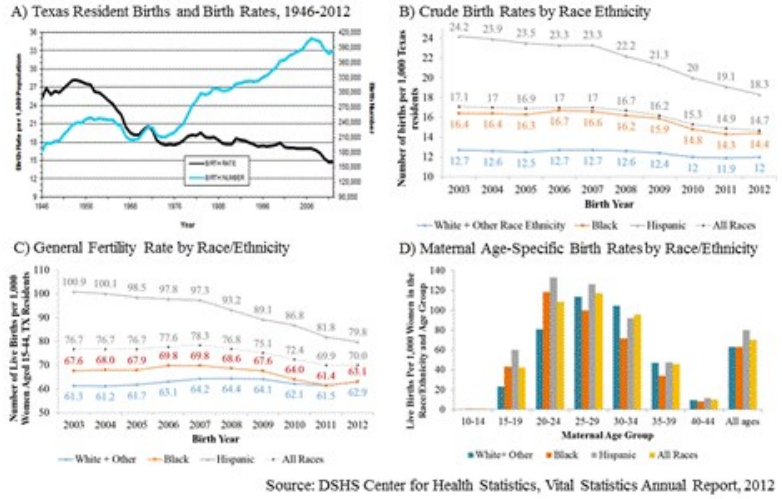
Source: DSHS Center for Health Statistics, Vital Statistics Annual Report, 2012

Figure 10. Historical and current birth demographic data, Texas Residents.



Source: DSHS Center for Health Statistics, Vital Statistics Annual Report, 2012

Figure 10. Historical and current birth demographic data, Texas Residents, through 2012.

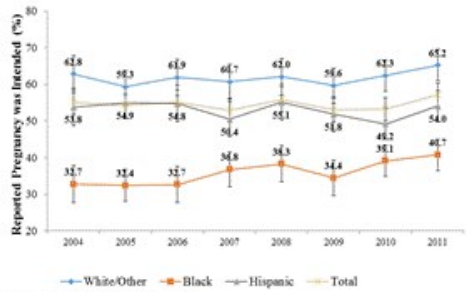


Source: DSHS Center for Health Statistics, Vital Statistics Annual Report, 2012

Pregnancy Intention

Texas PRAMS 2002-10 data show women with unintended pregnancies were more likely to be physically inactive, smoke, binge drink, be underweight and be anemic and less likely to take multivitamins pre-pregnancy [vi]. About 57% of all 2011 Texas pregnancies were intended, but rates differed significantly across racial/ethnic groups (Fig 11).

Figure 11. Women Reporting Existing Pregnancy Was Intended by Race/Ethnicity, Texas, 2002-2011

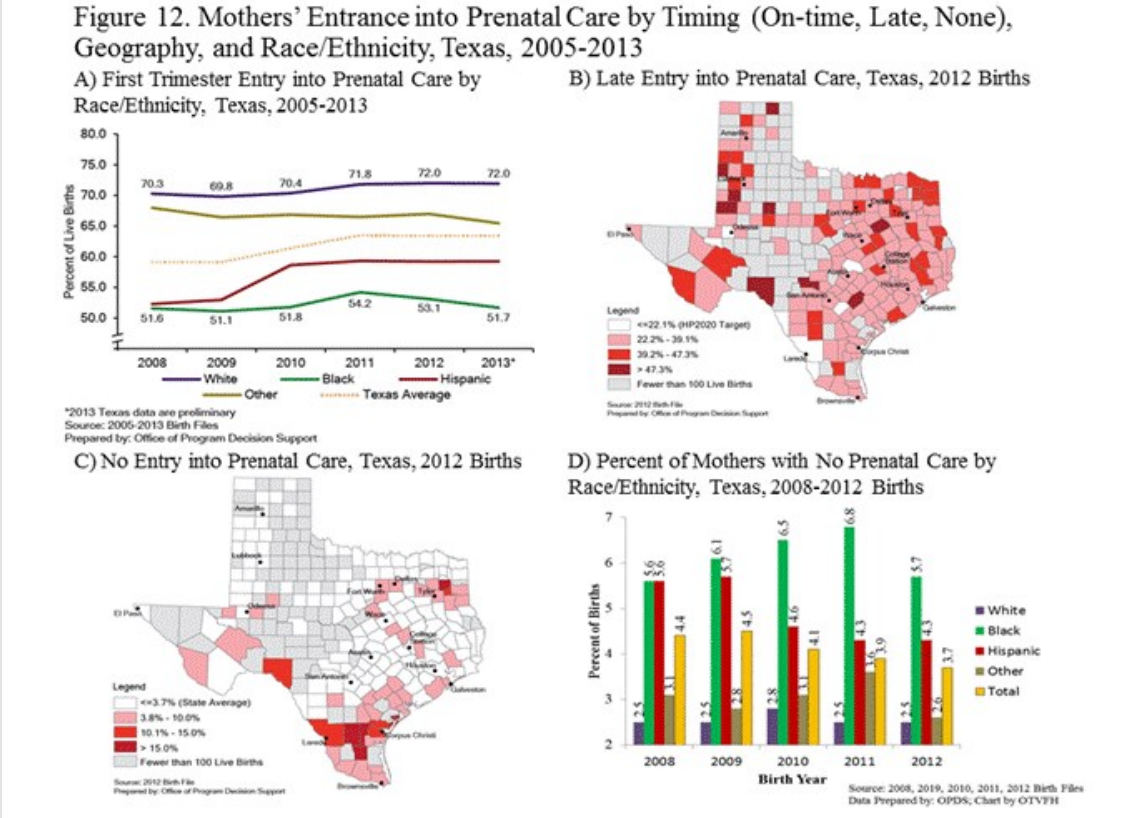


Error Bars: 95% Confidence Interval
Source: 2004-2011 Texas PRAMS
Prepared by: Office of Program Decision Support

Among Texas WCBA who were not trying to get pregnant at the time of conception of their last pregnancy, 54.7% reported neither they nor their partners were taking contraceptive measures.

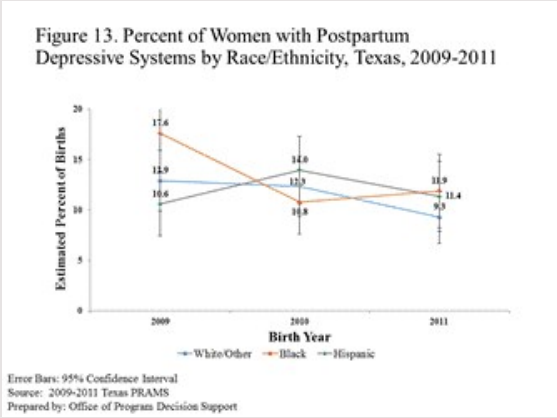
Prenatal Care

On-time prenatal care has increased in Texas since 2008 but no population group has reached the 77.8% HP2020 objective. Only 64.5% of women had their first visit in the first trimester (Fig 12A). Texas's low on-time prenatal care utilization is a statewide problem (Fig 12B), and in some geographic areas a substantial proportion of pregnant women receive no prenatal care (Fig 12C). Black and Hispanic women had higher rates of no prenatal care (Fig 12D).



Mental Health

In 2011, 10.6% of women reported postpartum depressive symptoms, varying across race/ethnicity from 9.3% among Whites to 11.9% among Blacks (Fig 13).



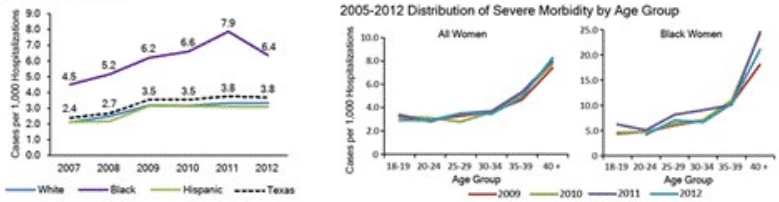
Severe Maternal Morbidity and Mortality

Texas' rate of severe morbidity among pregnancy-related hospitalizations has remained steady since 2009, with rates almost twice as high among Black women as those of White or Hispanic women (Fig 14).

Figure 14. Severe Maternal Morbidity Rate and Distribution by Age Group, Texas

A) Severe Maternal Morbidity Rate by Race/Ethnicity, Texas, 2007-2012 Hospitalizations.

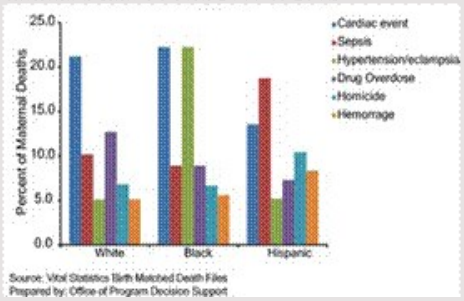
B) Distribution of Severe Maternal Morbidity by Age Group, Texas, 2005-2012 Hospitalizations



Source: 2005-2012 Texas Hospital Discharge Public Use Data: Risk of Mortality High & Extreme for Identified Deliveries
Prepared by: Office of Program Decision Support, FCHS, DSHS, 2014

The 2011 Texas maternal mortality rate was 24.4-30.7 deaths per 100,000 live births using death certificate coding. Among all recently pregnant women, excluding motor vehicle and cancer deaths, the leading two causes of death were cardiac events and hypertension/eclampsia (Fig 15), which disproportionately affect Black women.

Figure 15. Most Prevalent Causes of Death, Texas Maternal Death Cohort, 2011 & 2012



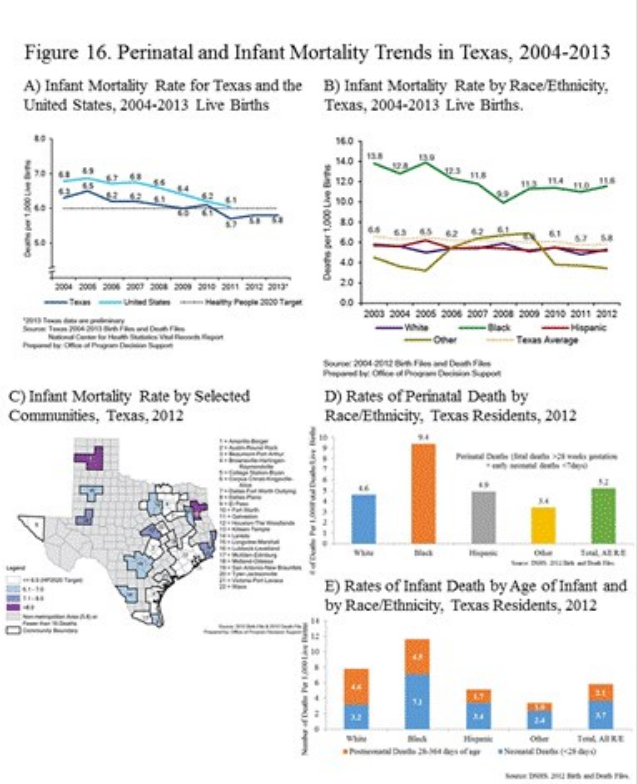
Texas data reveal rising rates of chronic conditions (e.g. diabetes, hypertension, obesity) and smoking among pregnant women in specific regions and sub-population groups. Furthermore, over half of pregnancies in Texas are unintended, and just over half of women who had an unintended pregnancy report neither they nor their partner were doing anything to keep from getting pregnant. Less than 67% of Texas women had a routine checkup in the last year, and focus group participants expressed a need for greater access to care, improvements in coordination of services and assistance navigating the health care system.

Significant disparities persist throughout the women's and maternal health indicators. These findings reveal a need to focus on prevention efforts including improved access to/quality of care before conception in order to identify and manage chronic conditions, assess reproductive plans and risks to reproductive health, and counsel on adopting healthy behaviors to prevent adverse health, pregnancy and birth outcomes.

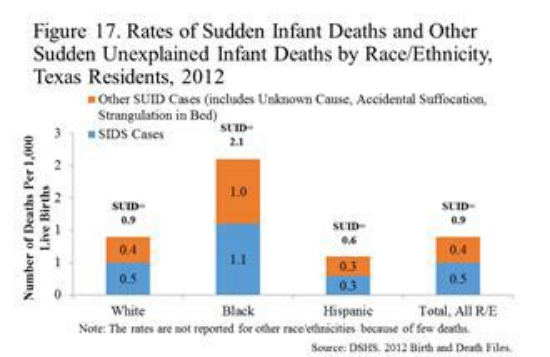
Perinatal/Infant Health

<u>Infant Mortality</u>

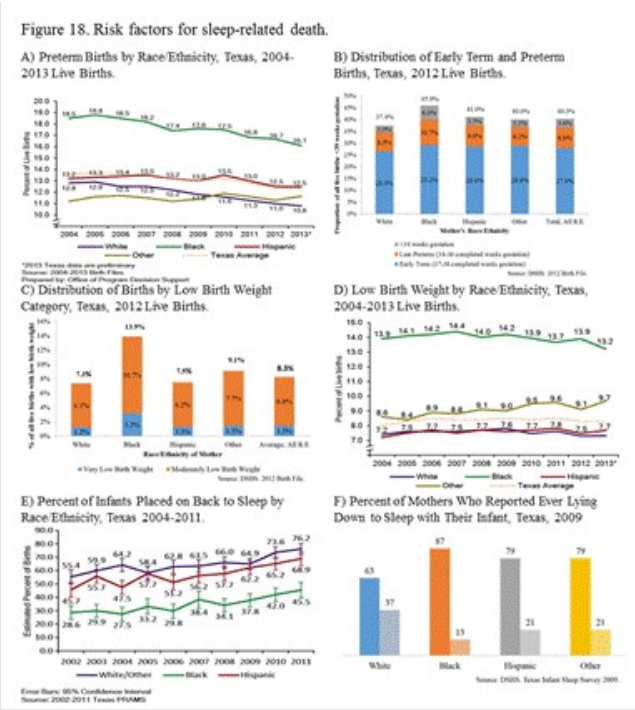
Infant mortality is associated not only with maternal factors like race/ethnicity, age, education, smoking and health status, but also with the conditions of the community in which a mother lives such as quality/access to health care, socioeconomic conditions and public health practices. Thus infant mortality is considered an indicator of national health and wellbeing. Texas' infant mortality rate (IMR has decreased over the past decade, meeting the HP2020 target of 6.0 deaths per 1,000 live births for the first time in 2009 (Fig 16A). Yet geographic and racial/ethnic disparities (Fig 16B-C) persist. In 2012, the Black IMR was about twice the state IMR in the peri-, neo- and post-neonatal periods (Fig 16D-E).

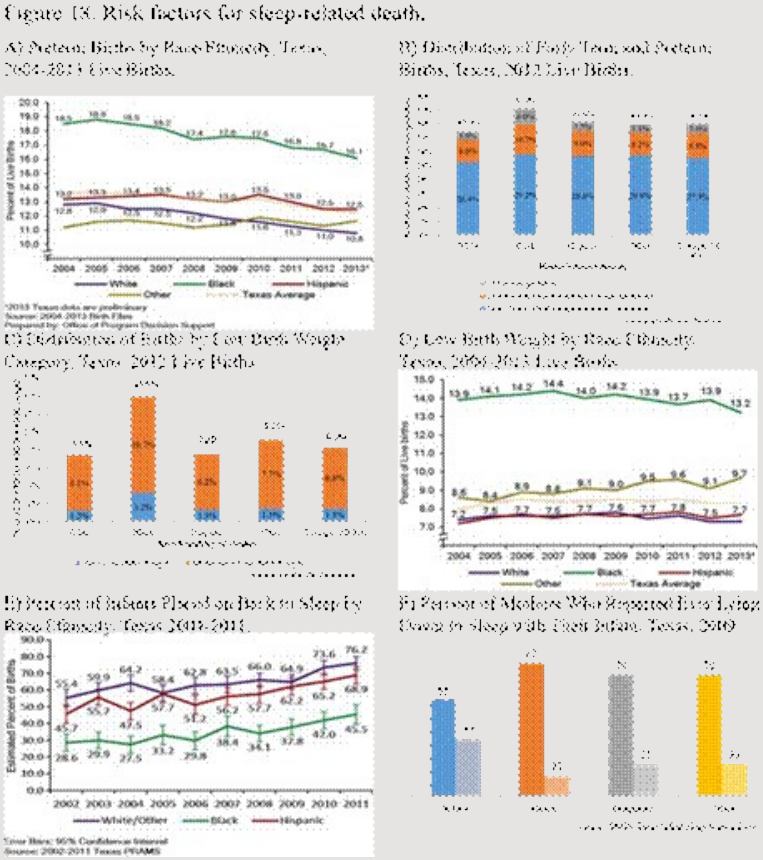


Sleep-related infant death (SUID, including SIDS) is the leading cause of postneonatal death and the third leading cause of infant death, after birth defects and preterm-related complications. About half of all Texas SUIDs in 2012 were attributed to SIDS. SIDS/SUID rates were much higher for infants born to Black mothers than other racial/ethnic groups.



Black infants are disproportionally burdened with factors[vii] associated with risk for sleep-related death (Fig 18). Preterm birth occurred in 16.1% of all births to Black mothers in 2013 (Fig 18A), and 46% of births to Black mothers were either early term or preterm in 2012 (18B). The proportion of LBW (Fig 18C-D) births among Black infants has consistently exceeded the state average. Black infants have had significantly lower rates of being placed to sleep in the supine (back) sleep position (Fig 18E) than infants of other race/ethnicities. Black women have higher rates of late entry in to prenatal care and inadequate prenatal care than women of other race/ethnicities (Fig 12). White women had the highest prevalence (9.1%) of prenatal smoking in 2013 (Fig 45) but Black women (4.3%) also fell behind the HP2020 objective to increase abstinence from cigarette smoking among pregnant women to 98.6%. Black mothers who recently gave birth report high rates of allowing smoking in their homes (Fig 48) and of ever lying down with their infants (Fig 18F). Black mothers also report lower rates of breastfeeding initiation, duration and exclusivity than other mothers, and are more likely to report experiencing barriers to breastfeeding in their homes, workplace and health care.



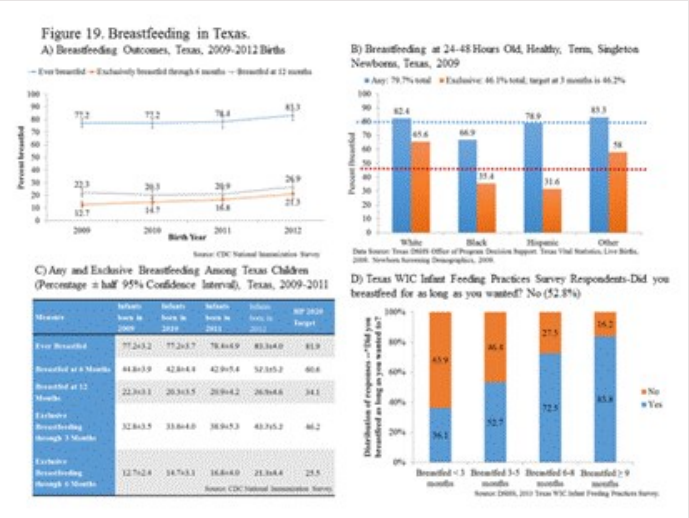


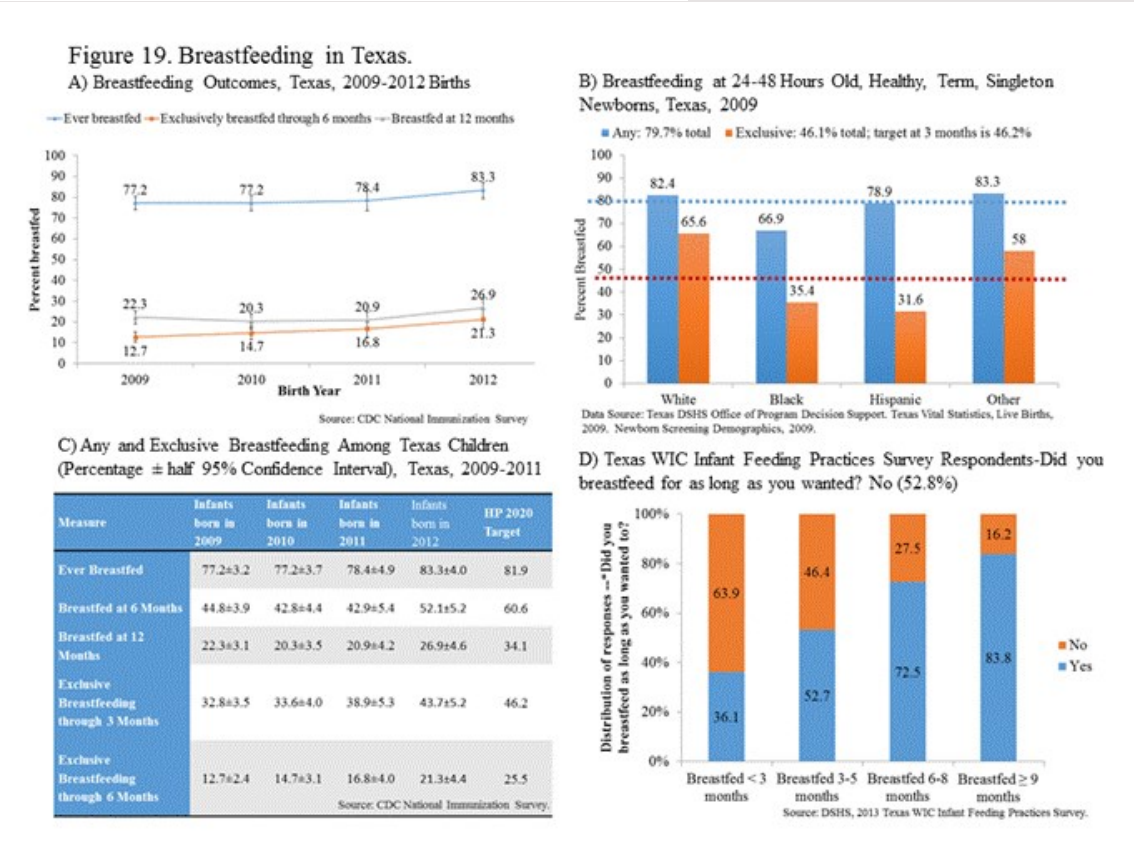
A data-linking and analytic project identified that 7.7% of all sleep-related deaths in 2010-12 were classified as confirmed abuse/neglect deaths. Analysis revealed that risk factors associated with these abuse/neglect-related cases were similar to known risks of all sleep-related deaths. Aiming for primary prevention (of SUID/SIDS and other preventable deaths), DFPS and DSHS developed a strategic plan to address sleep-related deaths at state and local levels.

Breastfeeding

Breastfeeding is a primary determinant of health, impacting health outcomes of women and their children throughout the lifespan. Over $31 billion[viii] per year in excess pediatric and maternal health related costs and significant maternal and infant morbidity and mortality occur in the United States related to suboptimal breastfeeding.

While 78.4% of Texas infants born in 2011 were ever breastfed, suboptimal breastfeeding exposed more than fourth- fifths of infants to excess health risks. Fewer than 17% of Texas infants exclusively breastfed through six months and 20.9% achieved the minimum recommended duration of continued breastfeeding for one year or longer (Fig 19A). More than half of infants born in 2009 received formula by the second day of life (Fig 19B). Texas falls well below HP2020 breastfeeding targets (Fig 19C), and many Texas mothers report not meeting their personal breastfeeding goals (Fig 19D).



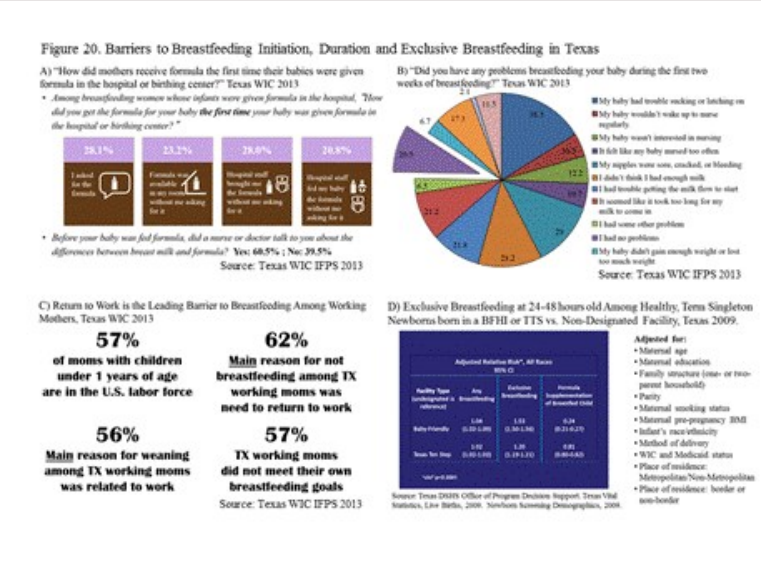


Measure	Infants born in 2009	Infants born in 2010	Infants born in 2011	Infants born in 2012	HP 2020 Target
Ever Breastfed	77.2±3.2	77.2±3.7	78.4±4.9	83.3±4.0	81.9
Breastfed at 6 Months	44.8±3.9	42.8±4.4	42.9±5.4	52.1±5.2	60.6
Breastfed at 12 Months	22.3±3.1	20.3±3.5	20.9±4.2	26.9±4.6	34.1
Exclusive Breastfeeding through 3 Months	32.8±3.5	33.6±4.0	38.9±5.3	43.7±5.2	46.2
Exclusive Breastfeeding through 6 Months	12.7±2.4	14.7±3.1	16.8±4.0	21.3±4.4	25.5

Source: CDC National Immunization Survey.

State data illustrate the range of barriers that mothers face with breastfeeding in health care, communities, and in

employment (Fig 20A-C).



Qualitative data from a variety of focus groups[1] reinforce the importance of population-based activities aimed at changing the policy, system and environmental context in which infant feeding decisions are made so that women who want to breastfeed are supported in meeting their breastfeeding goals. For example, infants who are born in hospitals that partially (TTS) or fully (BFHI) implement an evidence based bundle of maternity practices known as the Ten Steps to Successful Breastfeeding (Ten Steps) are significantly more likely to exclusively breastfeed in their second day of life than they would be if they were born in a non-designated facility (Fig 20D). Additional maternity care practices, including birth practices, are also known to impact breastfeeding outcomes and are a focus for improvement through efforts of TCHMB and other DSHS initiatives.

DSHS implements a comprehensive program of breastfeeding support, including a continuum of initiatives aimed at increasing uptake of the Ten Steps, and the Texas MFW (a nationally recognized Practice Tested Intervention) to increase workplace breastfeeding support. All activities coordinated and implemented by the DSHS State Breastfeeding Coordinator in consultation with the DSHS IFW. The IFW works with local, state, and national partners to accomplish the goals of its strategic plan, and has numerous successes in leveraging and integrating lactation support to improve outcomes.

Child Health

Child Fatalities

The leading causes of non-natural death for children 1-14 years of age in Texas are unintentional injury, including drowning and motor vehicle crashes, and homicide caused by child maltreatment.

Figure 21: Top Ten Leading Causes of Death by Age Group, Texas 2009-2013, All Races, Both Sexes

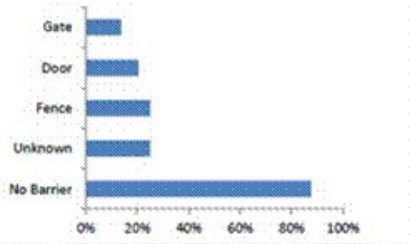
	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 2,614	Unintentional Injury 802	Unintentional Injury 389	Unintentional Injury 425	Unintentional Injury 5,964	Unintentional Injury 6,439	Unintentional Injury 5,826	Malignant Neoplasms 18,018	Malignant Neoplasms 38,940	Heart Disease 145,810	Heart Disease 193,688
2	Short Gestation 1,613	Congenital Anomalies 230	Malignant Neoplasms 232	Malignant Neoplasms 233	Suicide 2,065	Suicide 2,475	Malignant Neoplasms 4,656	Heart Disease 14,149	Heart Disease 27,278	Malignant Neoplasms 121,324	Malignant Neoplasms 186,213
3	SIDS 931	Malignant Neoplasms 213	Congenital Anomalies 63	Suicide 124	Homicide 1,865	Homicide 1,760	Heart Disease 4,266	Unintentional Injury 7,327	Unintentional Injury 5,588	Chronic Low Respiratory Disease 38,993	Unintentional Injury 46,879
4	Maternal Pregnancy Comp. 713	Homicide 169	Homicide 50	Homicide 69	Malignant Neoplasms 754	Malignant Neoplasms 1,612	Suicide 2,551	Liver Disease 4,278	Chronic Low Respiratory Disease 5,146	Cerebro-vascular 37,116	Chronic Low Respiratory Disease 45,991
5	Unintentional Injury 445	Heart Disease 92	Heart Disease 45	Congenital Anomalies 66	Heart Disease 443	Heart Disease 1,384	Homicide 1,173	Suicide 3,061	Diabetes Mellitus 4,966	Alzheimer's Disease 25,812	Cerebro-vascular 45,970
6	Placenta Cord Membranes 443	Influenza & Pneumonia 47	Chronic Low Respiratory Disease 33	Heart Disease 59	Congenital Anomalies 166	HIV 446	Liver Disease 1,103	Cerebro-vascular 2,663	Liver Disease 4,928	Diabetes Mellitus 16,664	Alzheimer's Disease 26,156
7	Bacterial Sepsis 312	Chronic Low Respiratory Disease 32	Influenza & Pneumonia 29	Influenza & Pneumonia 29	Complicated Pregnancy 105	Diabetes Mellitus 292	HIV 936	Diabetes Mellitus 2,296	Cerebro-vascular 4,840	Nephritis 13,996	Diabetes Mellitus 25,117
8	Neonatal Hemorrhage 266	Septicemia 30	Cerebro-vascular 24	Chronic Low Respiratory Disease 28	Cerebro-vascular 103	Cerebro-vascular 261	Cerebro-vascular 877	Chronic Low Respiratory Disease 1,499	Septicemia 2,551	Unintentional Injury 13,563	Nephritis 18,216
9	Respiratory Distress 243	Perinatal Period 26	Septicemia 13	Cerebro-vascular 27	Influenza & Pneumonia 92	Complicated Pregnancy 253	Diabetes Mellitus 831	Septicemia 1,329	Nephritis 2,471	Influenza & Pneumonia 12,463	Septicemia 17,219
10	Circulatory System Disease 230	Benign Neoplasms 23	Benign Neoplasms ---	Septicemia 17	Two Tied 72	Influenza & Pneumonia 223	Septicemia 481	HIV 1,279	Suicide 2,249	Septicemia 12,420	Influenza & Pneumonia 16,777

Source: CDC WISQARS

Drowning

The drowning mortality rate from 2006 to 2012 for children 1-4 years of age is 3.5 per 100,000 and 0.7 per 100,000 for children 5-15. CFRT review of drowning deaths in 2011 noted 56% of drowning fatalities occurred in private swimming pools. In 2011, 88% of these drowning deaths had no barrier present to prevent or deter a child from entering the pool. Poor supervision was a contributing factor in 59% of the drowning fatalities to children younger than 5 years of age and abuse/neglect was confirmed in 31.8% of cases.

Figure 22: Percentage of Private Pool Deaths by Barrier Type

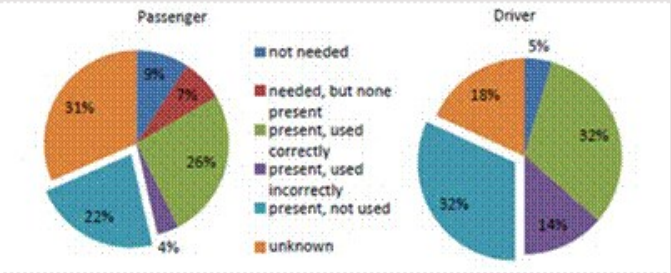


Source: CFRT 2013 Annual Report

Motor Vehicle Crashes

TxDOT 2013 data showed that 35% of children 1-14 years of age who died in motor vehicle crashes were unrestrained, with children 10-14 year olds having the lowest restraint use (25%) among fatalities. Eleven percent of children 1-14 years of age involved in motor vehicle crashes were seriously injured. CFRT data for 2011 deaths showed that 54% of drivers and passengers had safety restraint present in the vehicle but was not used. Using child safety seats and booster seats saves lives and reduces injury and related health care expenditures.

Figure 28 Motor Vehicle Deaths by Seat Belt Usage and Position



Source: CFRT 2013 Annual Report

Non-Fatal Injury

Unintentional non-fatal injuries are the most common reason for hospitalization in early childhood. These injuries can lead to significant lifelong struggles and disabilities. Traumatic brain injuries are often associated with unintentional injuries resulting from falls or MV crashes. Falls in early childhood vary significantly by age and account for 53% of hospitalizations for non-fatal injuries in Texas.

Table 3. Top Five Categories of Non-Fatal and Fatal Injuries among Children in Texas

Top 5 Non-Fatal Injury Categories			
Rank	Cause of Injury	#	%
1	Fall	54,755	47.93%
2	Motor vehicle/ traffic	23,948	20.96%
3	Struck by, against	9024	7.90%
4	Cut/ pierce	5228	4.58%
5	Transport, other	4711	4.12%

Top 5 Fatal Injury Categories			
Rank	Cause of Injury	#	%
1	Fall	1132	35.18%
2	Motor vehicle/ traffic	1110	34.49%
3	Firearm	457	14.20%
4	Struck by, against	127	3.95%
5	Other, specified	72	2.24%

Not mutually exclusive
Records contain up to five ICD-9 e-codes; these counts are the number of times each cause of injury code was reported, not the number of hospitalizations based on a framework detailed by the Centers for Disease Control and Prevention. For more details, visit http://www.cdc.gov/nchs/injury/injury_tools.htm

TEXAS

www.dshs.state.tx.us/injury

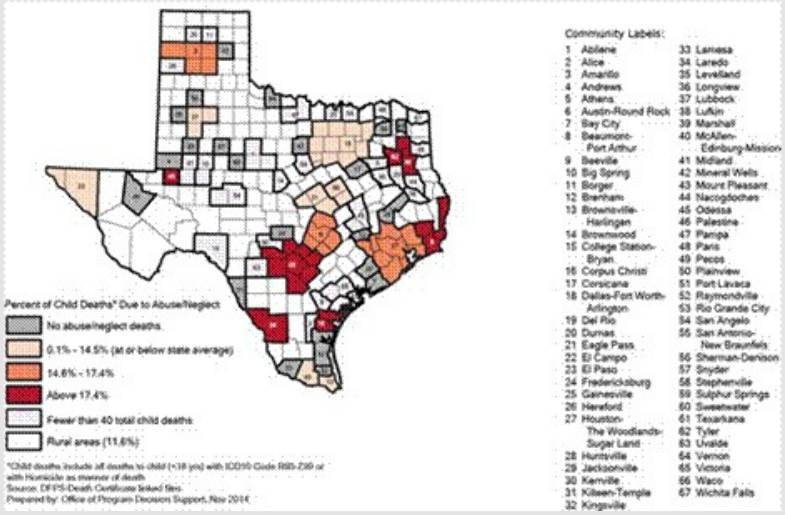
Child Maltreatment

The Adverse Childhood Experiences Study demonstrated a link between violence-related stressors (e.g. child abuse, neglect and repeated exposure to intimate partner violence) and risky behaviors and health problems in adulthood. [ix]

DFPS reported 168,164 Texas children were suspected of being neglected or abused in FY14. Of those, 66,572 children were confirmed victims, mostly of neglect, including neglectful supervision and, less frequently, medical/physical neglect. Of the confirmed abuse, 23% were due to physical, sexual or emotional abuse. Rates varied by race/ethnicity, as 44% of confirmed cases were Hispanic, 33% White, 16.8% Black, 6.1% “Other” and

0.1% Native Americans. Parents and other family members were perpetrator in nearly 97% of these cases. [x]The homicide mortality rate from 2006 to 2012 for children aged one to four years of age is 2.7 per 100,000 population and 0.7 per 100,000 population for children ages five to fourteen years.

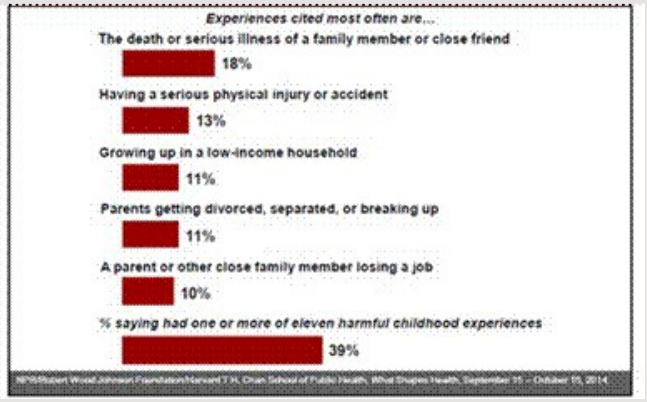
Figure 24. Percent of Child Deaths* that were Abuse/Neglect by Community, 2016-2017



Adverse Childhood Experiences

Several health risks can emerge during early childhood that can lead children to negative health effects that disrupt early brain development and compromise their nervous and immune systems. Childhood toxic stress can lead to later health problems including alcoholism, depression, eating disorders, heart disease, cancer and other chronic diseases. The NPR/Robert Wood Johnson Foundation/Harvard School of Public Health's *What Shapes Health* study indicated nearly 39% of Americans reported at least one childhood experience they believe had a harmful effect on their health later in life.

Figure 25. Childhood Experiences that Americans Believe Had a Harmful Effect on their Health Later in Life



Child Development

Safe, stable, nurturing relationships and environments between children and their caregivers provide a buffer against the effects of potential stressors and are fundamental to healthy brain development. Research shows that evidence- based home visiting programs are cost effective parenting programs proven to improve child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness.

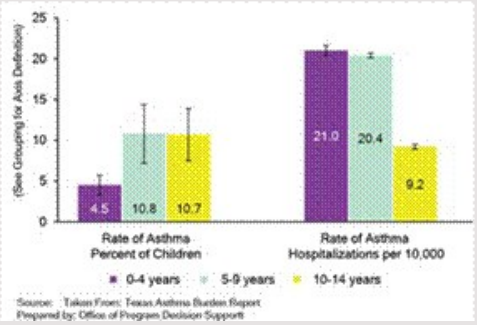
The NSCH 2012 noted that 36.2% of Texas children were at risk of developmental behavior problems between the ages of 4 months to 5 years, but only 30.4% of children between 10 months and 5 years received standardized screening for development of behavior problems. [x]Stakeholder meetings, webinars, surveys and focus groups identified concerns about developmental and behavioral outcomes, child development information, parenting support, availability of mental and behavioral health providers, and other related community supports. Opportunities for improvement exist as a result of

SAMHSA funding for the State Project LAUNCH grant and partnerships with many stakeholders to expand services to improve positive parenting, developmental screening and school readiness.

Asthma

Asthma is the most common chronic condition among children. [xiii] The 2014 Burden of Asthma Report estimated 9.1% of Texas children 0-17 years old have asthma. Children 0-4 years old have the lowest reported prevalence of asthma, but the highest hospitalization rate (Fig 26). This low prevalence and high hospitalization rate likely correspond with the child's initial diagnosis of asthma. Children 5-9 years old have a hospitalization rate of 20.4 per 10,000 but a prevalence rate similar to the state average [xiv], likely corresponding to the time period when parents and children are learning to control the asthma.

Figure 26. Asthma Prevalence and Hospitalization Rates by Age, Texas 2013

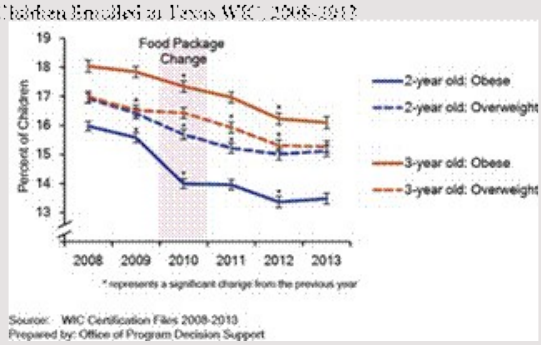


Hospitalization rates provide a picture of the extent to which asthma is controlled. Medicaid claims data reveals race/ethnic differences showing that black children are more likely to be in the hospital for their asthma than children of other race/ethnic groups. Ethnic differences in asthma prevalence, morbidity and mortality are highly correlated with poverty, urban air quality, indoor allergens, lack of patient education and inadequate medical care which decrease likelihood of asthma control. [xv] Asthma is the leading cause of chronic school absenteeism. [xvi]According to the 2006-10 BRFSS asthma survey, 53.9% of children with asthma missed school in the preceding year and 43.2% reported having an active school asthma management plan.

Obesity

Texas WIC 2008-13 data revealed significant decreases in the percent of obese two- and three-year olds receiving WIC services since major food packet and policy changes were implemented in 2009-10.

Figure 27. Changes in Obesity and Overweight in 2 and 3 year old Children Enrolled in Texas WIC, 2008-2013



The longitudinal change in BMI seen in the WIC population shows individual BMI generally increases from age two to age three. The extent of this BMI gain differs by race/ethnicity, with Hispanic children showing the biggest gains. Children whose mother was enrolled in WIC in 2012-13 had lower BMI at age three than those enrolled in 2008-09 before the food package change.

A common theme among all focus groups (CYSCHN and Title V mothers and father) was that parents felt they lack the tools to influence their young children's food choices. All focus groups expressed a lack of knowledge on how to get their children to

eat healthier food.

The Texas SPAN Survey indicates that fourth grade students, on average, engage in just over 30 minutes of vigorous physical activity 3.3 days a week. Parents' perception of neighborhood safety influences this level of physical activity. [xvii] Parents in the Title V focus groups expressed concern about neighborhood safety as a factor for letting their children play outside.

Poverty

The 2015 State of Texas Children Annual Kids Count Report noted that 25% (1,741,000 children) live in poverty. Though Texas' unemployment rate is 5%, many working families struggle to keep their children out of poverty and 18% of Texas households experience food insecurity. Texas is ranked 43rd in the nation for children having consistent access to food. SNAP is the most widely used federal nutrition program in Texas; 62% of SNAP beneficiaries are children. Almost 1 million women, infants and children ages 1-4 received WIC food vouchers.

Access to Health Care

Texas is ranked 49th nationally for the percentage of children with health insurance. Children without health insurance are more likely to have poorer health, experience higher rates of hospitalization, miss regular che[xviii], go without diagnostic screenings and critical preventative care, and have greater unmet mental health needs. Medical homes help provide coordinated comprehensive health care. In Texas, 51.8% of children received care within a medical home (Fig 28), however, national data indicates that the prevalence of medical home decreases as children get older.

Based on focus groups, surveys, stakeholder meetings and partner webinar feedback, childhood unintentional injuries and deaths are major concerns. DSHS and DFPS are partnering to reduce child injuries and deaths due to MV crashes, drowning and maltreatment. DSHS supports a strong infrastructure around the state to implement injury prevention initiatives through CFRTs and Safe Riders.

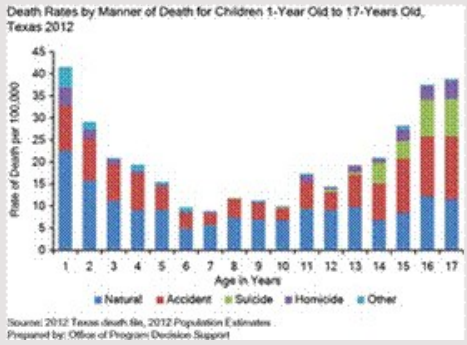
Adolescent Health

Youth gain 50% of their adult body weight, become capable of reproducing and experience major changes in their brains. All of these changes occur in the context of rapidly expanding social spheres and self-experimentation that is not always balanced. Understanding youth risk factors can help DSHS address this population's needs. Data presented here represent many of the risk factors that Texas youth face.

Fatalities

During the birth to 18 year range, the adolescent period has the second highest death rate after the infancy/early toddler period. Youth 15-17 years old have high rates of death from unnatural causes whereas infants/toddlers have high rates of death from natural causes (Fig 29).

Figure 29: Mortality Trends by Cause of Death and Age, Texas 2008-2012



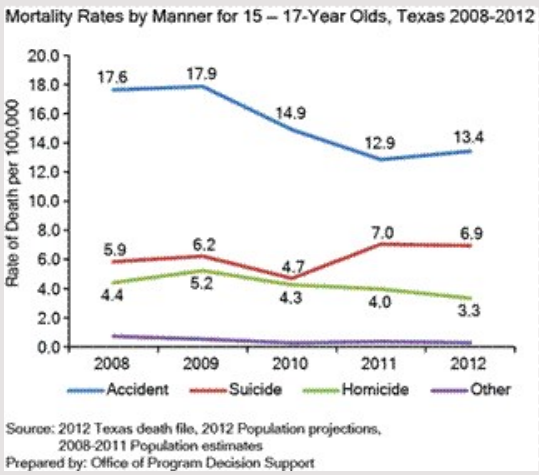
Motor Vehicle Crashes

Motor vehicle crashes are the leading cause of accidental death for 15-17 years of age (Fig 30). Since 2008, the rate of

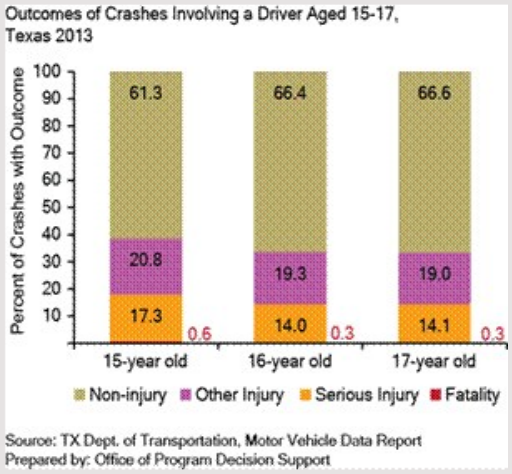
motor vehicle fatalities for this group has declined by 30.7%. In 2011, Texas local CFRTs examined motor vehicle deaths and found that in 32% of deaths, the victim was the driver. In all but one of these cases, the driver was between 15-17 years old.

Figure 30. Mortality by Cause and Crash Outcomes for 15-17 year olds, Texas 2008-2012

A

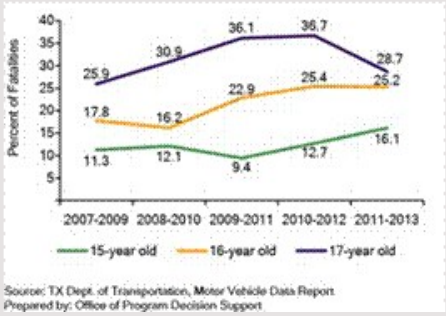


B



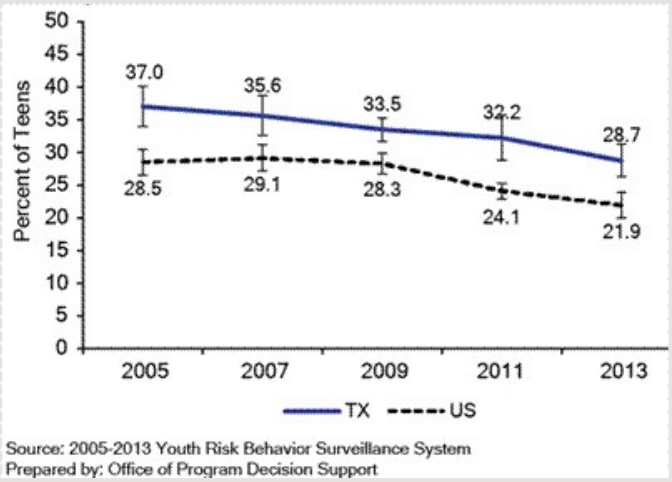
TxDOT 2013 reported drivers and passengers 15-17 years old were unrestrained in 56.8% of the motor vehicle fatalities. In 2011, Texas CFRT data showed the teen driver was unrestrained in 32% of reviewed teen driver deaths. Youth are also at risk of being in a crash when driving while intoxicated. In 2013, youth ages 15-17 driving under the influence of alcohol accounted for 1.56% of all DUI crashes in rural counties and 0.75% in urban counties (Fig 31).

Figure 31. Percent of Fatalities of Each Age Where a Driver Was Under the Influence, Texas 5-Year Rolling Percent 2007-2013



In YRBSS 2013, 28.7% of Texas youth reported they were a passenger in a vehicle with a driver who had been drinking alcohol. (Fig 32) Although decreasing since 2005, Texas' rate was still significantly higher than the national average.

Figure 32. Rate of Youth Passengers Who Rode with a Driver Who Had Been Drinking Alcohol, 2005-2013

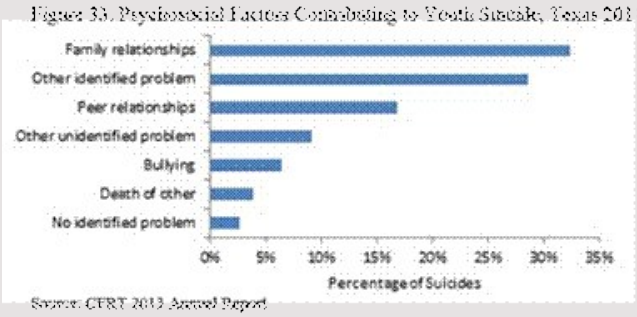


Suicides

Since 2008, suicide rates among 15-17 year olds have risen 17%. While this age group has the highest risk for suicide among all children under 18 years old, about 25% of child suicides in Texas in any given year are to youth under 15 years old.

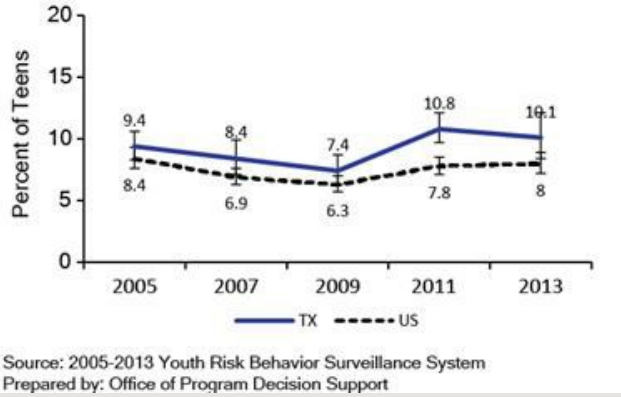
CFRTs examined youth suicides in Texas and identified contributory psycho-social factors (Fig 33).

Figure 33. Psychosocial Factors Contributing to Youth Suicide, Texas 2011



The link between depression, anxiety and suicidal behaviors is well established but there is a discrepancy between the prevalence of diagnosed depression and the percent of youth reporting attempting suicide. Based on 2011 YRBSS data, 10.1% of youth in grades 9-12 had attempted suicide in the past year (Fig 34), almost five times the rate of youth with diagnosed depression.

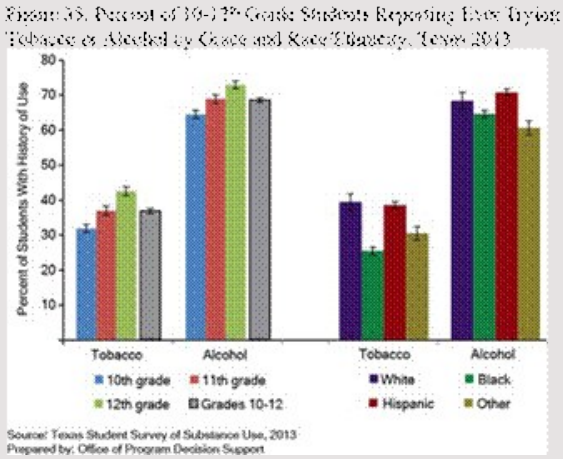
Figure 34. Percent of Youth Grades 9-12 Who Attempted Suicide
(one or more times in the 12 months preceding the survey), YRBSS 2011



Significantly more female youths reported suicide attempts than male youths, but there were no significant gender differences in depression history. Other psycho-social factors may contribute to suicide predisposition or there may be a significant portion of youth with undiagnosed/unrecognized depression.

Substance use

Focus group parents said top concerns for their adolescents were exposure to drugs, alcohol and sexual activity. According to the TSSSU, 42.3% of students in grade 12 had tried cigarettes and alcohol was the most prevalent substance tried at least once by 10-12th grade students. The rate of ever trying alcohol increased with grade level and varied by race/ethnicity (Fig 35).

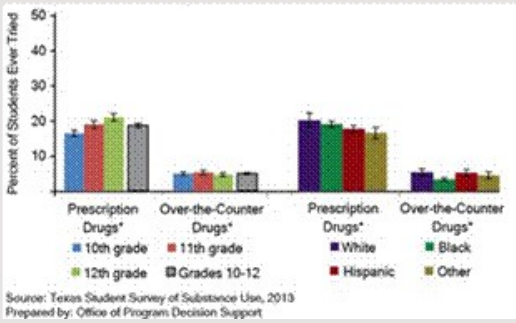


Binge drinking was reported by 25% of youth on the TSSSU. As with alcohol use, rates were significantly higher among White and Hispanic youth than Black youth.

Marijuana is the most frequently used illicit substance among youth. Marijuana-alcohol co-use prevalence is important to understand the public health and potential injury impact for adolescents. In Texas, 12.1% of 10-12$_{th}$ grade students reported using both marijuana and alcohol in the past month.

The Title V Community Outreach Survey identified abuse of prescription drugs as a community concern. Fig 36 supports this concern.

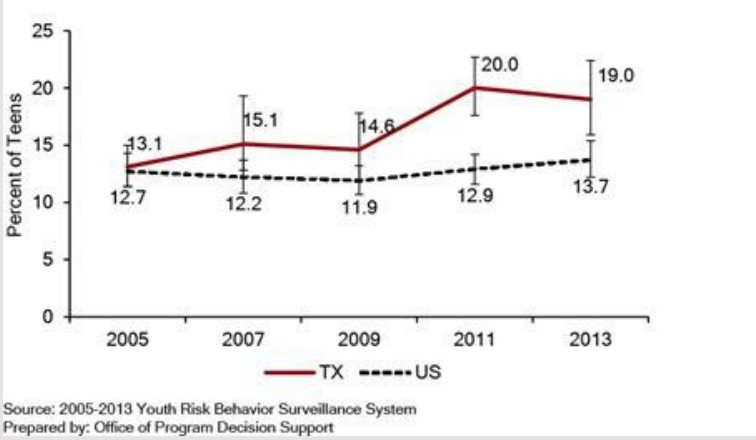
Figure 36. Percent of 10-12th Grade Students Reporting Ever Trying Prescription or Over-the-Counter Drugs for Recreational Use by Grade and Race/Ethnicity, Texas 2013



Sexual Behaviors

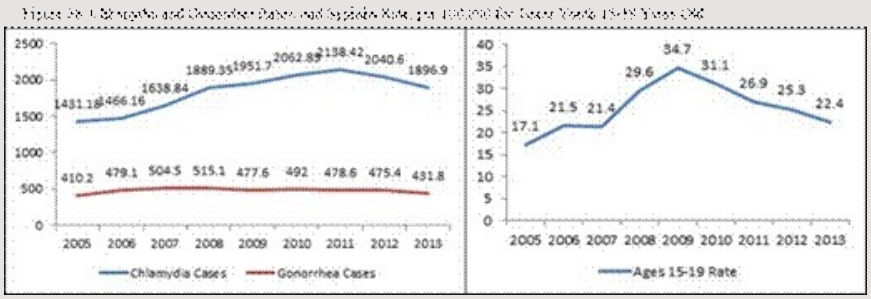
YRBSS 2013 estimated 45% of Texas 9-12 grade students have had sexual intercourse. Texas has the 12th highest prevalence rate for sexual intercourse and the third highest adolescent pregnancy rate in the nation. Among currently sexually active students, 19% reported having unprotected sex (Fig 37), the highest of the 31 states monitoring this through YRBSS.

Figure 37. Percent of Youth Grades 9-12 Who Did Not Use Any Method to Prevent Pregnancy (during last sexual intercourse among students who were currently sexually active), YRBSS 2013



Sexually Transmitted Infections (STIs)

Chlamydia and gonorrhea are the two most prevalent STIs among youth ages 15-19 and have increased since 2005. The rate of syphilis among youth also increased since 2005, peaking in 2009 (Fig 38).

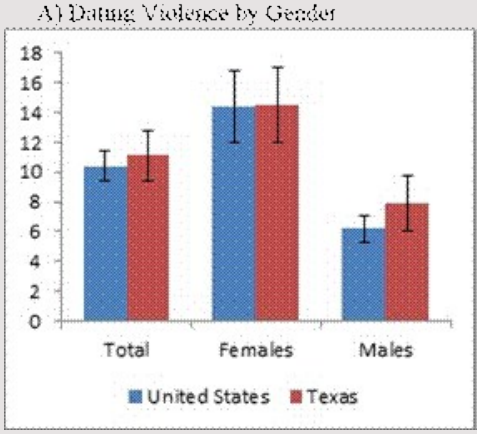


Dating and Intimate Partner Violence

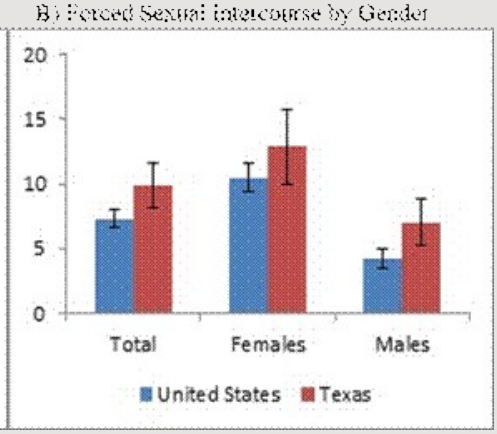
Dating and IPV can frequently result in bodily injury, either in the actual act or the reaction to resistance (Fig 39 A&B). Fewer than half of the respondents to the Title V Community Outreach Survey with children under 18 years old knew where to find information or resources about dating violence. Schools were noted as the most common place where parents received this information.

Figure 39. Gender-Based Violence Among Youth, YRBSS 2013

A) Dating Violence by Gender



B) Forced Sexual Intercourse by Gender



Obesity

The Title V Community Outreach Survey indicated overweight/obesity and the lack of exercise/physical activity as a top health concern. In Texas, obesity rates are lower for older students than younger students. SPAN 2009-11 found 59.6 of 8th grade students and 64.7% of 11th grade students were at healthy weight.

Some students' perceived weight differs from their actual weight. SPAN data shows this perception gap at both the low and high ends of the BMI scale. The relationship between perceived body weight, actual BMI, and history/risk of being bullied affects males more than females.

The risk factors that may not immediately be associated with injury are still part of the equation in the overall wellbeing of youth. Adolescents' potential to be involved in more than one risky behavior multiplies the chances of injury. According to the Children's Safety Network, unintentional injuries are the leading cause of death among adolescents and a leading cause of medical spending for adolescents ages 11-18. Preventing injury often costs less than treating the effects of injuries. Coordinated efforts among agencies and organizations may help reduce injuries and their consequences.

Children with Special Health Care Needs

The 2009-10 NS-CSHCN shows 13.4% of Texas children (versus 15.1% nationally) had special health care needs. Of those children identified as CYSHCN within Texas, 39.4% were Hispanic and 1/3 spoke Spanish as the primary household language [xix], consistent with the state as a whole. In addition to the increase in the state's population, the Texas Birth Defects Registry has seen an increased incidence of children with Down syndrome and congenital heart defects.

Texas has a greater proportion of children under 5 years of age living below 100% FPL (12.5%) than any other state [xx]. In Texas, 21.9% of CYSHCN lived below the poverty level, comparable to national rates (22.2% nationwide).[xxi]

According to the American Community Survey, among children younger than 18 years, Texas ranked 49th for children with health care coverage. [xxii] At the time of the 2009-10 NS-CSHCN, 15.6% of CYSHCN had been without health care coverage at some point within the last year compared to 9.3% nationally.

Core System Indicators

Review of existing data, including the 2009-10 NS-CSHCN, indicates the wellbeing of CYSHCN in Texas is often below other CYSHCN throughout the nation. Texas ranked in the bottom quartile of states and territories in the outcomes of children receiving their care within a medical home (40.1% in Texas compared to 43% nationally) and those receiving the services necessary to make the transition to adult health care (35.4% in Texas compared to 40% nationally).

In addition, Texas ranked below the national average on three of the four remaining core outcomes: families of CYSHCN have adequate private and/or public insurance to pay for the needed services (57.9% in Texas compared to 60.6% nationally); children are screened early and continuously for special health care needs (76.8% in Texas compared to 78.6% nationally); and community-based services are organized so families can use them easily (56.6% in Texas compared to 65.1% nationally).

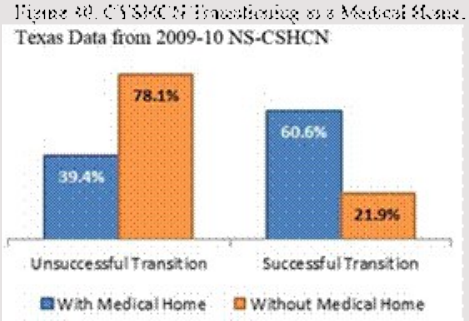
Transition

Transition is a dynamic, lifelong process that seeks to meet youth's individual needs as they move from childhood to adulthood.[xxiii] Transition and long-term planning can trigger anxiety and concern among parents. The 2014 CYSHCN Outreach Survey noted only 20% of respondents felt prepared for their child to transition to adulthood and over 40% indicated they had not prepared for transition.

A key finding from the focus groups of parents with CYSHCN was that families had a range of ideas about when transition planning should start, when transfer of care should happen, and of the various aspects of transition, including health care, education, social supports and legal domains. Parents in one Spanish speaking group were unaware of the term *transition* altogether. Others perceived no need to consider transition planning, noting their child's pediatrician agreed to continue to see them into adulthood.

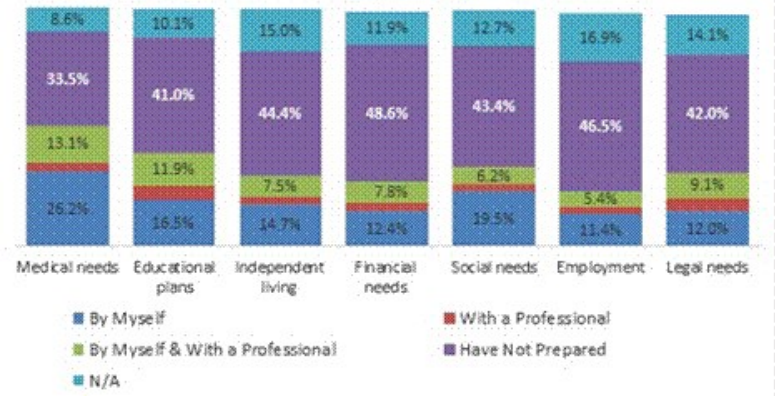
Medical homes help ease difficulties faced by families of transition-age youth. Ongoing coordinated care helps ensure CYSHCN transition to an adult model of care. However, as Texas children get older, fewer receive care within a medical home (43% of children ages 0-5, 40% of children ages 6-11, and 38% of children ages 12-17). [xxiv]

Figure 40. CYSHCN Transitioning to a Medical Home.



Most CYSHCN Outreach Survey respondents indicating they prepared for transition had done so alone (Fig 41). Focus group participants and stakeholders conveyed not having information regarding transition planning or written transition plans as barriers to transitioning to adult providers.

Figure 41. Who Has Helped You Prepare For Your Child's Transition to Adulthood, by Topic, Texas Data from CYSHCN Outreach Survey



Medical Home

Review of the 2009-10 NS-CSHCN shows receiving care within a medical home increases the likelihood other CYSHCN core systems outcomes, as well as transition will be met. Texas children who received care within a medical home were more likely to have consistent and adequate public or private insurance (73.2% versus 47.7%), more likely to meet the outcome for family partnerships (93.9% versus 54%), more likely to be screened early and continuously for special health care needs (82.4% versus 74.7%), and more easily access community-based services (78.2% versus 42.4%).

Providers

In the CYSHCN Outreach Survey, 77% of respondents indicated they have a usual source of sick care; however, 54.8% of respondents identified not having a medical provider where the family lives as a barrier. Stakeholder groups identified provider shortages, including primary and specialty care physicians and case managers. Participants also reported a lack of willingness by providers to work with CYSHCN. Stakeholders noted a limited number of dental providers and unwillingness of providers to accept complex patients particularly those with developmental disabilities. These barriers are most challenging for children who require intensive oral health treatment and/or anesthesia.

Stakeholders cited access to mental health services as a priority need. The majority of the counties in the state have too few school psychologists and psychiatrists. Most border counties in Texas qualify as mental health professional shortage areas.

Care Coordination

Comprehensive coordinated care within the medical home can help link CYSHCN and their families to necessary services and supports in the community. According the 2009-10 NS-CSHCN, less than one-quarter of CYSHCN in Texas received any help in arranging or coordinating care. The CYSHCN Outreach Survey cites coordination of care is a challenge, with 71.6% of respondents reporting they coordinate their child's care themselves (Fig 42).

Figure 42. Who Ensures Your Child Receives the Care He/She Needs, CYSHCN Outreach Survey

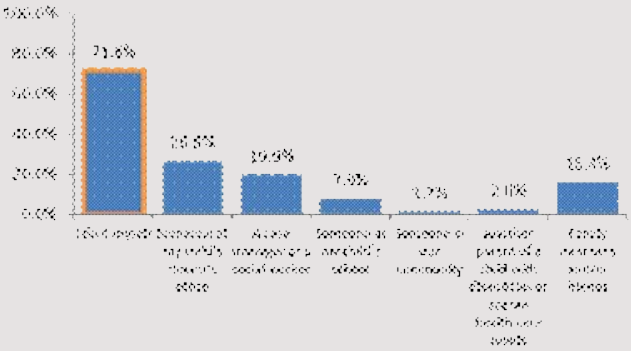
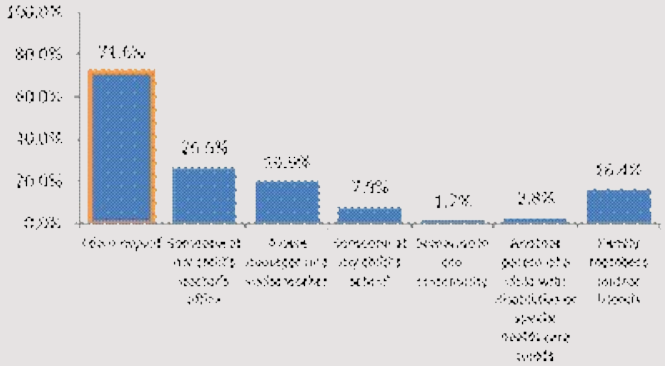


Figure 42. Who Ensures Your Child Receives the Care He/She Needs, CYSHCN Outreach Survey



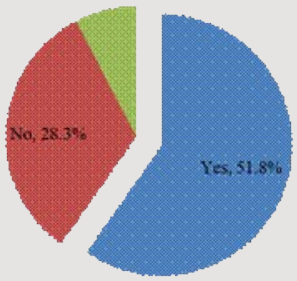
Stakeholder groups noted gaps in care occur when care is not coordinated among providers, including specialists, that lead to delays in referral and lack of continuity of care. Focus group parents noted care coordination is performed mostly by the parent and many were not familiar with the term. While some parents said they would not entrust this type of responsibility to anyone else, others thought having a care coordinator would enable them to work outside of the home.

Access and Availability of Resources

The 2009-10 NS-CSHCN indicated nearly one-quarter of CYSHCN nationally did not receive at least one of the services they needed. Stakeholder and focus group participants indicated lack of awareness of resources by both families and providers. Although there were some regional differences with regard to available resources and community activities, a general lack of access was a significant finding for all focus groups. Parents noted even though community resources may be available, they often cannot access them, due to difficulties in finding trustworthy caregivers, lack of extended family support, bias toward their children in public, and unaffordability. Families indicated they most frequently learn about resources from other parents. Families noted services are often offered during the standard workday, making it difficult to use them.

While the 2009-10 NS-CSHCN showed parents of 6.7% of CYSHCN nationwide reported a need for respite, the CYSHCN Outreach Survey noted 52% of parents in Texas indicated a need for respite (Fig 43). Stakeholder groups endorsed a need for caregiver respite. Parents in focus groups said respite provides an opportunity to spend time with other children, run errands, have dates with spouses, or just rest.

Figure 43. Parents Who Need a Short-Term Break or Respite, CYSHCN Outreach Survey



In the 2009-10 NS-CSHCN, Texas was higher than the national average in families reporting they received all of the respite needed in the last 12 months (63% versus 50.5%). Only 34% of families surveyed through the CYSHCN Outreach survey had received respite. Barriers included funding, provider restrictions, lack of knowledge and qualified trusted providers.

Lack of transportation was noted by 57.3% of families in the CYSHCN Outreach survey as an obstacle to seeking care for their child. Stakeholder groups reported people living in rural areas may not have access to public transportation and have to travel hundreds of miles for health care, while urban dwellers may have limited public transportation and costly fares. Family concerns included exposure to germs while ride-sharing, expense of transportation, and the public transportation systems itself. Parents using the Medicaid Transportation Program found it slow and time-consuming.

The CYSHCN Outreach Survey identified not having health insurance as a barrier (53.5%). Children without health insurance

are less likely to have a usual source of care [xxv]. While only 3.1% of respondents to the CYSHCN Outreach Survey indicated they had no form of health care coverage, 56.6% of parents indicated they cannot pay for all of their child's medical needs, and less than half (40.1%) of families reported insurance covers all of their child's medical needs.

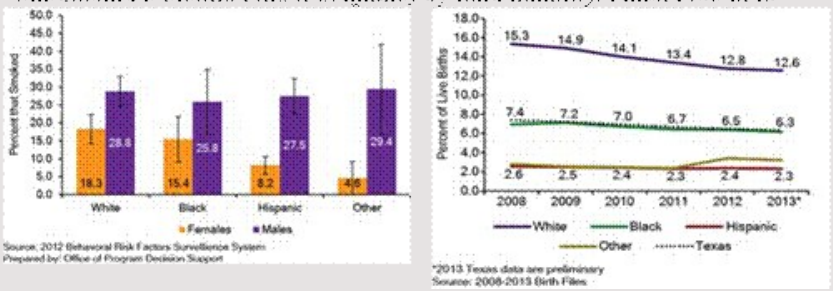
Community Integration

CYSHCN and their families live within their communities and have many of the same needs as those of typically developing children. The extent to which communities are accessible and welcoming minimizes the isolation experienced by many CYSHCN and their families. Most focus group participants said they feel alone in their journey regardless of the community's resources, accessibility or activities available. Home accessibility can be a major barrier to community engagement. One focus group parent lacked a ramp for her daughter's wheelchair so is rarely able to take her child anywhere. Others perceived their community as excluding them with harsh judgment, thoughtless actions, cruel words and impatience. As a result, parents look for support from other parents of CYSHCN.

Cross-Cutting/Life Course

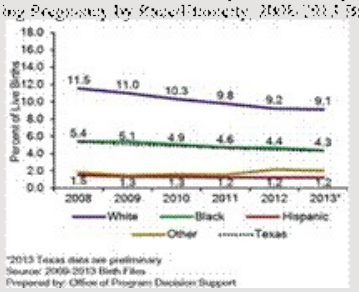
According to the 2011 BRFSS, Texas had the 15th lowest smoking rate in the United States[xxvi]12.7% of women were smokers. Smoking rates vary considerably by race/ethnicity (Fig 44A & B).

Figure 44. A) Smoking Rates by Sex and Ethnicity, Texas, 2012. B) Percent of Women who Smoked 3 Months Prior to Pregnancy by Race/Ethnicity, Texas, 2008-2013



While 95.6% of Texas women abstain from smoking during pregnancy, only Hispanic women are meeting the HP2020 target of 98.6% (Fig 45). In 2009, 29.7% of women who smoked three months prior to pregnancy did not smoke at all once becoming pregnant. In 2013, this rate of total abstinence from smoking had risen to 33.5%. Smoking rates among pregnant White women are almost eight times greater than among Hispanic women. Smoking rates among pregnant Black women are almost four times greater than among Hispanics.

Figure 45. Texas Women Who Reported Smoking During Pregnancy by Race/Ethnicity, 2008-2013 Births



In the regions of Texas with high smoking prevalence, rates are high for both White and Black women suggesting regional differences are a greater influence on smoking rates than racial/ethnic differences (Fig 46). While the overall rate of smoking

during pregnancy has been decreasing, the eastern area of Texas has rates over three times higher than the state smoking average.

Figure 46. Women Smoking During Pregnancy, Texas, 2012 Births

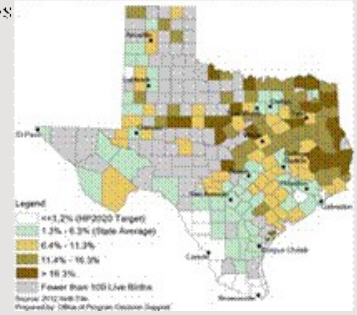
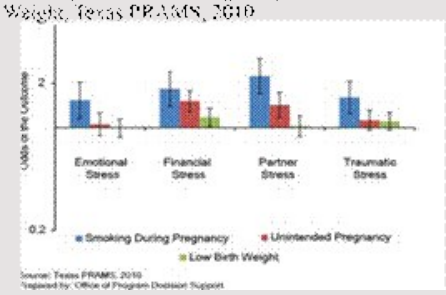


Figure 47. Type of Stress Associated with Prenatal Smoking, Unintended Pregnancy, and Low Birth Weight, Texas PRAMS, 2010

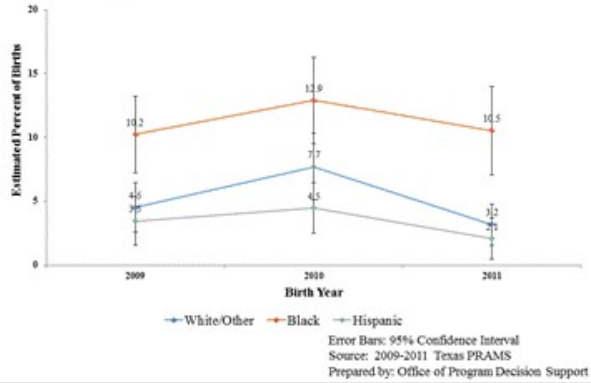


PRAMS data analysis showed elevated stress, especially partner stress, was associated with increased odds of smoking during pregnancy (Fig 47).

Smoking during pregnancy elevates the infant's risk for a variety of problems, including death. A study of the 2010 Texas linked birth-death files found women who smoked had more than a three-fold increase in the odds of their baby's death being classified as SIDS than women who did not smoke, even after adjusting for other maternal health issues, Medicaid status, and race/ethnicity.

Secondhand smoke exposure in Black households is significantly higher than in Hispanic and White households (Fig 48).

Figure 48. Percent of recently pregnant women who reported that smoking is allowed in the homes by race/ethnicity, 2009-2011



Children exposed to secondhand smoke in their homes have more frequent ear infections, acute respiratory illnesses and

related hospital admissions during infancy, severe asthma and asthma-related problems, lower respiratory tract infections leading hospitalizations and SIDS.

Focus group participants reported receiving information about the dangers of smoking but noted a lack of help or support to quit smoking during pregnancy. Individuals who successfully quit found it challenging to stay away from tobacco exposure from partners and other smokers.

For the complete "Scientific Analysis of Current State and Needs of MCH in Texas", please go here: http://www.dshs.state.tx.us/opds/OPDS-Reports.aspx.

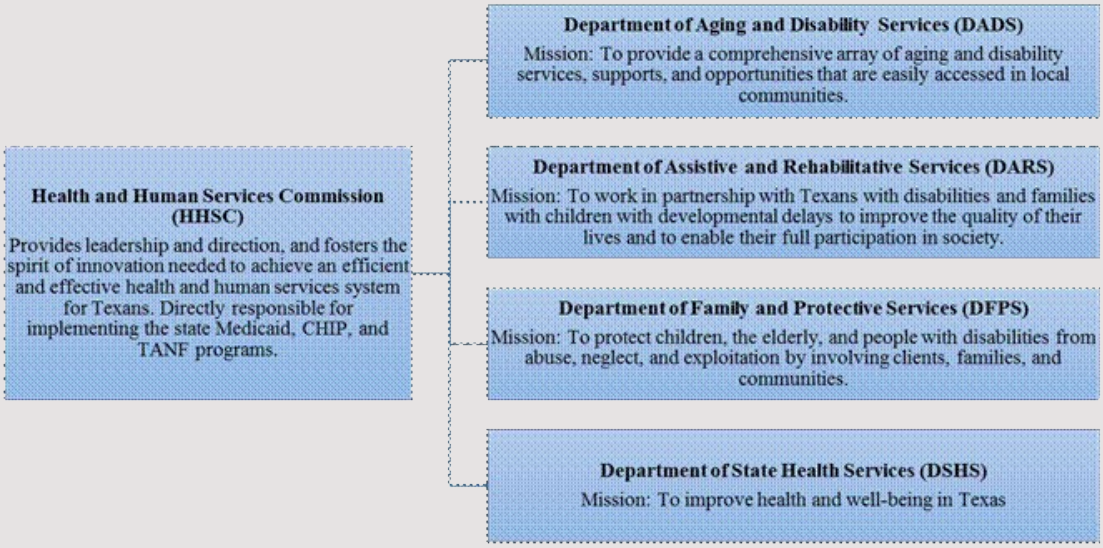
II.B.2.b Title V Program Capacity

II.B.2.b.i. 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. Governor Rick Perry named Mr. Chris Traylor as the HHSC Executive Commissioner to replace Executive Commissioner Kyle Janek effective July 1, 2015. Chris Traylor of Austin previously served as chief deputy commissioner at HHSC.
DSHS is the state agency responsible for the administration of Title V and is one of four HHS agencies under HHSC, the state agency responsible for oversight and coordination among all health and human services-related state agencies.

Fig 49. HHSC Departmental Organization



Kirk Cole, Interim Commissioner of DSHS oversees health-related prevention, direct care, regulatory and preparedness programs. DSHS performs its duties through staff located at the state headquarters in Austin and in eight geographical HSRs

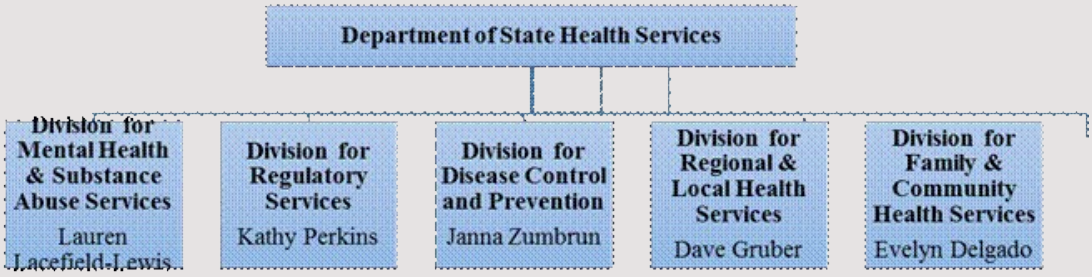
statewide; through contracts with local health departments, community-based organizations, and other groups; and in concert with other state agencies and local partners. Funds for agency activities originate from federal grants and allocations, state general revenue streams and local funding provided by contractors.

Functions related to administration, infrastructure and coordination are organized under three departmental areas (Fig 50).

Figure 50. DSHS Financial, Administrative and Support Services

DSHS programs are organized under five divisions (Fig 51).

Figure 51 DSHS Division Structure



Family and Community Health Services

The majority of direct health care delivery programs is located in FCHS and includes services for women, children and families and persons with special health care needs and health care safety net services (Fig 52). The Division also includes data analysis, research, and surveillance through the Office of Program Decision Support. Since July 2004, Evelyn Delgado has been the Assistant Commissioner of FCHS. Ms. Delgado has over 30 years of management experience in the private and public sectors. She previously served as Assistant Deputy Commissioner of Long Term Care Regulatory at the Texas Department of Human Services, protecting the health and safety of elderly and disabled citizens residing in nursing homes and other long term care facilities throughout Texas. Ms. Delgado has a business administration degree from Trinity University and is a graduate of the LBJ School of Government Governor's Executive Training program.

Figure 52 FCHS Organizational Structure

II.B.2.b.ii. 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.

In 2015, the Sunset Commission completed a two-year review of DSHS and other HHS agencies. As a result, some programs and agencies will be reorganized to increase efficiency. DSHS client services, state hospitals and regulatory functions will move to HHSC by 2017. A future study will examine whether DSHS should stay as an independent agency or move to HHSC.

Maternal/Women's Health

Title V 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.

Perinatal/Infant Health

Established in 1965, the Newborn Screening Program provides short-term follow-up for all newborns that have been screened and found to be presumptively positive for 53 rare disorders. In addition, Texas provides point-of-service screens for hearing and critical congenital heart defects.

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

Child Health

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.

CFRTs are authorized under Texas Family Code Sections 264.501-264.515. The CFRT State Committee is a multi-disciplinary 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 chidhood 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.

Adolescent Health

The Texas Healthy Adolescent Initiative is a PYD-focused community intervention to increase protective factors in youth and organize a Youth Adult Council to provide input on programming. The Rape Prevention and Education (RPE) program is a primary prevention initiative aimed at reducing sexual violence.

CSHCN

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.

Cross-Cutting

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

II.B.2.b.iii. MCH Workforce Development and Capacity

The Office of Title V and Family Health is responsible for MCH Services Block Grant management, reporting, consultation and compliance. 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 increase the knowledge of parents. Staff includes the Title V Director, Block Grant Administrator, subject matter experts in population domains, family-professional partnerships, the CHW workforce, and nurse consultants. This year, Title V will expand their collaboration with families by developing a Family Professional Partnership Workgroup.

Collaborative work includes partnering with HHSC on CHIP and the OPCCY to support efforts that coordinate programs and initiatives that serve children and youth across HHS systems. DSHS's CHW Program coordinates a statewide training and certification process for CHWs who are trusted members of their community who provide outreach/health education and assist people to gain access to needed services.

The Office of Program Decision Support (OPDS) provides centralized epidemiologic, data, research, and reporting support to all FCHS programs. Staff includes one director, one medical research specialist/team lead, six research specialists, three epidemiologists, two statisticians, one information/web specialist, and one administrative assistant. With four staff having PhDs and six staff with Master's degrees in statistics/social science, OPDS clearly 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. Importantly, OPDS directs the State Systems Development Initiative (SSDI) and the Texas Pregnancy Risk Assessment and Monitoring System (PRAMS), both of which are used to inform policy and practice in MCH, as well as many other cross-cutting strategies, interventions, and initiatives throughout the state.

The CSHCN SP is situated within the Purchased Health Services Unit (PHSU) of the Specialized Health Services Section. Within the PHSU, the Systems Development Group is responsible for overseeing the implementation of the CYSHCN Title V performance measure activities. The Title V CSHCN Director is a physician who serves as the Manager of Systems Development Group which is comprised of 8 staff positions, including program specialists and administrative support. The CSHCN SP employs staff who are parents of CYSHCN and participate in the program development, decision-making

process and provide ongoing program insight and feedback. The Specialized Health Services Section includes several health services programs, such as the Kidney Health Care Program, the Hemophilia Assistance Program, the Newborn Screening Unit, and the Health Screening and Case Management Unit which serve as areas of collaboration. The CSHCN SP develops and administers a comprehensive health care benefits program which includes Family Support Services and provides medical expertise and consultation to providers of CYSHCN. Case management is provided to CYSHCN and their families through community-based contractors and regional DSHS staff across the state. Additionally, Family Support and Community Resource contractors provide services such as respite care, family to family networking, and educational workshops and conferences. Program staff serves as CSHCN Services Program subject matter experts for these contractors by providing technical assistance, education, and resources. The CSHCN SP program staff facilitates and leads the Texas Title V Transition Workgroup and Medical Home Workgroup. Additional statewide activities in which staff participate include the Texas Council for Developmental Disabilities, ECI Advisory Council, Children's Policy Council and the Texas Respite Coalition. In addition, the State Adolescent Health Coordinator in the Office of Title V and Family Health serves as Texas' Family Delegate to AMCHP, is a former AMCHP Family Scholar, and served on the AMCHP Annual Conference Planning Committee. As a parent of a young adult with special health care needs and with over 20 years' experience in the interest of CYSHCN, she is a valued participant in program initiatives.

II.B.2.c. Partnerships, Collaboration, and Coordination

Through its interagency coordination efforts, the CSHCN Services Program has been effective in making other agencies aware of the CSHCN Title V performance measures, and, in many cases, uniting support for working toward achieving those measures. Program staff partner with the Texas Education Agency to help ensure that the public education infrastructure supports CYSHCN. These initiatives include the development of a legislatively mandated transition and employment guide and partnering with the Education Services Centers (ESCs) throughout the state to provide technical assistance and resources to educators. Collaboration with federal and state Medicaid programs occurs extensively through the participation of the PHSU Medical Director in the Benefits Management Workgroup, a Medicaid and CSHCN Services Program policy development and coordination workgroup led by HHSC and the claims contractor for Medicaid and the CSHCN Services Program. Recent legislation mandated the establishment and implementation of the STAR Kids Medicaid managed care program to provide services for children with disabilities to improve coordination and customization of care, access to care, health outcomes, cost containment, and quality of care. The STAR Kids model requires utilization of a health home, care management, and provision of comprehensive coordination of acute care and long-term service benefits. The CSHCN Services Program has provided resources and input into the development of this model.

The CSHCN Services Program collaborates and partners closely with many state and national initiatives promoting medical home and transition including the Statewide Association of Regional Medical Home AdvanCement (STARMHAC), a previous awardee of a HRSA State Implementation Grant for Systems of Services for CYSHCN (D70 grant), and the planning committee for the annual Chronic Illness and Disability Conference: Transition from Pediatric to Adult-Based Care. Texas was one of six states invited by *Got Transition?* to participate in the State Title V Leadership Transition Planning Group to increase utilization of the Six Core Elements of Health Care Transition, and participates in the AMCHP Action Learning Collaborative for the Standards for Systems of Care for CYSHCN. Along with the Texas Family Delegate for AMCHP, the Title V CSHCN Director serves on the planning committee for the annual Texas Primary Care and Health Home Summit. Within the CSHCN Services Program, staff members lead the statewide MHWG and the Texas Title V Transition Workgroup. These are broad-based multi-stakeholder groups involving family members, providers, representatives from insurance companies, advocacy organizations, and other interested stakeholders. CSHCN SP and OTVFH are collaborating with HHSC Office of Minority Health on a National MCH Workforce Development Center project to improve asthma care for children. In addition, the CSHCN SP is partnering with the AMCHP Family Delegate to identify and solicit input from family members in all domains to provide guidance for Title V projects.

THSteps administers preventive health services to Medicaid eligible clients from birth through 20 years of age. Title V partners with THSteps to develop free online provider education modules on multiple MCH topics. Title V also collaborates with WIC to promote breastfeeding, tobacco cessation, physical activity and nutrition.
Title V staff collaborate with the Texas Healthy Start Alliance which includes six sites that address population-based activities related to breastfeeding, immunizations, diabetes, obesity, folic acid promotion, preventing sexually transmitted infections, early prenatal care and car seat safety.Title V staff is the Principal Investigator on the CDC Rape Prevention and Education grant. Grant activities, administered through a contract with the Texas Office of the Attorney General, support the primary prevention of

sexual assault/violence with a focus on education.

Title V staff partner with the March of Dimes on the Big 5 State Prematurity Collaborative to explore data-driven perinatal quality improvement through evidence-based interventions.

DSHS administers the Healthy Texas Babies Initiative to help communities decrease infant mortality and preterm birth using evidence-based interventions. The Someday Starts Now website promotes pre- and interconception health and supports men in their role as fathers.

DSHS coordinated with the Maternal, Infant, and Early Childhood Home Visiting Program to conduct needs assessment and planning efforts for Texas. HHSC assumed responsibility for implementing the state's home visiting program. Through the DSHS Infant Feeding Workgroup coordinated by DSHS, NFP home visitors across the state completed DSHS Principles of Lactation Management training.

II.C. State Selected Priorities

No.	Priority Need
1	Children and Youth with Special Health Care Needs receive family-centered, coordinated care within a medical home model.
2	Children and Youth with Special Health Care Needs and their families have the services and supports necessary to transition to adulthood.
3	Advance Community Integration efforts.
4	Reduce health disparities for maternal and child health populations.
5	Promote collaborations including family professional partnerships (to enhance Maternal and Child Health programming).
6	Bolster access to quality statewide data, screening, and surveillance (to inform Maternal and Child Health programming).
7	Improve coordination of care for Maternal and Child Health populations.
8	Provide support to promote quality in primary care, women's health, and specialty services.
9	Ensure use of culturally and linguistically appropriate Maternal and Child Health education and outreach efforts.
10	Increase Maternal and Child Health safety programming.

Through the FY15 Needs Assessment process and stakeholder feedback, a list of health priorities was determined. These priorities were further categorized by common areas, such as health care coverage, access, and population health domain. A summary table was developed to display these health priorities in the context of input obtained during the Needs Assessment process and linked to previous national performance measures and life course indicators to share with agency leadership. These priorities were further refined and resulted in the selection of 10 new state priorities that were submitted in the FY16 application. As DSHS continues in the transformation of both the block grant and the Health and Human Services System in Texas, these priorities have been further evaluated and updated to reflect the ongoing work of the Title V program in the state. The summary table and priority needs were provided in the FY17 application.

Several of the new state selected priorities are a continuation or broadening of priorities previously selected in 2010. For example, priorities related to improvements in infrastructure, quality and coordination of care were broadened and encompassed in 2015 priorities focusing on coordination of care, support for promotion of quality care, and culturally and linguistically appropriate education and outreach. Furthermore, to expand on the existing focus on families, a priority on promoting family professional partnerships to enhance all MCH programming has been developed. Current CSHCN priorities encompass previously selected priorities and expand on current programming as the needs assessment revealed the need for ongoing focus in these areas. The needs assessment revealed significant disparities across multiple indicators and populations in the state, thus DSHS modified the priority of improving health outcomes via prevention interventions to a goal of reducing disparities for MCH populations. While the 2010 priority of increasing access to dental care was not explicitly identified as a current state priority, DSHS recognizes the impact of dental care on overall health and programming will continue to promote services and quality care for women and children in this area. The need for increased smoking cessation support was identified and will inform Title V programming and resources in the areas of smoking cessation during pregnancy and reduction of household smoking. Obesity has been identified as a priority by both stakeholders and DSHS, and has selected as a SPM within the crosscutting domain.

	Health Priority Comparison Table		
	2010 Priorities	**2015 Priorities**	**Comparison**
1.	Support and develop health care infrastructure that provides coordinated access to services in a culturally competent manner	Improve coordination of care for Maternal and Child Health populations Ensure use of culturally and linguistically appropriate Maternal and Child Health education and outreach efforts.	The themes of care coordination and culturally appropriate approaches is common. The 2015 change is the creation of a separate priority need to emphasize the cultural appropriate aspect as a part of all aspects of MCH programming.
2.	Increase the availability of quality mental health and substance abuse services	Provide support to promote quality in primary care, women's health, and specialty services.	The former priority was focused on mental health and substance abuse access while the new priority supports the promotion of quality care and expands the scope to include quality of care and all specialty services.
3.	Increase the number of youth with special health care needs who receive necessary services to transition to all aspects of adult life	Children and Youth with Special Health Care Needs and their families have the services and supports necessary to transition to adulthood.	The theme of transition for CYSHCN is common.

	Health Priority Comparison Table		
	2010 Priorities	**2015 Priorities**	**Comparison**
4.	Increase access to dental care		Stakeholder meetings and focus group results did not identify dental care as a specific need. DSHS will continue to provide dental services to pregnant women and children.
5.	Support community-based programs that strengthen parenting skills and promote healthy child and adolescent development	Promote collaborations including family professional partnerships (to enhance Maternal and Child Health programming).	The former priority was focused on programs targeted to parents to increase and improve their skills as parents, whereas the new priority is to insert family partnerships into all of the MCH programming to improve the content and delivery of programs that better meet the needs of parents and their families.
6.	Support the development of community-based systems that provide essential enabling services needed to improve health status		The changes to the definition of enabling services in the new guidance includes an emphasis on activities that reduce barriers to access to care. The new priority need to improve access to and quality of care is in alignment with the new guidance.
7.	Improve the organization of community-based systems of care for children and youth with special health care needs	Advance Community Integration efforts.	These priorities are similar in that as community-based systems of care are better organized, CYSHCN and their families are more likely to experience community integration. Strategies and activities to strengthen families are similar and include provision of family and community support services such as respite, family education and parent to parent networking.
8.	Use population-		The former priority is in

	Health Priority Comparison Table		
	2010 Priorities	**2015 Priorities**	**Comparison**
	based services including health promotion and disease prevention interventions to improve health outcomes of the MCH population		alignment with the old MCH pyramid and enabling services. The new priority of reducing health disparities will align more globally with the new pyramid as we build and improve systems to decrease and eliminate disparities.
9.	Ensure all children, including children and youth with special health care needs, have access to a medical home and other health care providers through increased training, recruitment, and retention strategies	Children and Youth with Special Health Care Needs receive family-centered, coordinated care within a medical home model.	The medical home theme remained common.
10.	Promote the expansion of new or existing evidence-based interventions to address maternal and child health needs	Increase Maternal and Child Health safety programming.	The former priority for expansion of evidence based interventions has been tailored to specify injury programming.
New		Bolster access to quality statewide data, screening, and surveillance (to inform Maternal and Child Health programming).	While Texas does, indeed, possess the needed data, research, and epidemiologic infrastructure and capacity to produce multiple high quality and complex products to inform maternal and child health programming, there remains a need for more accurate and timely statewide data when it comes to: a) assessing the needs of the CSHCN population through annual community outreach and provider surveys; and b) improving the quality of death certificate data to

	Health Priority Comparison Table		
	2010 Priorities	**2015 Priorities**	**Comparison**
			inform the work of the MMMTF.
New		Reduce health disparities for maternal and child health populations	The needs assessment data indicated the extent to which particular populations are disproportionately affected by poor health outcomes. The focus groups and stakeholder input also indicated the public awareness and concern about social determinants of health.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 1 - Percent of women with a past year preventive medical visit
- NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
- NPM 5 - Percent of infants placed to sleep on their backs
- NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
- NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
- NPM 11 - Percent of children with and without special health care needs having a medical home
- NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
- NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

1. Percent of women with a past year preventive visit (NPM 1).

A scientific analysis of BRFSS data as part of the Title V Five-Year NA indicates that less than two-thirds of Texas women of childbearing age reported having a routine checkup in the past year. Moreover, the results show that the rate of women giving birth who received adequate prenatal care has plateaued between 2011-2013, with only 64.5% of women having a prenatal visit in the first trimester of pregnancy. Being overweight or obese is at the heart of many adverse maternal and child health consequences across the lifespan; approximately 61% of women in Texas were overweight or obese in 2013. Rates of pre-pregnancy obesity have increased more than 22% for black and Hispanic women from 2005 to 2013 (from 25.7 to 31.4% among black women, and from 21.2 to 26.8% among Hispanic women). Rates of hypertension and diabetes among mothers giving birth in Texas have slowly increased between 2009-2013. Only Hispanic women met the Healthy People 2020 target (98.6%) for abstinence from smoking during pregnancy between 2008-2013. In 2010, women who smoked during pregnancy had a three-fold increase in the odds of their baby's death being classified as SIDS, compared to women who did not smoke. Texas PRAMS data reveal that only about 57% of all pregnancies in Texas were intended in 2011, and this rate of intended pregnancy has not significantly changed since 2004. Among Black women, only about 40% of pregnancies were intended in 2011. Of new mothers who reported not wanting to become pregnant, less than half (55.4%) reported that they or their partner were using any form of contraception in 2011. Therefore, using the results of the Title V Five-Year NA and building upon work from previous years, Title V has selected NPM 1, as there is a clear need to increase the infrastructure and capacity to promote preconception, prenatal, and interconception care, health, and wellness among WCBA.

2. Percent of infants placed to sleep on their back (NPM 5).

According to the Title V Five-Year NA, there has been a significant increase in the percent of infants being placed on their backs to sleep since 2002. However, there are still substantial racial/ethnic differences in this "safe sleep" practice. In 2011, only 45.5% of black mothers reported placing their infant to sleep on his/her back, compared with 68.9% of Hispanic mothers and 76.2% of White/Other mothers. Moreover, stakeholders agree that strengthening efforts and resources for implementing and targeting Safe Sleep programming is needed. Thus, utilizing the results of the Title V NA, stakeholder engagement and building upon work from previous years, NPM 5 was selected. Title V will continue close collaboration with HHS and other partners to ensure consistency of evidence-based safe sleep messaging, and promotion of safe sleep practices to Texas communities.

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

The Title V Five-Year NA showed that while Texas has high initiation of breastfeeding rates (an estimated 83.3 % in 2012), the % of women who exclusively breastfeed is still relatively low. According to 2012 National Immunization Survey results for Texas, 43.7 % of mothers reported exclusive breastfeeding at 3 months, and 21.3 % of mothers reported exclusive breastfeeding at 6 months. Further, only 7.7 % of births in 2011 occurred in a "Baby Friendly Hospital". Given the important role that breastfeeding plays in the prevention of acute and chronic diseases, obesity, and SIDS, together with NA findings, Title V selected NPM 4, as there is a clear need to continue to address barriers to breastfeeding. Breastfeeding provides complete nutrition and immune protection for infants. Babies who do not receive breast milk are at increased risk for a host of infectious diseases, sudden infant death syndrome, and necrotizing enterocolitis (a debilitating and often fatal intestinal condition of the preterm infant), as well as for chronic conditions including obesity and overweight, type 1and type 2 diabetes, asthma, childhood leukemia, atopic dermatitis and other adverse outcomes. Mothers who do not breastfeed are at increased lifetime risk for weight retention, type 2 diabetes, breast and ovarian cancers, cardiovascular disease, and rheumatoid arthritis. Not breastfeeding or early weaning is associated with an increased risk of maternal postpartum depression. Protection against poor maternal and infant health outcomes is greatest when infants exclusively breastfeed for the first six months of life and continue through one to two years of life or beyond, with appropriate introduction of complementary foods to the infant's diet along with breastmilk beginning at about six months of age. U.S. studies [1] estimate that suboptimal breastfeeding annually results in $31.2 billion excess costs in pediatric and maternal health-related expenses and excess morbidity and mortality including 911 pediatric deaths; 4,981 maternal breast cancer cases; 53,847 maternal hypertension cases; and 13,946 maternal myocardial infarction cases per year. 1. Bartick, M. Reinhold, A. The burden of suboptimal breastfeeding in the United States: A pediatric cost analysis. Pediatrics. 2010; Bartick, M. Stuebe, A. et al. Cost Analysis of Maternal Disease Associated With Suboptimal Breastfeeding. Obstetrics & Gynecology. 2013.

4. Rate of injury-related hospital admissions per population ages 0 through 19 years (NPM 7 – Texas is addressing this measure for both Child and Adolescent Health domains)

Findings from the Title V Five-Year NA show that child injury continues to be the leading cause of death for children aged 1-14, accounting for 35.3 % of all deaths among boys and 23.7 % of all deaths among girls in this age group in 2013. For 15 to 19 year olds, the leading cause for death and non-fatal hospitalization is unintentional MV accidents.

NA findings also indicate that non-natural child deaths frequently involve MV crashes, drowning, and child abuse and neglect for children 1-9 and MV crashes, suicide and homicide for youth 10-19. Unintentional non-fatal injuries are the most common reason for hospitalization in early childhood. These injuries can lead to significant lifelong challenges and disabilities. Traumatic brain injuries are often associated with unintentional injuries resulting from falls or MV crashes. Falls in early childhood vary significantly by age and account for 53% of hospitalizations for non-fatal injuries in Texas stakeholders also supported strengthening and building upon injury prevention efforts, and hence, NPM 7 was selected.

5. Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent completed screening tool (NPM 6)

According to the National Survey of Child Health (NSCH), only 30.4% of Texas children 10 months to 5 years old were screened for being at risk for developmental, behavioral, or social delays in 2011-2012. Children reaching developmental milestones is essential for school readiness and adult success. In addition, parents reported in Title V focus groups that they lack access to providers to assess their child's development. Developmental screening is critical for ensuring that children receive the comprehensive and coordinated care that they need. Further, a key finding of the Title V NA community outreach survey and focus groups was that parents and other stakeholders are concerned about childhood behavioral health and social issues. Therefore, NPM 6 was selected, as an increase in the prevalence of developmental screenings is sorely needed.

6. Percent of children with and without special health care needs having a medical home (NPM 11)

Review of the 2009/10 NS-CSHCN shows that less than one quarter of CYSHCN in Texas received any help in arranging or coordinating care, but that receiving care within a medical home makes it more likely other core systems outcomes for CYSHCN will be met. These findings are supported by results of the Title V Five-Year NA. An analysis of the CYSHCN Outreach Survey conducted as part of the NA identified coordination of care is a challenge, with 71.6% of respondents reporting that they coordinate their child's care themselves. Parents participating in NA focus groups supported the fact that care coordination is primarily performed by the parent and many were not familiar with the term care coordinator. Most parents who sought care coordination for their children among social workers, case managers and nurses were unsuccessful. Stakeholder groups noted a lack of awareness of resources and gaps in care exist when care is not coordinated among providers, including specialists. This can lead to a delay in referral and lack of access to services. It is clear from findings in both the 2009/10 NS-CSHCN and the Five-Year NA that Texas families are unfamiliar with the medical home model or how care coordination improves CYSHCN outcomes. Similarly, providers recognize and endorse the need for coordination of services; however, findings indicated that the overwhelming majority of families provide their own care coordination. Therefore, utilizing the results of the Five-Year NA, stakeholder engagement and building upon work from previous years, Title V has selected NPM 11.

7. Percent of children with and without special health care needs who received services necessary to make transitions to adult health care (NPM 12)

As part of the Five-Year NA, the 2014 CYSHCN Outreach Survey identified that only 20% of respondents felt prepared for their child to transition to adulthood. Over 40% of respondents indicated they had not prepared for transition. Most respondents who indicated that they have prepared for transition had done so by themselves. A key finding from the parent focus groups of CYSHCN was the wide range of ideas about when transition planning should start, when the transfer of care should happen, and of the various aspects of transitioning to adulthood, including health care, education, social supports and legal transition. Focus group participants conveyed that they were unsure where to go for assistance with transition planning, and families that were aware of transition resources reported difficulties in receiving services needed to prepare for the move to adult health care. Respondents in the stakeholder meetings noted that few doctors have the passion or willingness to take on the primary care role and coordinate the many specialists typically seen by young adults whose medical needs are complex. Stakeholders echoed the concerns that families do not have the information, services, or support needed to help their children transition from pediatric to adult care. They cited a lack of written transition plans as a barrier to transitioning to adult providers. Findings from the National Survey of CSHCN and Title V Five- Year NA show that youth in Texas are not prepared to transition to adulthood. Further, families are unsure how to help facilitate their youth's transition or find and access needed services. Similarly, stakeholders support that strengthening transition planning services for youth and families offer opportunities for improvement. Therefore, utilizing the results of the Five-Year NA, stakeholder engagement and building upon work from previous years, Title V has selected NPM 12.

8. A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes (NPM 14).

The results of the Title V Five-Year NA show that only Hispanic women met the Healthy People 2020 target (98.6 %) for abstinence from smoking during pregnancy between 2008-2013. Moreover, in 2010, women who smoked during

pregnancy had a three-fold increase in the odds of their baby's death being classified as SIDS, compared to women who did not smoke. Smoking during pregnancy elevates the infant's risk for a variety of problems, including death. A study of the 2010 Texas linked birth-death files found women who smoked had more than a three-fold increase in the odds of their baby's death being classified as SIDS than women who did not smoke, even after adjusting for other maternal health issues, Medicaid status, and race/ethnicity. Children exposed to secondhand smoke in their homes have more frequent ear infections, acute respiratory illnesses and related hospital admissions during infancy, severe asthma and asthma-related problems, lower respiratory tract infections leading hospitalizations and SIDS. However, when discussing smoking cessation has a health priority, a large proportion of Title V focus group participants were unaware of the increased risk of SIDS among mothers who smoked during their pregnancy. Together, the findings of the Title V NA analyses and focus groups point to the cross-cutting need to increase collaborative outreach efforts for tobacco prevention and cessation among pregnant women and families. Hence, NPM 14 was selected.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

- SPM 1 - Percent of CYSHCN and their families who received the supports and services necessary to be integrated into their communities
- SPM 2 - Percent of Texas WIC participants, ages 2-5, in the overweight/obese range
- SPM 3 - Infant Mortality Disparities: Ratio of Black to White infant mortality rate
- SPM 4 - Percent of young adults (ages 18-24) who visited a doctor for a routine checkup in the past year

1. Percent of CYSHCN and their families who received the supports and services necessary to be integrated into their communities (SPM 1)

Results of the Needs Assessment supported the 2009/10 NS-CSHCN finding that nearly one quarter of CYSHCN nationally did not receive at least one of the services they needed. While services may be available, lack of awareness of resources by both families and providers and lack of communication of available resources impeded access. Families indicated they most frequently learned about resources from other parents. The majority of family members of CYSHCN participating in focus groups reported feeling alone and isolated within their communities. Parents perceived their community as excluding them with harsh judgement, thoughtless actions, cruel words and impatience. As a result, parents look for support first from other parents feeling that only those with shared experiences can understand them. Parents expressed the desire for more community education about CYSHCN to promote awareness and integration. Parents noted a lack of programs and facilities that can accommodate their children and stressed a need for more inclusive sports activities and community-wide events. The CYSHCN Outreach Survey identified that 52% of parents in Texas indicated a need for respite. Despite the recognized need, Texas families face barriers to receiving respite. Only 34% of families surveyed received the needed support with funding cited as the most common barrier followed by lack of knowledge about respite and difficulty finding providers. Barriers to access identified by focus group participants included provider restrictions, reimbursement issues and lack of qualified, trustworthy providers. Access to needed resources helps assure that children grow up in families and participate in their communities with a strong sense of belonging. The extent to which communities are accessible, welcoming and have sufficient support services helps minimize the sense of isolation experienced by CYSHCN and their families. Therefore, utilizing the results of the Five-Year Needs Assessment, stakeholder engagement, and building upon work from previous years, the CSHCN SP developed a SPM supporting improved community integration for CYSHCN and their families.

2. Overweight or obesity across the life course, including: percent of infants born to mothers with prepregnancy BMI in the overweight/obese range; percent of WIC participants aged 2-5 with BMI in the overweight/obese range; percent of children with BMI in the overweight/obese range; percent of adolescents with BMI in the overweight/obese range; and percent of adults with BMI in the overweight/obese range (SPM 2)

Being overweight or obese is at the heart of many adverse maternal and child health consequences across the lifespan, with approximately 61% of women and 37% of children (ages 10-17) in Texas having a BMI in the overweight or obese range. Moreover, the rates of pre-pregnancy obesity have increased more than 9% for Hispanic and Black women since 2009. While the underlying causes of this increase in pre-pregnancy obesity are due to a host of factors, one environmental factor is lack of access to nutritious food. The Needs Assessment revealed that a greater number of white and Hispanic women live in environments that lack healthy food retail outlets, and Black women had a higher than expected concentration in areas with a large amount of fast food retailers. Yet, among all focus groups, obesity was listed as a top health concern, and all cited its links to heart disease, diabetes, and hypertension. Also, among the parents who responded to the Title V Community Outreach Survey, 54% chose obesity as a top health concern. Obesity can both cause development of a special health care need and be a consequence of having one. The 2011/2012 National Survey of Children's Health found that 39.9% of CSHCN age 10-17 years were overweight or obese based on Body Mass Index (BMI) compared to 35.5% of non-CSHCN in Texas. CSHCN in Texas were more likely overweight or obese according to BMI compared to nationwide (39.9% versus 35.3% respectively). Clearly, there is a need to address maternal and childhood obesity or being overweight through collaborative and systemic prevention and intervention efforts. Hence, a SPM was developed to measure the effectiveness of these public health strategies across the life course. Although the SPM Detail Sheet (Form 10b) would only allow reporting for one subgroup (percent of WIC participants aged 2-5), Texas intends to measure overweight/obesity in all MCH population subgroups.

3. Ratio of Black to White feto-infant mortality; and ratio of Black to White infant mortality (SPM 3)

The Needs Assessment revealed a persistent racial/ethnic disparity in the infant mortality rate (IMR) between Black mothers and all other racial/ethnic groups, with the IMR for Black mothers more than two times higher than it is for White or Hispanic mothers. A subsequent perinatal periods of risk analysis showed a similarly persistent racial/ethnic disparity in the feto-infant mortality rate (f-IMR), with the f-IMR for Black mothers almost twice as high as it is for White or Hispanic women. In fact, 2009-2012 data show the excess f-IMR for Blacks was 6.5; whereas it was 1.4 and 1.7 for Whites and Hispanics respectively. Needs Assessment findings also showed that disparities still exist in sleep-related infant deaths, with infants of Black mothers having lower rates of being placed on their back — an important strategy to reduce sleep-related infant deaths. In 2011, only 45.5% of Black infants were placed on their back to sleep, compared to 76.2% for White infants and 68.9% for Hispanic infants. Early and preterm birth is another major contributor to the Black infant mortality rate. In 2013, 16.1% of all births to Black mothers were preterm and in 2012, 46% of all births to Black mothers were either early term or preterm. Black women in Texas were also less likely to initiate breastfeeding (protective against infant mortality) in the hospital with 87.1% doing so in 2011,

compared to 94.6% of White women. Together, these results support the need to expand our collaborative capacity to decrease the prevalence of, and disparities surrounding, infant and feto-infant mortality. Therefore, a SPM was created to assess the impact of these collaborative efforts.

4. Percent of adolescents and young adults (ages 18-24) who visited a doctor for a routine checkup in the past year (SPM 4)

Although the overall mortality rate for adolescents is decreasing, the rates of accidental deaths and suicides as the leading causes of non-natural deaths are increasing. Results of the NA revealed that substance use, including alcohol, marijuana, and prescription drugs for nonmedical use, are still problematic, with alcohol and marijuana use higher among White and Hispanic youth. Furthermore, risky sexual behaviors have resulted in an increase in the prevalence of sexually transmitted infections, especially Chlamydia. Yet, according to data collected as part of the Adolescent and Young Adult Health Collaborative Improvement and Innovation Network (CollN), only one in three adolescents and young adults report having a quality care visit, and young adults self-report lower good or excellent health. Clearly, there is a need to enhance and expand adolescent injury prevention efforts to reduce adolescent deaths due to accidents and suicides, substance use, and sexually transmitted infections through the use of positive youth development — protective factors that are needed to become healthy and productive adults. Equally important is the need to further utilize systemic approaches and partnerships to promote the importance and availability of quality components of care for adolescents and young adults. Thus, a SPM was developed to gauge the effectiveness of these public health interventions. The wording of this measure to include “doctor visits” is a function of the only related data source, namely the BRFSS. However, this does not limit our intention to promote among adolescents wellness visits to other healthcare professionals. The wording of this measure to include “doctor visits” is a function of the only related data source, namely the BRFSS.

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

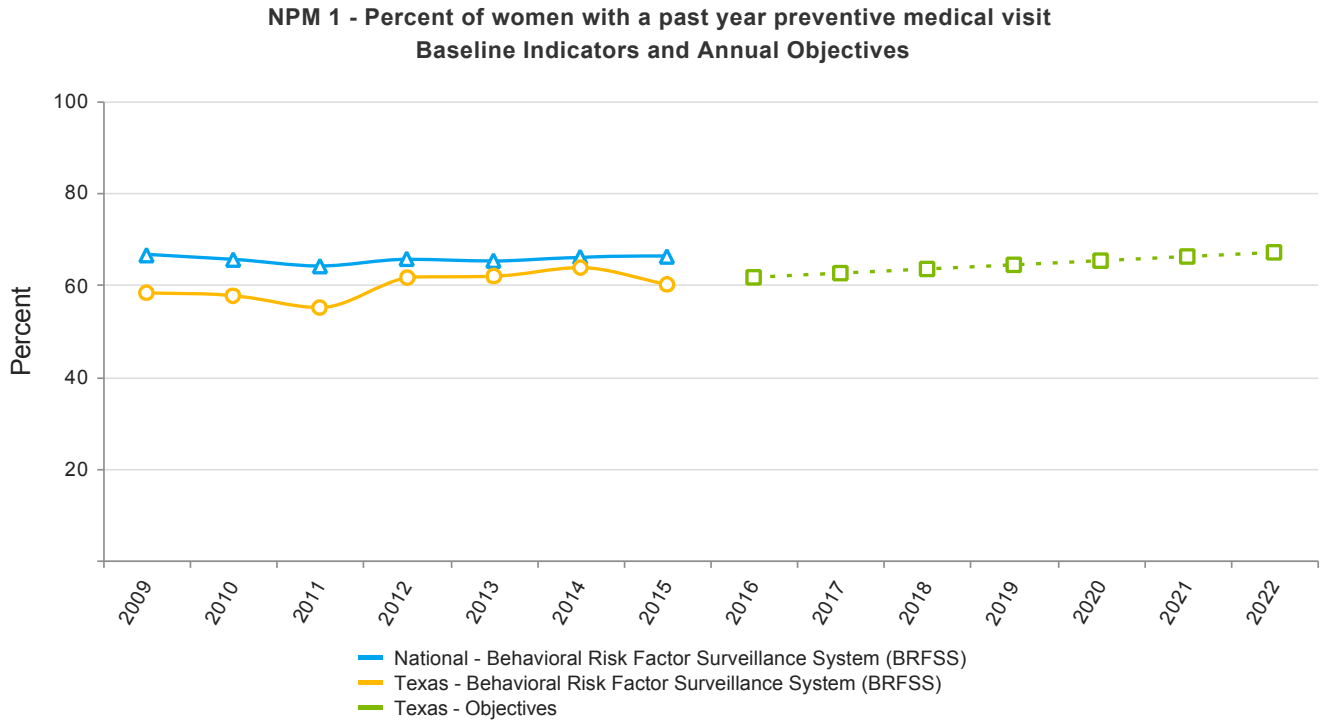
To address national and state performance measures Texas, MCHS strategically coordinates activities and efforts with partners and stakeholders to improve health outcomes for all MCH populations. To ensure statewide reach and MCH expertise throughout the Health Service Regions (HSRs), MCHS funds uniquely positioned DSHS staff in the 8 HSRs to support the planning, implementation, and evaluation of population-based services in communities around the state. To align with the goals of the Title V MCH Block Grant Transformation and improve accountability of performance in Texas, MCHS continues 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 are also funded to provide case management for CYSHCN and their families, and MCHS continues to support child and prenatal safety net services in Texas. Through coordinated efforts and statewide MCH infrastructure, Texas strives to improve the health of all MCH populations and meet the objectives outlined in the Action Plan.

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-2014	182.3	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2011_2015	34.2	NPM 1
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	8.3 %	NPM 1
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.4 %	NPM 1
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	6.8 %	NPM 1
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	10.2 %	NPM 1
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	2.8 %	NPM 1
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	7.3 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	28.2 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	5.5	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	5.9	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	3.9	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.9	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	186.4	NPM 1

National Performance Measures



Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	61.6
Annual Indicator	59.9
Numerator	3,003,165
Denominator	5,016,691
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	62.5	63.4	64.3	65.2	66.1	67.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Number of preconception health tools accessed from DSHS infant mortality reduction public awareness campaign website Someday Starts Now and the Health and Human Services (HHS) Warehouse

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	10,236
Numerator	
Denominator	
Data Source	Google Analytics and HHSC Warehouse
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	5,500.0	5,570.0	5,640.0	5,710.0	5,780.0	5,850.0

ESM 1.2 - Number of Texas Health Steps Online Provider Education (OPE) users completing preconception and prenatal health modules

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1,566
Numerator	
Denominator	
Data Source	Texas Health Steps Online Provider Education (OPE)
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	385.0	390.0	395.0	400.0	405.0	410.0

ESM 1.3 - Number of additional Historically Black Colleges and Universities (HBCUs) that implement the Preconception Peer Educators Program (PPE)

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	2
Numerator	
Denominator	
Data Source	UNTHSC Ft. Worth
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	2.0	2.0	2.0	1.0	0.0

ESM 1.4 - Establishment of support infrastructure for the Texas Collaborative for Healthy Mothers and Babies (TCHMB)

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	University of Texas System
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	No	No	No	No	No

ESM 1.5 - Create joint report with the Maternal Mortality and Morbidity Task Force (MMMTF) to the Texas Legislature on findings and recommendations to prevent severe maternal morbidity and mortality in Texas

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	Texas DSHS
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	Yes	No	Yes	No	Yes

ESM 1.6 - Preconception health strategic plan developed

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	Yes	No	No	No	No

ESM 1.7 - Texas Collaborative for Healthy Mothers and Babies (TCHMB) health and health care quality improvement projects conducted

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 1.8 - Texas Collaborative for Healthy Mothers and Babies (TCHMB) educational forum for health professionals held

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 1.9 - Communication of case reviews findings from maternal overdose deaths developed in partnership with the Maternal Mortality and Morbidity Task Force (MMMTF)

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	Yes	No	No	No	No

State Action Plan Table

State Action Plan Table (Texas) - Women/Maternal Health - Entry 1

Priority Need

Provide support to promote quality in primary care, women's health, and specialty services.

NPM

Percent of women with a past year preventive medical visit

Objectives

By 2020, increase the proportion of women who discussed preconception health with a health care worker prior to pregnancy to meet a target of 23.4%(PRAMS, 2012 baseline = 20.1%).

By 2020, increase the proportion of women giving birth who attend a postpartum care visit with a health care worker to meet a target of 88.5% or higher (PRAMS, 2012 baseline = 85.4%).

By 2020, reduce the proportion of women who self-report poor mental health for 5 or more days during the past month to meet a target of 19.0% (BRFSS, 2012 baseline = 24.4%).

Strategies

Strategy 1: Expand preconception health and health care outreach efforts to WCBA across DSHS and stakeholder programming.

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 and infectious diseases affecting maternal and child health.

Strategy 3: Assess landscape for support of preconception health initiatives throughout the state. Partner with public and private organizations, coalitions, clinicians, health plans, family advocates and other stakeholders to increase capacity, synergy and collective impact of initiatives to improve women's health and health care delivery.

Strategy 4: Partner with stakeholders to improve the quality of women's mental health services.

ESMs	Status
ESM 1.1 - Number of preconception health tools accessed from DSHS infant mortality reduction public awareness campaign website Someday Starts Now and the Health and Human Services (HHS) Warehouse	Active
ESM 1.2 - Number of Texas Health Steps Online Provider Education (OPE) users completing preconception and prenatal health modules	Active
ESM 1.3 - Number of additional Historically Black Colleges and Universities (HBCUs) that implement the Preconception Peer Educators Program (PPE)	Active
ESM 1.4 - Establishment of support infrastructure for the Texas Collaborative for Healthy Mothers and Babies (TCHMB)	Active
ESM 1.5 - Create joint report with the Maternal Mortality and Morbidity Task Force (MMMTF) to the Texas Legislature on findings and recommendations to prevent severe maternal morbidity and mortality in Texas	Active
ESM 1.6 - Preconception health strategic plan developed	Active
ESM 1.7 - Texas Collaborative for Healthy Mothers and Babies (TCHMB) health and health care quality improvement projects conducted	Active
ESM 1.8 - Texas Collaborative for Healthy Mothers and Babies (TCHMB) educational forum for health professionals held	Active
ESM 1.9 - Communication of case reviews findings from maternal overdose deaths developed in partnership with the Maternal Mortality and Morbidity Task Force (MMMTF)	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 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 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

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

Priority Need

Reduce health disparities for maternal and child health populations.

NPM

Percent of women with a past year preventive medical visit

Objectives

By 2020, increase by 10% the proportion of maternal deaths reviewed by the Texas Maternal Mortality and Morbidity Task Force (No baseline data currently available).

Strategies

Strategy 1: Through the Texas Maternal Mortality and Morbidity Task Force, analyze maternal morbidity and mortality cases and trends in Texas to address disparities in severe maternal morbidity and maternal mortality.

Strategy 2: Promote best practices and the uptake of recommended maternal and women's health practices that reduce risk and prevent feto-infant and maternal harm.

ESMs	Status
ESM 1.1 - Number of preconception health tools accessed from DSHS infant mortality reduction public awareness campaign website Someday Starts Now and the Health and Human Services (HHS) Warehouse	Active
ESM 1.2 - Number of Texas Health Steps Online Provider Education (OPE) users completing preconception and prenatal health modules	Active
ESM 1.3 - Number of additional Historically Black Colleges and Universities (HBCUs) that implement the Preconception Peer Educators Program (PPE)	Active
ESM 1.4 - Establishment of support infrastructure for the Texas Collaborative for Healthy Mothers and Babies (TCHMB)	Active
ESM 1.5 - Create joint report with the Maternal Mortality and Morbidity Task Force (MMMTF) to the Texas Legislature on findings and recommendations to prevent severe maternal morbidity and mortality in Texas	Active
ESM 1.6 - Preconception health strategic plan developed	Active
ESM 1.7 - Texas Collaborative for Healthy Mothers and Babies (TCHMB) health and health care quality improvement projects conducted	Active
ESM 1.8 - Texas Collaborative for Healthy Mothers and Babies (TCHMB) educational forum for health professionals held	Active
ESM 1.9 - Communication of case reviews findings from maternal overdose deaths developed in partnership with the Maternal Mortality and Morbidity Task Force (MMMTF)	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 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 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

Women/Maternal Health - Plan for the Application Year

NPM 1: Percentage of women with a past year preventative visit.

MCHS supports improving the quality of women's health and healthcare via integration of preconception/interconception care into routine primary and well-woman care through multiple strategies and initiatives. Strengthening coordination and continuity of care is critical to ensure risks are assessed and managed before and between pregnancies so that women can enter pregnancy if and when they choose to in optimal health, and to subsequently increase the likelihood of positive women's health, pregnancy and birth outcomes.

MCHS will continue to foster collaboration with partners to increase capacity, synergy and collective impact of initiatives to improve women's health and healthcare delivery. Work will continue to develop a strategic plan to serve as a roadmap for women's and maternal health programming, with a focus on the preconception / interconception periods. A gap analysis, conducted through interviews and listening sessions with DSHS public health partners, will be finalized to learn about opportunities and barriers for improving preconception health and health care (PCHHC). MCHS will use finding from this analysis to develop a state action plan for improving PCHHC in the state. Preconception health encompasses a multitude of health dimensions, including chronic conditions, tobacco use, reproductive and behavioral health, and social determinants, among others; thus a comprehensive approach is needed to impact health outcomes. As such, MCHS will continue to build and strengthen partnerships across and beyond the HHS system to assess the landscape for preconception / interconception health initiatives and promote integration of preconception health and healthcare into programs serving women.

MCHS will continue to participate in the BBO initiative and identify areas of collaboration. Partnerships will continue with the Health Promotion and Chronic Disease Prevention Section on projects related to tobacco and obesity. Efforts around substance use and postpartum depression, including resource development for providers, will be explored with the HHSC IDD and Behavioral Health Services Section.

MCHS will continue to fund and oversee the Texas Collaborative for Healthy Mothers and Babies (TCHMB) through a contract with the UT Health Science Center at Tyler. TCHMB is Texas' perinatal quality collaborative, and is focused on implementing initiatives that will improve quality of care and enhance women's, perinatal and infant health outcomes. Support will continue for the development of QI projects supportive of women's and maternal health and healthcare. The Obstetrics subcommittee is currently meeting with hospitals interested in adopting an Induction of Labor protocol tool, designed for assisting providers in following evidenced-based pathways through a patient's labor in order to avoid a primary cesarean section.

MCHS will continue to support population-based services and activities throughout Texas' regions to improve women's and maternal health outcomes. Regional population-based staff will continue to expand efforts to integrate preconception health programming and health promotion activities in FY 18. Staff in HSRs 2/3, 6/5S and 4/5N will continue to support the newly-founded PPE programs among the HBCUs in Dallas, Houston and Tyler and staff in HSR 7, 8 and 6/5S will assist UNTHSC contractors and MCHS staff to train and foster efforts among new programs at Huston-Tillotson in Austin, St. Phillips College in San Antonio, and Texas Southern University in Houston. In FY18 MCHS regional staff plan to spread statewide the Whole Person Project initiated in HSRs 1 and 7 in 2016. The Whole Person Project capitalizes on the health promotion and disease prevention potential of a single encounter by screening an individual for all services for which he or she may be eligible. For example, a woman who visits a DSHS clinic for STI testing will be offered all appropriate immunizations, offered a car seat inspection, assessed for involvement in sex trafficking, smoking cessation and offered resources and referral to medical home. The project will be augmented with addition of measures on pre- and inter-conception health. Staff plan to add One Key Question to the screening, support completion of a life planning tool, and assistance with accessing text4baby. Regional staff will continue to promote the pre- and inter-conception Texas Health Steps OPE modules among healthcare providers and will participate in clinical and community-based QI projects under the leadership of TCHMB, particularly focusing on supporting those activities taking place in rural parts of the state without local health departments.

MCHS will continue to work with partners to expand preconception/inter-conception health and healthcare educational outreach efforts across DSHS and stakeholder programming. MCHS will reach out to WCBA to raise awareness and increase understanding of preconception/interconception health behaviors and care services. Education and outreach materials will include tools, newsletters, conferences, and website resources including the DSHS MCH website and the Healthy Texas Babies (HTB) public outreach campaign Someday Starts Now (SSN). SSN provides educational information, tools and additional content in English and Spanish to increase public

awareness of preconception, maternal and infant health behaviors on birth and infant health outcomes. The website will be revised and updated, with content remaining appropriate to the literacy level, age, culture and language of our target population of women and men of childbearing age. A refresh of the SSN website will include a digital-first promotional approach with a new look and feel specifically aimed at the young adult and women/men of childbearing age target groups. Community and health care provider outreach tools and strategies of SSN will also be redesigned and aligned with DSHS and stakeholder priorities. The outreach campaign website can be accessed at www.SomedayStartsNow.com.

MCHS will also continue to expand and enhance the HTB Preconception Peer Educators program (PPE) across the state as one of its initiatives under the HTB infant mortality initiative. PPE is a national OMH program focused on reducing infant mortality in the African American community. College-age women and men are trained to educate their peers and community members the importance of preconception health, the impact of social determinants of health on their wellbeing, seeking regular preventive care and creating a reproductive life plan, with the goal of establishing the program at two new educational institutions in FY18. Within current PPE sites, a regional analysis assessment will be conducted by students in their respective campuses to ensure programs are implemented in ways that best serve the needs of individual HBCUs. A toolkit will be developed with information on the various components needed to implement the program on campuses, including a guide for implementation, the educational curriculum, and promotional materials. MCHS will continue to engage Texas HBCUs and explore other potential interested organizations and colleges to expand future implementation of the PPE program. MCHS will explore opportunities for expanding the program beyond HBCUs to other educational institutions with large African American student populations.

MCHS will develop and promote education opportunities and best practices for healthcare providers and other stakeholders working to improve the quality of women's preventive care services. MCHS will revise the SSN Life Planning Tool based on feedback gathered from the HTB community coalitions during FY17—the coalitions evaluated the life planning tool as part of their evidence-based clinical interventions promoting integration of preconception care into routine primary care. MCHS will promote the revised tool among primary healthcare providers, community organizations serving women including PPE, and through the SSN public awareness campaign. MCHS will realign HTB coalition efforts to specifically focus on racial/ethnic disparities in birth outcomes and achieving health and birth equity. Future coalition initiatives will be informed by results from community needs assessments and strategic planning guided by the Perinatal Periods of Risk framework, which is a comprehensive community-based approach for translating data into action to improve women's and infant health. A HTB Technical Assistance Contractor will be in place to support the coalitions' efforts in their community health needs assessment, organizational evaluation and to provide training and technical assistance in the development of strategic plans for designing, implementing and evaluating local equity projects.

MCHS will continue to promote the Texas Health Steps Online Provider Education (OPE) program suite of five preconception and prenatal health-focused continuing education modules. The goal of the modules is to equip healthcare professionals with knowledge and resources to improve the health of Texas women before and during pregnancy. The modules can be accessed at www.txhealthsteps.com. MCHS will continue to collaborate with CHW training programs to integrate preconception health and healthcare promotion into curricula. Promotion of healthcare provider education on women's preventive healthcare will continue via DSHS Grand Rounds presentations and website resources. Following a very successful "Healthy Texas Mothers and Babies Conference: A Clinical and Community Life Course Perspective" in 2015, MCHS will continue preliminary planning and assess the feasibility of another statewide conference to share information and best practices to engage, inform and education health care professionals to support improved and more equitable birth outcomes in Texas. MCHS will use the Pregnancy Risk Assessment Monitoring System (PRAMS) to assess the level of Texas women reporting providers discussed preconception health topics with them prior to pregnancy. Furthermore, MCHS will coordinate with UT/TCHMB partners to improve the quality and safety of maternal and women's health care by holding a workshop for professionals to advance evidence-based women's and perinatal health efforts around the state. The FY 18 workshop will focus on Zika.

Through ongoing participation in the ASTHO LARC collaborative, MCHS will work to improve the quality of women's healthcare by promoting use of the One Key Question—*would you like to become pregnant in the next year?* —with healthcare providers and social service organizations serving women. Texas was recently selected to participate in the CDC 6|18 Initiative, which convenes states' health care and public health sectors to improve health and control health care costs under a specific health condition of the state's choosing. MCHS will partner with Medicaid and other state agencies to educate providers around interventions to screen for pregnancy intention and prevent

unintended pregnancy, under the guidance and technical assistance of CDC and other federal partners.

Women with poor mental health prior to pregnancy may experience pregnancy complications, fetal demise, or a low birth weight baby. Racial and ethnic disparities exist with these outcomes. Furthermore, the Texas Maternal Mortality and Morbidity Task Force (MMMTF) has found mental and behavioral health issues contribute to severe maternal morbidity and mortality in Texas. Mental health is one of the preconception health domains identified by the CDC as having important ramifications for birth outcomes. Texas NA data indicated the rate of lifetime depression for women was more than twice that of men, with rates of diagnosed depression and anxiety differing by race/ethnicity. The preconception strategic plan will serve as a roadmap for developing an action plan specific to women's mental health, and will leverage existing partnerships to carry out such actions. Lastly MCHS will continue to use existing surveillance methods to assess mental health in WCBA.

To improve MCH safety programming, MCHS will continue to assess and monitor maternal mortality and severe maternal morbidity rates through the analysis of previously collected surveillance data. MCHS will work with stakeholders across the state to perform severe maternal morbidity and mortality review in Texas through coordination and technical assistance to the MMMTF. MMMTF is a legislatively mandated multidisciplinary advisory committee tasked with ensuring all aspects of women's care and associated factors—including health disparities, clinical and psychosocial matters—are represented and considered in evaluating adverse pregnancy and maternal health outcomes. MCHS will support analysis of cases, trends in maternal death and severe maternal morbidity in Texas, and the development of recommendations to improve women's and maternal care practices that reduce risk and prevent maternal and feto-infant harm. Infrastructure improvements underway will continue to facilitate the task force's ability to conduct more targeted reviews of cases. Through a contract with the University of North Texas Health Science Center to provide redaction and abstraction services, a goal of approximately 25 case summaries will be developed for the task force to review each quarter.

In partnership with the MMMTF, MCHS will develop communications of case review findings from maternal overdose deaths. Activities will continue to address the findings and recommendations from the MMMTF Legislative Report. One response to the task force's identified need for more reliable data reporting is the creation of a new electronic vital events registration system, scheduled to launch January 1, 2019. The Vital Statistics Unit (VSU) at TDSHS together with the Center for Health Statistics (CHS) are working to replace the existing electronic system for registering and collecting birth, death, fetal death, marriage and divorce records in Texas with a new system, referred to as the Texas Electronic Vital Events Registrar, or TxEVER. TxEVER will allow for additional quality checks (by VSU, CHS, and a third party vendor), as well as improved and more efficient receipt and recording of out-of-state deaths of Texas residents. MCHS will continue to support quality improvement initiatives at health care facilities and community-based services settings that address the leading causes of maternal mortality and morbidity, via partnerships with TCHMB and the HHSC Behavioral Health Services Section. MCHS is exploring opportunities to collaborate with and plan for the implementation of data-driven maternal safety and quality improvement initiatives, and will seek to coordinate with the Alliance for Innovation on Maternal Health (AIM) program for patient safety bundle implementation support, peer-to-peer engagements, and access to AIM's national data center.

MCHS 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, MCHS will work to establish and support quality improvement efforts in clinical and community settings related to women's health. MCHS will continue to collaborate on the Healthy Families Project to address women's health disparities and reduce infant mortality risk. Through oversight by the University of Texas Health Sciences Center at Tyler, contractors will continue to implement interventions in Hildalgo and Smith Counties. MCHS will also leverage partnerships with community-based, professional and governmental organizations across the state and at a national level, including the TCHMB, the Texas Perinatal Advisory Council (PAC), the National Preconception Health and Health Care Initiative, and CityMatCH workgroups to keep abreast of, promote and implement evidence-based practices that reduce excess maternal and feto-infant morbidity and mortality.

NPM 1: Percentage of women with a past year preventative visit.

Objective 1: By 2020, increase the proportion of women who discussed preconception health with a health care worker prior to pregnancy to meet a target of 23.4% (PRAMS, 2012 baseline = 20.1%).
Objective 2: By 2020, increase the proportion of women giving birth who attend a postpartum care visit with a health care worker to meet a target of 88.5% or higher (PRAMS, 2012 baseline = 85.4%).
Objective 3: By 2020, reduce the proportion of women who self-report poor mental health for 5 or more days during the past month to meet a target of 19.0% (BRFSS, 2012 baseline = 24.4%).

In FY16 DSHS worked to increase capacity, synergy and collective impact of initiatives to improve women's health and health care delivery. In November of 2015, DSHS executed an Interagency Cooperation Contract with the University of Texas Health Science Center at Tyler (UT) to facilitate the Texas Collaborative for Healthy Mothers and Babies (TCHMB), Texas' perinatal quality collaborative. TCHMB's mission is to advance health care quality and patient safety for all Texas mothers and babies through the collaboration of health and community stakeholders in the development of joint quality improvement (QI) initiatives, the advancement of data-driven best practices, and the promotion of education and training. In FY16 TCHMB was composed of an Executive Committee and three Subcommittees – *Neonatal, Obstetrics, and Community Health*. The need was identified to create an additional Subcommittee, *Data*, for the creation of data management, servers and system to support the QI projects. TCHMB successfully created a branding and logo identity, passed a Governance Plan, convened periodic executive and subcommittee meetings, identified pilot QI projects, held an in-person meeting of the collaborative's membership, worked on creating a data server for storage and analysis of data associated with TCHMB pilot projects, and launched their website www.txchmb.org. The in-person meeting included programmatic updates from HHS programs, reports from committees, guest speaker presentations about promising practices in perinatal substance use treatment and home visiting models, and a review of HHSC's Presumptive Eligibility (PE) program for short-term Medicaid and its potential impact on access to prenatal care for women.

In support of the OB subcommittee, UT conducted an analysis of hospital discharge data focused on maternal complications of childbirth, and a separate study on pregnancy characteristics of mothers by mode of delivery using data from the nationally representative Listening to Mothers III Survey (LTM). Initial analysis of the factors associated with induction of labor among primiparous women delivering at term in the LTM III survey suggest that nearly half of the women in the study underwent induction of labor, with a sizeable portion reporting subjective or non-medical reasons for induction, a better understanding of the characteristics associated with induction of labor at term may help reduce unnecessary intrapartum interventions and, ultimately, primary cesarean delivery. An abstract for a poster presentation at the 2017 American Congress of Obstetricians and Gynecologists (ACOG) of this analysis was submitted and approved. Evaluations of available toolkits/support tools related to induction of labor were also conducted to inform plans for a quality improvement project around induction of labor. The *Community Health subcommittee* selected inter-conception care as its long-term focus, with early entry into prenatal care as the first phase. UT conducted analysis of PRAMS data on characteristics of Texas women accessing prenatal care late in pregnancy. Further research was conducted on barriers and facilitators to accessing prenatal care; available toolkits and other supporting tools related to early access to prenatal care; an inventory of related Medicaid 1115 Transformation Waiver projects related to women's health and maternal and child health in Texas; HHSC Presumptive Eligibility Program criteria; and an assessment of prenatal care initiatives around the states, including Women with IMPACT, Strong Start, IMPACT for Families (Harris Health), and Travis County prenatal care re-design (Dell Medical School Department of Women's Health).

MCHS staff collaborated with other subject matter experts from the agency to develop the Texas Public Health Action Plan (TPHAP), with the goal of providing an overarching vision and framework to improve the state's public health system. This effort served as an opportunity to ensure the needs of the state's MCH population were elevated and incorporated into the state public health plan. MCHS staff provided subject matter expertise in Maternal and Child Health, Chronic Disease, Tobacco, and Safety and Injury Prevention and Control, Mental Health and Substance Abuse, Clinical Prevention and Primary Care Workgroups.

DSHS and HHSC began participation in the ASTHO Increasing Access to Contraception Learning Collaborative in October of 2015. Under this collaborative, Texas worked to increase access to immediate-postpartum long acting reversible contraception (LARC) in the state. Achievements included enactment of LARC reimbursement policies, and the creation of a LARC toolkit for healthcare providers—which provides information and resources to help

providers counsel and screen patients, obtain informed consent, train staff, manage LARC supplies, and receive Medicaid reimbursement. The CHI Associate Commissioner continued to serve as a consultant for the TMA Committee on Reproductive, Women's & Perinatal Health; and on the TPS Fetus & Newborn Committee. Information was presented on transformation of the HHS System, launch of two new women's health programs—Healthy Texas Women and Family Planning Program, changes to agency educational materials pertinent to maternal and perinatal health (including the *Information for Parent of Newborn Children* and the *Information about Down Syndrome for New and Expecting Parents* pamphlets), and efforts to support breastfeeding in Texas. MCHS staff continued to participate in the Consumer Workgroup of the NPHHCI. The NPHHCI is a public-private partnership of over 70 organizations focused on improving the health of young women and men and that of any children they may choose to have someday. The initiative was convened and is supported by the CDC, with additional support from the W.K. Kellogg Foundation. The consumer workgroup focuses on how to best message and engage diverse populations of women and men of reproductive age on preconception health. MCHS staff continued to participate in the HHSC Better Birth Outcomes Workgroup that works to improve access to women's preventive, interconception, prenatal, and perinatal health care. Topics included the LARC Prescription benefit, 17-P, Neonatal Abstinence Syndrome, Postpartum Depression and Zika. MCHS provided updates on the Someday Starts Now website, the Interagency Lactation Support Workgroup and the Infant Mortality CoIIN (Collaborative for Innovation and Improvement Network). Opportunities were explored for collaboration with DSHS and HHSC departments and initiatives, such as the Heart Disease and Stroke Program, Tobacco Prevention and Control, Obesity Prevention Program, and the Substance Use Disorder Unit.

MCHS worked with partners to expand preconception/inter-conception health and health care outreach efforts across MCHS and stakeholder programming. The Someday Starts Now (SSN) bilingual public awareness campaign was released in November 2012 to increase awareness of the modifiable risk factors that impact infant mortality and preterm birth among the general public, with particular attention focused on African American women of childbearing age. Resources, links and tools for women, fathers and health providers include Life Planning and Birth Plan Tools, posters on preconception, inter-conception and prenatal health, and a patient health priorities worksheet. Initially the campaign included a heavy rotation of television and radio public service announcements, online advertising, and launching of www.SomedayStartsNow.com and www.AlgunDiaEmpiezaAhora.com websites. A new micro-site for fathers, www.LiveLikeADad.com and www.ViveComoPapa.com, was released in 2015. In FY 2016 there were a total of 10,412 sessions with 22,317 page views from people from 78 countries. The micros site traffic also boasts 1,441 sessions and 7,113 page views in FY2016. A Task Order Request was released in FY16 to procure a new vendor to update the campaign with plans for redesign during 2017-2018 to align with the most current MCHS priorities and research, expand the target audience and provide a more streamlined digital experience. The MCHS Life Planning Tool is available for free download on the www.somedaystartsnow.com website and through the HHSC warehouse. In FY2016 a total of 6,390 English and 3,846 Spanish Life Planning Tools were ordered through the HHS warehouse.

MCHS partners with the University of North Texas Health Science Center to implement and spread the PPE program across all nine Texas HBCUs. Activities to build the groundwork for implementing PPE in HBCUs included conducting an analysis of National College Health Assessment data to understand health issues and behavioral trends of college-age students; contacting PPE programs in other states such as North Carolina, California, and Massachusetts to glean best practices and lessons learned from other PPE programs; establishing contact with Texas HBCUs and community organizations around HBCU campuses to introduce the program; developing outreach materials to use during visits to the campuses; developing a social media presence; and updating the PPE student training curriculum. Campus visits were instrumental to identify and convene the administrators and faculty/staff at each campus that will support and drive implementation of the program in that campus, which is critical for the program's success. An orientation event took place at the UNTHSC Fort Worth campus in Spring 2016. In attendance were students and faculty/staff advisors (26 and 9, respectively) from four HBCUs: Prairie View A&M University, Paul Quinn College, Wiley College, and Jarvis Christian College. Students were provided instruction on conducting a campus Community Readiness Assessment using a validated tool from Colorado State University. The assessment helps students and faculty determine the campus' readiness to implement the program, and to identify next steps needed to move the program forward. Students carried out their campus assessment soon after the orientation with technical assistance from program staff.

MCHS promoted educational resources for health care providers and other health care professionals to improve the quality of women's preventive care services. The Healthy Texas Babies initiative supports the creation and strengthening of local perinatal coalitions in the state through funding and programmatic technical assistance. HTB

coalitions are responsible for implementing evidence-based interventions based on Perinatal Periods of Risk (PPOR) mapping analysis conducted by MCHS. PPOR mapping shows that black infants have the greatest burden of fetal-infant death across all 4 PORs, with 61 percent of Black fetal-infant deaths being potentially preventable.

Currently there are six HTB-funded community coalitions in Texas, with 330 active members representing 15 diverse sectors (local health departments, public and private hospitals, community based organizations, and local businesses, etc.) and an additional 140 stakeholders engaged in coalition initiatives. Five of the coalitions are implementing evidence based interventions focused on the Maternal Health/Prematurity POR. These interventions promote integration of preconception and inter-conception care into routine primary care, using the SSN Life Planning Tool, as well as other evidence-based tools developed by partners outside the state. The target population is African American and Hispanic women of childbearing age and/or teens of all ethnicities. Baylor College of Medicine, is implementing an evidence based intervention under the Maternal Care POR, and is focused on a group prenatal care intervention for pregnant African American and Hispanic adolescents. The *Healthy Texas Babies Initiative Steering Committee* of Austin-Travis County Health and Human Services is adapting the SSN Life Planning Tool for teens using a focus group forum, and has chosen sites for an 11-session preconception health education curriculum to be delivered by peer educators. The Steering Committee met quarterly to plan out the Healthy Adolescent Peer-to-Peer and Austin Independent School District Teen Parent Programs and identify sites for implementation. The *Community Action Network* of Dallas County has focused on providing preconception training to providers at their Women's Healthy Centers as well as educating, referring, and promoting weight loss among overweight and obese patients at one clinic using the Reproductive Life Plan tool. In FY16 there were 14 staff trained at the Parkland Health Women's Health Center on how to incorporate the Life Planning Tool in providing one on one consultation with obese and overweight women, as well as preconception education to 174 clinical staff and managers. The *Healthy Me, Healthy You* coalition of Northeast Texas Public Health District has worked to increase the number of women who receive preconception education through targeted community outreach, including working with local Historically Black and other local colleges in the area and barber/beauty shop professionals and patrons. A local media campaign based on the SSN preconception health materials was implemented reaching at least 21,500 people, and participated in 13 outreach and community education events reaching approximately 2,125 individuals. SSN and other preconception health education material was disseminated in the local colleges and barber/beauty shops to set the groundwork for further collaboration and training. The *Tarrant County Infant Health Network* of Tarrant County Public Health Department worked to incorporate pregnancy intention screening into the electronic health record (HER) system at two of its county public health clinics, including the HIV and the adult health clinics. The Tarrant County Public Health Preventative Medicine Clinic successfully integrated the "One Key Question" into its HER and progress was made with the JPS Health System. *Healthy Babies Coalition* of Waco-McLennan County has worked closely with coalition members to expand public information dissemination and provider education around preconception health. In FY16 preconception health counseling was provided to 833 women of childbearing age in community clinics during well-woman appointments, and 150 providers were trained to utilize the preconception health toolkit/Life Planning Tool at 14 local Federally Qualified Health Centers. Lastly *Impacting Maternal and Prenatal Care Together (IMPACT)* of Baylor College of Medicine- Houston implementing the Centering Pregnancy program to improve prenatal health and birth outcomes had 49 pregnant adolescents complete the program in FY16, with 46 participants showing improved knowledge among teen mothers about pregnancy, labor, benefits of full-term delivery, and stress management. A series of webinars, and phone calls as well as site visits and an in-person meeting were carried out in order to provide technical assistance and collaborative learning opportunities to all six of the coalition coordinating teams.

HTB sponsored a DSHS Grand Rounds in Spring 2016 focused on Postpartum Depression Screening and Management, which was attended by 237 health care providers and health professionals. Other relevant DSHS Grand Round topics in FY16 include Case Studies Examining the Impact of Community Health Workers/Promotores, E-cigarette Epidemic among Youth and Young Adults, and Zika Virus.

MCHS collaborated with THSteps Online Provider Education (OPE) to develop a suite of five continuing education modules focused on preconception and prenatal health.
The modules equip health care professionals with knowledge and resources to improve the health of Texas women before and during pregnancy. A total of 1,566 modules were completed by health professionals, consisting of: Preconception and Prenatal Health: Overview (531), Preconception and Prenatal Health: Managing Chronic Health Issues Before and During Pregnancy (410), Preconception and Prenatal Health: Identifying and Intervening in High-Risk Behaviors (369), Preconception and Prenatal Health: Cytomegalovirus (163), and Preconception and Prenatal Health: Promoting and Maintaining Women’s Oral Health (93). The modules can be accessed at www.txhealthsteps.com.

MCHS provided subject matter expertise in creation of the Texas Long Acting Reversible Contraception (LARC) Toolkit developed by HHS. The LARC Toolkit aims to help providers increase availability of LARCs to all Texas women. The new Toolkit offers suggestions and resources to support implementation of a policy to make LARCs available to women throughout their reproductive life, including prior to the first pregnancy, during the postpartum period (both during the hospital stay and at the postpartum visit), and whenever family planning services are received. The toolkit can be found at https://hhs.texas.gov/sites/hhs/files/documents/doing-business-with-hhs/providers/health/women/texas-larc-toolkit.pdf.

MCHS used existing surveillance methods to assess reported mental health status among women of childbearing age. Per 2015 BRFSS data, 23.1% of women aged 18-44 reported poor mental health for five or more days in the past month. This prevalence was slightly elevated from the 2015 rate of 22.6%, but lower than the 2011 rate of 26.4%. There was variation by race/ethnicity in mental health status, with 30.3% of non-Hispanic white women reporting poor mental health for five or more days during the past month in 2015, compared with 28.2% of non-Hispanic black women and 17.7% of Hispanic women.

MCHS worked to build and strengthen partnerships with other divisions within the agency working on improving the mental health of Texas women. Mental and emotional health content was added to the breastfeeding promotion campaign *Every Ounce Counts*. The website includes information, tips and resources on self-care for women during pregnancy and after birth, information for women and their support networks about identifying the signs of perinatal depression and anxiety, and where to get help. This mental health content can be accessed in the *Self-Care: Mental and Emotional Health* section and the *For Dad*, *For Grandma*, and *Friends and Family* sections of *Every Ounce Counts* website at http://www.breastmilkcounts.com/self-care/mental-and-emotional-health/ and http://www.breastmilkcounts.com/teamwork/. Further, lactation support centers worked on incorporating perinatal depression screening into their assessment and referral procedures and workflow.

In September of 2015, DSHS began collaboration with HHSC, including the Center for the Elimination of Disproportionality and Disparities, on the Healthy Families Project (HFP), a women's health disparities and infant mortality risk reduction project. The purpose of the HFP is to increase access to family planning services and decrease the risk for infant mortality among Black and Hispanic women by providing communities with very flexible resources they can use to implement customized health care interventions within a health equity awareness framework. Through data analysis by MCHS, Hidalgo and Smith counties were identified to pilot projects with a focus on Hispanic women of childbearing age and African American/Black women of childbearing age, respectively. Regional meetings were held in each community to gather information from stakeholders to inform project planning. In Smith County, CHWs were identified as one resource to facilitate early identification of pregnancy, navigation of pregnant women into prenatal care services, and improving continuity of care and postnatal care. Opportunities also exist in provider education and training and incorporation of cultural competency. The Hidalgo County intervention will focus on partnering with the Nurse-Family Partnership to promote education, engagement and evaluation of prenatal care. At the end of FY 16, the HFP began contracting with the University of Texas Health Center at Tyler to facilitate the project and begin implementation of project activities.

Objective 4: By 2020, increase by 10% the proportion of maternal deaths reviewed by the Texas Maternal Mortality and Morbidity Task Force.

Through the 15-member Texas Maternal Mortality and Morbidity Task Force, MCHS analyzed severe maternal morbidity and mortality trends in Texas. The task force began review of maternal mortality cases with calendar year 2012. The task force uses the CDC definition of pregnancy-related death, which encompasses the death of a woman occurring within one year of termination of pregnancy from any cause related to or aggravated by pregnancy or its management. MCHS identified 89 qualified maternal deaths for review in the 2012 cohort. The task force met in person quarterly. The quarterly meeting included programmatic updates from DSHS and HHSC programs relevant to the task force, refinement of task force processes, case review discussions, and discussion of findings and recommendations from cases reviewed to date prior to development of joint task force and DSHS legislative report in summer 2016.

The Task Force, with the support of MCHS, reviews actual cases of maternal deaths to gain a more in-depth picture of the causes and risk factors to make recommendations for prevention. In late 2014, the task force began review of the 89 maternal mortality death cases with that occurred in calendar year 2012, the year with the highest maternal mortality rate thus far. In FY 2016, the task force reviewed 38 cases, with 13 of these cases having undergone a full

review of case records. Seven of the fully reviewed cases were closed, while six of them remained open, as the task force determined further records needed to be requested to undergo a more thorough examination of these cases' unique components and allow for determination of causality and preventability.

The task force and DSHS released the Joint Biennial Report to the Legislature in July 2016 that includes findings and recommendations to help reduce the incidence of pregnancy-related deaths and severe maternal morbidity in Texas. Statewide trends captured in this report include that 1) Black women bear the greatest burden of maternal death (11.4% of all live births in Texas but 28.8% of all maternal deaths in Texas); 2) cardiac events, drug overdose and hypertensive disorders are the leading causes of maternal death; 3) 60% of maternal deaths in 2012 occurred after six weeks following delivery; and 4) data quality issues pertaining to the death certificate coding made it difficult to identify obstetric-related deaths.

The Task Force identified missed opportunities for mental health and substance use screening encounters and subsequent referral. Notable variations were observed in how maternal deaths are investigated depending on the system involved and that some deaths that should have been investigated by Medical Examiners were not routed appropriately. Finally, the task force found that redaction of cases prior to nurse abstraction prolonged the time to review maternal death cases.

In reviewing calendar year 2012 severe maternal morbidity (SMM) data, new methodologies of calculating severe maternal morbidity revealed a higher prevalence of SMM than previously found by past studies. The task force found that hemorrhage and blood transfusion cases largely drive severe maternal morbidity in Texas, and that racial/ethnic and geographic disparities exist in cases of hemorrhage and/or blood transfusion, with black women and women in south and east Texas bearing a disproportionate burden of SMM due to these causes. Lastly, the task force found that mental illness and substance use disorders contribute to severe maternal morbidity.

To address the findings, the task force made the following recommendations: 1) increase access to health services during the year after delivery and throughout the interconception period to improve continuity of care, enable effective care transitions, promote safe birth spacing, reduce maternal morbidity, and reduce the cost of care in the Medicaid program; 2) increase provider and community awareness of health inequities and implement programs that increase the ability of women to self-advocate; 3) increase screening for and referral to behavioral health services; 4) increase staffing resources in support of the task force; 5) promote best practices for improving the quality of maternal death reporting and investigation; and 6) improve the quality of death certificate data.

Activities in FY 16 had begun to address many of the findings. Through the launch of the Healthy Texas Women's program in July of 2016, THHSC extended access to interconception/postpartum health care through the entire first year after delivery. By way of direct rollover from the Medicaid program, streamlined enrollment, and extensive outreach, the program provides access to family planning services, along with health care services, such as screening for and treatment of diabetes, hypertension, and high cholesterol for a subset of women. Screening and treatment for postpartum depression are also available. Funding was provided to the Behavioral Health Services Division at the Texas Health and Human Services Commission (THHSC) for 2016 and 2017 to treat and reduce the incidence, severity, and cost of NAS. An analysis of hospital inpatient discharges shows that the rate of neonatal abstinence syndrome (NAS) has steadily increased in Texas from 1.3 per 1,000 deliveries in 2008 to 2.4 per 1,000 deliveries in 2014, suggesting that more pregnant women are abusing opioids. TDSHS continued partnering with THHSC regarding mental health and substance abuse services for women as an important means toward further reduction of the risks for maternal mortality.

In efforts to increase staffing resources, the Maternal Mortality and Morbidity Nurse joined MCHS and staff began exploring options to contract with a public university to perform case redaction, abstraction and case summary services. Based on the methodologic issues discussed, plans began to improve the quality of death certificate data to better identify maternal deaths in Texas at a system-level. TDSHS began the process of replacing the existing electronic system for registering and collecting birth, death, fetal death, marriage, and divorce records in Texas, known as the Texas Electronic Registrar, with a new electronic system, Texas Electronic Vital Events Registrar (TxEVER), to be launched January 1, 2019. Features will be considered to help to improve the quality of death certificate data, and hence, the identification of maternal death in Texas.

Regional Population-based Activities

Regional staff have made progress integrating preconception care programming into their health promotion efforts and have been creative in their approaches. In Region 6/5S DSHS staff have approached Sam Houston State

University Health Center and are in the process of helping clinical staff prepare to utilize the Life Planning Tool and other materials from the SSN website in 2017. Those staff have also helped local beauty schools integrate preconception health materials from the Someday Starts Now Beauty and Barbershop Outreach Toolkit into their cosmetology curriculum. Students were provided a SomedayStartsNow.com-branded beauty cape and copies of the Life Planning Tool and instructed on how to integrate messaging on preconception health and poor birth outcomes among African American communities into their discussions with clients. Staff also successfully trained operators at eight African American beauty salons to utilize the SSN Beauty and Barbershop Outreach Toolkit.

Outreach to schools to promote preconception health in terms of informed decision-making is another common area of focus for regional staff. HSR 4/5N collaborated with UNTHSC to promote the PPE Orientation in Fort Worth among HBCUs in East Texas, particularly Wiley College, with which regional staff has a long-standing relationship. They also collaborated closely with the HTB Healthy Me, Healthy You coalition in Tyler to promote the preconception health campaign on the UT Tyler campus, hanging doorknob hangers and distributing their informational booklet which includes the Life Planning Tool among the dormitories and student health centers. Staff also were trained in Dallas in July as March of Dimes ambassadors to allow them to promote key prematurity and infant mortality prevention messages and link stakeholders to data and health promotion resources from the foundation.

Several of the regions have also taken a holistic approach when delivering routine care such as immunizations at field offices and clinics in the regions. HSR 9/10 has started blood pressure and diabetes screening and have referred 1387 people to local services for follow-up. HSR 1 and 7 have both developed a questionnaire to assess additional services for which a client seeking routine services such as immunizations or STI screening at a DSHS clinic may be eligible. These include adult immunizations such as HPV, flu and TDaP, suicide screening and referral, smoking cessation, and ppd skin test placement for those with tuberculosis (TB) risk factors.

In collaboration with their Communicable Disease program, population-based MCH staff in HSR 7 first conducted a chart audit for their TB, immunization, perinatal Hepatitis B and STI patients. They discovered several barriers to integrated care and found care was being delivered along strict service lines, with many missed opportunities for treatment, complementary health promotion and prevention. They updated their standing orders to support routine assessment and provision of broad preventive services and added “prompts” to their nursing assessment forms to remind nurses to consider other risk factors. Termed “The Whole Person Project,” this approach initiates a continuum of care for the client and allows the staff to take full advantage of their time with patients.

Staff are collecting data on the outcomes of this approach to determine its efficacy and initial results are promising. For example, of 70 clients visiting clinics in HSR 1 in FY 2016 for non-STI-related services and offered STI testing, 9 agreed to testing. Of 36 clients offered smoking cessation services when they visited the clinic for another reason, 18 agreed to the service. Even more impressive are the results of screening for sex trafficking – of 50 individuals approached with education about sex trafficking based on risk factors, 29 were provided referral to services and education. In total, of 239 individuals offered services through this holistic model in HSR 1, 28% were provided complementary services.

Performance analysis: The proportion of women reporting discussing preconception with a provider was 20.1% (CI: 16.9-23.3) in 2012—the year when the measure started being recorded in PRAMS. Though not statistically significant, this proportion decrease in 2014, with 19.3% (CI: 16.5-22.0) reporting discussing preconception health with a healthcare provider prior to pregnancy. MCHS made strides toward meeting the objectives of its ESMs during FY16 with over 10,000 Life Planning Tools were distributed; over 600 healthcare professionals completed educational preconception and prenatal care modules; the implementation of two HBCU’s the PPE program was met; establishment of infrastructure for TCHMB, and completion of a legislative report of the findings and recommendations of the MMMTF to improve maternal safety. Through initiatives implemented to improve women’s health and healthcare via FY16 programming, MCHS will continue to contribute to improve the quality of women’s healthcare in the state.

Challenges / Opportunities: The SSN public awareness campaign was not active during FY16, thus limiting outreach efforts for educating women and providers. Further assessment of women’s health programming in the state is needed to assess barriers and opportunities to improving the quality of preconception healthcare. This assessment and the strengthening and establishment of new partnerships across and outside the HHS System provide opportunity to improve preconception health in Texas by increasing coordination and collective impact of efforts around preconception health and health care.

Perinatal/Infant Health

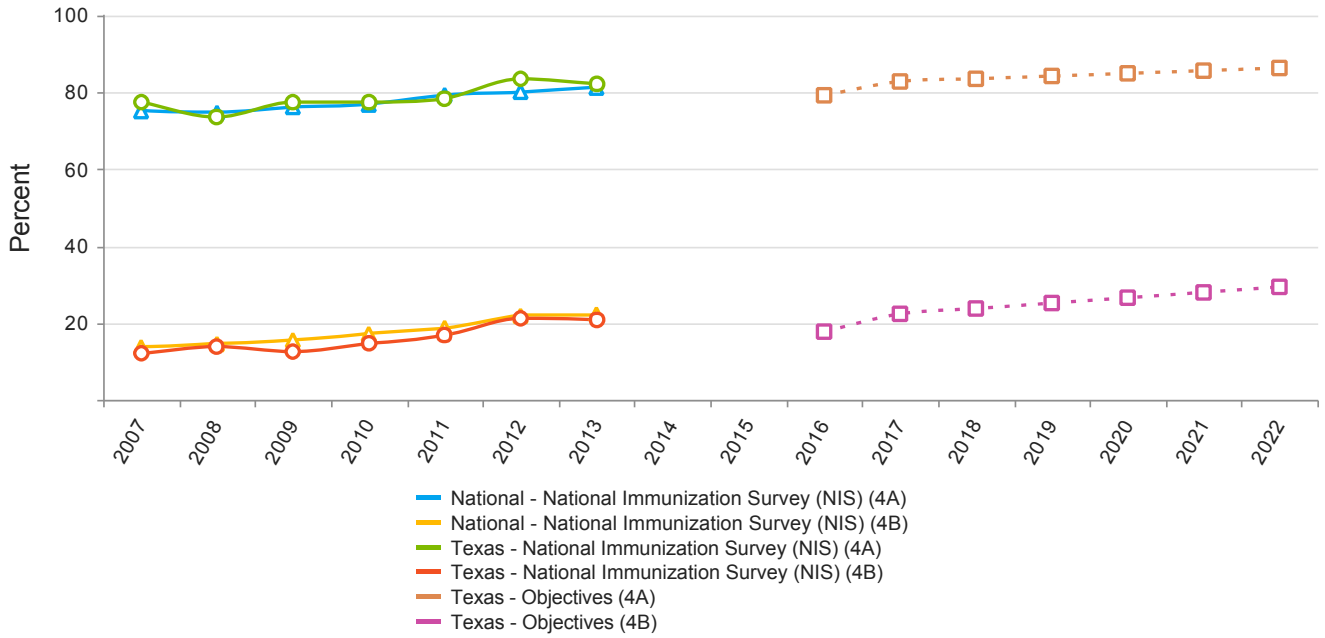
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	5.9	NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.9	NPM 4 NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	95.8	NPM 4 NPM 5

National Performance Measures

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

Baseline Indicators and Annual Objectives



NPM 4 - A) Percent of infants who are ever breastfed

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	79.1
Annual Indicator	81.9
Numerator	302,196
Denominator	368,965
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	82.7	83.4	84.1	84.8	85.5	86.2

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	17.8
Annual Indicator	21.0
Numerator	75,605
Denominator	360,397
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	22.4	23.8	25.2	26.6	28.0	29.4

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Breastfeeding support assessment findings available

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	Texas WIC Infant Feeding Practices Survey
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 4.2 - DSHS Infant Feeding Workgroup Strategic Plan available in 2017

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	DSHS Infant Feeding Workgroup
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	Yes	No	No	No	No

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
Annual Objective	
Annual Indicator	143
Numerator	
Denominator	
Data Source	DSHS Texas Ten Step Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	140.0	145.0	150.0	155.0	160.0	165.0

ESM 4.4 - Number of employers who receive information and technical assistance on Mother-Friendly breastfeeding support policies

Measure Status:	Active

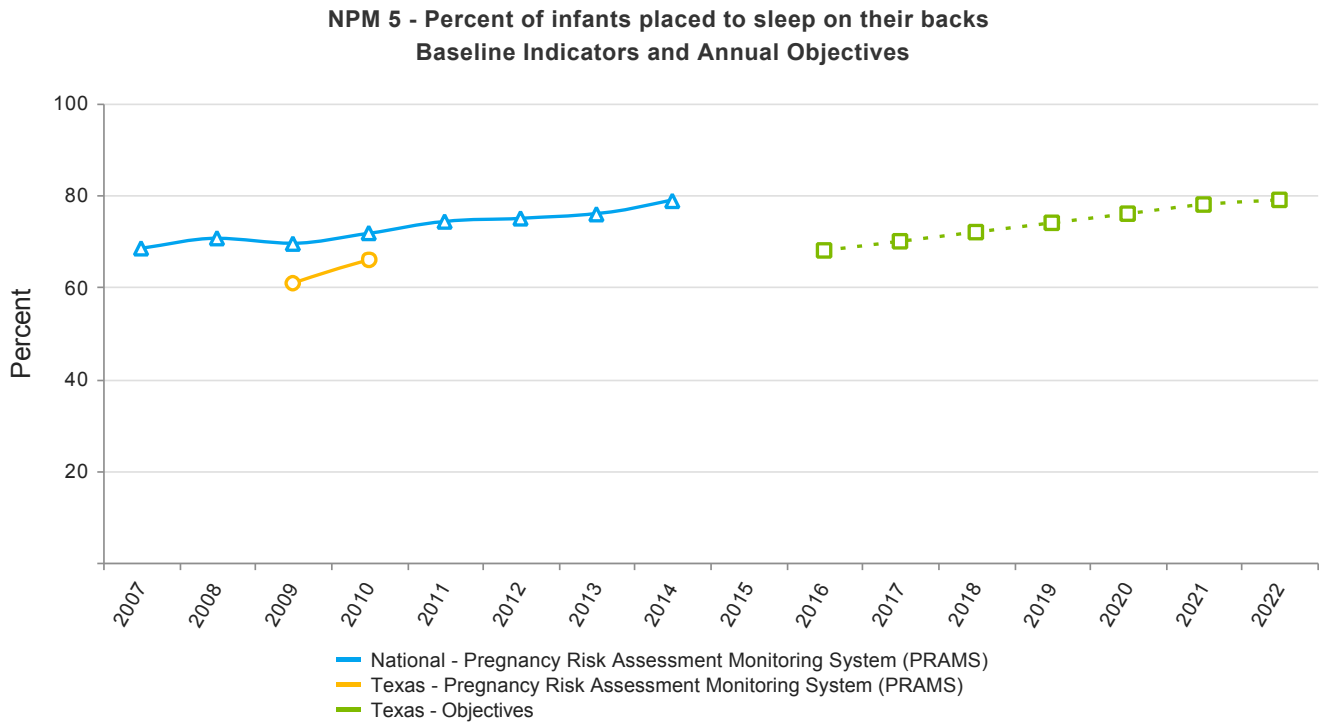
State Provided Data	
	2016
Annual Objective	
Annual Indicator	458
Numerator	
Denominator	
Data Source	DSHS Mother Friendly Worksite Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	400.0	400.0	400.0	400.0	400.0	400.0

ESM 4.5 - DSHS Infant Feeding Position Statement reviewed, revised and updated in FY2018

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	Yes	No	No	No	No



Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	67.9
Annual Indicator	66.0
Numerator	240,305
Denominator	364,373
Data Source	PRAMS
Data Source Year	2010

State Provided Data	
	2016
Annual Objective	67.9
Annual Indicator	69.4
Numerator	263,609
Denominator	379,932
Data Source	PRAMS
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	69.9	71.9	73.9	75.9	77.9	78.9

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Interagency Safe Sleep Messaging Strategic Communication Plan available in 2017

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Safe Sleep Messaging Interagency Workgroup
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	Yes	No	No	No	No

ESM 5.2 - Complete community assessments and infant mortality prevention strategic plans in Healthy Texas Babies (HTB) Coalition communities

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	Yes	Yes	No	No	No

State Performance Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	2.2
Numerator	10.9
Denominator	4.9
Data Source	Texas natality and mortality data
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.1	2.1	2.1	2.0	2.0	2.0

State Action Plan Table

State Action Plan Table (Texas) - Perinatal/Infant Health - Entry 1

Priority Need

Reduce health disparities for maternal and child health populations.

NPM

A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Objectives

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).

By 2020, increase the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies from 7.7% to 8.9%. (CDC Breastfeeding Report Card; Baby Friendly USA/Natality).

By 2020, increase the average Texas score on the CDC Maternity Practices in Infant Nutrition and Care (mPINC) Survey score from 73 to >78. (CDC Breastfeeding Report Card).

By 2020, increase the number of Texas Mother-Friendly Worksites from 2,250 to >3,000. (Program data).

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).

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 - Breastfeeding support assessment findings available	Active
ESM 4.2 - DSHS Infant Feeding Workgroup Strategic Plan available in 2017	Active
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	Active
ESM 4.4 - Number of employers who receive information and technical assistance on Mother-Friendly breastfeeding support policies	Active
ESM 4.5 - DSHS Infant Feeding Position Statement reviewed, revised and updated in FY2018	Active

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

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

Priority Need

Ensure use of culturally and linguistically appropriate Maternal and Child Health education and outreach efforts.

NPM

Percent of infants placed to sleep on their backs

Objectives

By 2020, increase the proportion of mothers who report their new babies sleep alone in their own cribs or beds in the same room where the mothers sleep by 2%. (No baseline data available; new 2016 PRAMS measure).

By 2020, reduce the proportion of mothers who report their new babies usually sleep with toys, cushions, or pillows, a blanket, and/or with crib bumper pads by 2%. (No baseline data available; new 2016 PRAMS measure).

By 2020, increase the proportion of mothers who report a health care worker told them about basic sleep safety by 2%. (No baseline data available; new 2016 PRAMS measure).

Strategies

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

Strategy 2: Establish a PRAMS baseline for proportion of mothers who report their new babies usually sleep with toys, cushions, or pillows, a blanket, and/or with crib bumper pads.

Strategy 3: Partner to expand, coordinate, and integrate sleep safety and SIDS risk reduction programmatic efforts and outreach across health and human service programming.

Strategy 4: Develop and disseminate materials, communications, outreach methods, and programmatic strategic plans for promotion of sleep safety and SIDS risk reduction.

Strategy 5: 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 - Interagency Safe Sleep Messaging Strategic Communication Plan available in 2017	Active
ESM 5.2 - Complete community assessments and infant mortality prevention strategic plans in Healthy Texas Babies (HTB) Coalition communities	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 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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

Priority Need

Reduce health disparities for maternal and child health populations.

NPM

Percent of infants placed to sleep on their backs

Objectives

By 2020, increase the proportion of mothers who believe that babies who are breastfed are less likely to die from SIDS from 45.3% to 46.7%. (DSHS WIC IFPS).

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 - Interagency Safe Sleep Messaging Strategic Communication Plan available in 2017	Active
ESM 5.2 - Complete community assessments and infant mortality prevention strategic plans in Healthy Texas Babies (HTB) Coalition communities	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 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Texas) - Perinatal/Infant Health - Entry 4

Priority Need

Reduce health disparities for maternal and child health populations.

SPM

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

Objectives

By 2020, increase the percentage of Black women reporting exclusive breastfeeding during the infant's hospital stay to 36% from baseline. (PRAMS, 2012 baseline = 30%).

By 2020, increase the percentage of Black women placing their infant on their back to sleep to 57% from baseline. (PRAMS, 2012 baseline = 51%).

Strategies

Strategy 1: Conduct community-specific needs assessments to evaluate high fetal and infant mortality rates among black infants.

Strategy 2: Conduct targeted public health messaging in counties with high Black infant mortality rates in the PPOR periods of Newborn Care and Infant Health through use of the Healthy Texas Babies' Public Awareness Campaign, Someday Starts Now, and in partnership with programs such as Healthy Start and WIC.

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

State Action Plan Table (Texas) - Perinatal/Infant Health - Entry 5

Priority Need

Reduce health disparities for maternal and child health populations.

SPM

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

Objectives

By 2020, increase the percentage of Black women entering prenatal care within the first trimester to 55.5% from baseline. (Birth File; 2014 baseline = 53.3%).

Strategies

Strategy 1: Conduct community-specific needs assessments to evaluate high fetal and infant mortality rates among black infants.

Strategy 2: Conduct targeted public health messaging in counties with low rates of first trimester prenatal care for Black women through use of the Healthy Texas Babies' Public Awareness Campaign, Someday Starts Now, and in partnership with entities such as Healthy Start and WIC.

Strategy 3: Conduct outreach within historically Black colleges and universities and junior colleges with high rates of Black student enrollment to provide preconception education.

Strategy 4: Improve the quality and timeliness of perinatal care provided to Black women through the work of the Healthy Texas Babies Initiative and other projects.

State Action Plan Table (Texas) - Perinatal/Infant Health - Entry 6

Priority Need

Reduce health disparities for maternal and child health populations.

SPM

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

Objectives

By 2020, maintain the percentage of Black women who report receiving 17P during their most recent pregnancy at 11%. (PRAMS, 2011 baseline = 11%; 2012 data were not used to develop measure because of low sample size).

Strategies

Strategy 1: Conduct community-specific needs assessments to evaluate high fetal and infant mortality rates among black infants.

Strategy 2: 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.

Strategy 3: Improve the quality of perinatal care provided to Black women through the work of the Healthy Texas Babies Initiative and other quality improvement projects.

Perinatal/Infant Health - Plan for the Application Year

Utilizing the results of the Five-Year Needs Assessment, stakeholder engagement, and building upon work from previous years, Texas selected the following Performance Measures for the Infant and Perinatal Health domain:

- NPM 4 - Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)
- NPM 5 - Safe sleep (percent of infants placed to sleep on their backs)
- SPM 3: - Infant Mortality Disparities (Ratio of Black to White infant mortality rate)

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 impact on maternal, infant and child health outcomes throughout the life course, including on common childhood infections, rare but serious child health conditions such as necrotizing enterocolitis, childhood leukemia and SIDS, and chronic health conditions including childhood asthma, obesity, celiac disease, and diabetes and maternal health conditions including cardiovascular disease, hypertension, breast and ovarian cancers, and rheumatoid arthritis. All DSHS breastfeeding activities are coordinated with oversight by the State Breastfeeding Coordinator in MCHS through the DSHS Infant Feeding Workgroup (IFW). The IFW has collaborated since 2009 to integrate data-driven strategies for development, implementation and evaluation of a comprehensive program of breastfeeding support 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, NICUs, health care professionals, employers and child care centers in implementation of recommended practices supportive of breastfeeding. In addition, DSHS works to develop capacity and strengthen infrastructures in local communities and statewide to increase access to the appropriate level of support and continuity of care for lactating mothers and their babies, and to strengthen systems to promote and support improved infant feeding outcomes in Texas. MCHS also coordinates a spectrum of assessment and evaluation activities to ensure data-informed programmatic planning and resource allocation while providing ongoing feedback into current initiatives.

State quantitative and qualitative data demonstrate the substantial systemic barriers that low-income women, Hispanic, Black, and Native American women, and other populations face in meeting their personal goals for breastfeeding. Data also illuminate the barriers to meeting public health objectives for breastfeeding. Many of these barriers can be addressed by changing the context in which a mother's infant feeding choices are made and carried out. 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: (a) provides access to and supports consideration of full, accurate, and un-biased information about the risks and benefits of feeding options, and (b) promotes and supports a woman's ability to carry out her choices. MCHS 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.

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 through examination of data and findings from multiple assessment and surveillance sources including the 2016 Texas WIC Infant Feeding Practices Survey, the BRFSS, the Texas Hospital Association Survey, and formative assessment reports. MCHS will work with Texas WIC to administer the next phase of the biennial Texas WIC Infant Feeding Practices Survey in FY2018. MCHS will continue to explore opportunities to examine existing data (e.g. the Newborn Screening demographic data feed-field) to increase knowledge about breastfeeding practices. MCHS will also continue to engage in formative and summative assessment activities related to hospital quality improvement for 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 (including birthing facilities, employers, state and local agencies, professional associations, insurers, state and local 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. The IFW will implement strategies and activities of its five year strategic action plan, as identified through the FY16/FY17 strategic planning process to serve as a road map for prioritization and advancement of the IFW's work.

The IFW will continue to work to strengthen connections between and among organizational stakeholders (e.g.

professional organizations, local WIC agencies, fitness/wellness councils, coalitions, municipalities, non-profits, public health- and/or foundational grantees) across the state to maximize statewide and local coordination and impact for improvements in breastfeeding support.

The IFW will continue to leverage partnerships to reach and support birthing facilities and their community stakeholders with information and assistance to increase uptake of the Ten Steps to Successful Breastfeeding, including the steps associated with hospital care practices and Steps 3 and 10, which are related to prenatal and postpartum breastfeeding support. The Ten Steps are 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 by designation as a Baby Friendly Hospital. MCHS offers a continuum of activities (Figure 1) 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 work to implement a second phase of the Texas Ten Step Star Achiever Initiative to engage hospitals in transformative quality improvement to improve breastfeeding outcome and to reduce disparities in infant feeding practices.

MCHS 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 to administer the Texas Mother-Friendly Worksite-Technical Assistance and Support Program (MFW-TASP), which provides information and technical assistance 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 Texas Mother-Friendly Worksite Program are eligible to have their worksites designated and recognized through the MFW program. Plans for a social marketing and communications strategy, as developed in FY17, will be launched to expand the reach of the program and target specific employment sectors to increase breastfeeding support for populations with significant barriers to combining working and breastfeeding.

Breastmilk use to optimize short- and long-term health outcomes is particularly critical among fragile and ill infants. Increased access to breastmilk for vulnerable infants will continue to be promoted through a variety of MCHS activities. The TCHMB Neonatal Subcommittee will continue to work to engage hospitals across the state to develop strategies to increase access to and use of breastmilk in Neonatal Intensive Care Units (NICU). DSHS will continue to coordinate with partners including the Texas Pediatric Society and HHSC (e.g. through the Better Birth Outcomes initiative and the DSHS HHSC Lactation Support Workgroup) to explore opportunities for increased access to human donor milk and mom's own milk for infants in the NICU, including coordinating efforts across programs to facilitate timely access to appropriate pumps, education, and support for establishment and maintenance of milk supply among WIC-and/or Medicaid-eligible infants. In addition, DSHS will continue to partner with Human Milk Banking Association of North America-affiliated mother's milk banks to provide health professionals with training opportunities as part of its clinical lactation practicum offered by the LSC's to learn about human donor milk and milk banking.

MCHS will continue to pilot the WIC Peer Dad program in up to four communities. Peer Dads provide education and support to with fathers in the WIC clinics about breastfeeding, infant care, baby behavior, and caring for the mother; teach breastfeeding classes in WIC clinics and other settings; and provide prenatal breastfeeding education to WIC mothers when female peer counselors are not available.

MCHS will continue to support the Lactation Support Center (LSC) Services - Strategic Expansion Program (LSCS-SEP) which expands services at the LSCs beyond services funded through WIC to also include:

- Provision of lactation education, counseling and referral services to non-WIC participants;
- Development and implementation of 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 Guide to Strategies to Support Breastfeeding Mothers and Babies, and other best practice resources.
- Conducting 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.
- Providing enabling services (e.g. transportation services; child care; extended hours; mobile clinics; home visiting; language services; etc.) to increase access to family centered, culturally relevant, timely care.

The IFW will continue to plan, develop and disseminate materials, communications, outreach methods, and programmatic strategies for promotion of breastfeeding support practices through existing breastfeeding campaigns as well as other communication platforms (e.g. SSN, Agrilife Extension) to reach audiences including 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 OPE platform, and through various live training and continuing education opportunities including those 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.

NPM 5: Percent of infants placed on their backs to sleep.

Prevention of infant mortality remains a key priority for DSHS. Texas needs assessment findings still show disparities in sleep-related infant deaths. Analyses conducted in 2011 (http://www.dshs.texas.gov/healthytexasbabies/data.aspx), 2013, and 2016 using the PPOR analytic approach identify the populations, areas of the state and PORs with the greatest burden of potentially preventable (excess) fetal-infant mortality, and target 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. The American Academy of Pediatrics' Task Force on Sudden Infant Death Syndrome Policy Statement, SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment (AAP Policy Statement), and its 2016 Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns provide evidence-based, comprehensive approaches to sleep safety and risk reduction for sleep-related infant deaths, including SIDS, and address both intrinsic and extrinsic risk factors. Nationally, several public health efforts have worked recently to identify effective strategies for comprehensively approaching the AAP Policy Statement risk reduction recommendations, including the ASTHO Safe Sleep Roundtable, the Safe Sleep Learning Network of the CoIIN, and the National Action Partnership to Promote Safe Sleep (NAPPSS) project. These initiatives and the updated AAP Policy Statement account for the cultural, familial, and social determinants of infant care behaviors, including sleep-related behaviors, and acknowledge the importance of the caregivers' experience and ultimate role as decision makers for infant care. A commentary (Moon RY, Fauk FR, 2016) on a recent study (Goldstein RD, et al, 2016) in Pediatrics reinforces, while efforts aimed at reducing risks in the sleep environment remain important, that"[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. MCHS 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 and evidence based manner consistent with the comprehensive, multi-factorial recommendations of the AAP Policy Statement.

MCHS 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 establishing appropriate quantitative measures for 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 "bright spots", and factors that potentiate behavior change among populations most at risk for sleep-related infant deaths. MCHS will continue to share monitoring and environmental scan findings through a variety of platforms to inform community-based safe sleep efforts. MCHS will work with communities, including through the Healthy Texas Babies community coalitions, to engage them 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.

MCHS 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. For example, the DSHS/DFPS Safe Sleep Messaging Interagency Workgroup (SSMIW) convenes infant- and family-serving programs from across the HHS System. The group was convened to coordinate messaging and strategies to increase statewide access to consistent, comprehensive, and evidence based information and programming that promotes sleep safety and risk-reduction strategies for sleep-related infant deaths.

The group works together to:

- Identify shared objectives and standards for consistent, comprehensive, and evidence-based messaging related to sleep safety and risk reduction for sleep-related infant deaths consistent with the AAP Policy Statement;
- Identify, review, and catalog existing national materials and relevant HHS-system programmatic resources including program activities, policies, materials, trainings/curricula, and messaging; and,
- Develop and implement 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 interagency strategic communication plan, to be finalized in FY17, was developed to provide a road map for coordinated activities,

and includes:

- 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.

MCHS will continue to facilitate training and educational opportunities for healthcare 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 CFRT trainings, webinars, Texas Health Steps OPE and through other opportunities developed as part of the SSMIW strategic communication plan.

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

Reduction of racial and ethnic disparities in birth outcomes between Black and White mothers in Texas remains a key priority of MCHS.

MCHS will continue to work with local communities to examine data related to disparate risks for excess fetal and infant mortality rates among Black infants and to identify evidence-informed strategies to address identified disparity gaps, such as through promotion of breastfeeding, sleep safety, and quality and timeliness of prenatal care. Subject matter experts and data analysts will work together to ensure that strategies, activities and messaging are targeted and locally appropriate.

MCHS will target areas of the state with locally relevant public health messaging. Needs assessment findings and data analysis, including ongoing PPOR analysis, continues to assist MCHS in targeting messages to Black women on topics such as seeking medical care for chronic health conditions, breastfeeding and safe sleep practices, early entry into prenatal care, smoking cessation, and perinatal and maternal health and wellness issues. This messaging will be conducted via the Healthy Texas Babies (HTB) infant mortality initiative, which includes multiple programs that can be used to address infant mortality disparities. The five essential program components of HTB are: the Texas Collaborative for Healthy Mothers and Babies (TCHMB), Texas' perinatal collaborative, the Someday Starts Now (SSN) public awareness campaign, the Preconception Peer Educator Program (PPE), Healthy Texas Babies Community Coalitions, and provider education.

A primary goal of TCHMB is to address disparities in birth outcomes. TCHMB serves as a conduit for reaching providers to disseminate best-practice resources for improving the quality and safety of perinatal and infant care. Subcommittee work in the areas of late entry into prenatal care, Long-Acting Reversible Contraception, breastmilk use in the neonatal setting, and obstetric safety bundles all can be leveraged to address disparities in infant health outcomes.

A reorganization of the HTB Community Coalition program began in FY17 and will continue into FY18 to create a data-driven, innovative and responsive approach for precision MCH public health initiatives at the state, regional and county levels to reduce infant mortality and specifically address disparities in birth outcomes. The HTB Community Coalitions are a point of engagement for local providers and stakeholders to work together to address infant mortality disparities and promote culturally effective care. MCHS will work with community partners to collect and assess feto-infant health, morbidity, and mortality data; review existing infant mortality strategies; identify appropriate community stakeholders and leaders to involve; and carry out additional needs assessment work as identified. The coalitions will collaborate with a technical assistance contractor to engage community partners and stakeholders and facilitate equity training and capacity building. This contractor will be responsible for the design of a curriculum to address race, inequity, disparities, leadership, working with vulnerable populations and non-traditional stakeholders, quality improvement, data to action, community engagement and social mobilization within the context of vulnerable populations and birth outcomes. The contractor will also provide technical assistance for enhancing local capacity for

community engagement, partnership building, program leveraging, outreach and mobilization.

A new phase of the Someday Starts Now campaign will be implemented in FY18, and will include updates and development of content to further engage women in healthy decision making and planning throughout the life course. Communication strategies and messaging will target men and women of childbearing age to increase awareness of the modifiable risk factors that impact infant mortality and preterm birth. The website, campaign and messaging will be developed adhering to guidelines for accessibility, diversity and cultural competency. Existing content will be enhanced to facilitate reach of young adults to educate and inform them about women's preconception and interconception health. SSN tools, including the Life Planning Tool and the Birth Planning Tool, will be promoted to facilitate communication between women and their providers so that women can more fully participate in the decisions that are made about their care. Male-targeted components of the SSN campaign reinforce other campaign components by providing information and messaging to help men support their partners in self-advocacy. The campaign will also use geo-contextual targeting of digital media and community outreach to support and enhance efforts of the HTB Community Coalitions to work toward reduction of Black feto-infant mortality in geographically and racially diverse communities.

TVCMH will increase the number of Historically Black Colleges and Universities using the HTB PPE program to educate young women and men about preconception health, social determinants of health, and risk factors that can impact pregnancy outcomes later in life such as obesity, smoking and sexually transmitted infections. The Someday Starts Now campaign will reinforce preconception health messaging and provide tools and resources in support of the PPE program.

MCHS will continue to monitor 17P use as an intervention for preterm birth. Staff will continue to participate in the Better Birth Outcomes and Healthy Families Project, and collaborate with key partners such as March of Dimes to impact disparities and infant mortality. Beginning in East and South Texas, MCHS will be conducting a regional analysis of maternal and infant health in Texas to identify top health related needs that warrant intervention within each of the eight Health Service Regions (HSRs). This analysis/needs assessment will help to inform regional activities that are relevant to specific community needs.

Texas has a robust program of breastfeeding initiatives but racial disparities persist in infant feeding outcomes. The Infant Feeding Workgroup will work to identify, examine, and actively target racial disparities in infant feeding outcomes at all stages of the assessment, planning, implementation, and evaluation cycle for breastfeeding projects including the Texas Mother-Friendly Worksite program and the continuum of Ten Step initiatives to improve maternity care practices described in the NPM 4 Breastfeeding section of the action plan narrative.

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

DSHS offers a comprehensive program of breastfeeding support to address known breastfeeding barriers where Texans give birth, work, and live to improve infant feeding outcomes including breastfeeding initiation, duration, exclusivity, and appropriate introduction of complementary foods. Breastfeeding initiatives include a comprehensive continuum of programming, communications, technical assistance, education, and training to support birthing facilities and health professionals in implementing recommended maternity care practices supportive of breastfeeding. In addition, DSHS offers direct- and 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 MCHS.

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%.
Objective 2: By 2020, increase the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies from 7.7% to 8.9%.
Objective 3: By 2020, increase the average Texas score on the CDC Maternity Practices in Infant Nutrition and Care (mPINC) Survey score from 73 to >78.

A continuum of initiatives—the *Right from the Start* awareness campaign, hospital summits, health care professional training and educational resources, the Texas Ten Step Program, and the Texas Ten Step Star Achiever Initiative, including the Texas Breastfeeding Learning Collaborative—are implemented to accelerate statewide birthing facility uptake of recommended maternity care practices (*the Ten Steps to Successful Breastfeeding*) for lactating mothers and their babies. These efforts are bolstered by a variety of state and national partnerships including with the Texas Pediatric Society, Texas Medical Association, the Association for State and Territorial Health Officials (ASTHO) Breastfeeding Learning Community, and the AMCHP Birth Outcomes Collaborative.

A second wave of the *Right from the Start* campaign was released in July 2016, with the goal of increasing awareness among key decision-makers in Texas birthing facilities about their role in improving breastfeeding outcomes. Campaign materials frame the Ten Steps to Successful Breastfeeding (Ten Steps) as a key component for quality maternity care, illustrate the impact that hospital policies and practices have on breastfeeding outcomes, and encourage hospitals to assess their current practices and consider opportunities for improvement. Materials included the booklet, *Right from the Start – How Texas Hospitals Can Improve Quality Through Breastfeeding Policies,* as well as supplemental materials positioned in the back pocket of the booklet folder. Supplemental materials included factsheets, national reports and checklists designed to provide information on how to assess current practices, identify best practices, and access resources for improving practices. Informational materials were delivered by mail to influencers within the hospital environment (e.g. administrators, medical, nursing, and unit directors, managers, and lactation lead) along with a letter from the DSHS Commissioner and notice of endorsement of the campaign by the Texas Pediatric Society, Texas Medical Association, and District IX of the American Congress of Obstetricians and Gynecologists.

The Texas Ten Step (TTS) Program recognizes hospitals that have adopted policies which address 85 percent of the Ten Steps, and encourages facilities to pursue Baby-Friendly Hospital designation. The number of facilities designated as Texas Ten Step almost doubled since 2010, increasing from 63 in 2010 to 124 facilities by the end of FY2016, and the number of Texas Baby-Friendly Hospitals more than tripled from 5 in 2010 to 18 by the end of

FY2016. By the end of FY2016, more than 77% of Texas births occurred in a birthing facilities that were engaged in implementing the Ten Steps through participation in the TTS Program, the Baby-Friendly Hospital Initiative, and/or a Ten Step improvement initiative including TTSSA TBLC (74 facilities; breastfeeding.nichq.org/solutions/texas-breastfeedingcollaborative), W.K. Kellogg Foundation's CHAMPS (5 facilities), and in the CDC's EMPower Breastfeeding (6 facilities). There were 12,218 visits to www.TexasTenStep.org.

The TCHMB *Neonatal Subcommittee* initiated a QI project to increase the use of human milk in the NICU. Members developed a recruitment packet, consisting of a project overview, self-assessment survey, and Facility Information and Administrative Commitment form, worked on selecting the final measures for the project (breastfeeding while in NICU, breastfeeding at discharge from NICU), and began recruiting hospitals to participate in the subcommittee's QI initiative, with assistance from professional organizations like the March of Dimes and the Texas Hospital Association. Fifteen hospitals expressed interest in participating, and 10 hospitals completed the self-assessment survey; the project will impact over 500 NICU beds. The *Obstetrics (OB) subcommittee* focused on reducing the rate of failed induction of labor, and are evaluating whether implementation of a standardized induction of labor (oxytocin standardized) protocol reduces failed induction of labor. The subcommittee created an Induction of Labor Toolkit, developed a readiness assessment tool for selecting pilot hospitals for its QI project, worked with medical residents and graduate students to identify specific interventions for piloting in hospitals, and worked with the Texas Hospital Association to recruit hospitals.

Outreach activities also included webinars, presentations and exhibits. DSHS provided continuing education to more than 100 health professionals through two TBLC learning sessions and to 3,591 health professionals through 99 breastfeeding trainings. More than 600 health professionals were trained through the LSCs, and continuing education was provided to health care professionals through the Texas Health Steps OPE platform for completion of 2,546 breastfeeding courses (*Breastfeeding*, *Ten Steps to Successful Breastfeeding: Breastfeeding Overview*, *Ten Steps to Successful Breastfeeding: Birth Practices that Support Breastfeeding*, and *Ten Steps to Successful Breastfeeding: Prenatal and Postnatal Practices that Support Breastfeeding*).

Hospitals responding to the 2016 DSHS/AHA/THA Annual Survey of Hospitals were asked to respond to the question[1], "How many International Board Certified Lactation Consultant (IBCLC) full-time equivalents (FTEs) does your facility have on staff?" Data have not yet been analyzed.

Objective 4: By 2020, increase the number of Texas Mother-Friendly Worksites from 2,250 to >3,000.
Activities to reduce work-related breastfeeding barriers include recognizing employers that develop worksite lactation support policies and programs and receive designation through the Texas Mother-Friendly Worksite (MFW) Program. Technical assistance and support is provided to employers through the MFW-Technical Assistance and Support Program (MFW-TASP) and bolstered through awareness/media activities and numerous state and local partnerships. Families are provided with information about combining working and breastfeeding through the Breastmilk: Every Ounce Counts Campaign.

Outreach and administrative capacity for the Texas Mother-Friendly Worksite (MFW) Program was increased through a contract for the MFW Technical Assistance and Support Program (MFW-TASP) that was executed in late FY2015, with a program coordinator appointed in August 2015. More than 2,300 worksites were designated through the MFW Program at the end of FY2016, with new designations including worksites from diverse sectors, with notable designations including a heavy equipment manufacturer, multiple YMCA locations, a chemical plant, 8 municipalities, four counties, a large public hospital district, a large healthcare clinic system, and a major metropolitan city's independent school district. Technical assistance on policy and/or program development was provided to 345 employers. TexasMotherFriendly.org had 15,310 visits. Information about MFW was provided through exhibits at five conferences, resulting in 259 new employer leads. A total of 226 attendees participated in webinars offered through the Mother-Friendly Worksite "Supporting Worksite Lactation" webinar series. Information about MFW best practices were requested by and provided to other state and local health departments and

disseminated through presentations and exhibits.

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%.

The MCHS DSHS Breastfeeding Coordinator coordinated administration of the 2016 Texas WIC Infant Feeding Practices Survey. A total of 10,325 surveys were completed from March 1 through April 22, 2016 and returned for scoring. Data analysis was completed within MCHE, and a report was developed to provide WIC local agencies and interested stakeholders with information about infant feeding knowledge, attitudes and behaviors among mothers whose infants participate in the Texas WIC program. Respondents who reported that their infants were ever breastfed, even if only once (86%) and that they were no longer breastfeeding at the time of the survey were asked the question: "Did you breastfeed for as long as you wanted to?" The proportion of respondents reporting they were able to breastfeed for as long as they wanted increased from 46.2% in 2013 to 49.3% (50.7% responding that they did not breastfeed for as long as they wanted) in 2016. Perceptions of inadequate milk supply, returning to work outside the home, and difficulties with breastfeeding were leading reasons for early weaning.

NIS data indicate that breastfeeding prevalence among Texas infants born in 2013 was 81.9% initiation, 46.5% at 6 months, 26.8% at 12 months, 41.4% exclusive at 3 months, and 21.1% at 6 months. Breastfeeding initiation among infants born to women who enrolled in WIC during pregnancy (Born-to-WIC) was 86.2% in August 2016.

MCHS worked with the DSHS Health Survey Users Group to include a state added breastfeeding awareness module to the Behavioral Risk Factor Surveillance System (BRFSS) 2016 Survey Questionnaire, consisting of nine questions intended to assess attitudes toward breastfeeding in community settings and toward worksite support of lactating mothers. Data will be analyzed in FY17, and can be compared to findings from previous years (i.e. 2012, 2011, 2010, and 2007).

There were 360,586 visits to the Breastmilkcounts.com website, Texas' one stop breastfeeding resource including information to prepare new moms on what to expect, help current breastfeeding moms continue breastfeeding, and give working moms tips on how to continue breastfeeding once they've gone back to work, along with many other resources. Two Peer Counselor (PC) Training Workshops were held to develop PC programs in local WIC agencies and other settings. Texas had 423 PCs (many of whom work part time) across the state. PCs and other WIC breastfeeding staff participated on hospital improvement teams in the TTSSA TBLC.

MCHS continued to fund two previously-funded WIC Peer Dad (PD) programs in San Antonio and in the Brazos Valley, and expanded funding to begin PD programs in two new locations (in East Texas/Tyler and in the Rio Grande Valley/Harlingen), bringing the total number of Texas Peer Dad programs to six.

Beginning late FY2015, MCHS began funding four Lactation Service Centers (LSCs) that were originally established to serve only WIC clients. With MCHS funding, the LSCs now provide direct lactation support services to non-WIC participants while continuing to serve WIC enrolled families through Texas WIC funding. A total of 22,035 mothers received lactation education, support and consultation contacts at the LSCs, with 2,546 non-WIC enrolled participants receiving lactation consultations with an International Board Certified Lactation Consultants (IBCLCs). One LSC found that 29% of the Non-WIC clients receiving IBCLC services met WIC eligibility guidelines and were subsequently enrolled in WIC services.

In FY2015, DSHS worked with a contractor to conduct a breastfeeding environmental scan and initiated development of the DSHS Breastfeeding 2016-2020 strategic plan. The contract could not be executed during FY16, strategic planning will resume in FY2017 without assistance of a contractor.

DSHS staff provided technical assistance to DSHS programs, state and local agencies, breastfeeding coalitions, other state health departments, and national organizations. DSHS staff participated in four national collaboratives related to breastfeeding including ASTHO Breastfeeding Learning Community, AMCHP/Robert Wood Johnson Birth Outcomes Collaborative, and Carolina Global Breastfeeding Institute's national collaboratives for breastfeeding support in child care and in maternity settings. DSHS presented Texas breastfeeding information at seven national meetings, and shared information with national, state and local coalitions and through participation in collaboratives, community and governmental partnerships, conferences, meetings and events related to breastfeeding promotion and support.

The DSHS/Medicaid breastfeeding workgroup explored provision and scope of breastfeeding support services in Texas WIC, other DSHS programs and Medicaid. A Medicaid Lactation Support Service Policy was drafted to include IBCLC services as a benefit and to provide specifications and clarification of eligibility for breast pump equipment. Medical review of the draft policy began in Summer 2016. MCHS staff participated in ongoing meetings with HHSC and with the Texas Pediatric Society Committee of Fetus and Newborn Special Task Force on Improving Breast Milk Use in Texas Hospitals regarding a donor human milk benefit.

Regional Population-based Services
The approach to breastfeeding promotion by regional population-based staff took three general forms in 2016: promotion of evidence-based materials in breastfeeding classes, training of DSHS staff as IBCLCs and breastfeeding educators and mother-friendly worksite promotion among large employers and government entities. Regions 2/3, 6/5S and 9/10 held 43 in-person breastfeeding classes while HSR 8 developed informational packets in collaboration with WIC distributed at local hospitals. HSR 2/3 approached the Nursing program at Weatherford College in Parker County and successfully augmented the information on breastfeeding in the curriculum. That region also had four staff trained as DSHS breastfeeding educators. Region 8 has one staff nurse currently becoming certified as an IBCLC.

HSR 7 started the year conducting an environmental scan to assess the availability of breastfeeding rooms for employees of governmental organizations and schools. They discovered that only one ISD in Lampasas has a room for this purpose and will spend 2017 working on this issue with the other organizations identified during the scan. HSR 6/5S responded to the perceived need to educate employers on HB 786 providing for break time for nursing mothers under FLSA. They contacted nine organizations and found that none fully met the requirements of HB 786. They will continue to work on this issue in 2017, guiding local organizations through the MFWS application process. HSR 9/10 approached 3 ISDs about the MFWS program and will continue to work on this issue in 2017; their efforts were hampered by staff turnover.

Performance Analysis: The proportion of infants who ever breastfeed met the Healthy people 2020 target, but rates of continued- and exclusive breastfeeding still fall below targets. The rate of exclusive breastfeeding has significantly increased over the past five years.

Challenges/ Opportunities: DSHS continues to build on successful initiatives and expand capacity across sectors to address disparities and barriers to breastfeeding.

NPM #5 Percent of infants placed to sleep on their backs

Objective 1: By 2020, increase the proportion of mothers who report their new babies sleep alone in their own cribs or beds in the same room where the mothers sleep by 2%.

Objective 2: By 2020, reduce the proportion of mothers who report their new babies usually sleep with toys, cushions, or pillows, a blanket, and/or with crib bumper pads by 2%.
Objective 3: By 2020, increase the proportion of mothers who report a health care worker told them about basic sleep safety from by 2%.

The DSHS/DFPS Safe Sleep Messaging Inter-Agency Workgroup (SSMIAW) was convened in FY2015 and worked in FY2016 to coordinate messaging related to safe sleep and prevention of sleep related deaths. The workgroup cataloged and evaluated more than 100 programmatic materials and training curricula of participating MCH-serving programs, including DSHS WIC, DSHS MCH, DFPS Child Protective Services, DFPS Prevention and Early Intervention, HHSC Home Visiting, and DFPS Child Care Licensing Programs. Images and written content were reviewed against the 2011 AAP Task Force of SIDS recommendations for sleep safety, and more than 10 materials were subsequently revised to remove inconsistent messaging. The workgroup reviewed models for agency safe sleep messaging standards. Standards will be drafted in FY2017 for consideration of adoption at an agency or HHSC-System level. Information from an environmental scan, literature review, theory review, and audience brainstorming was compiled to begin drafting a comprehensive problem description as a basis for a strategic communication plan.

MCHS and DFPS staff presented information about collaborative strategic planning, including about the SSMIAW at DSHS Grand Rounds and at the 2016 AMCHP annual conference in a presentation entitled *Using Data to Realign Resources: Strategic Planning to Reduce Child Abuse and Neglect Fatalities.* The Grand Rounds presentation is archived at: http://www.dshs.texas.gov/grandrounds/presentations-fall2015.shtm#sept2

MCHS collaborated with DFPS to implement focus groups, through a DFPS contract, to explore knowledge and perceptions about sleep safety with mothers, fathers, grandmothers, nurses and child care providers across Texas. Finding from these focus groups will be compiled with other problem description resources to finalize the problem description to stimulate and inform development of a multi-agency safe sleep strategic communication plan in FY2017.

Objective 4: By 2020, increase the proportion of mothers who believe that babies who are breastfed are less likely to die from SIDS from 45.3% to 46.7%. (DSHS WIC IFPS).
DSHS maintains the resource "Information for Parents of Newborns" in English and Spanish. This booklet educates parents on important topics related to the health and well-being of their newborn, including breastfeeding, safe sleep, and immunizations and includes information about the reduced risk for SIDS conferred by breastfeeding. It is mandatory for prenatal care providers and birthing facilities to provide the booklet's information to all pregnant women and their partners and, when possible, other adults who will care for the infant during pregnancy and the delivery stay. In FY2016, DSHS distributed approximately 98,421 print booklets in English and 20,509 in Spanish. Due to a change in the ordering process, these numbers do not reflect all booklets ordered from the DSHS warehouse. Many birthing facilities incorporate the information from the booklet into their own materials to distribute to parents, thus these numbers do not fully reflect the number of parents reached by this information. Families, providers, and other stakeholders can e-mail titlev@dshs.state.tx.us with questions about the booklet

Information about the protective effects of breastfeeding against SIDS are also communicated through the Texas WIC publication, *Breastfeeding Guide: How to Get Off to a Great Start*. The booklet is distributed to WIC participants in their local WIC clinics, and may also be distributed to expectant and new parents who are maternity patients at a designated Texas Ten Step facility.

MCHS staff provided a continuing education presentation*, Safe Sleep for Texas Babies: Comprehensive*

Recommendations to Reduce Risk of Sleep Related Death, to Texas WIC professionals and other invited stakeholders, including nurses and IBCLCs, at the annual Texas WIC Nutrition and Breastfeeding Conference.

Regional Population-based Activities

Regional MCHS staff focused safe sleep efforts on promotion of the DSHS Safe to Sleep Community Training and integration of safe sleep messaging with other planned activities such as car seat inspections. HSR 4/5N distributed Pack'n'Plays at two trainings of community members on safe sleep. MCHS SMEs and Regional staff continued evaluating safe sleep programs and interventions to ensure initiatives were evidence-based/evidence-informed and aligned with AAP recommendations.

Performance Analysis: Progress is underway to establish infrastructures and strategic directions to increase uptake of safe sleep practices in Texas.

Challenges/ Opportunities: Transformation of the HHSC-System opportunity and shared strategic goals provide enhanced opportunities for collaboration to develop coordinated, synergistic strategies and messaging to optimize impact.

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[1] This data has been annually collected, as developed in collaboration between Center for Health Statistics and MCH staff, beginning with the 2009 DSHS/AHA/THA Annual Survey of Hospitals

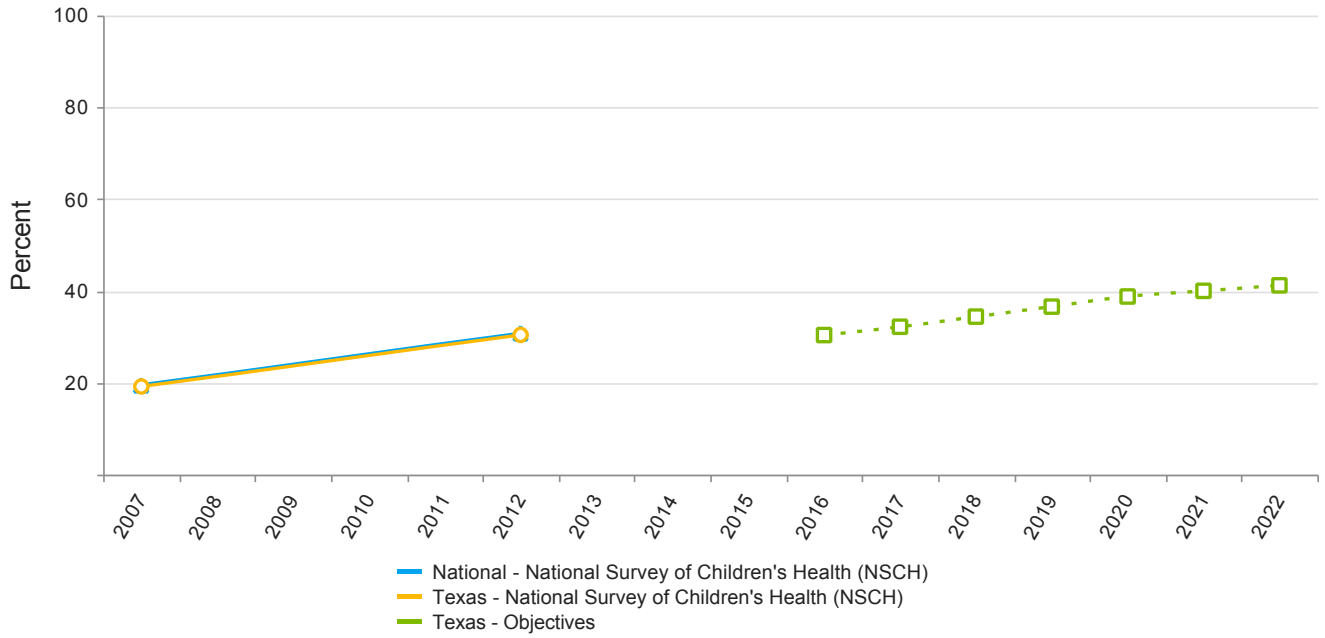
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available	NPM 6
NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000	NVSS-2015	19.1	NPM 7
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	30.8	NPM 7
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	14.1	NPM 7
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	9.0	NPM 7
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	82.0 %	NPM 6

National Performance Measures

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	30.4
Annual Indicator	30.4
Numerator	559,623
Denominator	1,839,623
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	32.2	34.4	36.6	38.8	40.0	41.2

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
Annual Objective	
Annual Indicator	6,429
Numerator	
Denominator	
Data Source	Texas Health Steps Online Provider Education (OPE)
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	6,750.0	7,087.0	7,441.0	7,831.0	8,222.0	8,633.0

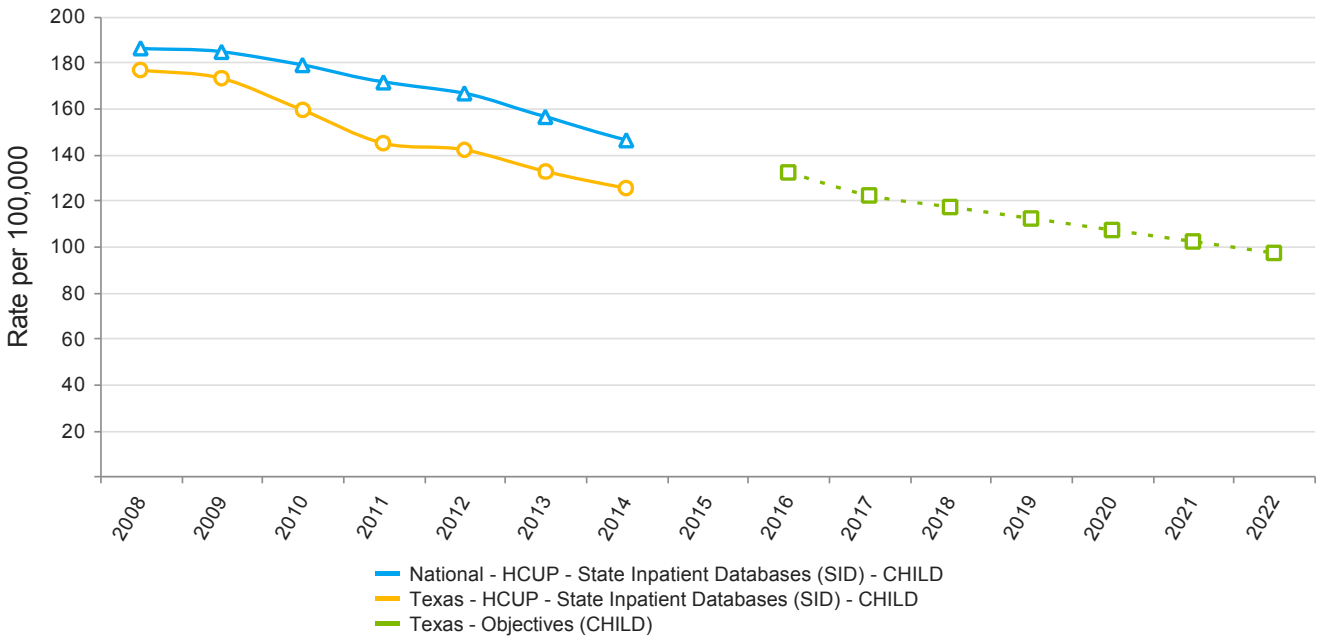
ESM 6.2 - Number of additional individuals trained in early childhood developmental screening and referral in the Texas LAUNCH communities

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	27
Numerator	
Denominator	
Data Source	Project LAUNCH
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	300.0	100.0	73.0	0.0	0.0	0.0

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
Baseline Indicators and Annual Objectives



NPM 7 - Child Health

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - CHILD	
	2016
Annual Objective	132
Annual Indicator	125.3
Numerator	4,981
Denominator	3,974,223
Data Source	SID-CHILD
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	122.0	117.0	112.0	107.0	102.0	97.0

Evidence-Based or –Informed Strategy Measures

ESM 7.1 - Number of Texas Health Steps Online Provider Education (OPE) users completing injury prevention modules.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	12,279
Numerator	
Denominator	
Data Source	Texas Health Steps Online Provider Education (OPE)
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	12,893.0	13,538.0	14,215.0	14,926.0	15,672.0	16,456.0

ESM 7.2 - 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
Annual Objective	
Annual Indicator	40
Numerator	
Denominator	
Data Source	DSHS School Health Program Gov Delivery
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	25.0	25.0	25.0	25.0	25.0	25.0

ESM 7.3 - Lead a statewide comprehensive injury prevention conference.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Texas DSHS
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	No	No	No	No	No

ESM 7.4 - Train Child Fatality Review (CFR) teams on injury prevention

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Texas DSHS
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	No	Yes	No	Yes

ESM 7.5 - Percent of child deaths reviewed by Child Fatality Review Teams (CFRT)

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Child Fatality Review Teams and Vital Statistics
Data Source Year	2014
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	37.0	37.5	38.0	38.5	39.0	39.5

ESM 7.6 - Percent of youth reporting connection to at least one caring adult

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	YRBSS
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	68.0	70.0	70.0	70.2	70.2	70.5

State Action Plan Table

State Action Plan Table (Texas) - Child Health - Entry 1

Priority Need

Bolster access to quality statewide data, screening, and surveillance (to inform Maternal and Child Health programming).

NPM

Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Objectives

By 2020, increase the number of CFRT, educators and providers that are provided child injury education, support and community resources from baseline by two percentage points. (No baseline available; baseline will be established)

Strategies

Strategy 1: Establish baseline for CFRT, educators and providers that have received child injury education, support and community resources.

Strategy 2: Support providers, state and community partners, and regional staff's injury prevention efforts by providing injury prevention information, trainings and resources.

Strategy 3: Support injury prevention education and resources to school educators, administrators, parents and community and state partners.

Strategy 4: Increase CFRT, MedCARES and other injury prevention state and community partnerships by convening partners to expand capacity and resources.

Strategy 5: Support state and national initiatives including the Child Safety CoIIN, MedCARES and CFRT.

ESMs	Status
ESM 7.1 - Number of Texas Health Steps Online Provider Education (OPE) users completing injury prevention modules.	Active
ESM 7.2 - Number of School Health Friday Beat newsletters per fiscal year with at least one injury prevention resource provided	Active
ESM 7.3 - Lead a statewide comprehensive injury prevention conference.	Active
ESM 7.4 - Train Child Fatality Review (CFR) teams on injury prevention	Active
ESM 7.5 - Percent of child deaths reviewed by Child Fatality Review Teams (CFRT)	Active
ESM 7.6 - Percent of youth reporting connection to at least one caring adult	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

Increase Maternal and Child Health safety programming.

NPM

Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Objectives

By 2020, increase the percentage of child death reviewed by Child Fatality Review Teams by two percentage points. (Baseline = 37%)

Strategies

Strategy 1: Support the training and staffing of CFRT coordinators in pilot communities and throughout Texas.

Strategy 2: Review current procedures in the collection, assessment and documentation of child deaths in the CFRT data reporting system.

Strategy 3: Support training of CFRTs in data collection and data entry.

ESMs	Status
ESM 7.1 - Number of Texas Health Steps Online Provider Education (OPE) users completing injury prevention modules.	Active
ESM 7.2 - Number of School Health Friday Beat newsletters per fiscal year with at least one injury prevention resource provided	Active
ESM 7.3 - Lead a statewide comprehensive injury prevention conference.	Active
ESM 7.4 - Train Child Fatality Review (CFR) teams on injury prevention	Active
ESM 7.5 - Percent of child deaths reviewed by Child Fatality Review Teams (CFRT)	Active
ESM 7.6 - Percent of youth reporting connection to at least one caring adult	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 3

Priority Need

Improve coordination of care for Maternal and Child Health populations.

NPM

Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Objectives

By 2020, increase the number of educators and providers that received developmental screening education, support and community resources from a baseline baseline of 4,260 to18,000.

Strategies

Strategy 1: Work with partners including AET, CSHCN, PEI, Home Visiting, ECI, MHSA and communities to promote early childhood developmental screening resources and tools for use by parents.

Strategy 2: Support providers, teachers and regional staff's developmental screening efforts by providing developmental screening information, trainings and resources through our Texas Health Steps on line provider education modules.

Strategy 3: Work with state and community partners to bolster access to quality screening tools and the coordination of data resources.

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 additional individuals trained in early childhood developmental screening and referral in the Texas LAUNCH communities	Active

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (Texas) - Child Health - Entry 4

Priority Need

Provide support to promote quality in primary care, women's health, and specialty services.

NPM

Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Objectives

By 2020, 500 individuals will be trained in ASQ:3 and ASQ-SE:2 early childhood developmental screening tools and referral resources in the Texas LAUNCH communities. (Baseline=2)

Strategies

Provide funding to communities through the Texas LAUNCH grant to develop or expand systems and infrastructure to assess and provide services to children with developmental needs in health disparate areas.

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 additional individuals trained in early childhood developmental screening and referral in the Texas LAUNCH communities	Active

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children in excellent or very good health

NPM 6: Percent of children, age 9 through 71 months, receiving a developmental screen using a parent-completed screening tool.

Children reaching developmental milestones is essential for school readiness and adult success. However, according to the 2011/12 National Survey of Children's Health only 30.4% of Texas children 10 months to 5 years at risk for developmental, behavioral and social delays was screened using a reported standardized screening tool. In the same survey, 30.2% of parents reported their children age 4 months to 5 years to be at moderate or high risk of developmental, behavioral or social delays and 40.5% of children age 2-17 with problems requiring counseling were unable to receive mental health care. This data mirrors the responses received from parents in the MCHS needs assessment focus groups where parents reported a need but lack of access to providers to assess their child's development.

MCHS will continue to lead the SAMHSA State Project LAUNCH Expansion grant (Texas LAUNCH) to improve early childhood systems (ages 0 to 8), strengthen parenting competencies, and improve children's developmental and behavioral outcomes. The Texas LAUNCH -Early Childhood Committee (TL-ECC) formally the Project LAUNCH State Early Child Wellness Workgroup, will continue in partnership with Aliviane, Inc., University of Texas Institute for Excellence in Mental Health (TIEMH) and several additional key partners including: DFPS-PEI/Home Visiting, Mental Health and Substance Abuse (MHSA) Division, Texas Systems of Care, ECI, Medicaid, Child Care Licensing, Texas Workforce Commission, Head Start Collaboration, Texas Association for the Education of Young Children (TAEYC), University of Texas, Houston-Act Early Texas! and Texans Care for Children. The TL-ECC will continue to focus statewide planning around Texas LAUNCH priorities through the work done in the TL-ECC workgroups to implement strategies based on the TL-ECC's short and long term goals focusing on: family strengthening, developmental screening access, early childhood data coordination and collection, and early childhood workforce development.

Texas LAUNCH will continue to fund communities to develop systems and infrastructure to facilitate access to developmental screenings and further implementation of services to children with developmental needs in health disparate areas. Three organizations: MHMR of Tarrant County, Family Service Association of San Antonio and Ysleta del Sur Pueblo were selected as the community Texas LAUNCH contractors based on their demonstrated significant need and opportunity to serve disparate populations. Integration efforts include training and support on developmental screenings to local child care centers, ECI, Home Visiting, Regional Staff, Tribal and Head Start programs with a goal to provide services to 1,000 children over the course of the grant. Texas LAUNCH will continue to increase training and mentoring opportunities in early childhood mental health to enhance the workforce providing services and support to children ages 0 to 8 and their caregivers statewide, including early childhood mental health consultation to child care and Pre-K programs. MCHS will continue to work with key partners to bolster access to quality statewide data, screening, and surveillance. Using the TL-ECC resources, the Texas LAUNCH community evaluation and quality improvement plan will be used to examine successes, barriers, and accomplishment of project tasks and goals. Evaluation and impact will focus on each unique community, targeting the strategies identified by that locale to achieve the program goals and provide on-going data to guide local changes. Evaluation will examine state system changes aimed at reducing barriers to developmental screening and enhancing the infrastructure and support for early childhood development.

To support developmental screening initiatives MCHS will continue to serve on the ECI advisory committee and the AET! Autism Commission (AET! AC), established by the HRSA State Planning Grant for Improving Services for Children and Youth with Autism Spectrum Disorder (ASD) awarded to UTHealth. While the AET! Application for the HRSA Innovation in Care Integration for Children and Youth with ASD and Other Developmental Disabilities Program was not funded, MCHS and AET! will continue partnering on the Texas LAUNCH initiative and explore additional opportunities for collaboration.

The Texas LAUNCH funding will end in FY 19. With the support of the TL-ECC, MCHS is making plans for sustainability of the grants efforts in regards to developmental screenings. Sustainability efforts will focus on continuing the TL-ECC workgroup of state and community leaders, assessing resources and creating a plan to incorporate developmental screening trainings, programs and partnerships into existing Healthy Child Care Texas program, MedCARES program, and the MCHS regional staff's efforts.

To promote the need for developmental screenings, MCHS will continue to update and disseminate the Parents Guide to Raising Happy Healthy Children, a legislatively mandated guide provided by physicians to all new parents who receive Medicaid. This comprehensive guide is in print and on-line and includes time lines for immunizations, developmental milestones, healthy eating and parenting guidance. http://texanscareforchildren.org/parents. The Parents Guide to Raising Happy Healthy Children will be revised to include the American Academy of Pediatrics recommendation that standardized developmental screenings should be administered regularly at the 9, 18, and 30-month visits. Regional staff will promote the guide among primary care and pediatric providers in their regions.

MCHS will promote developmental screening tools, resources, Texas LAUNCH grant information, partner resources and THS-OPE modules through the MCHS website, list-serves, and regional and state partnerships. HSR 6/5S plans to conduct a community assessment in FY18 to examine how well child-serving organizations in rural Walker County understand and utilize developmental screening tools among children nine to 71 months old.

Education will be provided through the THS-OPE modules related to developmental screening to providers, teachers, regional staff and other key stakeholders. HSR 2/3 will be promoting THS-OPE modules among at least three child care centers in three rural counties near the Oklahoma border with the intention of increasing awareness of the importance of developmental screening and improving early identification of developmental delays and referral to the child's primary care provider. They plan to measure the impact of this promotion by collecting the completion certificates of child care center staff.

Funding will continue for the Healthy Child Care Texas (HCCT) Program's Child Care Health Consultant (CCHC) training adapted from the National Training Institute (NTI) for Child Care Health Consultants, a state-of-the-art train-the-trainer program based on Caring for Our Children National Health and Safety Performance Standard: Guidelines for Out-of-Home Child Care Programs. The curriculum addresses multiple aspects of health and safety as well as developmental milestones. MCHS provides the CCHC certification and training requirements which ensures that qualified health and child care professionals are available to provide health and safety assessment and guidance to out-of-home child care centers and family child care homes in Texas. MCHS will expand the program to increase the number of trainers able to provide developmental milestone guidance and screening resources to child care facilities.

MCHS will continue to work with and provide developmental screening resources and trainings to MCHS regional staff, CHWs and support CSHCN SDG community based contractors.

NPM 7: Rate of injury-related hospital admissions per population ages 0 through 19.

The leading cause of death, injury and disability for children 1-14 years of age in Texas and nationally is due to unintentional injuries. 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.

One of the leading causes of childhood injury and death is a result of motor vehicle crashes. Car seat use reduces the risk for death to infants (aged <1 year) by 71% and to toddlers (aged 1–4 years) by 54% in passenger vehicles, and booster seat use reduces the risk for serious injury by 45% for children aged 4–8 years when compared with seat belt use alone. MCHS will continue to partner with CFRT, Safe Riders, injury prevention programs and MCHS regional staff to streamline child passenger safety messages and activities, and increase the adoption of effective child passenger safety interventions at state and local levels. The partnership will work towards increasing access to child passenger safety seat distribution sites with trained safety seat technicians available to educate parents on how to install car seats, a well-known best practice to address MV child injury.

In FY18, MCHS will lead of the national Child Passenger Safety CoIIN collaboration with state and regional Injury Prevention partners, the DSHS Injury Epidemiology & Surveillance Branch, Border Health, Child Protective Services, law enforcement, CEDD, Home Visiting and MCHS regional staff. A map was created in FY17 showing the locations of child passenger safety technicians throughout the state. In FY18, the CoIIN team will expand on the work done in FY17 and survey currently certified child passenger safety technicians identified by Safe Kids to determine active participation in inspection stations and/or car seat inspections. The survey will determine areas with highest need for additional technicians and assist in planning future trainings. The collaboration will continue to address car seat availability around the state.

Another significant cause of injury and death for children is due to maltreatment. MCHS and DFPS created a strategic plan in 2015 to reduce child deaths due to maltreatment. This workgroup identified geographic areas in Texas with the highest risk of child maltreatment-related injuries and composed an action plan to address prevention efforts for each area. Hyperthermia and pedestrian back-over deaths were two types of injuries identified as high risk. To reduce hyperthermia deaths, MCHS, Safe Riders and DFPS developed materials for the MCHS *Information for Parents of Newborns* guide in FY16 and are continuing to distribute this guide, as legislatively mandated, and promote these materials through the MCHS website to increase public awareness of the risk of hyperthermia due to children being left in hot cars. Dallas-Fort Worth was identified as the highest risk area for child death due to hyperthermia. MCHS staff will work with child passenger safety fitting stations in the Dallas-Fort Worth area to distribute hyperthermia education. To reduce pedestrian back-over deaths, MCHS, DFPS, and Injury Prevention programs will continue to work with local CFRTs to address motor vehicle and pedestrian safety. MCHS staff will collaborate with MCHS regional staff, DFPS home visiting programs, child passenger safety technicians and local CFRTs to incorporate back over safety education into current activities.

MCHS will continue to implement the legislatively mandated MedCARES grant program to develop and support regional initiatives providing a comprehensive approach to preventing, assessing, diagnosing, and treating child abuse and neglect. An additional goal of the program is to increase access to medical child abuse experts to improve timely and accurate child abuse diagnoses. This is being accomplished through the MedCARES teaching hospitals, Child Abuse Pediatrician fellowship programs that infuse experts into the state to support this goal. The grant augments existing statewide services and strengthens cross-sector relationships to enhance referrals focusing specifically on the significance of the health care system and its ability to serve children and families. There are 11 MedCARES programs around the state located in hospitals and academic health centers with expertise in pediatric health care. MedCARES programs will continue to expand prevention and education activities to provide education to Children's Advocacy Centers (CAC), schools, community partners and law enforcement on recognizing and reporting child abuse.

MCHS will continue to support and collaborate with the School Health program in the creation and distribution of the Friday Beat, a newsletter that is sent to over 3,878 administrators, teachers, nurses, health educators, parents and other interested partners 2-4 times each month. Friday Beat features articles and resources related to injury prevention in each edition.

MCHS will continue to update and disseminate the *Parents Guide to Raising Happy Healthy Children.* This comprehensive guide is legislatively mandated to be provided by a physician to all new parents who receive Medicaid. The guide is in print and on-line and provides health and safety information, resources and parental guidance. http://texanscareforchildren.org/parents.

Funding will continue for the Healthy Child Care Texas (HCCT) program's CCHC training, adapted from the National Training Institute (NTI), for CCHC, a state-of-the-art train-the trainer program based on *Caring for Our Children National Health and Safety Performance Standard: Guidelines for Out-of-Home Child Care Programs.* The curriculum addresses multiple aspects of injury prevention in a child care setting including drowning, poisoning, falls, and recognizing abuse. In addition to education on the prevention of injuries, HCCT also provides education on how to provide an environment free of toxins and chemicals. MCHS provides the CCHC certification and training requirements which ensures that qualified health and child care professionals are available to provide health and safety assessment and guidance to out-of-home child care centers and family child care homes in Texas. MCHS will assess the barriers found in the program related to cost to child care centers to access CCHC and implement needed child care center changes and the lack of CCHC available around the state. MCHS will work to expand the program to increase the number of trainers able to provide health and safety guidance and resources to child care facilities and provide support for child care centers to access CCHC services.

As a result of the regional in-person CFRT trainings that took place in FY17, MCHS and CFRT's have recognized the need for continued training and education. The SCFRTC will continue to develop training mechanisms for ongoing education for the CFRT's. Training will be based on need and could include death scene investigation information, data collection techniques and suggestions, injury prevention programming guidance or national CFRT online database data entry technical assistance.

Based on recommendations of the legislation-mandated Protect Our Kids Commission (a committee charged with studying and making recommendations to reduce child maltreatment in Texas), MCHS will continue to focus on increasing the number of active local CFRTs to cover 100% of Texas counties, increase training for teams, consistency of CFR data collection, and shortening the time frame for cases to be reviewed.

Through a grant from The Children's Justice Act, MCHS is funded to support two full time local CFRT coordinators, one in an urban area and one in a rural area. In FY17 MCHS selected coordinator locations and interviewed potential candidates. With the hiring of the coordinators at the end of FY17 beginning of FY18, MCHS will assess to see if there is an increased capacity to review child deaths, including increasing meeting consistency, improvement of data quality and quantity of cases reviewed in order to improve guidance and accuracy.

Education will continue to be provided through the THS-OPE modules related to injury prevention to providers, teachers, regional staff and other key stakeholders.

MCHS and MCHE will continue to oversee the University of Texas SPAN survey and analyze the child and adolescent questions related to bullying. MCHS is restructuring the contract with the University of Texas to increase and improve infrastructure to ensure more timely data collection, analysis and dissemination. Regional staff in HSR 4/5N have been instrumental in recent years in improving the reach of this activity by utilizing their staff as liaisons with schools and will continue to do so in FY18.

MCHS will continue to work with and provide injury prevention resources and trainings to MCHS regional staff and CHW's through MCH regional meetings, Friday Beat dissemination, direct contact and trainings.

All regional staff have prioritized child passenger safety efforts by increasing the number of child passenger safety

events and working to maintain staff skills in child passenger safety inspection and teaching. Other common areas of focus are bike safety and water safety. These are mostly addressed through presentations in schools and community organizations and at public events, such as bike rodeos and community health fairs.

NPM 6: Percent of children, age 9 through 71 months, receiving a developmental screen using a parent-completed screening tool.

Objective 1: By 2020, increase the number of educators and providers that received developmental screening education, support and community resources from baseline by two percentage points. (Baseline = 4260)

Objective 2: By 2020, 16 individuals will be trained in the ASQ and ASQ-SE early childhood developmental screening tools and referral resources in the Texas LAUNCH funded communities. (Baseline =2)

To support the SAMSHA Texas Project LAUNCH Expansion Grant, MCHS partnered with the University of Texas Institute for Excellence in Mental Health (UTIEMH), Aliviane Inc. and key partners: DFPS-PEI/Home Visiting, Mental Health and Substance Abuse (MHSA) Division, Texas Systems of Care, and ECI to form the Texas LAUNCH-Early Childhood Committee (TL-ECC), formally the Project LAUNCH State Early Child Wellness Workgroup. In addition, the following agencies and state partners joined the committee: Medicaid, DFPS Child Care Licensing, Texas Workforce Commission, Head Start Collaboration, Texas Association for the Education of Young Children (TAEYC), Act Early Texas! (AET!), and Texans Care for Children. Partnerships were formalized through Memorandum's of Understanding (MOU) to support the TL-ECC by providing a representative with decision-making authority to participate in the meetings, provide data, promote resources, provide guidance to Texas LAUNCH communities, participate in infrastructure building, and policy and workforce development. Three meetings were held in FY16 and topics included introducing the selected Texas LAUNCH community contractors, MHMR of Tarrant County, Family Service Association of San Antonio and Ysleta del Sur Pueblo in El Paso, an overview of the Texas LAUNCH evaluation plan common indicators, an overview of the Incredible Years parenting program, and the early childhood mental health workforce development survey. The TL-ECC focused statewide planning around Texas LAUNCH priorities by creating workgroups that conducted a SWOT analysis and is in the process of creating short and long term goals around family strengthening, developmental screening access, early childhood data coordination and collection, and early childhood workforce development.

The Title V Medical Director attended the Lone Star LEND FY16 site visit conducted by HRSA and presented an overview of MCHS including CSHCN SDG activities in Texas. Discussion focused on Title V Block Grant transformation activities, current statewide initiatives and efforts to strengthen family/professional partnerships. Possibilities for future collaboration were explored. MCHS attended the 4th Annual Lone Star LEND Conference to share medical home and health care transition resources.

MCHS continued to serve on the AET! Autism Commission (AC) established by the HRSA State Planning Grant for Improving Services for Children and Youth with Autism Spectrum Disorder (ASD) awarded to UTHealth. MCHS served on internal AET! AC workgroups including those focused on the transition to adulthood and medical home access. The AET! AC explored implementation of the Project ECHO (Extension for Community Healthcare Outcomes) Autism model within Academic Autism Centers as a strategy to increase workforce capacity in rural areas of the state. During FY16, MCHS assisted the AET! AC with an application for the HRSA Innovation in Care Integration for Children and Youth with ASD and Other Developmental Disabilities Program.

As part of the AET! State Planning Grant, a statewide Needs Assessment was completed that surveyed parents of children, youth and adults with autism. Results of the survey indicated that the average age of a child when parents first became concerned about their child's development was 2.25 years of age, however the average age of their child when they first looked for a formal evaluation/diagnosis was 3.37 years of age with the average age of diagnosis being around 5.11 years of age. Of the 1,134 responses, parents indicated that their children were most often diagnosed by developmental pediatricians, followed by a psychologist, the educational team and neurologist. Parents indicated that the diagnosis was made by their primary care physician only 8% of the time. Further, parents indicated after receiving a diagnosis they were most often referred for a follow up appointment, followed closely by providing a referral to ECI. In addition, referrals to specialists for further assessment or treatment and to support groups, websites, and literature were also provided to about a third of the families. Parents also indicated that 16% of professionals made no referrals for further follow-up or provided additional resources and services to the family after the child's diagnosis. The Texas State Autism Plan and Needs Assessment developed by the AET! AC will continue to inform MCHS programming.

The MCHS Medical Director served on the ECI Medical Advisory Committee to review diagnoses for automatic inclusion in ECI program eligibility criteria. The MCHS Medical Director continues to participate in the ECI State Systemic Improvement Plan (SSIP) and serve on the ECI Advisory Committee. The SSIP is a comprehensive, multi-year plan for improving results for infants and toddlers with disabilities and their families. SSIP focuses on

substantially increasing the rate of growth in infants and toddlers demonstrating positive social-emotional skills. In FY16 SSIP began the implementation phase (Phase II) of the three phase project. The MCHS Director, CYSHCN Director and MCHS Child Health Coordinator presented an overview of the Title V program, including the results of the 5 Year Needs Assessment, selection of National Performance Measures, and activities associated with Project LAUNCH and MedCARES at an ECI Advisory Committee meeting. CSHCN SDG community based contractors promoted Autism awareness through the ABC-SA's 12th Annual Walk for Autism where 5,000 people and 85 exhibitors were in attendance. Families attending the Walk were able to obtain autism resources and were educated about services in the community. In addition, SHARE held their SHARE Autism Walk, which included a Resource Fair and activities for the children. Four thousand people attended with 40 organizations participating in the Resource Fair. Families were able to connect with resources and other families who care for children with special needs.

In FY16 a total of 6,429 developmental screening/early childhood development THS-OPE modules were completed. The modules included ADHD and ASD, Developmental Screening Tool and Surveillance, and Newborn Screening. The modules were promoted through monthly newsletters, regional staff, Texas LAUNCH communities and partners, trainings, and TL-ECC meetings.

During FY16 four new modules which focus on developmental screening/early childhood development were added: Pediatric Depression, Behavioral Health: Screening and Intervention, Childhood Trauma and Toxic Stress, and Hearing and Vision Screening. MCHS will include these modules for future reporting.

To ensure Texas LAUNCH utilized developmental screening best practices, TL-ECC partners reviewed current developmental screenings tools, researched who currently performs developmental screenings, reviewed processes for data collection, and reviewed procedures that should occur following a positive screen. Research revealed that most screenings were being administered by Medicaid medical providers, Home Visiting programs, and child care and education facilities, such as Head Start. These entities primarily used the Ages and Stages developmental screening tools to administer screens. Based on these findings, MCHS selected the Ages and Stages developmental screening tools for the Texas LAUNCH communities to administer to their children. Future discussions will continue to focus on making data more accessible to the group and state through the collection and assessment of Texas LAUNCH community contractor data and collaboration efforts through the TL-ECC workgroup. Work continues to identify best practices for positive screen follow-up and to ensure screening in appropriate geographic areas without duplication of services.

Ysleta del Sur Pueblo in El Paso, Family Service Association of San Antonio, and MHMR Tarrant County in Fort Worth were selected as Texas LAUNCH sites through the 2015 Project LAUNCH Expansion grant. These communities, in collaboration with community partners, local early child wellness councils and early child care centers, drafted individual work plans to establish what screening tools for administration by the Texas LAUNCH communities.

Ages and Stages staff, the creators of the ASQ-3 and ASQ:SE-2 screening tools, provided a train-the-trainer training to 16 members of the Texas LAUNCH team, Home Visiting staff and other local leaders on training others to administer the ASQ-3 and ASQ:SE-2 screenings. The newly trained staff then trained 27 additional individuals on administering the screenings in the Texas LAUNCH communities.

Performance Analysis:

The number of completed THS-OPE developmental screening modules increased by 66% (4,260 in FY15 to 6,429 in FY16). Heightened promotion and programming contributed to the increase in completed modules over the year.

The goal of training 16 individuals in ASQ-3 and ASQ:SE-2 by 2020 was accomplished this year as 27 individuals were trained. This result is due to the funding of the Texas LAUNCH communities, the establishment of the State Project LAUNCH-Early Childhood Committee, and the Ages and Stages train the trainer training.

Challenges/Opportunities:

Opportunity exists to enhance infrastructure through MCHS regional staff and the provision of technical assistance to build capacity and knowledge around needs, resources, and programming for early childhood developmental screenings. Opportunities exist to continue to increase provider capacity and capability through the development and promotion of OPE modules.

In FY16, Project LAUNCH communities experienced challenges with timeline implementation, but all SAMHSA grant requirements and timelines were met throughout the year. It is anticipated that timelines will be maintained in FY17. Additional opportunities exist to further increase the number of individuals trained in the ASQ-3 and ASQ:2E.

NPM 7: Rate of injury-related hospital admissions per population ages 0 through 19.

Objective 1: By 2020, increase the number of CFRT, educators and providers that are provided child injury education, support and community resources from baseline by two percentage points.

In order to assess the injury landscape in Texas, MCHS held multiple meetings with Safe Riders, DSHS Injury Epidemiology & Surveillance Branch, Border Health, Child Protective Services, Home Visiting, Child Fatality Review Teams, law enforcement, the Center for the Elimination of Disproportionalities and Disparities (CEDD), School Health and other Injury Prevention programs around the state. Discussions focused on existing injury data and expanding data and surveillance capacity as well as ensuring the correct E-codes are used to better understand circumstances surrounding the injury. In addition, the group discussed consistent messaging for DSHS documents and websites and the distribution of injury prevention materials. The group collaborated on the Child Safety CoIIN activities related to Child Passenger Safety and the planning of the MCHS FY17 Injury Prevention Conference. MCHS is preparing to make this a formal group with more regular meetings and strategic planning of activities as a new Injury Prevention section is being formed.

In 2015 MCHS and DFPS formed a unique collaboration and created a strategic plan to reduce child deaths due to maltreatment. Nearly one-third of the motor vehicle-related child abuse and neglect fatalities were due to hyperthermia. These deaths were primarily due to neglectful caregivers leaving kids in hot cars. In efforts to decrease hyperthermia deaths, MCHS partnered with Safe Riders to implement temperature gauge car demonstrations to increase public awareness of the risks of hyperthermia due to children being left in hot cars. Safe Riders, in collaboration with Safe Kids Texas Heatstroke Task Force provided 41 demonstrations around the state.

MCHS staff attended the Texas Injury Prevention Leadership Symposium. The purpose of the Symposium was to cultivate a network of injury prevention leaders in Texas; strengthen injury prevention capacity in the state; engage critical thinking skills; put evidence-informed theory into practice; and foster collaboration among agencies and organizations. As a result of this symposium MCHS developed stronger collaborative relationships with key injury prevention partners, such as the Injury Prevention Center of Greater Dallas, Dell Children's Hospital and Texas Children's Hospital. These collaborations helped improve injury data collection, promoted injury prevention best practices, and provided resources for the development of the MCHS Injury Prevention conference.

Through meetings, conferences and monthly newsletters, MCHS promoted the use of the THS-OPE injury prevention modules to stakeholders around the state. A total of 6,070 providers completed the 7 THS-OPE pediatric related injury modules. Topics of the modules included pediatric head injury, preventing unintentional injury and childhood trauma and toxic stress. The Recognizing; Reporting and Prevention Child Abuse module is being added, as child abuse is a significant cause of child injury and this module was not initially included.

MCHS provided resources including articles, trainings, and fact sheets to the DSHS School Health Program which contributed to the development of 46 issues of the weekly electronic newsletter, the Friday Beat. The newsletter was disseminated to 3,878 unique school personnel, parents, community and state partners and contained 103 articles with topics related to injury prevention. Resources included the promotion of the 30th Annual Conference on the Prevention of Child Abuse; the CDC's Microsite HEADS UP that provides concussion-safety materials related to 11 different sports and can be embedded in a school's website, and information from the Children's Safety Network with topics that included fall prevention, bike helmet use, and bullying prevention and interventions.

MCHS collaborated with Texans Care for Children on the *Parents Guide to Raising Happy Healthy Children*, a legislatively mandated guide distributed by a health care provider to all parents of a newborn who receive Medicaid. This comprehensive guide was distributed to 113,050 individuals and includes early childhood (ages 0-5) health, safety, and child development resources as well as parental guidance. http://texanscareforchildren.org/parents.

MCHS partnered with Healthy Child Care Texas to train 44 Child Care Health Consultants (CCHC). Three trainings were held in Austin, San Antonio and Dallas. The trainings included participants from agencies such as Head Start, Workforce Solutions, Texas Association for the Education of the Young Child (TAEYC), and private consultants. In addition to the CCHC training, TAEYC provided a 2-hour overview on the CCHC program to 75+ Child Care Licensing Representatives from the Southwest District (San Antonio, Corpus Christi, Laredo and El Paso).

In an effort to bring injury prevention partners together from across the state and to facilitate the utilization of best practices, MCHS initiated a contract to develop and host an injury prevention conference in FY17. Attendees will include members of the state and local CFRTs, MedCARES grant recipients and other key stakeholders, with topics to include safe sleep, child abuse prevention, child passenger safety, injury prevention best and promising practices, and Texas injury data.

MCHS collaborated with Safe Riders to facilitate the Texas Child Passenger Safety CoIIN bringing together partners

from Border Health, Child Protective Services, law enforcement, CEDD and Home Visiting. The workgroup streamlined Child Passenger Safety messages and activities through updating materials and creating regional Child Passenger Safety data maps. MCHS partnered with DSHS regional staff to assess opportunities to increase Child Passenger Safety activities through certified technicians and distribution sites. Safe Riders provided information and resources on the program, and additional TA was given to increase Child Passenger Safety activities in regions.

MCHS continued to oversee the legislatively mandated MedCARES grant program to develop and support regional initiatives to improve the assessment, diagnosis, and treatment of child abuse and neglect. Through 11 contractors, 513 educational trainings were given to health care providers and staff, child protective services, law enforcement, child advocacy centers, faith-based organizations, K-12 academic institutions, child care organizations, and families to increase recognition and reporting of child abuse for early identification and intervention. MCHS continued to provide additional funding to MedCARES providers to increase prevention efforts, facilitate community training opportunities, and distribute prevention information on various topics directly to parents, providers, caseworkers, and law enforcement personnel. Topics included child safety, infant care, and Period of PURPLE Crying (POPC). Trainings included recognizing and reporting abuse, abusive head trauma, injury biomechanics, conditions that mimic abuse, and the importance of family history.

Objective 2: By 2020, increase the percentage of child death reviewed by Child Fatality Review Teams by two percentage points. (Baseline = 37%)

Child Fatality Review (CFR) is a public health strategy to understand child deaths through multidisciplinary review at the local level. The Texas CFR 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. SCFRT members are subject matter experts from law enforcement, the medical community, Child Protective Services (CPS), child advocacy organizations, the court system, the behavioral health community, and more.

In FY16, the State Child Fatality Review Team (CFRT) Coordinator published the 2015 biennial CFRT report for legislators. The report (http://www.dshs.texas.gov/mch/child_fatality_review.shtm) included data analysis of child deaths from 2012 and 2013 and recommendations to legislators that would impact child and adolescent health and injury prevention. The report outlined leading causes of and risk factors in child and adolescent deaths. According to the report, motor vehicle deaths are the leading cause of accidental death for children. Most children who died due to motor vehicle crash were passengers with the majority sitting in the back seat. The most common site for drowning deaths are pools. More than two-thirds of the pool, hot tub or spa drowning deaths were to children 1-4 years of age. Local CFRTs found that child abuse and neglect fatalities primarily involved children under the age of five years. The SCFRT provided recommendations to the legislature for injury prevention. Those recommendations included:

- Pass distracted driver legislation to address the risks of using wireless communication devices while driving.
- Pass legislation that makes it an offense if a person operates a motor vehicle on a public highway while having any detectable amount of alcohol in the person's system while transporting a minor (under the age of 17).
- Pass legislation that requires new residential swimming pools have a circumferential isolation pool fence installed that completely separates the house and play area of the yard from the pool.
- Pass legislation to add active shooter training for school personnel to the Center for Safe Schools School Safety Certification Program.

The State CFRT identified the need for statewide trainings to standardize collection and reporting of data. MCHS began the development of a contract to provide vendor support for the SCFRT Coordinator in the planning, advertising, and implementation of eight child fatality review team regional trainings. Local CFRT members will be trained in death scene investigation, injury prevention and the collection of data to increase the quantity and quality of data collected. A review of the current CFR procedures and tools for the data reporting system was conducted. The Child Fatality Review Operating Procedures manual was updated. The State CFRT coordinator participated in a national data quality workgroup with the National Center for Fatality Review and Prevention on the development of a list of priority variables for child fatality review teams to use throughout Texas and the US. This list of priority variables contained a data dictionary with further clarification for teams. This list will be added to the Child Fatality Review Operating Procedures manual and shared during the FY17 trainings to local CFRT teams. Training materials will be posted on the MCH website after the regional trainings are complete.

In order to establish a baseline for local CFRT membership, the State CFRT Coordinator contacted local teams to update member distribution lists. Local CFRTs are volunteer-based and organized by county or multi-county geographic areas. Team 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?

Texas was awarded a Children's Justice Act grant in FY16. The State CFRT Coordinator developed this project to support the hiring of two local CFRT coordinators in one urban and one rural pilot community. The goal of the project will be to determine the benefit of paid staff in the quality of the collection and reporting of CFR data, as well as implementation of injury prevention initiatives in the local pilot communities. Through these efforts, it is anticipated that there will be increased capacity to review child deaths, increased meeting consistency across teams, improvement of data quality, and increased quantity of cases reviewed in order to improve guidance and accuracy.

Regional Population-based Activities:

Child health promotion activities in the Health Service Regions are largely focused on injury prevention and are driven by the needs identified by local CFRTs. The role of the CFRT in giving direction to the efforts of population-based DSHS staff is pivotal; in many regions the CFRTs are led by DSHS staff who provide facilitation services, manage data and assist groups with translation of findings to action. Three HSRs (HSR 2/3, HSR 6/5 and HSR 8) have started new CFRTs or added counties to expand an existing local CFRT. In 2016 HSR 11 worked with some of the local CFRT members to lay the foundation for a local child injury prevention team.

Staff have responded to a perceived need for child passenger safety training and provision of car seats and education to families in a variety of creative ways. In 2016 MCHS regional staff installed or checked 1,924 car seats; and provided 1,569 car seats through distribution and education sites through Texas Safe Riders. Many staff have felt compelled to have their staff trained as child passenger safety technicians because of a perceived lack of car seat installation and inspection services in rural areas of their regions. Car seat installation clinics are utilized as an opportunity to convey information on hyperthermia and correct maternal seat belt usage. HSR 11 used Texas EMS and Trauma Registries Data to examine leading causes of injury among pediatric patients and found motor vehicle accidents are consistently the first or second-leading causes in their region. They have since been working on a community-informed car seat assessment tool based on a model from Scotland. They hope to do a region-wide survey of car seats installed in the vehicles they inspect to get a better understanding of what would motivate better car seat use and what problems with car seats are unique to their region and border populations.

Staff have found that programs that integrate multiple opportunities to convey messaging in a comprehensive format work well with the populations they serve. In HSR 1, for example, the First Year of Life Curriculum was developed by staff based on Safe Kids Worldwide materials. The class prepares new parents for the challenges of injury prevention in the first year and cover topics such as safe sleep, choking hazards, lead safety, and car seats. HSR 11 and HSR 6/5S have utilized the March of Dimes Comenzando Bien / Becoming a Mom curriculum to cover a variety of child safety issues and other topics related to baby's first year like breastfeeding and car seat safety. Offered in a group setting, these kinds of programs have the added benefit of promoting an atmosphere of peer support.

Staff also capitalize on the opportunity for community-level injury prevention change through provider education and community-based trainings. MCHS regional staff in HSR 8 hosted 3 CFRT child death prevention events: Child Abuse Summit, Victoria Baby Expo focused on safe sleep and child health/safety Annual Outdoor Day. HSR 6/5S holds an annual Nursing Conference on Injury Prevention. Several regions are promoting the Period of PURPLE Crying in childbirth classes to reduce abusive head trauma.

Performance Analysis: There was an increase in injury prevention activities from previous years due to the coordination of efforts around the Child Passenger Safety CoIIN, the planning of the regional CFRT trainings, MCHS attendance at the Injury Prevention Summit, planning meetings with injury prevention partners, MedCARES increase in child abuse prevention activities and trainings and the planning of the Injury Prevention conference. Although the goal of increasing the percentage of child death reviewed by Child Fatality Review Teams has not yet been met, the activities performed in FY16 continues to be steps forward towards meeting the objective.

Challenges/Opportunities: In FY16, there were challenges with timeline implementation for CFR team trainings, the hiring of CFRT coordinators, and the planning of the Injury Prevention conference. However, MCHS, SCFRT and Injury Prevention partners continued to meet and plan future collaboration activities, data collection, trainings and a state Injury Prevention conference.

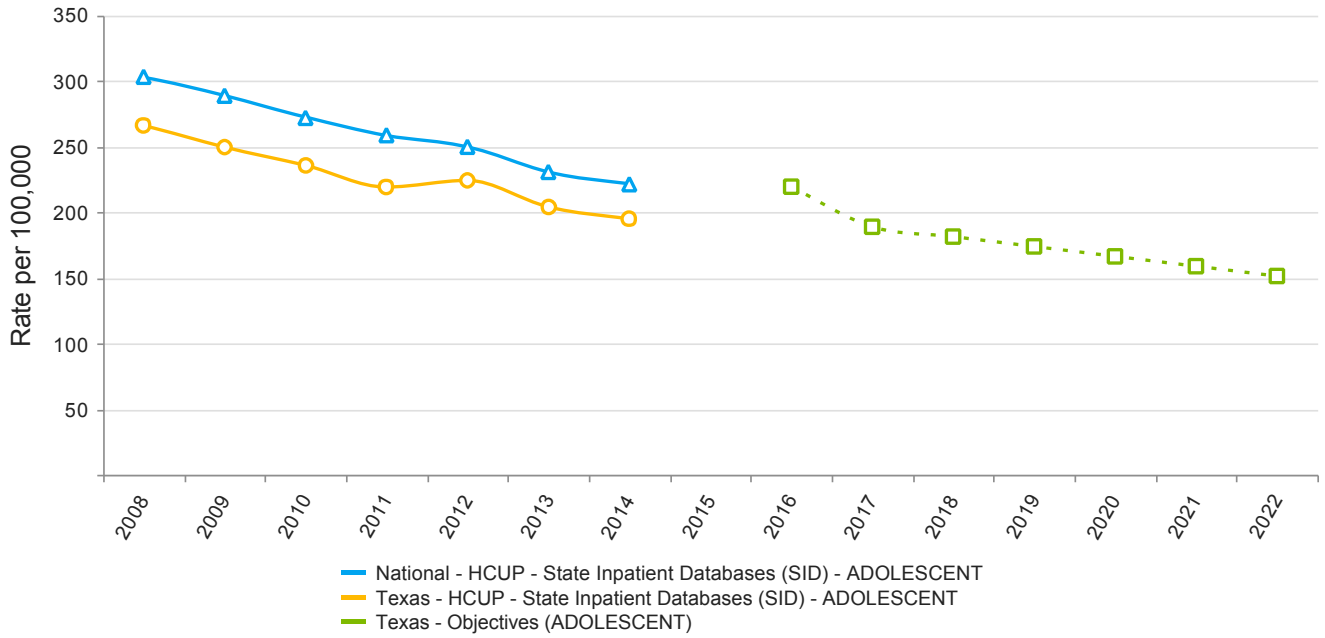
Adolescent Health

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-2015	19.1	NPM 7
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	30.8	NPM 7
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	14.1	NPM 7
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	9.0	NPM 7

National Performance Measures

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
Baseline Indicators and Annual Objectives



NPM 7 - Adolescent Health

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - ADOLESCENT	
	2016
Annual Objective	219.3
Annual Indicator	194.7
Numerator	7,599
Denominator	3,902,181
Data Source	SID-ADOLESCENT
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	188.9	181.4	173.9	166.4	158.9	151.4

Evidence-Based or –Informed Strategy Measures

ESM 7.1 - Number of Texas Health Steps Online Provider Education (OPE) users completing injury prevention modules.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	12,279
Numerator	
Denominator	
Data Source	Texas Health Steps Online Provider Education (OPE)
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	12,893.0	13,538.0	14,215.0	14,926.0	15,672.0	16,456.0

ESM 7.2 - 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
Annual Objective	
Annual Indicator	40
Numerator	
Denominator	
Data Source	DSHS School Health Program Gov Delivery
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	25.0	25.0	25.0	25.0	25.0	25.0

ESM 7.3 - Lead a statewide comprehensive injury prevention conference.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Texas DSHS
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	No	No	No	No	No

ESM 7.4 - Train Child Fatality Review (CFR) teams on injury prevention

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Texas DSHS
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	No	Yes	No	Yes

ESM 7.5 - Percent of child deaths reviewed by Child Fatality Review Teams (CFRT)

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Child Fatality Review Teams and Vital Statistics
Data Source Year	2014
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	37.0	37.5	38.0	38.5	39.0	39.5

ESM 7.6 - Percent of youth reporting connection to at least one caring adult

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	YRBSS
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	68.0	70.0	70.0	70.2	70.2	70.5

State Performance Measures

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
Annual Objective	
Annual Indicator	49.2
Numerator	1,421,277
Denominator	2,888,775
Data Source	Texas Behavioral Risk Factor Surveillance System (
Data Source Year	2015
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	57.6	57.9	58.2	58.5	58.8	59.1

State Action Plan Table

State Action Plan Table (Texas) - Adolescent Health - Entry 1

Priority Need

Increase Maternal and Child Health safety programming.

NPM

Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Objectives

By 2020, increase the proportion of adolescents participating in Title V-funded Positive Youth Development by five percentage points (PPRI, June 2016 Baseline of community-based only [clinics not available yet] = 39 youth in YACs, Baseline of 2634 in program)

Strategies

Strategy 1: Assess utilization of questions, activities and monitoring strategies related to PYD

Strategy 2: Educate/Promote questions, activities and monitoring strategies related to PYD

Strategy 3: Collect and analyze data on THAI contracts

Strategy 4: Gather baseline data of adolescents who are A) connected to a parent or other positive adult caregiver and B) involved in leadership activities

ESMs	Status
ESM 7.1 - Number of Texas Health Steps Online Provider Education (OPE) users completing injury prevention modules.	Active
ESM 7.2 - Number of School Health Friday Beat newsletters per fiscal year with at least one injury prevention resource provided	Active
ESM 7.3 - Lead a statewide comprehensive injury prevention conference.	Active
ESM 7.4 - Train Child Fatality Review (CFR) teams on injury prevention	Active
ESM 7.5 - Percent of child deaths reviewed by Child Fatality Review Teams (CFRT)	Active
ESM 7.6 - Percent of youth reporting connection to at least one caring adult	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

Promote collaborations including family professional partnerships (to enhance Maternal and Child Health programming).

NPM

Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Objectives

By 2020, increase the number of programs utilizing youth voice in their family-professional partnerships by one percentage point. (2016 THAI Baseline 2016 = 9 community-based and 3 clinic-based)

Strategies

Strategy 1: Develop, coordinate and disseminate PYD resources to state and local partners.

Strategy 2: Maintain assessment of the number of state-level activities /programs utilizing a youth voice component.

Strategy 3: Participate in state-level activities in order to promote PYD.

Strategy 4: Promote injury prevention at multiple conferences and workgroups to include fostering youth & family representation.

ESMs	Status
ESM 7.1 - Number of Texas Health Steps Online Provider Education (OPE) users completing injury prevention modules.	Active
ESM 7.2 - Number of School Health Friday Beat newsletters per fiscal year with at least one injury prevention resource provided	Active
ESM 7.3 - Lead a statewide comprehensive injury prevention conference.	Active
ESM 7.4 - Train Child Fatality Review (CFR) teams on injury prevention	Active
ESM 7.5 - Percent of child deaths reviewed by Child Fatality Review Teams (CFRT)	Active
ESM 7.6 - Percent of youth reporting connection to at least one caring adult	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 3

Priority Need

Bolster access to quality statewide data, screening, and surveillance (to inform Maternal and Child Health programming).

NPM

Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Objectives

By 2020, increase the number of CFRT, educators and providers that are provided adolescent injury education, support and community resources from baseline by two percentage points.

Strategies

Strategy 1: Monitor number for CFRT, educators and providers that have received child injury education, support and community resources.

Strategy 2: Support providers, state and community partners, and regional staff's injury prevention efforts by providing injury prevention information, trainings, and resources.

Strategy 3: Support injury prevention education and resources to school educators, administrators, parents and community and state partners.

Strategy 4: Increase CFRT and other injury prevention state and community partnerships by supporting partners to expand capacity and resources.

Strategy 5: Support state and national initiatives including the Child Safety CoIIN and CFRT

ESMs	Status
ESM 7.1 - Number of Texas Health Steps Online Provider Education (OPE) users completing injury prevention modules.	Active
ESM 7.2 - Number of School Health Friday Beat newsletters per fiscal year with at least one injury prevention resource provided	Active
ESM 7.3 - Lead a statewide comprehensive injury prevention conference.	Active
ESM 7.4 - Train Child Fatality Review (CFR) teams on injury prevention	Active
ESM 7.5 - Percent of child deaths reviewed by Child Fatality Review Teams (CFRT)	Active
ESM 7.6 - Percent of youth reporting connection to at least one caring adult	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 4

Priority Need

Increase Maternal and Child Health safety programming.

NPM

Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Objectives

By 2020, increase the percentage of child death reviewed by Child Fatality Review Teams by two percentage points. (2015 CFRT Report, 2013 Baseline = 37%)

Strategies

Strategy 1: Support the ongoing training and staffing of CFRT coordinators in pilot communities and throughout Texas.

Strategy 2: Promote current procedures in the collection, assessment and documentation of child deaths in the CFRT data reporting system.

Strategy 3: Support ongoing training of CFRTs in data collection and data entry.

ESMs	Status
ESM 7.1 - Number of Texas Health Steps Online Provider Education (OPE) users completing injury prevention modules.	Active
ESM 7.2 - Number of School Health Friday Beat newsletters per fiscal year with at least one injury prevention resource provided	Active
ESM 7.3 - Lead a statewide comprehensive injury prevention conference.	Active
ESM 7.4 - Train Child Fatality Review (CFR) teams on injury prevention	Active
ESM 7.5 - Percent of child deaths reviewed by Child Fatality Review Teams (CFRT)	Active
ESM 7.6 - Percent of youth reporting connection to at least one caring adult	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 5

Priority Need

Provide support to promote quality in primary care, women's health, and specialty services.

SPM

Percent of young adults (ages 18-24) who visited a doctor for a routine checkup in the past year

Objectives

By 2020, increase the percentage of adolescents 12-18 years of age and young adults 18-24 years of age that report visiting a doctor for routine check-ups to promote personal health and wellness by two percentage points (2014 baseline = 57.9%).

Strategies

Strategy 1: Develop and distribute resources and education on adolescent-friendly strategies.

Strategy 2: Increase the number of clinics who incorporate adolescent-friendly strategies.

Strategy 3: Participate in state and national initiatives.

Adolescent Health - Plan for the Application Year

Based on the Five-Year NA, consistent peer feedback, stakeholder input, and integration of best practice and ongoing quality improvement, Texas will continue to focus on injury prevention and quality components of the adolescent well visit. Strategies and activities related to medical home, transition, and community integration are incorporated into current programming as appropriate.

Positive Youth Development (PYD) is a cornerstone of Texas Adolescent Health (AH) strategies and initiatives. PYD focuses on the development of relationships with caring adults, supportive relationships with parents, supportive peer networks, promoting positive connections to school, and supportive communities.

MCHS will continue to lead and leverage state-level partnerships to ensure there is coordination and complimentary adolescent health programming to infuse projects with PYD as it is addresses specific needs. MCHS will continue to lead the Adolescent Health Workgroup which is a quarterly meeting of state-level programs who work with youth as part of or as the primary focus of their population to share strategies, information, and resources. The GovDelivery Adolescent Health list, which has over 6,800 subscribers, will be utilized to distribute materials and information. MCHS will continue to update the DSHS MCH website to streamline it by reducing the number of pages, refresh the resources available, and make it more user friendly. The new version will provide resources regarding injury prevention, obesity, and adolescent well visits to the public and interested stakeholders.

NPM 7: Rate of injury-related hospital admissions per population ages 0 through 19.

PYD is a proven strategy to reduce risk factors and increase protective factors in youth. Promotion of 'connectedness' and healthy development for youth within their community is important in establishing life-long health and reducing injuries that result in hospitalization. Supportive relationships can help prevent risky behavior and provide opportunities for early detection and intervention when problems emerge. MCHS will provide question recommendations to future Texas YRBSS for monitoring, coordination of, and assessment of PYD as it relates to connectedness to adult influencers and provide subject matter expertise to the YRBSS workgroup as a whole. MCHS will continue to promote youth-focused programming and appropriate screening and referral; develop resources for state and local partners; and gather youth input to provide ongoing feedback and opportunities to improve adolescent programming.

The current grant cycle of the Texas Healthy Adolescent Initiative (THAI) will end in FY18. THAI community-based contractors have identified activities to impact local risk factors and expanded opportunities were identified with clinic-based contractors. Contractors will continue to directly impact communities by working to improve the overall health and well-being of Texas adolescents, 10-24 years of age, increase youth's protective factors, prepare youth with a strong foundation for adult life, and support positive life choices. THAI contractors will continue to facilitate local Youth-Adult Councils (YACs), utilize the PYD framework to implement EBPs with a focus on at least one of eight potential risk factors (for community-based contracts) or comprehensive screening/referral/follow up (for clinic-based contracts), and participate in an ongoing independent evaluation. Contractors will work on risk factors that are indicative of the identified state priority needs related to health disparities, community integration, family/professional partnerships, access to and quality of primary care, and safety programming. Ongoing independent evaluation will continue to provide necessary data to support and improve THAI plans. Preliminary evaluation that showed that YACs are successful in providing youth with connections to caring adults, experience in providing input into community programming, and opportunities to gain skills in leadership will continue to guide programming and future projects. In FY18, MCHS will closely monitor evaluation results to inform MCHS staff on the structure of future Title V-funded Adolescent Health projects. THAI will continue to increase the number of youth participating in programming that encourages acquisition of developmental assets and provides alternatives to participation in risky behaviors. Youth who have a healthy, positive outlet are less likely to take unhealthy risks which will reduce the likelihood of experiencing, intentionally or unintentionally, injury or death.

MCHS will continue to fund the Youth Engagement Specialist(s) project through UTIEMH to provide expertise on youth-related issues and promote the value of youth at the decision-making table in order to expand youth voice representation at multiple levels. The project will offer education and support to stakeholders and agencies interested in engaging and retaining authentic youth voice in planning and programming; enhance projects across the state including state-level and adolescent-focused activities; support youth interested in leadership opportunities; promote PYD principles; and ensure strategies are in place to engage youth as leaders. The state-level Youth Council has developed youth-led projects that MCHS will endeavor to support as the projects are more fully developed.

Building on strategies initiated in FY16, MCHS will continue to develop and promote educational materials, including the 12 THSteps' OPE modules specific to Adolescent Injury Prevention. Additionally, new OPE modules have been identified that align with Injury Prevention including "Recognizing, Reporting, and Preventing Child Abuse" and "Childhood and Adolescent Depression". Modules will be promoted through GovDelivery, contractors, and event

activities. Articles and resources related to injury prevention will be featured in each issue of the Friday Beat, an e-newsletter for school administrators, teachers, nurses, health educators, and other interested school health partners.

Building on the Injury Prevention Summit (held May 2016) which helped establish new partnerships to reduce injury-related hospitalizations of youth, and the MCHS Injury Prevention Conference which was held in May 2017; led MCHS to identify the need for an Injury Prevention Workgroup to inform activities in FY18 and beyond. MCHS will convene a workgroup to set priorities, develop activities, and determine opportunites for ongoing collaboration.

MCHS will continue to participate in the CS CoIIN, including the 'Suicide and Self-Harm Prevention', 'Child Passenger Safety' and 'Teen Driver Safety' topic areas. The Texas CS CoIIN will continue to work with other states to drive system level change and integrate evidence-based child safety practices into relevant care settings. The overarching goal is to reduce serious injuries and fatalities among youth by improving partnerships and implementing shared best practices for vulnerable populations. Identified in FY17 as a synergistic relationship, one of the THAI contracts will continue to provide data to inform the suicide/self-harm strategy and will share successful activities as well as participate in quality improvement through PDSAs. MCHS's CoIIN chose to also focus on a Texas community with one of the highest teen motor vehicle injury rates. Using data provided by MCHE on high motor vehicle incident rates in Webb County, MCHS initiated discussions to explore potential collaborations to reduce adolescent injuries and fatalities in that community. In FY18, MCHS will expand the dialogue to include actionable plans within the community. MCHS will also reach out to other state- and local-level agencies to impact the Teen Driver Safety topic.

The current goal to improve knowledge with IP stakeholders and CFRT teams in order to build capacity and foster networking opportunities around injury prevention will remain. Building on the eight regional trainings of CFRT Teams and the Texas Injury Prevention (IP) Conference in FY17, MCHS will develop an ongoing plan for education and resource sharing, including alternating the CFRT trainings and reaching out to stakeholders to establish an IP workgroup in future years. CFRT trainings will utilize support of team member attendance at conferences, webinars, and technical assistance.

MCHS will continue to provide technical assistance to local CFRT teams in order to increase quality and quantity of deaths reviewed. The 8 regional trainings conducted by the State CFRT Coordinator in FY17 will help inform activities as MCHS develops educational materials (webinars, workshops, etc.) to provide ongoing training and support to local CFRTs. 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. Through a Children's Justice Act grant, MCHS funded two full-time local CFRT coordinators in one urban and one rural area. These coordinators will continue monitoring activities that increase meeting consistency and improve data quality and quantity.

MCHS will participate in Cohort II of the AMCHP AYAH CoIIN as well visits are an opportunity to provide anticipatory guidance and early intervention for emerging risky behaviors that lead to injury. MCHS will continue to represent Texas as the Principal Investigator for the Rape Prevention and Education (RPE) grant. RPE-funded organizations will continue to utilize the public health model and primary prevention activities to promote PYD and by-stander intervention trainings. In FY18, initial results from an external evaluation will become available. MCHS, OAG, and TAASA will begin improving technical assistance and training to local RPE-funded sites as the needs are identified through the evaluation.

SPM 4: Percent of adolescents and young adults (ages 18-24) who visited a doctor for a routine checkup in the past year.

One central theme that emerged from the NA stakeholder meetings was the need to improve coordination and quality of care for adolescents and young adults. Additionally, many parents voiced concerns regarding teenagers' exposure to drugs, gangs, and sexual activity. Efforts by the AYAH CoIIN supported this need. MCHS will continue addressing these concerns by funding THAI clinics through FY18 to become more adolescent- friendly and increase provider resources for youth. Additionally, MCHS staff will continue to identify organizations interested in becoming youth friendly in order to provide support and expertise to reach that goal. Initial discussions with partners in FY17 to explore the World Health Organization's recent release of the 8 components to adolescent-friendly health services in order to establish standards for healthcare providers interested in serving youth.

THAI clinic-based contracts focus on adolescent well visits to increase the number of youth that access services, use screening tools to assure early detection of emerging issues, and improve the clinic environment to become more adolescent-friendly. Young people prefer health services that are youth-friendly, culturally competent, affordable, convenient, and confidential. Through the THAI effort, MCHS will continue to work with healthcare professionals to help their facilities become adolescent-friendly while supporting involvement of youth and parents. From the initial

proposal requirements of a self-assessment, THAI contractors have, and will, annually assess the structure of their organization that helped inform where they need to; improve the physical environment to make it more adolescent friendly, ensure uniform processes for adolescent well visits (AWV), enhance the referral system, and connect with the local adolescent population through the local Youth-Adult Councils. In identifying quality components of care, THAI clinic-based contractors will continue to refine the use of screening tools, review procedures as needed to ensure appropriate identification of risks, provide referrals to local and regional resources, and follow up with identified at-risk youth. In the clinic settings, THAI is utilizing strategies to improve AWVs through media campaigns and sharing protocols and practices with each other. In FY18, MCHS will partner with THAI sites to identify and develop a step-by-step process to accomplish "adolescent friendliness" with the goal to share with clinics across the state interested in improving AWVs.

The THAI clinic-based contractors will continue collecting feedback and work to improve areas of need based on the evaluation in FY18. Successes from the initial THAI clinic-based contracts will inform development of future activities.

MCHS will continue to partner with stakeholders at the state and community level to develop and share adolescent-friendly strategies to healthcare providers across the state. Through ongoing work on AMCHP's Adolescent & Young Adult Health (AYAH) CoIIN – Cohort II, Texas will refine uniform screening recommendations, standardized screening tools, procedure examples, referral resources, policy examples, and consistent messaging targeted at youth and their families. The intended products will be available and promoted to healthcare professionals in Texas in FY18.

Regional Population-based Activities:

Regional MCHS staff will continue supporting injury prevention through presentations, trainings, and meeting attendance. Topics will include suicide prevention, adolescent health promotion, healthy teen relationships, human trafficking, bullying prevention, and impaired driving prevention. Additionally, regional staff will promote the THSteps' OPE modules specific to Adolescent Injury Prevention.

MCHS has adjusted a goal to have one adolescent-friendly clinic in each HSR by approaching this goal from a regional level. MCHS will work with regional staff to identify at least one adolescent-friendly clinic (or one that is willing to become one) within each HSR and provide support to improve each clinic's AWV numbers and environment. These clinics will be a resource to other healthcare providers in each area.

NPM #7: Rate of hospitalization for non-fatal injury per 100,000 adolescents 10-19

Objective #1: By 2020, increase the proportion of adolescents participating in Title V-funded Positive Youth Development (PYD) by five percentage points (baseline FY15 - 39 in Youth-Adult Councils (YACs), FY16 - 2634 in programs)
Objective #2: By 2020, increase the number of programs utilizing youth voice in their family-professional partnerships by one percentage point (Baseline 9 community-based contracts)

MCHS endorsed the utilization of **P**ositive **Y**outh **D**evelopment (PYD) as the foundation for the Adolescent Health infrastructure so as to focus on the entire adolescent, not just on health concerns or problems that adolescents face. In order to assess and monitor the utilization of PYD across the state, MCHS continued to participate in state and community program planning to promote PYD as a best practice. Staff submitted a proposal requesting a college intern to begin tracking available data sources at the national and state level, and assess data needs and gaps in order to develop a data plan to fully measure adolescent integration into the communities as well as share best practice strategies.

MCHS participated in the YRBSS workgroup and submitted Texas-specific questions for consideration in order to assess current youth activities and monitor Texas' progress towards "connectedness" of youth to a caring adult. The 7 new questions, chosen from the 2017 CDC optional list, aimed to evaluate connectedness "to family" and "to the community". These will be added to the YRBS survey that will be administered in FY17 and include questions about motor vehicle safety, weight control, food security, and preventive health care.

To educate and promote strategies related to PYD, the PYD model was required in the THAI programs, infused in the Youth Engagement contract, and shared with the Adolescent Health Workgroup. This included support of youth voice in family-professional partnerships.

The 4 year Texas Healthy Adolescent Initiative (THAI) program aims to improve the overall health and well-being of Texas adolescents, 10-24 years of age, to increase their protective factors, prepare them with a strong foundation for adult life, and support positive life choices. THAI community-based contractors facilitated Youth-Adult Councils (YACs), utilized PYD in administering their evidence-based tools, focused on at least one of eight potential risk factors (motor vehicle, mental health/suicide, dating violence, juvenile delinquency, HIV/STDs, obesity, substance abuse or access to care/transition), and participated in an ongoing independent evaluation.

The THAI project was developed to support youth participation in programming by requiring YACs within nine community-based contracts to provide input into program decisions while collecting and analyzing data on youth engagement progress through an external evaluator, Texas A&M University's Public Policy Research Institute (PPRI). Using the five key areas of social determinants of health developed by Healthy People 2020, THAI worked with YAC members and participants on sustainability by working on the Office of Adolescent Health's guide; education on community-identified risk factors through programming, media messaging and internal trainings; social and community connectedness through multi-media; information on health and health care; and neighborhood environments that influence youth behaviors.

In order to effectively plan programming, MCHS required contractors to ensure that youth were present and participated in their local YAC meetings. Each contractor was allowed to set the schedule and agendas for the YAC meetings with the recommendation that adolescents need consistent and frequent interaction to remain focused. Excluding summer months, the contractors found that monthly meetings worked the best. Meetings focused on

program implementation progress, development of media messaging, and trainings specific to the risk factor(s) chosen. The THAI community-based YACs improved participation over the year by increasing youth membership from 39 to 63 participants; and adult participation from 53 to 68 members. On average, youth were present at over 92% of monthly meetings showing that the strategies local contractors' used were successful and the youth were engaged. THAI contractors used multiple mechanisms to entice youth to attend including arranging meetings that were held at a time and location that were convenient for youth, searching for innovative activities to keep youth engaged, and arranging for transportation if possible. Meetings provided opportunities for YAC members to provide ideas and strategies on the project, network with community organizations, and begin exploring the needs of the youth in that community.

THAI community-based contracts, through both the YAC activity and the evidence-based strategies, successfully achieved each of the major objectives for the second year of the grant. The objectives were to choose and implement a PYD program; design a media campaign; update the community gap analysis from the original proposal; collect YAC and program participant satisfaction data in order to inform the project design; and initiate sustainability planning via the Office of Adolescent Health guidance. Both FY15 and FY16 have served as startup periods for the YAC and PYD programs respectively.

The THAI external evaluator, Texas A&M's Public Policy Research Institute (PPRI), conducted a search for evaluation tools that measured youth engagement and reviewed surveys that were attached to curricula and other informative surveys in order to evaluate THAI contractor sites. Through discussion with MCHS and MCHE, question selection was refined and vetted to ensure goals for the project were met. Three surveys were selected. One was the Organizational Functioning Assessment which is a 33 question survey that asks about how youth felt about their participation, if the Council processes were clear and consistent, and if youth felt they had leadership opportunities. Another survey, the Young Engagement Tool (YET), is a 13 question survey that measures a youth's perspective on community and world issues, their feelings about themselves and their future, if they felt they could make a difference in their world, and their opinion on whether the YAC incorporated youth voice. The third survey was the PYD functioning assessment. This 15 question tool looked at the YAC operations, collaboration between youth and adults, healthy relationships, and incorporated questions from the Conservation Company's Core Capacity Assessment (www.tccgrp.com) focused on collaboration and the CoalitionsWork's Member survey (http://coalitionswork.com). PPRI developed the PYD functioning assessment specifically for THAI. In FY15 and FY16, PPRI administered the Organizational Functioning Assessment, the YET and the PYD. Highlights of the FY16 Organizational Functioning Assessment showed that youth and adult satisfaction of the YAC functioning remained very high as youth members felt that they had opportunities to participate, the YAC used clear and consistent processes, and youth felt they had leadership opportunities. Adults felt having youth at the table was a strength, felt the YAC used funds fairly, and felt they took the youths' ideas and suggestions seriously. Results from the FY16 YET showed that more youth felt they were more interested in community and world problems, felt better about themselves and their future, and felt they could make a difference than in the FY15 survey. According to the YET, giving youth members the opportunities and support to express themselves and the partnerships established between youth and adults were the most often cited strengths of the project. Challenges were noted in communication, sustained interest, and staying on task during meetings. The PYD functioning assessment tool showed every item had a statistically significant improvement from baseline data collected as a member joined.

Through the THAI project, MCHS added three clinic-based THAI sites. The framework of the clinic-based contracts was based on the community THAI, particularly the Youth-Adult Councils and using the PYD focus. Clinics submitted, with their original application, a "Youth Friendliness" self-assessment with the intent of establishing a baseline to focus the activities of the YAC. MCHS staff adapted this assessment from Healthy Teen Network resources. Contractors began to lay the foundation for a local YAC and reported successfully connecting with twelve youth and adults willing to participate. One site developed a "youth tour" assessment that was used by YAC adolescent

members to provide feedback to the clinic as well. This was shared with all clinic sites as well as the AYAH CoIIN. This project began looking at current Adolescent Well Visits (AWVs) in order to increase the number of youth getting an AWV as well as improve the quality of those visits. Plans to follow up on referrals were initiated as well. One success of THAI clinics was the uniform self-assessment of “youth-friendliness” for all three clinic-based contracts and the utilization of YAC youth members to tour each clinic and provide recommendations to improve youth-friendliness. Recommendations included suggestions on the set-up of the physical environment (youth-targeted messaging, comfortable seating, youth-oriented exam rooms) and input into ways to connect to youth patients (text messaging or email). MCHS will share this tool with other youth-serving programs to begin tracking “youth voice” throughout the state.

Based on the success with the THAI YACs at the local level, MCHS moved forward on development of a state-level Youth Council through a contract with UT Institute for Excellence in Mental Health (UTIEMH) to hire Youth Engagement Specialist(s) as subject matter experts/consultants. The UTIEMH Youth Engagement Project started in late FY16. One initial step of this project was to identify and support youth across the state through a Youth Council called ACCEPT. Some other foundational activities included gathering youth voice resources to share and disseminate, recruiting youth (including young adults) to be on a core steering committee (Youth Council) for the Project, and developing a social media presence to distribute information on youth engagement as well as provide a platform for teens and young adults to stay connected. The Youth Engagement Specialists identified potential programs at the state level to begin to provide overall guidance to the Adolescent Health components of the program, developed a training on youth engagement, and participated in state-level planning groups. These efforts aligned with HRSA’s directive to formalize family partnerships and expanded upon a federally funded HHSC Behavioral Health project, Systems of Care, in which youth participated in public health decisions. MCHS participated in the state-planning workgroup to provide support and guidance on PYD.

Three MCHS staff and 5 core members of the Adolescent & Young Adult Health (AYAH) CoIIN team attended the kick-off meeting in September 2015. After the kick-off, MCHS began holding monthly conference calls to plan Texas’ activities. Texas chose to participate on the 3 National Strategy Teams (NSTs): Access to Care, Quality of Preventive Services, and State/System level policies. Through this project, Texas refined the youth-friendly self-assessment for clinics, developed a literature resource on improving adolescent well visits, and hosted a 2-day workshop for the 3 THAI clinic sites. The workshop was scheduled to train staff on working with adolescents in a decision-making role. This project highlighted the connection between adolescent well visits and injury reduction as an annual primary care visit is a prime opportunity to provide injury prevention counseling. Based on this connection, AH staff recommended that MCHS focus on increasing the percentage of adolescents and young adults who visit a doctor for a routine checkup as a State Performance Measure.
The Adolescent Health Workgroup was designed to provide the opportunity for state agencies that serve adolescents to share current activities, provide networking and collaboration opportunities, and resource sharing throughout the year. Through this Workgroup, MCHS participated in state-level activities focused on the promotion of PYD by facilitating four multi-agency workgroup meetings of over 40 participants representing approximately 30 programs who have an adolescent component to their work. In addition to providing updates on current activities in each program, meetings included a presentation from MCHE on data related to violent deaths and an opportunity to invite the YES team to work on authentic youth engagement.

MCHS participated in other national and state-level activities such as the National Network of State Adolescent Health Coordinators and the Texas CSHCN SDG Medical Home and Texas Title V Transition Workgroups to provide subject matter expertise and incorporate successful strategies into the Adolescent Health Domain. MCHS continued to partner with state and community agencies and stakeholders to develop and share adolescent-friendly ideas across the state which included attendance at the System of Care Council, Texas Prevention Priorities Workgroup,

Alliance for Adolescent Recovery Treatment Planning Group, and conference planning committees (Strengthening Youth & Families, Partners In Prevention, and Primary Care and Health Home Summit). These opportunities allowed MCHS to promote youth involvement and provide technical assistance as needed through educational documents, media platforms, or presentations.

Objective #3: By 2020, 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 in FY17)

MCHS provided subject matter expertise in the development of many of the injury modules through Texas Health Steps' Online Provider Education (OPE) and developed a flyer promoting the modules related to injury prevention. This flyer was distributed at conferences and regional offices as part of healthcare provider recruitment efforts. In FY 16, twelve Injury Prevention modules were completed by 11,325 providers.
MCHS required THAI clinic-based contracts to complete 13 Texas Health Steps OPE modules to ensure that THAI staff had appropriate training related to Adolescent Health. Completion of the modules is anticipated in FY17. In addition to injury prevention, module topics include screenings, consent process and laws, Motivational Interviewing, transition to adulthood, Interpersonal Youth Violence, substance use, chronic illness management, and identification of risky behaviors.

DSHS released 46 issues of "The Friday Beat", an e-newsletter targeted to school nurses and other professionals, to disseminate information about nutrition, physical activity, obesity and other health related topics. The Friday Beat provided 103 unique articles, resources, and educational opportunities related to Injury Prevention to over 3,800 unique users. The articles provided school stakeholders with resources on student safety, emerging best practices, and programs to implement within a school setting. An example of a valuable resource was the *Promoting Student Achievement through Improved Health Policy.* This quick primer is based on CDC's "Whole School, Whole Community, Whole Child" model which highlights 10 important areas for connecting health and learning: health education; physical education and physical activity; nutrition; school health services; counseling, psychological, and social services; employee wellness; safe physical environments, social and emotional school climate; family engagement; and community involvement. Another important resource featured in the Friday Beat included a link to the "Falls in Children and Youth: Hospitalizations" infographic (https://www.childrenssafetynetwork.org/infographics/falls-hospitalizations) from the Children's Safety Network (https://www.childrenssafetynetwork.org/).

MCHS attended a Texas Injury Prevention Leadership Symposium in May of 2016. The purposes of the Symposium were to cultivate a network of injury prevention leaders in Texas, strengthen injury prevention capacity in the state, engage critical thinking skills, put evidence-informed theory into practice, and foster collaboration among agencies/organizations. As a result of this symposium, MCHS developed stronger collaborative relationships with key injury prevention partners, such as the Injury Prevention Center of Greater Dallas, Dell Children's Hospital, and Texas Children's Hospital. These collaborations helped improve injury data collection, promoted injury prevention best practices, and provided resources for the development of the MCHS Injury Prevention Conference scheduled in FY17. MCHS initiated a contract to develop and host the conference in an effort to bring injury prevention partners together from across the state and facilitate the utilization of best practices. Attendees will include members of the state and local CFRTs, MedCARES grant recipients and other key stakeholders, with topics to include safe sleep, child abuse prevention, positive youth development, teen driving safety, injury prevention best and promising practices, and Texas injury data.

MCHS was accepted to participate in the Child Safety (CS) CoIIN. The State CFRT Coordinator, the DSHS Safe

Riders manager, and the DSHS Injury Epidemiology & Surveillance Branch manager attended the kick-off meeting. The overarching goal of the CS CoIIN is to reduce fatal and serious injuries among infants, children, and youth in participating states and jurisdictions over the course of one year by improving partnerships; and expand the implementation and spread of best practices, especially among the most vulnerable populations. Adolescent Health staff participated on the Child Safety CoIIN through membership on the Teen Driving Safety and Teen Suicide and Self Harm Committees. A benefit to the CS CoIIN activities was the connection to the Texas Teen Safe Driving Coalition (TTDSC) which has a website funded through Allstate Insurance. Discussions with TTDSC included the provision of data regarding the number of active coalition members participating in the state teen driving coalition, and determining the feasibility of adding to the teen driving coalition website for Texas as a way to track how many parents signed up for the 52 weeks of teen driving messages. Parent education has been shown to be the only evidence-informed way to prevent teen driving fatalities and injuries. Due to TTDSCs inability to move forward with this project, MCHS began efforts to identify new partners and projects.

In FY16, the MCHS adolescent website saw over 24,700 views to multiple pages though specific data for each page was not readily available due to DSHS website issues. Proposed FY18 updates to the adolescent health section will incorporate injury prevention messaging and resources.

Objective #4: By 2020, increase the percentage of child deaths reviewed by CFRTs by two percentage points (baseline: CFRT report, 2013 – 37%)

Child Fatality Review (CFR) is a public health strategy to understand child deaths through multidisciplinary review at the local level. The Texas CFR 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. SCFRT members are subject matter experts from law enforcement, the medical community, Child Protective Services (CPS), child advocacy organizations, the court system, the behavioral health community, and other interested stakeholders.

In FY16, the State Child Fatality Review Team (CFRT) Coordinator published the 2015 biennial CFRT report for legislators. The report (http://www.dshs.texas.gov/mch/child_fatality_review.shtm) included data analysis of child deaths from 2012 and 2013 and recommendations to legislators that would impact adolescent health and injury prevention. The report outlined leading causes of and risk factors in adolescent deaths. According to the report, motor vehicle deaths are the leading cause of accidental death for children. Most children who died due to motor vehicle crash were passengers with the majority sitting in the back seat. Assault was the second leading cause of death contributing to child homicide, weapon/firearm and asphyxia were consistently the most prevalent method of child suicide. The data helped the SCFRT provide recommendations to the legislature for injury and fatality prevention. Recommendations impacting adolescents and young adults included:

- Pass distracted driver legislation to address the risks of using wireless communication devices while driving.
- Pass legislation that makes it an offense if a person operates a motor vehicle on a public highway while having any detectable amount of alcohol in the person's system while transporting a minor (under the age of 17).
- Repeal Texas Transportation Code, Section 521.205, which allows a parent, step-parent, legal guardian, step-grandparent or grandparent to provide a driver education course to eligible minors 16-18 years of age.
- Pass legislation to amend the Code of Criminal Procedure, Article 45.0215, to include defendants younger than 18 years of age and their parent, guardian, or managing conservator to appear in court on hearings of moving violation.
- Pass legislation to add active shooter training for school personnel to the Center for Safe Schools School Safety Certification Program.

The State CFRT identified the need for statewide trainings to standardize collection and reporting of data. MCHS began the development of a contract to provide vendor support for the SCFRT Coordinator in the planning, advertising, and implementation of eight child fatality review team regional trainings. Local CFRT members will be trained in death scene investigation, injury prevention, and the collection of data to increase the quantity and quality of data collected. A review of the current CFR procedures and tools for the data reporting system was conducted. The Child Fatality Review Operating Procedures manual was updated. The State CFRT coordinator participated in a national data quality workgroup with the National Center for Fatality Review and Prevention on the development of a list of priority variables for child fatality review teams to use throughout Texas and the US. This list of priority variables contained a data dictionary with further clarification for teams. This list will be added to the Child Fatality Review Operating Procedures manual and shared during the FY17 trainings to local CFRT teams. Training materials will be posted on the MCH website after the regional trainings are complete.

Local CFRTs are volunteer-based and organized by county or multi-county geographic areas. Team 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? In order to establish a baseline for local CFRT membership, the State CFRT Coordinator contacted local teams to update member distribution lists. Three areas (HSR 2/3, HSR 6/5 and HSR 8) added, or are in the process of adding, counties to existing local CFRTs.

Texas was awarded a Children's Justice Act grant in FY16. The State CFRT Coordinator developed this project to support the hiring of two local CFRT coordinators in one urban and one rural pilot community. The goal of the project will be to determine the benefit of paid staff in the quality of the collection and reporting of CFR data as well as implementation of injury prevention initiatives in the local pilot communities. Through these efforts, it is anticipated that there will be increased capacity to review child deaths, increased meeting consistency across teams, improvement of data quality, and increased quantity of cases reviewed in order to improve guidance and accuracy.

Additional activities facilitated by MCHS included the Rape Prevention & Education (RPE) Grant from the CDC to address sexual assault, one of the main causes of intentional injury as well as a causational relationship to suicide. For Texas, the RPE grant is managed through MCHS Adolescent Health. In FY16, RPE incorporated a Public Health approach and developed minimum standards for the use of prevention principles to fund 25 rape crisis centers which was a 50% reduction in contracted sites. Through the Primary Prevention Planning Committee, RPE identified 12 principles to guide contractors in selection of curricula. The trainings need to be comprehensive, based on primary prevention, have sufficient dosage (a minimum of 9 in-person sessions), socio-culturally relevant, collaborative, based on evidence, presented by well-trained implementers, appropriately timed in development, using a sound theory of change, support of positive relationships, using varied teaching methods, and include outcome evaluation. Through promotion of these principles, sites were provided adequate fiscal support for contracted centers to impact primary prevention in their community. RPE continued to identify common data sets for sites to begin evaluation and analysis in FY17. MCHS attended CDC's grantee meeting and the National Sexual Assault Conference to obtain emerging best practice, network, and share successful strategies on primary prevention.

MCHS, MCHE, and HHSC staff, through the Suicide Prevention Program and the Center for the Elimination of Disproportionality & Disparities, began studying data related to Black violent death and White suicides through a Research Training Institute (RTI) project. Initial review showed that the violent death/suicide ratio of Blacks compared to Whites was enlightening. Initial review showed that Blacks had a high violent death rate compared to their suicide rate while Whites had a high suicide rate compared to their violent death rate. The goal of RTI is to create a state surveillance system that is inclusive of suicide and other violent deaths in youth and young adults ages 10 to 24 years, and to initiate a foundation for continuous quality improvement and feedback that bridges state public health

with local stakeholders. MCHE and Suicide Prevention attended a one-week training on using data to action. Texas will be using both MCHE and RTI data to identify communities that showed, through data, to have a number of indicators that could increase the number of suicides and violent deaths. The state group will work to engage those communities in order to explore and develop educational intervention and prevention services to reduce the violent death rate.

Regional Population-based Activities:
Regional MCHS staff were involved in several innovative initiatives focused on enhancing youth safety, raising awareness of social justice issues, and promoting preventive health. Issues that continued to gather energy among regional staff and CFRT groups as they responded to local deaths and injuries were bullying and suicide prevention. Presentations or trainings on the anti-bullying "Rising Up" program, "Resisting Aggression Defensively" (RAD Kids), and the ASK and QPR suicide prevention interventions were held across the state. HSR 6/5S conducted an environmental scan to identify ISDs without a suicide prevention policy and helped them initiate policies or fill in gaps.

HSR 4/5N led the establishment of the Northeast Texas Brain Injury Coalition which brought together professionals; from acute and chronic brain injury medicine, Pineywoods Regional Advisory Council, and researchers; to set a platform for prevention, treatment, and long-term care of brain injury in Northeast Texas. This resulted in a traumatic brain injury summit in April 2016 and commitment to ongoing efforts to improve prevention efforts through collective impact. HSR 4/5N, through a long-standing partnership with a local coalition that identified a need for ATV safety in the region, also updated and promoted an ATV safety training and video. The training and video were shared with other regions, and, through a collaboration with a local THAI contractor, were shown to over 1,200 high school youth. In Region 4/5N, staff partnered with the Pay Attention East Texas (PAET) Coalition. The PAET Coalition focuses on distracted driving and motor vehicle safety to address the 86% higher fatality rate from motor vehicle crashed experienced in East Texas. To assist the coalition in this pursuit, DSHS staff initiated a project to identify two of the highest-risk crash sites in the region to develop evidence-based programmatic responses.

Through regional population based activities, HSR 11 staff focused activities on adolescent leadership that included a Peer Assistance & Leadership (PAL®) curriculum (http://palusa.org/) certification training for 30 attendees in four schools and eight youth-serving organizations and four regional DSHS staff. The PAL® curriculum began in 1980 as a "peer helping" program, combining "peer assistance" and "peer leadership" strategies originally developed in the late 1970's. Over the last couple decades, it has significantly enhanced and expanded on these basic prevention strategies, evolving the PAL® peer helping program from an informal, extra-curricular activity in a single school district, into a formally structured, curriculum-based program, adopted by the Texas Education Agency (TEA) as an accredited elective course. The certification allowed access to the curriculum, support from the developer, and utilization of the material.

Regional staff continued to maintain visibility as a resource on positive youth development, promotion of anti-distracted driving programs, and utilization of data to drive community efforts.

Performance Analysis: THAI community-based contracts, through both the YAC activity and the evidence-based strategies, successfully achieved each of the major objectives for the second year of the grant. YAC satisfaction remained very high and youth YAC members reported higher PYD competencies than in FY15. PYD program implementation varied across sites, though impacts were largely positive. Injury prevention strategies became more focused which assisted in a more defined strategy plan. MCHS staff utilized multiple platforms, including OPE, GovDelivery, websites, and workgroups, to share Injury Prevention programs, strategies, and resources.

Challenges / Opportunities: THAI data was challenging to synthesize as each THAI community-based site wanted to impact a different combination of risk attributes. Therefore, assessments were customized to capture change in the specific factors prioritized in each community and made generalizations difficult. Requiring youth to be present at all YAC meetings created a challenge for sites due to transportation issues and student schedules. Contract staff worked creatively to overcome these barriers. OPE began providing case studies, quick courses (5 minute reviews), podcasts, and tutorials to continue online education support to providers.

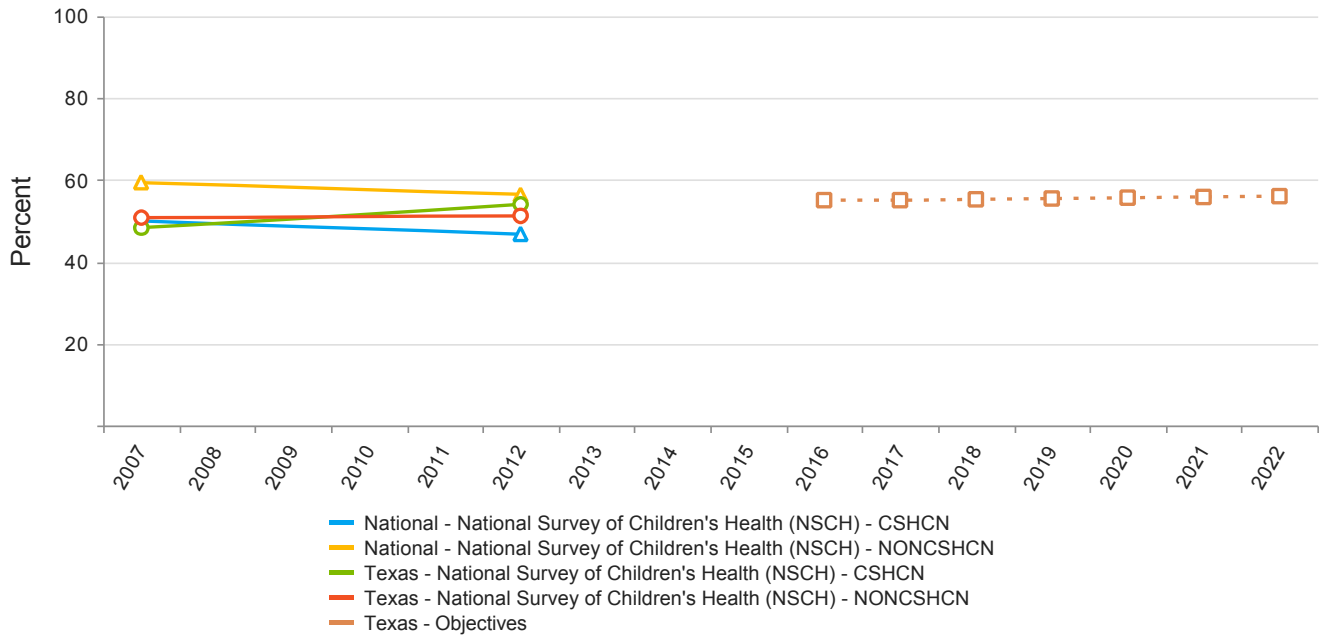
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	NS-CSHCN-2009_2010	17.8 %	NPM 11 NPM 12
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	82.0 %	NPM 11 NPM 12
NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)	NIS-2015	71.2 %	NPM 11
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	62.1 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	60.1 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	41.4 %	NPM 11
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	85.1 %	NPM 11
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2015	89.6 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs having a medical home
Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	55
Annual Indicator	53.9
Numerator	706,631
Denominator	1,310,061
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	55.0	55.2	55.4	55.6	55.8	56.0

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
Annual Objective	
Annual Indicator	35.7
Numerator	218
Denominator	610
Data Source	Texas 2016 CSHCN SP Outreach Survey
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	37.5	38.0	38.5	39.0	39.5	40.0

ESM 11.2 - Percent of physicians demonstrating knowledge of medical home characteristics

Measure Status:	Inactive - Replaced

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	16.0	17.0	18.0	19.0	20.0	

ESM 11.3 - Distribution of Medical Home and Transition Physician Surveys

Measure Status:	Inactive - Replaced

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	

ESM 11.4 - Percent increase in medical home provider education

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4.0	8.0	12.0	16.0	20.0	24.0

ESM 11.5 - Meet with clinical champions for provider engagement

Measure Status:	Active

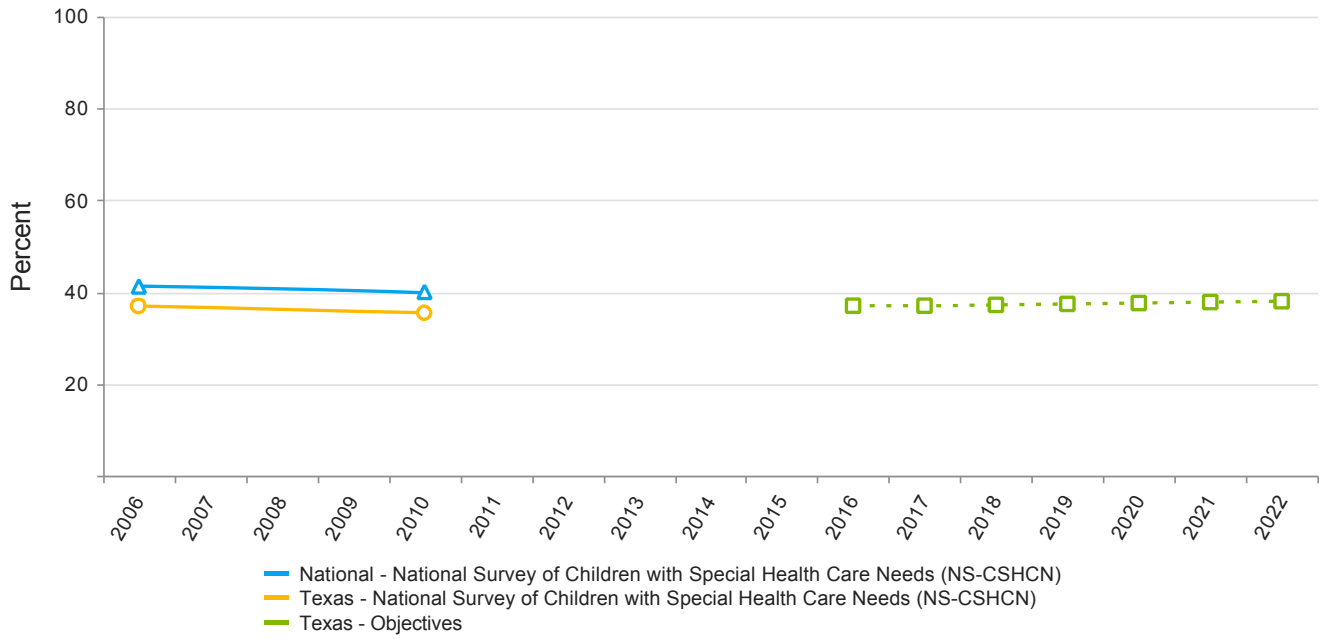
Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	Yes	No	No	No	No

ESM 11.6 - Create a provider engagement strategic plan

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	No	No	Yes	No	No

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	37
Annual Indicator	35.4
Numerator	101,253
Denominator	286,298
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	37.0	37.2	37.4	37.6	37.8	38.0

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
Annual Objective	
Annual Indicator	19.8
Numerator	46
Denominator	232
Data Source	Texas 2016 CSHCN Outreach Survey
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	19.5	20.0	20.5	21.0	21.5	22.0

ESM 12.2 - Percent of physicians demonstrating knowledge of the transition from pediatric to adult health care

Measure Status:	Inactive - Replaced

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	21.0	22.0	23.0	24.0	25.0	

ESM 12.3 - Distribution of CYSHCN Outreach Survey

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	DSHS CSHCN Systems Development Group
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 12.4 - Percent increase in transition provider education

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	4.0	6.0	8.0	10.0	12.0

State Performance Measures

SPM 1 - Percent of CYSHCN and their families who received the supports and services necessary to be integrated into their communities

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	37.5
Numerator	224
Denominator	598
Data Source	Annual CYSHCN Outreach Survey
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	37.5	38.0	38.5	39.0	39.5	40.0

State Action Plan Table

State Action Plan Table (Texas) - Children with Special Health Care Needs - Entry 1

Priority Need

Children and Youth with Special Health Care Needs receive family-centered, coordinated care within a medical home model.

NPM

Percent of children with and without special health care needs having a medical home

Objectives

By 2020, 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).

Strategies

Strategy 1: Assess level of CYSHCN and family understanding of medical home.

Strategy 2: Educate and reach out to families of CYSHCN to improve understanding of medical home.

Strategy 3: Support families to improve provision of medical home services for CYSHCN.

ESMs	Status
ESM 11.1 - Percent of families receiving professional care coordination for their child	Active
ESM 11.2 - Percent of physicians demonstrating knowledge of medical home characteristics	Inactive
ESM 11.3 - Distribution of Medical Home and Transition Physician Surveys	Inactive
ESM 11.4 - Percent increase in medical home provider education	Active
ESM 11.5 - Meet with clinical champions for provider engagement	Active
ESM 11.6 - Create a provider engagement strategic plan	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

State Action Plan Table (Texas) - Children with Special Health Care Needs - Entry 2

Priority Need

Children and Youth with Special Health Care Needs receive family-centered, coordinated care within a medical home model.

NPM

Percent of children with and without special health care needs having a medical home

Objectives

By 2020, increase the percentage of providers of CYSHCN who are provided education about medical home by 5% above baseline (FY15 OPE participant baseline = 313).

Strategies

Strategy 1: Assess level of CYSHCN providers' understanding of medical home.

Strategy 2: Educate and reach out to providers of CYSHCN to improve understanding of medical home.

ESMs	Status
ESM 11.1 - Percent of families receiving professional care coordination for their child	Active
ESM 11.2 - Percent of physicians demonstrating knowledge of medical home characteristics	Inactive
ESM 11.3 - Distribution of Medical Home and Transition Physician Surveys	Inactive
ESM 11.4 - Percent increase in medical home provider education	Active
ESM 11.5 - Meet with clinical champions for provider engagement	Active
ESM 11.6 - Create a provider engagement strategic plan	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

State Action Plan Table (Texas) - Children with Special Health Care Needs - Entry 3

Priority Need

Children and Youth with Special Health Care Needs receive family-centered, coordinated care within a medical home model.

NPM

Percent of children with and without special health care needs having a medical home

Objectives

By 2020, increase the percentage of providers of CYSHCN who are supported in participating in medical home advancement activities by 5% above baseline. (Baseline to be established during FY17).

Strategies

Strategy 1: Assess level CYSHCN providers' participation in medical home activities.

Strategy 2: Support providers to improve provision of medical home services for CYSHCN.

Strategy 3: Promote best-practices in the provision of medical home services.

ESMs	Status
ESM 11.1 - Percent of families receiving professional care coordination for their child	Active
ESM 11.2 - Percent of physicians demonstrating knowledge of medical home characteristics	Inactive
ESM 11.3 - Distribution of Medical Home and Transition Physician Surveys	Inactive
ESM 11.4 - Percent increase in medical home provider education	Active
ESM 11.5 - Meet with clinical champions for provider engagement	Active
ESM 11.6 - Create a provider engagement strategic plan	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

State Action Plan Table (Texas) - Children with Special Health Care Needs - Entry 4

Priority Need

Children and Youth with Special Health Care Needs and their families have the services and supports necessary to transition to adulthood.

NPM

Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Objectives

By 2020, 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).

Strategies

Strategy 1: Assess level of CYSHCN and family understanding of transition from pediatric to adult health care.

Strategy 2: Educate and reach out to families of CYSHCN to improve understanding of transition from pediatric to adult health care.

Strategy 3: Support families to improve provision of youth transition services from pediatric to adult health care.

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 - Percent of physicians demonstrating knowledge of the transition from pediatric to adult health care	Inactive
ESM 12.3 - Distribution of CYSHCN Outreach Survey	Active
ESM 12.4 - Percent increase in transition provider education	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (Texas) - Children with Special Health Care Needs - Entry 5

Priority Need

Children and Youth with Special Health Care Needs and their families have the services and supports necessary to transition to adulthood.

NPM

Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Objectives

By 2020, increase the percentage of pediatric and adult providers who are provided education on transition from pediatric to adult health care by 2% above baseline. (FY15 OPE Participants Baseline = 1,084).

Strategies

Strategy 1: Assess level of CYSHCN providers' understanding of transition from pediatric to adult health care.

Strategy 2: Educate and reach out to providers of CYSHCN to improve understanding of transition from pediatric to adult health care.

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 - Percent of physicians demonstrating knowledge of the transition from pediatric to adult health care	Inactive
ESM 12.3 - Distribution of CYSHCN Outreach Survey	Active
ESM 12.4 - Percent increase in transition provider education	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (Texas) - Children with Special Health Care Needs - Entry 6

Priority Need

Children and Youth with Special Health Care Needs and their families have the services and supports necessary to transition to adulthood.

NPM

Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Objectives

By 2020, increase the percentage of pediatric and adult providers who are supported in the provision of transition services from pediatric to adult health care by 2%. (Baseline to be established during FY17).

Strategies

Strategy 1: Assess provision of transition services from pediatric to adult health care.

Strategy 2: Support providers to improve provision of transition services from pediatric to adult health care.

Strategy 3: Promote best-practices in the provision of transition services.

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 - Percent of physicians demonstrating knowledge of the transition from pediatric to adult health care	Inactive
ESM 12.3 - Distribution of CYSHCN Outreach Survey	Active
ESM 12.4 - Percent increase in transition provider education	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (Texas) - Children with Special Health Care Needs - Entry 7

Priority Need

Advance Community Integration efforts.

SPM

Percent of CYSHCN and their families who received the supports and services necessary to be integrated into their communities

Objectives

By 2020, increase the percentage of CYSHCN and their families who are provided education and support on utilization of family supports and community resources by 2%. (Baseline to be established during FY17).

Strategies

Strategy 1: Assess availability of resources for families within their communities.

Strategy 2: Educate and reach out to families of CYSHCN to improve utilization of available family supports and community resources.

Strategy 3: Support families to receive family supports and community resources.

State Action Plan Table (Texas) - Children with Special Health Care Needs - Entry 8

Priority Need

Advance Community Integration efforts.

SPM

Percent of CYSHCN and their families who received the supports and services necessary to be integrated into their communities

Objectives

By 2020, increase the percentage of providers of CYSHCN who are provided education and support on the provision of family supports and community resources by 2%. (Baseline to be established during FY17).

Strategies

Strategy 1: Assess where families are receiving family supports and community resources.

Strategy 2: Educate and reach out to providers to improve understanding of available resources for families within their communities.

Strategy 3: Support providers to increase the availability of resources for families within their communities.

Children with Special Health Care Needs - Plan for the Application Year

Within a continuous quality improvement framework, information gathered during ongoing needs assessment activities and national data sources will inform program priorities and activities related to medical home, transition, and community integration. NS-CSHCN and NSCH data will be supplemented with state-based data sources. Families and young adults with disabilities continue to serve as integral partners in the ongoing needs assessment process. Annual, Texas-specific data enables MCHS to monitor process and outcome measures related to CSHCN performance measures.

NPM 11: NPM Percent of children with and without special health care needs having a medical home.

In response to NA findings and progress on medical home advancement within Texas, MCHS has outlined multiple strategies within the State Action Plan Table to further understanding of medical home in Texas by both families and providers. MCHS will convene a workgroup of provider champions to assess MCHSs provider engagement efforts. In partnership with families, MCHS will distribute the CYSHCN Outreach Survey across the state to assess the availability of resources for families within their communities and identify where families are receiving services. Discussion groups and interactive feedback sessions will be conducted as part of ongoing NA activities.

An ongoing initiative, the MHWG, meets quarterly and convenes key stakeholders to exchange best-practice resources and provide members opportunities to collaborate and gain knowledge. Projects include expanding the membership base to ensure key stakeholder participation and implementation of the five-year strategic plan which incorporates specific, measurable goals.

In collaboration with community-based partners, MCHS will educate and reach out to families and providers of CYSHCN to improve understanding of medical home. Education and outreach materials including publications, presentations, webinars, tools, newsletters and other informational resources will be refined and distributed. Education on medical home through contracts, community-based contractors, GovDelivery, MHWG, TTVTW, website resources and local, regional and state conferences is ongoing. MCHS representation on and monitoring of state advisory committees and workgroups advances medical home education and understanding for families, physicians and other key stakeholders.

Medical home support funding through contracts improves provision of medical home services for CYSHCN. Case management through community-based contractors and regional staff supports better coordination of services for CYSHCN and their families. Family/professional partnerships will be strengthened through collaborative activities in the TTVTW, MHWG and participation in state and national medical home initiatives.

MCHS promotes best-practices in the provision of medical home services including the Standards for Systems of Care for CYSHCN, Six Core Elements of Health Care Transition, National CLAS Standards and Life Course Framework, and incorporating the work of the Community of Practice for Supporting Families through the MHWG, TTVTW, statewide workgroups, community-based contractors and other forums.

In partnership with the UT School of Social Work, an interdisciplinary curriculum utilizing best practices was developed and piloted and will be refined to increase future healthcare professionals' knowledge and understanding of transition within the medical home. MCHS will collaborate with Texas A & M University to develop a tool to support pediatric and adult primary, specialty, Internal Medicine-Pediatrics and family practice providers in preparing CYSHCN and their families for transition to adult health care within a medical home. In partnership with Easter Seals of Greater Houston, a family transition tool, based on best-practices, family input and principles of self-determination, will continue to be developed.

Collaboration with key stakeholders is ongoing within the state and staff continue participating in planning statewide conferences such as the Texas Primary Care and Health Home Summit. Participation in and facilitation of national and state medical home initiatives further advances best practices among providers and families. Partially funded through MCHS, HHSC administers comprehensive health care benefits through providers across the state.

MCHS will continue to work closely with partners to address the emergence of Zika through education, surveillance, and connection to services. CHW instructors and programs will be trained to use new curriculum and tools along the Texas/Mexico border. New materials for providers will offer education about testing and management of the Zika virus and a communication plan will be developed to aid in outreach efforts for providers. MCHS and Texas' BDES will continue partnering to carry out activities related to Texas' CDC grant on microcephaly and Zika virus. TxP2P will play an integral role in conducting family outreach. A pilot initiative will be planned and carried out to connect families of children with Congenital Zika Syndrome to services. MCHS staff will continue participating in national meetings and initiatives such as the AAP's Project ECHO Zika Advisory Committee and CDC's Zika Care Connect.

NPM 12: Percent of children with and without special health care needs who received services necessary to transition to adult health care.

Based on NA findings and to advance progress on transition to adulthood for youth in Texas, MCHS has outlined multiple strategies within the State Action Plan Table to further understanding of health care transition in Texas by both families and providers. In partnership with families and building on previous NA activities, MCHS will continue developing interactive feedback methods to assess levels of physician understanding and implementation of transition from pediatric to adult health care. Discussion groups and interactive feedback sessions will be conducted as part of the ongoing NA activities. Results will be analyzed and findings utilized to inform program priorities and activities.

Through the implementation of a strategic plan, the TTVTW is spearheading efforts to improve transition outcomes for CYSHCN in Texas. The workgroup convenes key stakeholders on a quarterly basis serving as a forum to exchange best-practice resources, provide opportunities for members to highlight progress and increase knowledge related to transition to adulthood.

In collaboration with community-based partners, Title V will educate and reach out to families and providers of CYSHCN to improve understanding of health care transition. Education and outreach materials including publications, presentations, webinars, tools, newsletters and other informational resources will be refined and distributed. Education on health care transition through contracts, community-based contractors, GovDelivery, MHWG, TTVTW, website resources and local, regional and/or state conferences is ongoing. MCHS representation on and monitoring of state advisory committees and workgroups advances health care transition education and understanding for families, physicians and other key stakeholders.

Medical home support funding through grants and contracts improves provision of transition planning and coordination of services for CYSHCN. Community-based case management contractors and regional staff help families plan for transition and link to services. Family/professional partnerships will be strengthened through collaborative activities in the TTVTW, MHWG and participation in state and national transition improvement initiatives.

MCHS promotes best-practices in provision of transition planning services including the Standards for Systems of Care for CYSHCN, Six Core Elements of Health Care Transition, National CLAS Standards, Life Course Framework and incorporating the work of the Community of Practice for Supporting Families through the MHWG, TTVTW, statewide workgroups, community-based contractors and other forums.

In partnership with the UT School of Social Work, an interdisciplinary curriculum utilizing best practices has been developed and implemented to increase future healthcare professionals' knowledge and understanding of transition within the medical home. MCHS will partner with Texas A & M University to develop a tool to support pediatric and adult primary, specialty, Internal Medicine-Pediatrics and family practice providers in preparing CYSHCN and their families for transition to adult health care within a medical home. In collaboration with Easter Seals of Greater Houston, a family tool, based on best-practices, family input and principles of self-determination will continue to be developed to address all aspects of transition including health care, postsecondary education, vocational training, legal needs, financial management, employment, social and recreational activities, and independent living. MCHS will collaborate with Texas A & M University to develop a tool to support pediatric and adult primary, specialty, Internal Medicine-Pediatrics and family practice providers in preparing CYSHCN and their families for transition to adult health care within a medical home. Collaboration with key stakeholders is ongoing within the state and staff continue participating in planning statewide conferences such as the Chronic Illness and Disability Conference: Transition from Pediatric to Adult-based Care. Participation in and facilitation of national and state transition initiatives further promotes best-practices among providers and families.

SPM 1: Percent of CYSHCN and their families who received the supports and services necessary to be integrated in their communities.

In response to NA findings and improve efforts supporting CYSHCN and their families to be fully integrated into their communities, MCHS has outlined multiple strategies within the State Action Plan Table to strengthen community-based services. In partnership with families, MCHS will continue distributing a survey across the state to assess the availability of resources for families within their communities and identify where families are receiving services. Discussion groups and interactive conference sessions may be held as part of ongoing NA activities.

In collaboration with community-based partners, MCHS will educate and reach out to families and providers of CYSHCN to improve understanding of available community resources. Education and outreach materials including publications, presentations, webinars, tools, newsletters and other informational resources will be refined and distributed. Education to promote community integration through MCHS contractors, GovDelivery, MHWG, TTVTW, website resources and local, regional and/or state conferences is ongoing. MCHS representation on and monitoring of state advisory committees and workgroups promotes community integration by increasing family and provider awareness and understanding of available resources.

Funding through Case Management and Family Supports & Community Resources contracts improves provision of

community services and supports to families of CYSHCN. Community-based contractors provide services including, but not limited to, home- and center-based respite, family and sibling support, education, social/recreational activities and funding to support access to necessary services not otherwise covered. Case management provides coordination of services and linkages to community resources. Family/professional partnerships will be strengthened through collaborative activities in the TTVTW, MHWG and participation in state and national initiatives.

MCHS promotes best-practices in provision of family support services including the Standards for Systems of Care for CYSHCN, National CLAS Standards, Life Course Framework, incorporating the work of the Community of Practice for Supporting Families and People First Language through the MHWG, TTVTW, statewide workgroups, community-based contractors and other forums. Participation in and facilitation of national and state initiatives supporting CYSHCN and their families further advances best-practices among providers and families.

NPM 11: NPM Percent of children with and without special health care needs having a medical home.

OBJECTIVE 1: By 2020, 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).

In partnership with families and other key stakeholders, MCHS developed and distributed the 2016 CYSHCN Outreach Survey across the state to monitor Texas' ongoing progress toward meeting the performance measure and outcomes relevant to medical home for CYSHCN and their families. Survey findings identified 54% of respondents indicated that obtaining care focused on their child's special health care needs would ensure their child receives all needed care. The most common reason given for not being able to seek help for their CYSHCN was that their medical provider was too far away (20.7%). Survey respondents and discussion group participants consistently reported the unavailability of local doctors, specialists, dentists and therapists kept families from seeking help. The need for more financial assistance with copays and medications, as well as with therapies ordered by doctors but not covered by insurance, followed as a common reason for not accessing medical care. The majority of respondents indicated that they alone made sure their child receives all needed care (81.5%).

MCHS staff and contractors presented and exhibited at conferences, health fairs and other forums throughout the state to share information with families on accessing coverage and care. Staff exhibited at the UTHSC-SA's 3rd annual Parent Education Day held for families of individuals with Cystic Fibrosis (CF). The MCHS Medical Director, Director of TxP2P, and a member of the MHWG co-presented, "Building Your Child's Medical Team through a Medical Home" at TxP2P's annual conference. Additionally, MCHS staff co-presented, "Strategies for Managing Difficult Medical Experiences" with a nurse practitioner from Dell Children's Medical Center's Comprehensive Care Clinic. A TxP2P conference session led by parents of children with medical complexity, "Making Decisions for Your Child with Medically Complex Special Health Care Needs" offered guidance to parents making life or death decisions on a daily basis. TxP2P staff presented on care notebooks and promoted their online care notebook resources and Medical Home Toolkit in their quarterly newsletter to encourage utilization. The TxP2P newsletter also featured an article on the CSHCN SP's health care benefits program. Bryan's House shared information with the Senior Fire Prevention Officer from the City of Dallas Fire-Rescue Department on the needs of CYSHCN and their families. Subsequently, an education initiative to teach families in their own homes about fire prevention was planned for FY17. The Children's Special Needs Network's annual conference included a workshop on emergency preparedness. The DSHS emergency preparedness materials were shared with families and providers at conferences and health fairs.

The DSHS regional staff and MCHS contractors helped CYSHCN and their families with care coordination by facilitating access to primary and specialty providers, health care coverage, medical transportation and other needed health-related services. Contractors assisted 2,097 clients with case management services. Of clients with a PCP, 98% had seen their PCP within the past 12 months (n=1,944). Regional staff conducted 1,045 encounters with clients to assist them in establishing a medical home. Contractors assisted families with 5,446 medical home services including emergency preparedness planning, health insurance applications, school support, and finding specialty and dental care. Contractor case management clients reported high satisfaction with the continuity, coordination and comprehensiveness of services, with 95%, 98% and 97% satisfaction rates, respectively.

Contractor collaboration with FQHCs continued and supported access to medical and dental care. By establishing and strengthening partnerships with foundations, contractors helped families access funds for medical expenses not otherwise covered including therapies, medical equipment and expenses related to out of town travel for medical services. Contractors developed preparedness plans with families and connected them with local emergency personnel. Efforts to support families in accessing health care, equipment and medications helped keep children out of the hospital. The CHOSeN clinic provided care coordination for children with medical complexity by assisting with surgeries, transportation, extended hospital stays, proper discharge, accessing medical equipment, and palliative and/or hospice care at home. The clinic updated their family education manual for youth with medical complexity to include Spanish and Vietnamese translation, ensured families with language barriers had proper interpretation services for all appointments, attended special education meetings to advocate for children and worked with mental health professionals to educate the care team on how to better assist patients before referring to mental health specialists.

A total of 1,793 clients received CSHCN SP health care benefits and 61 were on the waiting list in FY16 (data as of 12/31/16). A total of 900 clients were removed from the waiting list throughout FY16 and became eligible for health care benefits. Of these children removed from the waiting list, 583 had no other health care coverage. Case management services through DSHS regional staff was available to all children receiving benefits and those on the waiting list. The CSHCN SP's health care benefits program also assisted 23 families with insurance premium payments. The IBIS system was launched to automate client, provider and claim functions. Improvements to the

content management system was implemented to gain efficiency, increase accuracy and further reduce paper processes. Multiple trainings on eligibility, imaging, and IBIS processes were conducted for regional staff across the state.

Families were informed of program updates, upcoming webinars, workshops, conferences, new resources, and opportunities for families to partner with decision makers through GovDelivery, ongoing website postings and newsletter articles. Improvements to the CSHCN website enabled MCHS to disseminate time-sensitive news and announcements to stakeholders including families. GovDelivery Medical Home Topic subscribers increased from 2,429 to 4,097 (as of 01/09/2017). The Newsletter for Families featured articles, "Flu and RSV Season," "Protect from and Prevent Mosquito Bites," and "To Share or Not to Share" (i.e., personal health information) to raise awareness and educate families. MCHS collaborated with TxP2P, the AMCHP Family Delegate and THSteps to update the medical home brochure for families. A total of 2,006 medical home brochures for families were distributed throughout the state. There were 6,097 page visits to the medical home webpage for families.

MCHS monitored developments of the STAR kids Medicaid managed care program for CYSHCN scheduled to launch on 11/01/16. The MCHS Medical Director participated in the STAR Kids Quality Workgroup and staff attended quarterly STAR Kids Advisory Council meetings. The Standards for Systems of Care for CYSHCN, shared with the Advisory Council in FY15 and the Quality Workgroup in FY16, provided a resource to workgroup efforts in FY16. Staff attended a two-day training for managed care organization leadership and reviewed the STAR Kids Screening and Assessment Instrument. Multiple community-based contractors attended regional informational meetings and supported families in preparing for changes associated with STAR Kids implementation.

OBJECTIVE 2: By 2020, increase the percentage of providers of CYSHCN who are provided education about medical home by 5% above baseline (FY15 OPE participant baseline = 313).

A survey for providers which included medical home topics was developed for distribution in FY17. A low response rate led to reformatting and disseminating two separate surveys. Additionally, revised ESMs will allow MCHS to formulate strategic goals to increase the number of physicians and other providers engaged in MCHS activities for CYSHCN. Increased engagement will improve needs assessment response rates and increase MCHS's reach to providers across the state.

The MCHS Medical Director presented an overview of MCHS activities for CYSHCN at the TMA's Committee on Primary Care and Medical Home and served as a consultant to the TPS Committee on Children with Disabilities. MCHS staff and the AMCHP Family Delegate were members of the Texas Primary Care and Health Home Summit Steering Committee which planned the 4th Annual Texas Primary Care and Health Home Summit. The conference was attended by 240 providers, community organizations, stakeholders and family members. The MCHS MCH Medical Director and MCHE staff presented, "Results of the Texas Title V Five Year Needs Assessment" and MCHS provided funding for eight community-based contractor staff members to attend. MCHS staff exhibited at the 2015 Texas Immunization Conference, Annual Vital Statistics Conference and TPS' Annual Meeting. Staff also attended the NASHP Annual Conference in Dallas, TX.

A presentation on STAR Kids, the new Medicaid managed care model developed for children with special health care needs, was featured on a contractor quarterly conference call. The CHOSeN clinic social worker presented information on STAR Kids to the UTHSC-H's General Pediatrics Team.

The MCHS CYSHCN Director and program staff attended Dell Children's Medical Center's Grand Rounds presentation, "Dell Medical School Inter-Professional Integration Curriculum" as part of a collaborative initiative with the UT School of Social Work to develop an interdisciplinary curriculum. The discussion detailed core competencies of a new teaching methodology planned for implementation within UT pharmacy, nursing and social work learning environments during FY17.

The THSteps OPE modules for Medical Home and My First Dental Home were completed by 371 and 1,086 providers in Texas respectively.

OBJECTIVE 3: By 2020, increase the percentage of providers of CYSHCN who are supported in participating in medical home advancement activities by 5% above baseline. (Baseline to be established during FY17).

The MCHS Medical Director represented AMCHP and MCHS as a participant in the AAP/CDC Clinical Evaluation and Management of Infants with Congenital Zika Virus Infection meeting and contributed to the CDC report, "Update: Interim Guidance for the Evaluation and Management of Infants with Possible Congenital Zika Virus Infection – United States, August 2016." The MCHS Medical Director was invited to serve on the AAP's Project ECHO Zika Advisory Committee. The committee provides strategic oversight to the development of a health professional education and training curriculum to ensure that medical home services are provided to families of infants confirmed to have Congenital Zika Syndrome.

The MCHS CYSHCN Director was invited by AMCHP and NASHP to participate in the 2016 National Workgroup to review and suggest updates to the Standards for Systems of Care for CYSHCN. Members of Texas' ALC presented, "Using the National Standards to Improve Medical Home Services" at the Primary Care and Health Home Summit and conducted sustainability meetings throughout FY16. The Standards for Systems of Care for CYSHCN were downloaded from the CSHCN SP's webpage 740 times.

The MHWG met quarterly to review ongoing initiatives, monitor national activities and promote best practices. Presentations included an overview of the Standards for Systems of Care for CYSHCN, Person-Centered Thinking & Life Course Approach, speakers from the National CMHI and regular updates on STAR Kids. Members continued strategic planning activities by identifying priorities and setting goals which included engaging CYSHCN, their families, physicians and other stakeholders to promote medical home implementation in Texas; educating CYSHCN, their families, physicians and other key stakeholders on the medical home model; and, increasing statewide medical home capacity to provide health care transition services for CYSHCN in collaboration with the TTVTW. There were over 825 page visits to the MHWG webpage.

The MCHS CYSHCN Director and staff attended Project LAUNCH meetings and served on the Texas LAUNCH – Early Childhood Committee. MCHS staff collaborated with the state's Child Health coordinator to advance developmental screening outcomes by increasing access to developmental screenings in Texas for children, ages 0-8. Staff participated in ongoing AYAH CoIIN project meetings and provided technical assistance and resources to project sites.

MCHS Medical Home Supports contractors implemented quality initiatives utilizing the CMHI Medical Home Index. The Child Study Clinic developed a parent advisory group to improve care coordination and developed a new website to better communicate with families and ease access to health information. The CHOSeN clinic continued working with Project DOCC to enable Parent Teachers to educate pediatric residents on the experience of caring for children with disabilities or chronic illnesses.

The UTHSC-SA's medical home-related projects included expanding services for adults with CF, implementing 24-hour access, streamlining communication, developing care management binders, conducting a patient education campaign and hosting the annual CF Family Education day which was attended by the local military CF center, area CF fundraising chapter and DSHS. Psychiatric resources expanded by partnering with a mental health professional to address issues specific to family functioning. Needs of siblings not diagnosed with CF became a focus through quality improvement processes.

Performance Analysis: Increasing awareness and access to a medical home remain CSHCN SDG priorities. The MHWG, Texas Primary Care and Health Home Summit, STAR Kids and other major state initiatives have increased recognition and implementation of the medical home model.

Challenges/ Opportunities: Limited resources and challenges with sustainability impacted collaboration with medical home initiatives statewide. MCHS continues strategizing to strengthen engagement of clinical stakeholders with varying strengths, needs, interests and levels of expertise to enhance supports for CYSHCN and their families. The provision of education and training on the medical home model for clinicians to maximize CYSHCN access to comprehensive, coordinated primary care remains a significant opportunity.

NPM 12: Percent of children with and without special health care needs who received services necessary to transition to adult health care.

OBJECTIVE 1: By 2020, 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).

In partnership with families and other key stakeholders, MCHS developed and distributed the 2016 CYSHCN Outreach Survey across the state. Young adults aged 18 years and older were invited to participate in the FY16 survey. The majority of parents and young adults indicated they did not feel prepared for transition or were unsure if they felt prepared. Only 19.4% of parents and youth responding to the survey reported receiving professional help with transition to adulthood in four or more of the seven program-defined areas. Parents and youth indicated their top need in preparing for the transition to adulthood was help and guidance from those who are experts in planning.

MCHS staff presented "Health Wellness and Education: Partnering with families to build a solid foundation for successful transition outcomes" at the Texas Transition Conference and "Parents as Partners in Health Care Transition" at TxP2P's annual conference. Staff shared information at the Destination…Life and ESC 13 regional transition fairs. Over 5,890 "Transition Resources for Youth in Texas" brochures were distributed across the state. Families were informed of program updates, upcoming webinars, workshops, conferences, new resources, and opportunities to partner with decision makers through GovDelivery, Newsletter for Families articles, ongoing website postings and contractors' electronic newsletters. There were 1,711 page visits to the transition webpage for families

and providers. The online transition toolkit was updated with new resources and reformatted to improve ease of use. The toolkit components were downloaded 2,455 times from the MCHS website. GovDelivery Transition Topic subscribers increased from 2,453 to 4,082 (as of 01/09/17).

MCHS contractors provided 3,165 transition case management services for CYSHCN over age 12. Case managers worked with families to address independent living, medical, education, employment, legal and/or financial needs. Regional staff conducted 944 encounters with clients to assist them with transition resources prior to aging out of the CSHCN SP. MCHS funding supported TxP2P's Pathways to Adulthood (PTA) program which offered one day workshops highlighting all major transition topics: funding and services, education, legal issues, medical needs and creative approaches for planning, housing, employment and support networks. A total of 146 parents and 76 professionals engaged in PTA workshops throughout Texas during FY16. MCHS announced plans to fund the PTA program through FY18. The TxP2P annual conference featured a Peer to Peer Summit attended by 39 teens and included sessions promoting self-advocacy and independence.

Contractors partnered with vocational service providers, ESC's, post-secondary institutions and local organizations to improve opportunities for youth transitioning out of high school. Bryan's House reported 106 youth participating in the case management program began college during the fall of 2015. In partnership with Amarillo College and the Panhandle Coalition of Transition Services, Coalition of Health Services raised funds for post-secondary scholarships through their annual LITE luncheon. A total of 52 scholarships in the amount of $1000 each were awarded to students with disabilities. Community-based contractors supported parents and youth by providing linkages to local resources. Children's Special Needs Network hosted their annual conference which included sessions on transition to adulthood and the new ABLE act. The University of Houston Families CAN program hosted regular transition workshops for parents and youth and an education night for families. West Texas Rehabilitation Center held their annual transition conference to help families learn about resources for young adults with disabilities.

MCHS's Medical Home Support contractor, the UTHSC-H CHOSeN clinic, assisted families of children with medical complexity with transition planning and reported many youth began actively engaging in the process. The contractor developed resources for both young adults who will live independently and those who will be supported by a caregiver in adulthood. The clinic worked to build relationships with specialists and primary care providers willing to care for their patients in adulthood. The CHOSeN's clinic staff provided input on Texas Children's Hospital's collaborative initiative to develop transition policies and procedures for utilization by multiple specialty clinics within the hospital system. The UTHSC-SA transition clinic enrolled youth and young adults in their transition training program to encourage self-care and self-management. The contractor added adult specialists to their team and developed relationships with adult providers in the community to help ensure care for young adults aging out of pediatric care. South Texas Assessment and Referral Services researched transition resources to update materials shared with families and improve the planning process.

OBJECTIVE 2: By 2020, increase the percentage of pediatric and adult providers who are provided education on transition from pediatric to adult health care by 2% above baseline. (FY15 OPE Participants Baseline = 1,084).

MCHS developed a "Transition Resource Guide for Providers" utilizing Got Transition's materials which were distributed to over 600 providers throughout the state. The THSteps Transition Services for CYSHCN and Adolescent Health OPE modules were completed by 1,340 and 1,034 providers in Texas, respectively. The MCHS MCH Medical Director presented "Improving Transition Outcomes for Individuals with Autism Spectrum Disorders" at the 2016 Texas Autism Research Conference and "Transitioning to Adulthood in the Medical Home for CYSHCN in Texas" at the 11th Annual Texas Conference on Health Disparities.

As a follow-up to a workshop given at the TxP2P conference, MCHS staff were invited to present, "Empowering Youth and Families as Partners in Health Care Transition" to United Health Care's new Service Coordinators and Transition Specialists hired to serve families in STAR Kids. The webinar was scheduled to take place in early FY17.

OBJECTIVE 3: By 2020, increase the percentage of pediatric and adult providers who are supported in the provision of transition services from pediatric to adult health care by 2%. (Baseline to be established during FY17).

The MCHS CYSHCN Director and staff co-presented with Got Transition's Co-Director during AMCHP's "Strengthening the Evidence Base" webinar to provide technical assistance to state MCHS programs who selected NPM 12. MCHS updated presentation materials to include examples of customized clinical tools adapted from Got Transition's Six Core Elements by the American College of Physician's Pediatric to Adult Care Transitions Initiative.

MCHS staff and TxP2P served on the planning committee for the 16th Annual Chronic Illness and Disability: Transition from Pediatric to Adult Based Care Conference with over 200 participants. A total of 28 family members and youth attended, of which 24 received a scholarship for registration and travel provided by MCHS. Over 125 individuals participated in the conference via remote broadcast at 12 sites throughout Texas and 227 via 23

additional sites nationwide. Multiple community-based contractors hosted remote broadcast sites and resource fairs enabling families in rural areas to access the conference. TxP2P recruited broadcast sites, facilitated distribution of family scholarships and provided conference speakers and panelists. Got Transition's Co-Directors presented on "Starting a Transition Improvement Process with the Six Core Elements of Health Care Transition: Lessons Learned from Two Integrated Delivery Systems."

The TTVTW Five Year Strategic Plan was finalized and posted to the CYSHCN webpage. Goals included engaging youth, young adults, families, and physicians in efforts to improve transition care; educating youth and young adults, families and physicians about transition services; and, increasing statewide medical home capacity to provide integrated and coordinated care for youth and young adults. The TTVTW meetings included presentations on Supported Decision-making and Alternatives to Guardianship, Payment for Transition Services, Youth Engagement, "Developing a Road Map to a Positive Future" and Health in (educational) Transition Services. The workgroup's webpage had 721 page visits.

Collaboration with the Institute for Person-Centered Practices resulted in strategies for improving supports and resources in school settings utilizing the Life Course framework. MCHS connected subject matter experts from the Institute with the Baylor COM Chief of Adolescent Medicine and Sports Medicine to plan for a plenary session on Life Course at the FY17 annual Chronic Illness and Disability conference. MCHS staff incorporated the Life Course Toolkit developed by the Community of Practice for Supporting Families of Individuals with I/DD into presentations for families, educators and providers.

MCHS continued collaboration with the UT School of Social Work to develop and pilot an interdisciplinary, graduate-level curriculum for future providers to improve transition outcomes within a medical home. The project team developed learning modules, individual learner and program assessments and an evaluation plan. Curriculum content was informed by best practice frameworks. MCHS facilitated a technical assistance call for project leads with Got Transition's Co-Directors to ensure the curriculum incorporated components of the Six Core Elements. MCHS continued its involvement with Got Transition's State MCHS Leadership Transition Planning Group. The Co-Director of Got Transition presented to STAR Kids managed care organizations on ways to incorporate the Six Core Elements into the STAR Kids Medicaid program. MCHS funded a project to identify a subject-matter expert on youth engagement in collaboration with Texas System of Care, a statewide partnership identifying strategies for local communities to better address the needs of children and youth with serious mental health concerns. The Youth Engagement Specialist position was created to promote the youth voice and support youth serving as subject matter experts on statewide and national advisory committees, councils and workgroups. The project resulted in a representative from Texas being appointed to the National Young Adult Transition Advisory Group established to inform Got Transition and ensures youth involvement. The state Adolescent Health Coordinator collaborated with the Got Transition Co-Director to prioritize the Six Core Elements for community organizations who identified transition as a risk factor for the adolescent populations they serve.

One-time awards were granted to four MCHS clinical partners to participate in health care quality improvement projects during FY17. Contractors will use the Six Core Elements and quality improvement tools to advance clinical services for CYSHCN.

Project proposals to develop a Transition Family Tool (TFT) and Transition Provider Tool (TPT) were solicited and reviewed. The TFT will be designed to address all aspects of transition, including health care, postsecondary education, vocational training, legal needs, financial management, employment, social and recreational activities, and independent living. The new tool will be available in multiple platforms to families across Texas. The TPT will support pediatric and adult primary, specialty, Med-Peds and family practice providers in preparing CYSHCN and their families for transitioning to adult health care within a medical home model. The TPT will address health care transition supports needed by CYSHCN in a comprehensive manner. The TFT and TPT project teams will be informed by family input, principles of self-determination, best practices and recommendations from subject matter experts and other interested stakeholders.

The HRSA Healthy Tomorrows Partnership for Children Program five-year grant was awarded to the Transition Medicine Program at the Baylor COM, a former MCHS contractor. The MCHS Medical Director was invited to serve on the project's advisory board. The proposed initiative will engage two clinical practices per year in a quality improvement process while assisting youth transitioning to adult care. AMCHP's Best Practices Review Panel accepted the MCHS-funded Health Care Transition Planning Tool developed by Texas Children's Hospital as a best practice and featured it in the Innovation Station. The article, "Current Issues in Transitioning from Pediatric to Adult-based Care for Youth with Chronic Health Care Needs" was co-authored by a former MCHS contractor and published in the Journal of Pediatrics.

Performance Analysis:

Efforts to promote quality transition services and offer training and technical assistance opportunities for contractors

and families continued. MCHS participated in multiple state-level forums on transition emphasizing the significance of health care best practices.

Challenges/Opportunities:

Lack of adult providers, payment for transition services and lack of family and provider understanding of health care transition contribute to poor outcomes for Texas youth. The STAR Kids Medicaid managed care program for CYSHCN includes contractual requirements for transition planning and is on track to launch in early FY17. The new model offers opportunities to improve outcomes through youth and family engagement in transition planning. MCHS forged strategic partnerships with education stakeholders and explored opportunities to include health care transition in school-based transition planning. MCHS projects to develop a provider tool and an interactive website for families to begin in FY17 are anticipated to improve outcomes for youth in all areas of transition.

SPM 1: Percent of CYSHCN and their families who received the supports and services necessary to be integrated in their communities.

In partnership with families and other key stakeholders, MCHS developed and distributed the 2016 CYSHCN Outreach Survey across the state. As part of continuing NA activities, discussion groups with youth and family members were held at TxP2P's annual conference and included questions focused on community integration.

The majority of survey respondents reported experiencing feelings of isolation because of their child's disability (55.3%). Only 43.9% of parents surveyed felt a sense of belonging in their community while 20.8% of respondents were unsure how they felt. A total of 68.4% of parents (n=645) reported they need respite to help care for their child(ren), however, only 20% of parents who want respite indicated that they currently use respite services. Further, 16.6% of parents surveyed reported they needed respite but never received it. Top reasons indicated for not using respite included: not having money to pay for respite (29.8%); difficulty finding people who can provide respite (27.9%); and not trusting others to provide their child's needed care (24.6%). Most parents participating in discussion groups stated they rely on family and/or friends for respite because of the convenience and trust factor. Among Spanish speaking parents attending focus groups, a common theme was a parental sense of responsibility to care for their CYSHCN alone without imposing on others.

Additional Outreach Survey findings identified that only 37.4% of parents were aware of services and/or activities in their neighborhood and utilized them. Families were asked where they get certain types of services. Respondents indicated they turn to parent groups like TxP2P for parent education, reported utilizing faith-based organizations to obtain family or marriage counseling and access inclusive social or recreational activities. Parents' primary source of assistance with obtaining medical supplies or medications was the doctor's office. State and local agencies or organizations were used most often for assistance with basic needs. Respondents indicated they rely on family members for transportation, parent support, sibling support and respite. Free or low-cost activities in the local community which are inclusive of children and youth with and without special health care needs was identified as a need by survey participants.

MCHS staff actively collaborated in numerous national and statewide initiatives representing DSHS and the CYSHCN population. Workgroup participation to improve community-based services supporting families and promote integration included the Texas Council for Developmental Disabilities and CRCG Statewide Workgroup. Staff was selected to serve on the newly formed national Lifespan Respite Advisory Committee co-led by the ARCH National Respite Network and the Supporting Families Community of Practice. The workgroup was established to develop resources to build capacity of Lifespan Respite grantees and partners to help families and caregivers in identifying and accessing integrated respite services and supports utilizing a Life Course framework. Staff participated in development of the Texas Respite Coalition's (TRC) strategic plan for respite and was appointed to serve as the DSHS representative on the new legislatively mandated Texas Respite Advisory Committee (TRAC) which replaced the TRC. The Executive Director of TxP2P was also appointed to serve on the workgroup. Primary TRAC objectives include developing strategies to reduce barriers to access respite services, improving the quality of respite services and providing training, education and support to family caregivers. MCHS staff collaborated in development of the Children's Policy Council's (CPC) biennial report to the legislature. Recommendations supporting meaningful community involvement and integration were included in the report. The legislatively mandated Policy Council for Children and Families will replace the CPC in FY17 and work to improve 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. The majority of Council members are parents. MCHS staff participated in the CRCG Statewide Workgroup and Technical Assistance/Training Subcommittee meetings to strengthen supports for youth and families at risk of or experiencing crisis. MCHS community-based contractors supported local CRCG activities to help families identify and access needed services.

In conjunction with National Caregiver's Month, the Transition Medicine Clinic at the Baylor COM hosted its 2nd annual Healing with a Heart Caregiver Seminar. MCHS staff served on the event planning committee. The workshop

offered parents, family members, and caregivers of individuals with special health care needs a forum to learn, connect and refresh. Participant surveys indicated overwhelming satisfaction with the workshop.

The Executive Director of TxP2P was awarded AMCHP's 2016 Merle McPherson Leadership Award for her significant, immeasurable contributions over 25 years in engaging and empowering families. TxP2P held its 12th Annual Statewide Parent Conference which included over 60 sessions attended by 511 parents, youth and professionals. The keynote presentation focused on ensuring a meaningful life for children with disabilities utilizing person-centered thinking tools within a Life Course framework. Sessions focused on siblings and fathers were well attended and received. Over 60 children or youth were provided childcare or attended the Peer to Peer (teen) Summit making it possible for more families to attend. MCHS presented, exhibited and funded stipends for 40 families to attend. TxP2P parent experts, through a sole source agreement, participated in ongoing needs assessment activities and advised MCHS in the development and implementation of new and existing projects.

MCHS Case Management and Family Supports & Community Resources (FSCR) community-based contractors actively participated in initiatives to build natural supports and promote community integration. Contractors hosted center-based respite, offered reimbursement for home-based respite, held educational workshops, led parent and sibling support groups, managed loan and recycle closets, helped with insurance applications, assisted families with transportation needs, linked families to long term services and supports, shared resources on behavior services and provided funds and referrals to avert crises and meet basic needs, including housing.

MCHS contractors and the CSHCN SP's health care benefits program provided respite and family support services to 3,620 children and families. Families received 96,846 respite hours. The CSHCN SP provided funding for four families to receive home modifications. After school respite at MCHS contractor, Bryan's House, encouraged development of friendships between CYSHCN and their typically developing peers which resulted in notably increased independence and self-confidence. Sharing Hands (SHARE) expanded its respite program to serve children with medical complexity. SHARE also hosted a Sibling's Day Celebration and helped families in the NICU through parent-to-parent support and education. The vital supports provided eased financial stress and helped ensure children with disabilities grow up in families. Respite Care of San Antonio (RCSA) partnered with a local bank to provide a 'Money Matters' training for families which covered topics of money management and credit. Paso del Norte Children's Development Center served military families, including in Parents Night Out, to improve support for families who don't have relatives nearby to help. The CSNN began reaching out to children with medical complexity not able to leave home and provided them with 'wish list' recreational items such as board games, books and movies. Girls, Inc., led discussions on anti-bullying, self-esteem, leadership and literacy at area schools to inform and empower youth.

Community-based contractors educated providers on available community services to promote integration. The Executive Director of TxP2P presented on the NLTx website to the ADRCs and MCHS provided training to CSHCN SP's health care benefits' eligibility staff on the site to better help families in identifying community resources. TxP2P's NICU Coordinator wrote the article, "A Lifeline for Families" on the value of parent-to-parent support for publication in the WIC provider newsletter. RCSA hosted medical students to educate future providers on the need for respite services for CYSHCN. The Arc of San Antonio's (ARCSA) Community Educator conducted presentations to community agencies, clinics, hospitals, and school districts to educate providers on the needs of families and share resource information. The ARCSA's case management staff participated in person-centered thinking training conducted by the Institute for Person-Centered Practices and presented a workshop on Alternatives to Guardianship, including Supported Decision-making, for professionals attending the Texas Autism Conference. The Coalition of Health Services and other contractors conducted outreach to pediatric therapy and vocational rehabilitation providers to share resource information on available community services for CYSHCN and their families.

MCHS provided technical assistance training to community-based contractors and regional case management staff on utilizing SMART goals and objectives to develop Individualized Service Plans for families receiving case management. Family satisfaction with contractor services was 97% overall. Of families served by FSCR contractors, 97% indicated services were accessible, family-centered and compassionate.

Additional efforts led or supported by MCHS to further community integration included education and resource sharing with parents and providers through GovDelivery, MHWG and TTVTW meetings; active involvement on interagency workgroups; and presenting and/or exhibiting at statewide conferences. Utilizing GovDelivery, information on upcoming webinars, workshops, conferences, new resources, and opportunities for families to partners with decision makers was disseminated to stakeholders. GovDelivery CSHCN Topic subscribers increased from 6,457 to 7,967 (as of 01/09/2017). Print materials for distribution to families were reviewed and additional information resources on People First Language were added to promote awareness. MCHS staff attended and exhibited at the 2016 Inclusion Works conference hosted by The Arc of Texas.

The Navigate Life Texas (NLTx) website was nominated for the 22nd Annual Communicator Awards and received

Awards of Distinction in the categories of family/parenting websites and health websites. MCHS staff continued reviewing and contributing ideas for content enhancement for the site with particular focus on Supported Decision-Making as an alternative to guardianship. TxP2P remained a key collaborator on the project and ensured all content was written, reviewed, and/or edited by a parent.

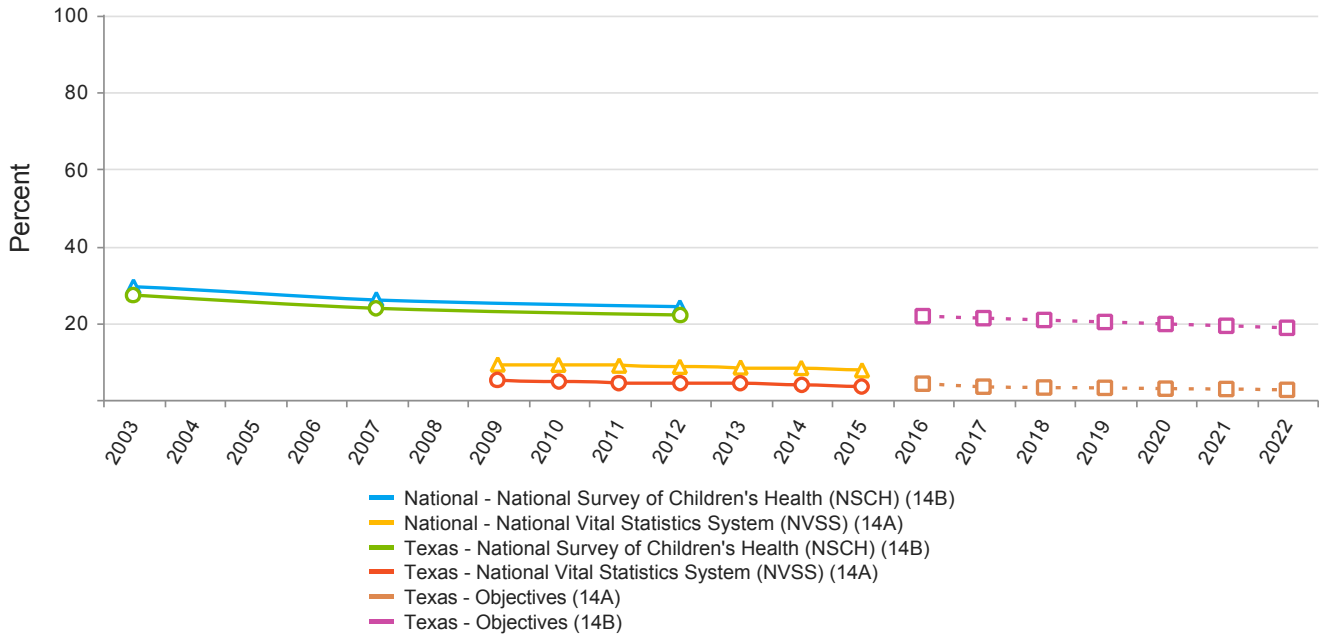
Cross-Cutting/Life Course

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-2014	182.3	NPM 14
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2011_2015	34.2	NPM 14
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	8.3 %	NPM 14
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.4 %	NPM 14
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	6.8 %	NPM 14
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	10.2 %	NPM 14
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	2.8 %	NPM 14
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	7.3 %	NPM 14
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	28.2 %	NPM 14
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	5.5	NPM 14
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	5.9	NPM 14
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	3.9	NPM 14
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.9	NPM 14
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	186.4	NPM 14
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	95.8	NPM 14
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	82.0 %	NPM 14

National Performance Measures

NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes
Baseline Indicators and Annual Objectives



NPM 14 - A) Percent of women who smoke during pregnancy

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	4.3
Annual Indicator	3.6
Numerator	14,521
Denominator	403,518
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	3.5	3.3	3.2	3.0	2.9	2.7

NPM 14 - B) Percent of children who live in households where someone smokes

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	21.8
Annual Indicator	21.9
Numerator	1,510,537
Denominator	6,900,294
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	21.3	20.8	20.3	19.8	19.3	18.8

Evidence-Based or –Informed Strategy Measures

ESM 14.1 - Number of health care service providers who adopt an electronic medical record (EMR) interface to electronically refer caregivers who smoke to the Texas Tobacco Quitline

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Data Not Available
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	500.0	600.0	5,000.0	5,500.0	6,000.0	6,500.0

State Performance Measures

SPM 2 - Percent of Texas WIC participants, ages 2-5, in the overweight/obese range

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	28.5
Numerator	113,597
Denominator	398,359
Data Source	Texas WIC client data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	27.8	27.1	26.4	25.8	25.1	24.5

State Action Plan Table

State Action Plan Table (Texas) - Cross-Cutting/Life Course - Entry 1

Priority Need

Reduce health disparities for maternal and child health populations.

NPM

A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Objectives

By 2020, increase abstinence from cigarette smoking among pregnant women to meet or exceed a target of 97% (National Vital Statistics System-Natality, 2014 baseline = 96.1%).

By 2020, increase the proportion of new mothers who report smoking is not allowed in their home to meet or exceed a target of 98% (PRAMS, 2012 baseline = 97%).

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.

Strategy 4: Develop, promote and disseminate educational resources for health care professionals and other stakeholders that improve smoking cessation support and disseminate knowledge and best practices.

Strategy 5: Increase capacity across sectors to address risk factors for children with asthma including secondhand smoke and other harmful exposures.

ESMs	Status
ESM 14.1 - Number of health care service providers who adopt an electronic medical record (EMR) interface to electronically refer caregivers who smoke to the Texas Tobacco Quitline	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 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 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 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (Texas) - Cross-Cutting/Life Course - Entry 2

Priority Need

Reduce health disparities for maternal and child health populations.

SPM

Percent of Texas WIC participants, ages 2-5, in the overweight/obese range

Objectives

By 2020, decrease the percentage of WIC participants aged 2-5 with a BMI in the overweight or obese range from 28.6% to 24.35%.

By 2020, reduce the percent of children and adolescents in grades 8 and 11 with BMI in overweight or obese range from 38.1% to 36%. (SPAN 2010).

By 2020, decrease the percent of children in 4th grade with a BMI in the overweight or obese range from 42.8% to 40%. (SPAN 2010).

Strategies

Strategy 1: Assist providers, state and community partners, and regional staff's obesity prevention efforts by providing obesity prevention information and resources.

Strategy 2: Promote obesity prevention education and resources to school educators, administrators, parents and community and state partners.

Strategy 3: Collaborate with state partners such as OPP, WIC, Child Care Licensing and School Health in the creation and sustainability of obesity prevention initiatives and data collection.

Strategy 4: Continue to support THAI, SPAN, Healthy Child Care Texas and Mother Friendly Worksites obesity prevention initiatives and data collection.

State Action Plan Table (Texas) - Cross-Cutting/Life Course - Entry 3

Priority Need

Reduce health disparities for maternal and child health populations.

SPM

Percent of Texas WIC participants, ages 2-5, in the overweight/obese range

Objectives

By 2020, reduce the number of adolescents in Title V-funded programs with adverse BMI rates by 1%. (No baseline available; assessing baseline as a strategy)

Strategies

Strategy 1: Assess current THAI clinic-based site data

Strategy 2: Promote educational materials to support providers.

NPM 14: A) % women who smoke during pregnancy; B) % children living in households where someone smokes

Texas selected NPM 14 based on needs that emerged from the 2015 NA, and the harmful effects of smoking during pregnancy and secondhand smoke on women and children, including increased risk of preterm delivery, low birthweight, miscarriage, SIDS and health problems such as asthma. DSHS outlined strategies to improve synergy and collective impact of programmatic efforts that will promote recommendations and best practices to reduce tobacco exposure among women, children and families.

Needs assessment results showed women who smoked had more than a three-fold increase in the odds of their infant's death being classified as SIDS than women who did not smoke. In addition, data also revealed geographic and racial/ethnic disparities in smoking rates, with the highest rates found in the eastern regions of the state; and household smoking rates being three times greater in non-Hispanic black households than in non-Hispanic White households, and five times greater than in Hispanic households in 2011. Focus group participants and stakeholders also expressed a need for increased education at the patient and provider level to help adopt and promote healthy behaviors and help navigate the healthcare system.

As almost half of pregnancies in Texas are unintended and less than two-thirds of Texas women had their first prenatal care visit during the first trimester, it is imperative to reach women prior to pregnancy with smoking prevention and cessation messaging and interventions. MCHS will reach out to WCBA, including pregnant women, to raise awareness and increase understanding of risk factors of smoking during pregnancy and secondhand smoke on the health of infants and children. Education and outreach materials will include presentations, tools, newsletters, conferences, and website resources including the Healthy Texas Babies public outreach campaign Someday Starts Now (SSN). MCHS will leverage the SSN platform to promote educational information that increases knowledge and builds self-efficacy for preventive health and health promotion behaviors related to tobacco cessation before, during and beyond pregnancy. SSN website content will be enhanced to include promotion of DSHS Tobacco Prevention and Control Branch smoking cessation resources. Smoking cessation efforts will also be incorporated as part of safe sleep outreach efforts. Messaging will be appropriate to the literacy level, age, culture and language of the target population. MCHS will continue to incorporate tobacco prevention messaging in implementation of the Preconception Peer Educators (PPE) program, which trains college students on a peer educator model to promote healthy living practices that will lead to improved health and birth outcomes. Messaging will be appropriate to the literacy level, age, culture and language of the target population.

In FY18, MCHS will begin year 2 of the Pediatric eTobacco Protocol Project. MCHS is partnering with the DSHS Tobacco Prevention and Control Branch to address the household smoke component of NPM14. NextGen is developing an electronic medical record (EMR) pediatric interface to complement their existing Electronic Tobacco Referral Protocol (eTP) template – an evidence-based electronic quitline referral tool shown to increase volume of QL referrals from healthcare providers (NAQC, 2013). With the pediatric interface, the clinician is systematically prompted to ask the parent/caregiver if the pediatric patient is exposed to SHS. If the answer is "Yes," then a pop-up box will walk the provider through a few questions to refer the parent/caregiver to the QL. The pediatric tool will become a standard component of the NextGen eTP package for future clients and will be made available to all current NextGen eTP users via downloadable update.

The tool will be piloted in two Federally Qualified Health Centers (FQHCs) in Central Texas: Lone Star Circle of Care (LSCC) and People's Community Clinic (PCC). Expansion to NextGen eTP clients will take place in FY18 (year 2) with particular emphasis on promoting the tool to FQHCs, in order to maximize reach to high-need populations with disproportionately high smoking rates. The interface development process will repeat and expand with the Epic EMR system and other systems across the state in Years 3 and 4. Evaluation will be conducted each year.

In FY18, changes will be made per results of end-user focus groups. The technical assistance package will be expanded and offered to NextGen client systems currently using eTP prior to development of the pediatric interface. The pediatric tool will be available to current eTP users via downloadable update, and will be included as part of the complete eTP package for future users.

MCHS will continue participating on the DSHS Tobacco Initiative Interagency Workgroup (TIIWG). In FY18, the TIIWG is expected to work on implementation of efforts that were planned and during the first year of operation. MCHS involvement in this group ensures that MCH populations and NPM14 strategies and objectives are included in the TIIWG planning efforts.

MCHS will work with partners and stakeholders to assess, plan, develop, promote, disseminate and evaluate materials, communications, and programmatic activities that promote smoking cessation and reduce tobacco exposure among women, children and families. MCHS will also collaborate with partners to develop and promote educational resources for health care providers and other health care professionals that disseminate smoking

cessation knowledge, best practices and resources and improve the quality of health services for women and children.

From the needs assessment data and stakeholder input emerged the need for a stronger approach to tobacco prevention and cessation. Texas Health Steps OPE offers free continuing education courses for primary care providers and other health professionals. Courses offer updated clinical, regulatory, and best practice guidelines for a range of preventive health, oral health, mental health, and case management topics. MCHS collaborated with OPE to develop a suite of five continuing education modules focused on Preconception and Prenatal Health, one of which is devoted to high risk behaviors including smoking, with the goal of equipping health care professionals with knowledge and resources to improve the health of Texas women before and during pregnancy. Language on health risks of smoking and secondhand smoke is also included in other OPE modules such as Infant Safe Sleep and Identifying and Treating Young People with High Risk Behaviors. MCHS will continue to promote Texas Health Steps Online Provider Education (OPE) online modules with health care professionals and partners serving women and children in the state. Tobacco prevention and cessation related modules include Preconception and Prenatal Health: Identifying and Intervening in High-Risk Behaviors, Infant Safe Sleep, and Identifying and Treating Young People with High Risk Behaviors. The modules can be accessed at www.txhealthsteps.com. The modules can be accessed at www.txhealthsteps.com.

MCHS will continue to work with CHW training programs to integrate into curricula risks of smoking, including secondhand smoke, on birth outcomes and women's, infants' and children's' health, and promote adoption of positive health behaviors. MCHS will continue to partner with the Tobacco Prevention and Control Branch to develop and disseminate interventions that educate and support health care providers on adopting evidence-based guidelines and protocols, such as incorporating the Ask, Advice, Refer protocol for tobacco-cessation counseling and referral to the Quit Line into health care providers' EMR systems. Promotion of provider and stakeholder education on reduction of high risk behaviors such as smoking will continue via Grand Rounds, presentations and website resources. MCHS will also continue surveillance of smoking rates among WCBA, pregnant women, and children who live in households where someone smokes through analysis of previously collected surveillance data including the Pregnancy Risk Assessment Monitoring System (PRAMS), birth file data, and Quit line data.

Lastly, MCHS will continue to work with partners to increase capacity across sectors to address risk factors for children with asthma including secondhand smoke and other harmful exposures through parental education provided by health care providers, CHWs and other stakeholders. MCHS will continue to work with the Corpus Christi coalition on their efforts to train CHWs on the asthma Healthy Homes curriculum, which will increase CHW's capacity to educate and support families on asthma management. MCHS will collaborate with the Tobacco Prevention and Control Branch to support existing efforts to promote smoke-free multi-unit housing. Efforts are underway to assist HUD in implementing the new HUD Smoke-Free Rule, and provide tobacco education/cessation services to Public Housing Authority residents. MCHS can play a role in the provision of education and resources, and via a collective impact approach leveraging regional coalitions and partnership.

MCHS will continue to foster partnerships with other key stakeholders from across and beyond the Texas Health and Human Services System to strengthen collaboration, synergy and collective impact of smoking prevention and cessation programmatic activities. MCHS will collaborate with partners, including the Tobacco Prevention and Control Branch, the Texas Home Visiting Program, and the Health Promotion and Chronic Disease Prevention Section, to assess needs, gaps and opportunities to increase implementation of recommended smoking prevention and cessation best practices. MCHS will work to elevate understanding of risks of smoking during pregnancy and of smoke exposure on children, and will collaborate to increase integration of these special populations into tobacco prevention and control policies and practices across programs.

SPM 2: A) Percent of infants born to mothers with pre-pregnancy BMI in the overweight/obese range; B) Percent of WIC participants aged 2-5 with BMI in the overweight/obese range; C) Percent of children with BMI in the overweight/obese range; D) Percent of adolescents with BMI in the overweight/obese range; E) Percent of adults with BMI in the overweight/obese range.

Prevention of overweight and obesity throughout the lifespan continues to be a priority in Texas. Findings from the 2015 Needs Assessment illuminated both geographic and demographic disparities in the state, presenting an opportunity for MCHS to address the issues through selection of obesity as a new State Performance Measure. Within the Texas DSHS, programs in several divisions maintain both the infrastructure and subject matter expertise to implement obesity prevention efforts: the Obesity Prevention Program and MCHS, both housed within the Division for Community Health Improvement; and Population-based Services, housed within the Regional and Local Health Operations Division. Through assessing gaps and opportunities, identifying key stakeholders, and leveraging existing state partnerships, MCHS will approach statewide obesity prevention strategically and with a life course perspective.

Texas continues to make great strides in addressing the obesity epidemic and in preventing chronic conditions

across the lifespan. Organizations and individuals around the state are working to improve health outcomes in communities, schools, health care settings and worksites, and MCHS is well-positioned to support the planning and implementation of these statewide efforts. This can be accomplished through collective impact approaches, strategic alliances, partnership development and capacity building to achieve policy, systems and environmental changes that promote health throughout the state. MCHS will continue to coordinate with regional staff to ensure alignment of central office and regional efforts to address obesity in Texas. Coordination will occur via face-to-face meetings, webinars, and teleconferences facilitated by the Regional Population-Based Maternal Child Health Services Nurse Consultant. Through data-driven planning, programmatic efforts with focus on systems and community-level interventions to facilitate changes to impact multiple population domains. Using a collective impact framework and the existing statewide MCH infrastructure, Texas will be able to leverage the regional work currently underway, including policy-systems-level efforts to promote the biggest impact on obesity.

MCHS and MCHE staff will continue to work on the SPAN project by providing guidance on survey questions, reporting, and maintaining IRB compliance. SPAN is the School Physical Activity and Nutrition survey conducted in collaboration with the Michael and Susan Dell Center for Healthy Living at the University of Texas School of Public Health, and involves surveillance of children in grades 2, 4, 8, and 11. MCHS will continue to fund the SPAN survey in FY18 and will include Texas the border regions.

The Farm to Work initiative began at DSHS and is a partnership between worksites and their local farmers. It is supported by Sustainable Food Center of Austin (SFC), DSHS, and WebChronic LLC. These partnerships create markets for local farmers to sell nutritious, sustainably grown produce directly to the staff of participating organizations. The Farm to Work Program provides worksites and employees with access to fresh, locally-grown fruits and vegetables, facilitates direct sales for family farmers, promotes awareness of the food system and educate consumers about sustainable food and farms, and offers educational opportunities for employees and their families about the importance of fresh food and nutrition

Participating organizations have access to the custom made Farm To Work online shopping cart. Interested staff members can order a basket of locally grown produce using a credit or debit card via a secure web site. Baskets are delivered to worksites according to a schedule. The basket of sustainably grown fruits and vegetables is determined by what's in season and ripe on the family farm for that week. There is no subscription fee or requirement to order each week. Currently 45 worksites in Austin, San Antonio, and Houston are participating and the organizations include state and city agencies, local non-profits, and private companies.

Goals of the FY17-FY18 Farm to Work project include:

- Increase Farm to Work gross sales by 8%, thereby increasing consumption of fresh local produce across all worksites. Improve infrastructure for coordinators to promote the program at their worksites. Create and provide promotional templates and materials that cater to families with children and women of childbearing age.
- Improve operations of current and future worksites. Update Farm to Work Coordinator toolkit.
- Improve sustainability of the Farm to Work online platform by transitioning the programming language from ColdFusion to PHP.

In FY18, the Farm to Work Coordinator Toolkit will be updated, promotional materials will be printed and disseminated, and the Farm to Work administrative interface will transition. MCHS will coordinate with project coordinators in the Obesity Prevention Program to provide subject matter expertise as needed, and ensure completion of project components.

MCHS will continue to connect with existing partners already that address obesity at the state and local levels, and maintain the focus on assessing needs, gaps, and opportunities to impact maternal and child health populations. The ongoing assessment of the larger partner landscape is necessary to ensure knowledge of Texas organizations and stakeholder groups who have a vested interest in preventing obesity. Leveraging regional networks and partnerships, potentially through School Health Advisory Councils, is critical for successful obesity prevention efforts.

Experiences during pregnancy and from birth through a child's second birthday shape a child's metabolism, development, and behaviors in ways that can influence obesity risk, health, and well-being throughout childhood, adolescence, and beyond. Infant and young child feeding practices (e.g. breastfeeding, appropriate management of supplemental or replacement feedings when any or full breastfeeding is not possible or desired, appropriate introduction of nutrient-dense complementary foods, adult-child interaction during feeding), physical activity, screen time, and sleep behaviors are all critical targets for preventing childhood overweight and obesity and improved health and development outcomes throughout the life course. MCHS will assess the current state of the systems and factors that impact infant and young child (0-2) weight, and plan for a landscape assessment including a review of the literature; development of an evidence-informed planning framework; identification and assessment of existing relevant data sources, partners, stakeholders, policies, initiatives, and other structures and resources operating in

Texas; and a gap analysis.

Through dialogue with WIC, opportunities to increase the contribution of fruit and vegetables to the diets of the 2-5 year old population continue to be explored. Opportunities to address obesity prevention through additional breastfeeding efforts are also under consideration. These efforts would supplement the multitude of other breastfeeding initiatives already in place in Texas, and may include expansion of mother-friendly worksite efforts. MCHS intends to continue surveillance around school-age children through the School Physical Activity and Nutrition (SPAN) survey and data collection. Information from the SPAN survey will help inform future programming for children and adolescents. MCHS will also continue partnering with DFPS on early childcare setting interventions, and collaborate with OPP to identify opportunities for community-level policy, system, and environmental change approaches to improve healthy eating and active living. MCHS is exploring opportunities to promote worksite nutrition initiatives throughout Texas that increase access to and consumption of fresh fruits and vegetables.

Existing resources and educational opportunities may be enhanced or expanded to include obesity prevention messaging and outreach. MCHS will foster collaborative partnerships with Texas Health Steps Online Provider Education to explore opportunities to promote utilization of modules currently addressing obesity prevention, as well as promote obesity-related training such as the Growing Community training for Community Health Workers. Existing MCHS and agency websites and informational materials may be amended to allow for targeted obesity prevention messaging and communication. MCHS is also exploring opportunities to address interconception weight gain to improve birth and health outcomes.

Based on NA findings as well as other data sources, Texas adolescents struggle with weight control. For FY18, MCHS will continue to focus on overweight/obesity for the AH domain. Some of the THAI community-based contractors already address nutrition and physical activity. THAI clinic-based contracts will increase this focus by tracking BMI with appropriate referral and follow up. Through collaborative efforts, including support funding through contracts, MCHS will identify and share educational information with families of CYSHCN, providers and other key partners to encourage obesity prevention.

NPM 14: A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Objective 1: By 2020, increase abstinence from cigarette smoking among pregnant women to meet or exceed a target of 97% (National Vital Statistics System-Natality, 2014 baseline = 96.1%).
Objective 2: By 2020, increase the proportion of new mothers who report smoking is not allowed in their home to meet or exceed a target of 98% (PRAMS, 2012 baseline = 97%).

MCHS collaborated with partners across the Health and Human Services system to assess needs, gaps and opportunities to increase implementation of recommended smoking prevention and cessation best practices. MCHS participated in the DSHS Tobacco Initiative with representation on the Interagency Workgroup. This initiative began in FY15 by the DSHS Interim Commissioner, and ensures coordination of HHS system-wide tobacco efforts. The TIIWG consists of appointed designees representing program and administrative functions within the agency. Each division has designated one or two individuals to serve as the core group on this working group. There are also ad hoc members whose participation is be based on content-specific needs. Every member is required to provide input on potential impacts to their division or opportunities to leverage division resources to further the goals of the DSHS Tobacco Initiative. Members are authorized by the division head to speak for the division on tobacco-related matters affecting the entire department. The scope for the TIIWG is to provide input and plans regarding all proposed DSHS tobacco prevention and cessation activities. The team advises, consults, and devises strategies, roles, goals, objectives and action steps necessary to successfully implement each strategy/initiative as identified. The Tobacco Initiative Executive Sponsors and/or the DSHS Executive Leadership team have final approval of any planning deliverables.

During FY16, there were 25 articles published in the Friday Beat publication that were related to tobacco cessation. The Friday Beat is a weekly e-newsletter that aligns with the components of the Whole School, Whole Community, Whole Child model, and connects the public with upcoming trainings, funding sources and resources. The Friday Beat can be accessed at www.dshs.texas.gov/schoolhealth/fridaybeat.shtm.

MCHS promoted continuing education opportunities for health care professionals serving women and children in the state. Texas Health Steps OPE offers free continuing education courses for primary care providers and other health professionals. Courses offer updated clinical, regulatory, and best practice guidelines for a range of preventive health, oral health, mental health, and case management topics. Several modules address smoking cessation, with the goal of equipping health care professionals with knowledge and resources to prevent and help Texas women quit smoking for their own health and that of their children before, during and after pregnancy. A total of 697 tobacco-cessation related modules were completed (including Preconception and Prenatal Health: Identifying and Intervening in High-Risk Behaviors, Infant Safe Sleep, and Identifying and Treating Young People with High Risk Behaviors). The modules can be accessed at www.txhealthsteps.com.

MCHS promoted smoking cessation among women and families. The Healthy Texas Babies public outreach campaign Someday Starts Now (SNN) contains information to increase knowledge and build self-efficacy for ceasing and avoiding smoking before, during, and after pregnancy. SSN promotes several resources to help women and men quit tobacco, including the “Yes! I’m Ready to Quit” page of the DSHS Tobacco Prevention and Control Branch, and the American Cancer Society Quitline. These sites contain resources for the public such as a Quit plan, quitting tips, information on medications to ease withdrawal symptoms, and success stories. Resources for healthcare providers include tools to help providers assess patients’ interest in quitting and successfully guiding them through tobacco-cessation counseling.

MCHS partnered with the Tobacco Prevention and Control Branch to develop and disseminate interventions that educate and support health care providers on adopting evidence-based guidelines and protocols. A joint project during FY16 piloted an intervention to increase quit attempts and reduce rates of smoking and secondhand smoke exposure among women of childbearing age and children. The goal of the project was to encourage healthcare providers to adopt the evidence-based Ask-Advise-Refer protocol (AAR) for addressing tobacco use and dependence in health care delivery into standard practice. Pediatricians and OBGYNs in Rusk and Nueces counties were sent packets with guidelines and resources for administering AAR. The packets included a clinical toolkit specific to each discipline (pediatric or obstetric), prescription pads, a list of new clinical tools available, and contact information of community resources specific to the geographic location. A total of 370 providers (91 obstetric

providers and 279 pediatric providers) received the toolkits in Nueces and Rusk counties. A webinar for obstetricians and pediatricians respectively were created to support the use of the toolkits. The webinars presented smoking prevalence data in Texas by region, secondhand smoke exposure, the types of tobacco smoke, the risks of smoking for women and children including adverse outcomes, the role of the health care provider in parental smoking cessation, and discussed clinical practice guidelines and tools to help patients quit smoking. The webinar can be accessed on the "For health care providers and EMR vendors" page at www.uttobacco.org. There was a small increase in the number of unique website viewers following project material publication.

MCHS continued surveillance of smoking rates among WCBA, pregnant women, and children who live in households where someone smokes. Per 2015 Texas BRFSS, the prevalence of current smoking among women aged 18-44 was 13.2%. This was slightly higher than the rate of 12.8% in 2014. The smoking prevalence varied by race and ethnicity: 21.4% for non-Hispanic white women, 17.7% for non-Hispanic black women, and 7.2% for Hispanic women in 2015. Abstinence of cigarette smoking among pregnant women was 96.4% in 2015 (National Vital Statistics System-Natality). Per 2015 birth file provisional data, 3.6% of women giving birth reported smoking during pregnancy, down from 4.3% in 2013 and 3.9% in 2014. Per the 2014 birth file, 8.1% of white women reported smoking during pregnancy, compared to 4.1% of black women, 1.1% of Hispanic women, and 1.9% of women classified as being of "other" race-ethnicity. Per 2014 PRAMS data, the most current year available: 7.7% of women reported smoking during the last three months of pregnancy; the smoking prevalence varied by race and ethnicity: 6.6% of Black women, 11.7% of women in the White/Other category, and 4.2% of Hispanic women. Of women who had their delivery paid by Medicaid, 11.1% reported smoking during the last three months of pregnancy, compared to 4.1% of women who had their delivery paid by private insurance. Prevalence of smoking also varied by level of educational attainment: 8.4% of women with less than a high school education reported smoking during the last three months of pregnancy, compared to 14.0% of women with a high school education, and 3.7% of women with greater than a high school education. Per 2014 PRAMS data, 11.6% of women reported they were current smokers in the postpartum period, and 95.8% of women reported smoking is not allowed in their home.

MCHS began planning efforts for a pediatric e-Tobacco protocol project in conjunction with the Tobacco Prevention and Control Branch. Through a contractual agreement with the Tobacco Research and Evaluation Team (TRET) at The University of Texas at Austin, this project pilots a systems-level intervention to increase quit attempts among parents/caregivers and reduce rates of household smoke exposure. The project addresses pediatric patient needs by building a tool to electronically refer parents/caregivers who smoke around the pediatric patient to services provided by the Texas Tobacco Quit Line (QL).

A high percentage of parents come into a pediatric appointment with little knowledge about the harm of secondhand smoke exposure to children and/or available quit resources, suggesting a strong need for increased intervention. Proactive phone calls and referrals are suggested as an improved means of intervention, particularly for smoking parents with low education levels or no access to health care. Proactive referrals may be particularly effective as smokers are sometimes reluctant to make use of cessation programs, but the programs typically wait for the smoker to take the initiative. Quit (or attempted quit) rates are less frequent among less educated adults, suggesting that successfully taking the opportunities to educate parents may result in the development of caregiver readiness to quit smoking. Although parents differ in ability and desire to receive advice about the effects of their smoking habits on their children, they are typically willing to listen to and incorporate advice given by a perceived expert. The majority of parents would like – and expect – to receive more advice and information from health care professionals about specific health risks related to their child's secondhand smoke exposure. Child healthcare visits may provide a unique opportunity for physicians to address parental cessation and for parents to access cessation resources for two reasons: first, the parents may not be seeing a physician for their own benefit; and second, experiencing discomfort due to parental and smoker role conflict is likely to result in increased motivation to quit.

Regional Population-Based Activities

Regional activities on tobacco cessation are grounded in a strong relationship with the local Tobacco Control Coordinator who works side-by-side with population-based MCH staff. Having this close connection and direction allows MCH staff to take their cues from priorities set forth by the Tobacco Prevention and Control Branch, while focusing on evidence-based strategies for implementation among MCH populations. Several regions are employing the Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) Model distributed by the Society for Public Health Education. In 2016 four regions initiated the process of having their staff trained as trainers in SCRIPT and identifying clinical partners to train and implement the program. Four practices in HSR 1 are currently implementing the program while several in HSRs 4/5N, 9/10 and 11 have had their staff trained by DSHS and will be implementing the program in 2017.

HSRs 7, 8, 9/10 and 11 have each taken a different approach to promotion of smoking cessation for pregnant women and education on the dangers of second-hand smoke. HSR 7 arranged individual visits by DSHS staff to 68 prenatal care providers across the region to distribute health promotion materials and educated providers on resources available to support smoking cessation among pregnant women. Smoking cessation efforts among regional staff in HSRs 8 and 11 have been integrated into existing activities such as childbirth classes, WIC and employee wellness programs. HSR 9/10 has focused efforts on promoting smoke-free homes among students in high school and their parents, WIC, and day cares and with informational displays at libraries around the region.

HSR 9/10 has also begun discussions on tobacco-free policies with a local jail, the University of Texas - Permian Basin and the local child welfare board. In FY 2016 HSR 6/5S conducted a scan of policies in eight ISDs to determine if smoke-free policies included language about e-cigarettes. They found that five of those surveyed did not include such language and they will provide technical assistance to make this inclusion in 2017.Other policy efforts in HSR 6/5S are focused on promotion of tobacco-free ordinances at the city level and tobacco cessation education through the local health coalition. DSHS staff are also offering technical assistance to the Bay City Housing and Urban Development office as it implements a smoke-free policy for multi-family housing units.

Performance analysis: Texas made progress toward meeting its objective of increasing abstinence from cigarette smoking among pregnant women, with 96.4% of pregnant women in 2015 reporting they abstained from smoking, compared to 96.1% in 2014. The proportion of women reported smoking is allowed in their home remained relatively stable, with 96.0% of women reporting smoking is not allowed in their home per 2014 PRAMS data, compared to 97% in 2012.

Challenges / opportunities: The SSN public awareness campaign was not active during FY16, thus slowing outreach efforts for enhancing education content for women and provider on smoking cessation and evidence-based resources available. The strengthening and establishment of new partnerships and collaborations across and outside the HHS System provide opportunity for increased synergy and collective impact of efforts across stakeholder efforts focused on improving women's health and healthcare.

SPM 2: A) Percent of infants born to mothers with pre-pregnancy BMI in the overweight/obese range; B) Percent of WIC participants aged 2-5 with BMI in the overweight/obese range; C) Percent of children with BMI in the overweight/obese range; D) Percent of adolescents with BMI in the overweight/obese range; E) Percent of adults with BMI in the overweight/obese range

In FY16, MCHS responded to NA data by transitioning from an obesity prevention performance measure focused on school-aged children to a lifecourse performance measure that addressed all population domains. This measure was designed to incorporate five separate data sources in order to measure process across multiple populations. In FY16, MCHS assessed the DSHS obesity prevention landscape by consulting with WIC and chronic disease prevention partners on a monthly basis over the course of the fiscal year.

MCHS continued surveillance efforts related to obesity across MCH populations through analysis of previously collected surveillance data, to inform data-driven decisions in program development. Data from the 2016 Texas WIC Infant Feeding Practices Survey were compiled and analyzed. Forty-nine percent of respondents reported that their infants first received foods or liquids other than breastmilk or formula prior to 6 months, varying from 63.4% in PHR 2 to 38.0% in PHR 10. More than one-third (38.1%) of respondents reported that they had ever added cereal or other solids to their babies' bottles, ranging from a high of 47.9% in PHR 2 to a low of 26.9% in PHR 10.

MCHS continues to support the School Physical Activity and Nutrition (SPAN) survey, a surveillance system that monitors the prevalence of, and secular trends in, overweight and obesity in school children in Texas. The survey identifies factors in Texas students that may be associated with obesity. The latest iteration of this survey (data collected in 2015 and 2016) includes information on children and adolescents in grades 2, 4, 8, and 11. Final data for this current survey are expected by June 2017. Information from SPAN assists in the development of targeted programs and policies to address overweight and obesity among Texas youth. Data from SPAN has also led to

several scientific discoveries with important implications for reducing childhood obesity. Since 2012, nine peer-reviewed journal articles have been published utilizing SPAN data, and 5 additional research manuscripts are currently in progress. All but one of these journals/manuscripts include a MCHS staff member as a co-author. Noteworthy are research findings showing that social aspects of the home food environment are strongly associated with whether children consume healthy or unhealthy foods, suggesting that parents can modify mealtime structure to improve their child's eating habits (Ranjit et al. 2015). It has also been found that adolescents tend to overestimate their height and underestimate their weight, resulting in an underestimate of their body mass index calculated from self-report measures. To remedy this, correction equations were developed to more accurately classify overweight or obese status, which has, in turn, led to better surveillance of adolescent obesity (Perez et al. 2015). Also, SPAN research has indicated that Hispanic and Black children in Texas are still significantly more likely to be obese compared to non-Hispanic Whites, even when adjusting for county-level factors, gender, and age (Salinas et al. 2013). In FY16, 189 schools participated in the study with 54 of those being from the border regions. Among the participating schools, 8053 children were surveyed and 2593 children had their BMI assessed. Since the inception of SPAN, 31 publications and 3 manuscripts on childhood physical activity and nutrition behaviors have been authored in Texas.

Existing activities within MCH population health domains provided an opportunity to begin planning and implementation of state performance measure initiatives. In Adolescent Health, the three THAI clinic-based site projects began in March of 2016, and through a goal of evaluation of 1,300 adolescents, provide an opportunity for obesity monitoring and intervention. These contractors are required to have clinic staff complete the Management of Overweight and Obesity OPE module over the course of FY16 and FY17. Furthermore, DSHS' Friday Beat promoted obesity prevention to over 3800 unique users in FY16 by providing 291 articles related to obesity and obesity prevention.

Additional obesity prevention activities focused on CYSHCN and their families. MCHS contractor, Texas Children's Hospital (TCH), held Saturday Wellness Program workshops for CYSHCN with obesity and their families to promote the importance of good nutrition and exercise in improving health outcomes. Nutrition education, supported by a clinical psychologist and licensed professional counselor, was expanded to address the behavioral factors of eating and health. At the request of families, a weekly series of classes on nutrition was developed. Events for CYSHCN and their families were held in celebration of National Nutrition Month (March) and resource information shared was shared during Kids Eat Right Month (August). To raise awareness about the project and help support more families, outreach efforts were expanded to area pediatricians.

MCHS and agency partners attended the 2016 MCH WDC Summer Skills Institute where national SMEs and technical assistance providers delivered education on a variety of program planning and evaluation frameworks, including collective impact. MCHS applied acquired skills and frameworks to the "health transformation issue" of obesity in MCH population domains. The work completed during the Institute will inform future obesity prevention programming for child, adolescent and CSHCN domains. Specific tools/skills included the LEAN canvas, systems tools, levels of leverage framework, and return on investment calculations.

Other crosscutting activities in FY16 included DSHS' contribution to the development of the 2017 Interagency Obesity Report, which was an update to the 2015 Report to the Legislature from the Interagency Obesity Council, as mandated by Chapter 114 of the Health and Safety Code (Senate Bill 556, 80th Regular Session of the Texas Legislature) and revised per Senate Bill 870 passed during the 81st Regular Session. MCHS staff reviewed the report, provided feedback, and provided additional content.

By exploring opportunities to collaborate on current and future efforts, MCHS identified a Farm to Work initiative to pursue in partnership with the DSHS Obesity Prevention Program. The Farm to Work program is a modified community supported agriculture model at worksites that provides employees a weekly or biweekly opportunity to order a basket of fresh produce from a local farmer and pick it up at their worksite. Farm to Work currently operates at 45 worksites in Austin, San Antonio, and Houston. The project allows for adult employees of participating businesses to obtain fresh fruits and vegetables at work, thus increasing the fruit and vegetable consumption of

family members. Fruit and vegetable consumption is low in Texas, with adults having consumed fruits and vegetables 1.0 and 1.6 times per day, respectively, and adolescents having consumed fruits and vegetables 1.0 times and 1.0 times per day, respectively, in 2013. The program has exceeded $1.6 million in cumulative sales and had served over 18,000 unique customers as of May 2016.

Farm to Work participants were healthier and consumed more fruits and vegetables compared to nonparticipants according to a 2013 survey. Participants ate 3.36 servings of vegetables a day (1 serving = ½ cup) versus 2.63 for nonparticipants, and fruit intake was 2.63 servings for participants versus 2.18 servings for nonparticipants. Participants self-reported decreased occurrence of heart attacks, diabetes, pre-diabetes, high blood pressure, high blood cholesterol, and obesity. "Very good" or "excellent" health was self-reported by 75% of participants as opposed to 65.1% of nonparticipants. Most participants (78.5%) were women and Farm to Work participants had an average household size of 2.43 members, with most households (81.1%) between 1 and 3 members in 2013. In FY16, plans to expand the reach and promotion of Farm to Work were developed for implementation in FY17 and FY18.

Regional Population-Based Activities

Only three regions took on obesity prevention activities in FY 2016 despite the prevalence of obesity among women of childbearing age and children in Texas. Barriers discussed by regional staff include difficulty finding population-level programming that can be implemented by a limited number of staff and challenges finding programs with sufficient evidence base that will be supported by community partners. As a result, efforts in 2016 supported data collection, expansion of advocacy infrastructure and continuation of annual and ongoing community events. In HSR 4/5N DSHS staff have collaborated to conduct the School Physical Activity and Nutrition (SPAN) survey among second, fourth, eighth and eleventh graders. In 2016 they successfully surveyed six of the ten school districts, a total of 916 students. Regional staff also helped the Leadership Encouraging Activity and Nutrition (LEAN) obesity prevention coalition in Rusk County to add two new community partners.

The Kids Health Party in HSR 8 involved ten ISDs and 349 fifth grade children in a health and physical activity promotion event. School representatives who attended the event were surveyed and 90 percent reported that the objectives of the event were met. HSR 8 and 9/10 have held similar events using the MyPlate program materials in collaboration with WIC. In HSR 8 DSHS staff coordinated 11 presentations at libraries, apartment complexes and food fairs. In HSR 9/10 265 participants attended MyPlate presentations.

Opportunities exist to further strengthen statewide efforts through a comprehensive and coordinated approach to address obesity along with regional staff and partners. Regional staff addressed the previous obesity measure through implementation of community activities and efforts. To reduce the prevalence of obesity in Texas, MCHS will enhance regional coordination and strategically plan programming to collectively make an impact on obesity throughout the lifecourse.

Other Programmatic Activities

Community Health Workers

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 the HHSC Office of Minority Health and Health Equity and THSteps related to the culturally effective health care and Culturally and Linguistically Appropriate Services (CLAS) Standards. In January over 60 CHWs completed theses online modules. DSHS and HHSC are collaborating to provide the Spanish translation of the CLAS module as online continuing education for Spanish-speaking CHWs. The Texas Dental Association worked with DSHS, Texas Tech University Health Science Center, and the CHW Training and Certification Advisory Committee to design a free curriculum which provides culturally appropriate oral health information for CHWs across Texas, including those in remote locations. The curriculum included modules across MCH populations, including infants and toddlers, children, adolescents, and adults.

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. In FY16 DSHS provided a Grand Rounds that examined the impact of CHWs through case studies. Presenters highlighted the growing interest and utilization of CHW internationally and in Texas within clinical and community-based settings. Nearly 500 individuals attended the Grand Rounds sessions through the in-person presentation or webinar, including 200 CHWs.

In December 2009, Texas had 625 certified CHWs, rising to over 4,000 in December 2016. Although the number of certified CHWs is expected to grow in Texas as CHWs are increasingly integrated in health and social service systems across the state, retaining experienced CHWs and instructors will be among the opportunities and challenges in 2017. DSHS and HHSC continue to work together with the CHW Training and Certification Advisory Committee and other stakeholders to identify potential financing mechanisms to support CHW-provided services within Medicaid and other payment systems.

Working with the CHW Training and Certification Advisory Committee, DSHS surveyed CHWs in 2015 and 2016 to evaluate CHWs' perspectives on the benefits and challenges of certification. Respondents felt that their CHW certification was meaningful and valuable, most notably as it increases self-confidence, makes a difference in the community, and encourages respect and acknowledgement by other professionals. Respondents noted that a lack of employment opportunities for CHWs was a significant challenge.

In 2016, DSHS staff presented information on CHWs' roles in Title V Maternal and Child Health and diabetes prevention and self-management education at the national Unity Conference for CHWs and the American Public Health Association (APHA) Annual Meeting.

DSHS worked to enhance community-clinical linkages through efforts to increase chronic disease training opportunities for CHWs. Through a contract with the University of Texas at Austin, CHWs in Travis, Dallas, Webb, and Starr counties received tobacco cessation training in English and Spanish on Ask, Advise, Refer using the Help to Quit app as the referral tool.

CHWs serve a critical role in the Texas response to Zika. DSHS held a special DSHS Grand Rounds session on Zika Virus Disease in April 2016 to include health professionals, including CHWs, in a discussion of Zika virus symptoms, incidence, distribution of the disease, modes of transmission, and strategies to prevent transmission. In 2016, DSHS worked with a number of CHW training organizations who held 35 regional or local workshops on Zika awareness and prevention to provide over 1,400 CHWs with the knowledge and resources to bring culturally tailored and linguistically appropriate messages to communities. DSHS also completed the Spanish portal for the CHW website to ensure access to information and resources for Spanish-speaking CHWs. The Title V MCH Medical Director attended the STPA Zika training in the Rio Grande Valley in 2017. Ongoing collaboration with the medical community will allow increased support and infrastructure for CHW activities related to Zika.

Birth Defects Surveillance

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. In FY16, BDES entered over 27,000 cases of birth defects (i.e., individuals affected by one or more birth defects) into the web-based abstraction system (Maven) during that year. By the end of FY16, the Registry had nearly completed the 2014 delivery year.

The DSHS Birth Defects Epidemiology and Surveillance (BDES) Branch is the recipient of a CDC grant focused on surveillance, intervention, and referral to services for infants in Texas with microcephaly and other Zika-related conditions. BDES is analyzing historical microcephaly data to better understand patterns, trends and causes of microcephaly in Texas, as well as conducting rapid ascertainment of Zika-related birth defects. Family outreach has been conducted through a partnership with TxP2P as part of this grant.

Oral Health Preventive Dental Services Data Collection System

The Oral Health Program (OHP) at DSHS strives to identify the oral health needs of Texans and to provide resources that meet those needs. The OHP 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 OHP 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 OHP 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 OHP to track trends of the prevalence and extent of oral disease and the presence of dental sealants. The next BSS will take place in the 2017-18 school year and will evaluate Texas third graders.

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. During the 2015-16 school year the OHP, with its partners, provided limited oral evaluations to 15,733 children and placed dental sealants on 8,567 children. Dental sealants are estimated to reduce the cost of dental care by ~$70 per tooth surface, resulting in a substantial savings for Texas.

In 2016, the OHP launched its Healthy Texas Smiles for Moms and Babies (HTSMB) project through funding provided by a Health Services and Resources Administration (HRSA) Perinatal and Infant Oral Health Quality Improvement grant. This is a three-year grant with the goal of improving the oral health of at-risk pregnant women and infants. HTSMB is targeting this population through home visiting programs. The OHP is collaborating with the Texas Department of Family and Protective Services Prevention and Early Intervention Program which includes

Texas Nurse Family Partnership (NFP), and with the Texas Head Start State Collaboration Office, which oversees Texas Early Head Start Home-Based. Over the course of the project HTSMB will be educating home visitors from these two programs and providing them with a curriculum for their home visiting clients. The curriculum includes an oral health assessment so the information the home visitor provides can be individualized. HTSMB is also providing the home visitors with additional resources and materials they can use to educate their clients and help them set and achieve goals. In March 2017 the OHP conducted its first HTSMB workshop for two San Antonio Nurse Family Partnership programs. There were fifteen nurses that participated. There has been ongoing communication between the OHP and the two pilot programs to ensure the education, resources and tools provided are resulting in more oral health education and dental referrals for clients. The next HTSMB workshop will be held in late May for NFP programs located in Wichita Falls and Edinburg.

Another focus of the HTSMB project is medical and dental provider education. HTSMB is developing evidence-based Texas Perinatal and Infant Oral Health Guidelines which will be promoted through conferences and other educational opportunities. The guidelines underscore that medical providers of pregnant women and infants should routinely refer their patients to a dentist and that dentists should receive and care for these patient populations. There will also be a public-facing component of these guidelines so pregnant women and parents can be educated directly on the safety and importance of oral care during these life stages.

The OHP is funded through the Title V MCH Block Grant, and MCHS and the OHP look for ways to collaborate on the shared goal of improving the health of mothers and children. MCHS is collaborating with the OHP in the development of the oral health guidelines and the OHP is purchasing booth space at an upcoming American College of Obstetrics and Gynecology (ACOG) district meeting to promote the HTSMB project. MCHS will provide information on Zika and other topics relevant to maternal and child health. The OHP partners with the MCHS Medical Director to ensure materials developed by the OHP provide consistent messaging on maternal and child health issues.

Newborn Screening

Title V funds are used to support the Newborn Screening (NBS) Clinical Care Coordination Program and the Texas Early Hearing Detection and Intervention (TEHDI) Program. The NBS Program screens for 53 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 program promoted four NBS provider education modules, utilized by over 3,700 NBS providers through Online Provider Education (OPE) and also experienced more than 214,000 website visits and more than 300 open records requests. NBS also distributed over 100,000 educational materials to providers and new and expectant parents in FY16.

The Department's 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. In FY2016, 67% held distinguished certification.

During FY2016, a total of 395,317 infants born in Texas required a hearing screening. Of these infants, 99% (392,488) received the screening prior to discharge; with 97% (380,986) passing the screen. Of those infants, 11,502 (3.0%) did not pass the birth admission hearing screen and required follow-up care. Of the initial 395,317 infants, 1,677 (.04%) did not receive a hearing screen prior to discharge from the birthing facility and will also need follow-up care.

During FY 2016, a total of 317,126 educational materials were distributed to parents and providers. There were 945

Open Records Requests from non-state agencies. TEHDI also exhibited materials and gave presentations at conferences and meetings including the Texas Association of Family Practice Physicians, Texas Hospital Association, Texas Academy of Physician Assistants, Texas Public Health Association, Texas Medical Association, Association of Women's Health, Obstetric and Neonatal Nurses, Developmental-Behavioral Pediatrics for Primary Care, The Texas Academy of Audiology, Texas Pediatric Society, Texas Parent to Parent Organization, Texas Hands and Voices, Texas Academy of Audiology, and the Texas Association of Parents and Educators of the Deaf.

II.F.2 MCH Workforce Development and Capacity

Texas continues to adapt to the changing MCH needs throughout the state. To better serve MCH populations to address these needs 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) consists of MCH Programs, CSHCN SDG, and MCH Epidemiology (MCHE). The CHW Unit was a component of the Section until 9/1/17 due to agency transformation. Key positions within the Section include the Block Grant Administrator, the MCH Program Coordinator, and the Infant Mortality Reduction Specialist. The MCH Unit is comprised of subject matter experts in infant and perinatal health, women and maternal health, child health, and adolescent health. The Maternal, Women's, Perinatal, and Infant Health Team within the Section is led by the State Breastfeeding Coordinator/MCH Nurse Consultant and includes the Maternal Mortality and Morbidity Nurse, the Women's and Perinatal Coordinator, and the Perinatal and Infant Coordinator. The Child Health and Adolescent Health Coordinators work with the state CFRT coordinator on programing and surveillance activities. Finally, Regional Pop-Based activities are implemented across the state in communities through DSHS regional staff and are coordinated through the Regional Population-Based Maternal Child Health Services Nurse Consultant.

With decades of combined experience in Maternal and Child Health and expertise in working with CYSHCN, the CSHCN SDG oversees the implementation of the CYSHCN Title V performance measure activities. The CSHCN SDG includes the Title V CSHCN Director and five full time Program Specialists. Two staff have Masters level degrees in public health/public affairs. 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 such as respite. Case Management and FSCR are provided to CYSHCN and their families through community-based contractors and/or regional DSHS staff across the state. 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 Workgroup and the Texas Title V Transition Workgroup 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 and Health Home Summit, Texas Council for Developmental Disabilities, Children's Policy Council, and the Texas Respite Coalition. Additionally, the State Adolescent Health Coordinator in the Office of Title V and Family Health serves as Texas' Family Delegate to AMCHP, is a former AMCHP Family Scholar, and serves on multiple AMCHP Committees. As a parent of an adult with special health care needs and with over 20 years' experience in the interest of CYSHCN, she is a valued participant in program initiatives.

MCHS continues to ensure subject matter expertise through ongoing educational opportunities. MCHS and agency partners attended the 2016 MCH WDC Summer Skills Institute where national SMEs and technical assistance providers delivered education on a variety of program planning and evaluation frameworks, including collective impact. MCHS applied acquired skills and frameworks to the "health transformation issue" of obesity in MCH population domains. The work completed during the Institute will inform future obesity prevention programming for child, adolescent and CSHCN domains. Other specific tools/skills include – LEAN canvas, systems tools, levels of leverage framework and return on investment calculations.

Staff are recognized for their performance and leadership in MCH. Kelsey Anderson, a CSHCN Program Specialist with MCHS, was awarded the 2017 Region VI Emerging Maternal & Child Health Professional Award by AMCHP. Julie Stagg, the State Breastfeeding Coordinator and Team Lead, received a scholarship to attend AMCHP in 2017. The Women's and Perinatal Health Coordinator received a scholarship to attend City Match. The Perinatal and Infant Coordinator was selected to participate in the 2017 AMCHP Leadership Lab Next Generation cohort.

Within MCHS, a new programmatic team was formed and several new positions have been strategically filled in FY16 and FY17:

Manda Hall, M.D. was named the Title V Maternal and Child Health Medical Director at the Texas Department of State Health Services in March of 2016. Prior to this position, Dr. Hall served as the Title V 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 the Association of Maternal and Child Health Programs Region VI Director and is a member of the organization's Legislative and Health Care Finance Committee. She graduated in May of 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 and serves as a mentor in the University of Texas Health Careers and Mentorship Program. Dr. Hall is an Adjunct Assistant Professor in the Department of Pediatrics at Texas A&M College of

Medicine.

Jeremy Triplett was named the Title V Maternal and Child Health Unit Director in August 2016. He previously worked as the Operations Manager for the Purchased Health Services Unit, who oversaw the daily operations for the Children With Special Needs, Kidney Health Care and the Hemophilia Assistance Programs. Mr. Triplett earned his Bachelor's degree in Psychology from St. Mary's University in 1998, and is currently enrolled in the AMCHP Leadership Lab for new MCH leaders.

Rachel Jew, MPAff was named the Title V Children and Youth with Special Health Care Needs Director in July 2016. Previously she was the Public Health Manager for the Texas Pediatric Society, the Texas Chapter of the AAP, and she worked as a Data Analyst and Program Specialist for the Children with Special Health Care Needs Services Program where her work focused on transition to adulthood. Ms. Jew has a bachelor's degree in psychology from the University of Texas at Austin and a master's degree from the Lyndon B. Johnson School of Public Affairs at the University of Texas at Austin. She is a graduate of the Public Management and Leadership Certificate Program at the University of Texas at Austin and is participating in AMCHP's Leadership Lab 2017 New Directors Cohort.

Aisling McGuckin MSN, MPH, CCE joined the Title V Maternal Child Health Unit in March 2017. Ms. McGuckin is the Regional Population-Based Maternal Child Health Services (MCH) Nurse Consultant. This new position will increase the resources and technical assistance available to regional population-based MCH staff. Ms. McGuckin was most recently MCH Director for the Dallas Chapter of the March of Dimes. Ms. McGuckin was previously employed by MCHS as MCH Nurse Consultant from 2011-2015 coordinating the Healthy Texas Babies initiative. Prior to coming to Texas, Ms. McGuckin was nurse supervisor at the Baltimore County Health Department for two community health clinics. Other clinical experiences include wound care, emergency medicine, correctional nursing, teaching community health nursing clinicals and directing a non-profit organization in Baltimore City focused on training refugees and asylees as community health workers.

Audrey Young, MPH was named the Maternal and Child Health Program Coordinator in February 2017. Previously she was the Health Policy Analyst for the Center for Health Policy and Performance at DSHS where she helped develop state policies focused on maternal and child health. Ms. Young has a bachelor's degree in kinesiology from Texas A&M University and a master's degree from the School of Public Health at Texas A&M University Health Science Center.

Molly Lindner, MPH received her MPH from Emory University and became the Title V Perinatal and Infant Coordinator in 2016. She has worked as a senior public health advisor with the US Agency for International Development, as a consultant for the Mexican Secretary of Health, as a program manager with the AAP, and Senior Project Associate with the National Center for Education in MCH. Most recently, Ms. Lindner received a certificate in Lactation Counseling and opened a maternity and lactation studio in Mexico.

MCH Block Grant funds support DSHS regional staff across the 8 Health Service Regions (HSR) to plan, implement, and evaluate population-based services in their communities to address Title V national and state performance measures. Title V supports FTEs throughout the health service regions, 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. Title V provides resource information related to Texas Title V performance measures through monthly updates and meetings to improve regional staff's MCH knowledge and skills. Community assessment was identified as a priority staff development need in 2016. Approximately 85 DSHS staff participated in a 3-day workshop in May 2016 to improve skills in this area. Title V subject matter experts and regional staff work together to plan, implement, and evaluate local or community-level evidence-based interventions or promising practices. In 2016, all 8 HSRs implemented activities related to Safe Sleep and Child Injury, while 7 of 8 implemented activities related to Smoking During Pregnancy and Household Smoking.

MCHE provides centralized epidemiologic, data, research, and reporting support to all MCH programs. MCHE is comprised of one director, one medical research specialist/team lead, five research specialists, three epidemiologists, one statistician, one information/web specialist, and one administrative assistant. With four staff having PhDs and five staff with Master's degrees in statistics/social science, MCHE clearly 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. In fact, all research 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 maternal and child health research, epidemiology, and program evaluation. Importantly, MCHE directs the State Systems Development Initiative (SSDI) and the Texas Pregnancy Risk Assessment and Monitoring System (PRAMS), both of which are used to inform policy and practice in MCH, as well as many other cross-cutting strategies, interventions, and initiatives throughout the state.

Texas utilizes MCH Block Grant funds to enhance the knowledge and skills of Community Health Workers (CHWs) as a critical workforce in supporting the state's overall system of care for MCH populations. Title V supports staffing and infrastructure for the Promotor (a) or Community Health Worker Training and Certification Program. Staff include, 4 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.

Title V supports the Promotor(a) or CHW Training and Certification Advisory Committee, which advises DSHS and HHSC on the implementation of CHW training standards. Committee membership includes CHWs, professionals who work with CHWs, a higher education member, and public members. Several Committee members are also CHW instructors and are affiliated with approved training programs. The Advisory Committee actively worked to address priorities within 4 areas; program rules, outreach and education, training and certification, and workforce solutions and employment. The Advisory Committee continued to work with DSHS and HHSC to explore financing mechanisms for CHW services to increase capacity and ensure sustainability of best practices models utilizing CHWs.

Title V 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. DSHS staff across the agency assist in reviewing CHW curriculum content to provide the most up-to-date information and evidence-based practices across a wide range of topics and emerging health issues for CHWs in Texas. In 2016, CHW training organizations collaborated with DSHS to identify approved CHW curriculum that could be shared with other training programs

In 2016, over 596 individuals graduated from a CHW competency-based certification course. Continuing education is crucial to ensure continued workforce development. CHW training programs provided over 352 continuing education courses in 2016 via distance learning and in-person workshops.

DSHS recognizes the value of the 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.

II.F.3. Family Consumer Partnership

MCHS has a long history of collaboration with families and participants. Promoting and strengthening family - professional partnerships remains a key priority and area of focus at DSHS. Families are valued for their input and perspective including the expertise and understanding of their child, family, personal strengths and individual needs. 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.

Continuous engagement with families includes collaboration through numerous forums including the TTVTW and MHWG led by the CSHCN SDG, Youth-Adult Councils in THAI communities and "individual" representation within HTB Coalitions. MCHS provides representation on the Texas Council for Developmental Disabilities, Policy Council for Children and Families, ECI Advisory Council, the Statewide Community Resource Coordination Group Workgroup, Child and Youth Behavioral Health Subcommittee (which merged the System of Care Consortium with the Trauma Informed Care (TIC) and Texas Children Recovering From Trauma (TCRFT) advisory groups in FY16, Texas Respite Advisory Committee, Texas Prevention Priorities Workgroup and the Alliance for Adolescent Recovery & Treatment.

MCHS serves on multiple conference planning committees including the Baylor College of Medicine's annual Chronic Illness and Disability: Transition from Pediatric to Adult-Based Care Conference, Texas Primary Care and Health Home Summit, Strengthening Youth & Families Conference, DFPS' Partners In Prevention Conference, and TxP2P's Annual Parent Conference. Stipends funded through MCHS make it possible for family members, youth and community-based contractors to attend these conferences. Active MCHS participation with planning helps ensure the presence and voice of families and stakeholders.

In addition to review by the Family Delegate, MCHS receives ongoing input on Block Grant Application narratives, satisfaction surveys and workgroup activities through its contractual relationship with TxP2P, Texas' Family Voices affiliate. The Co-Director of TxP2P, a parent, is a key member of the block grant review team and actively participates in the annual meeting with federal partners.

Further, MCHS 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 as well.

MCHS is committed to involving youth and families in system improvement initiatives. Texas' AMCHP Family Delegate works closely with the CSHCN SDG on numerous projects, including the TTVTW and MHWG. Parents, youth and young adults are invited to join the TTVTW and MHWG to share knowledge and experiences, develop strategic goals and objectives, and learn about best practices in the areas of transition and medical home respectively.

Texas' AMCHP Family Delegate, in collaboration with MCHS staff, initiated development of a Family-Professional Partnership (FPP) Strategic Plan in FY15 to promote family/professional partnerships within all MCH populations, aligning with MCH 3.0 Transformation efforts. Building on and incorporating proven, successful CSHCN SDG activities, the AMCHP Family Delegate is leading efforts to involve stakeholders within each population health domain to strengthen existing partnerships and gather input. In FY17, MCHS staff conducted a SWOT analysis to pinpoint program areas within each population domain that are actively partnering with families and identify opportunities to strengthen the family voice. The priority is to build on current activities to effectively engage families and expand efforts to gather family input representing all population domains.

Input from families and youth is essential for developing quality, family-centered initiatives and improving outcomes for all MCH populations. MCHS will continue to seek opportunities to encourage meaningful family engagement in all systems supporting families.

II.F.4. Health Reform

Information is not provided for this optional section.

II.F.5. Emerging Issues

85th Legislative Session

Legislation passed by the Texas Legislature in 2017 with an impact on the maternal and child health population in Texas or the health outcomes associated with this population includes:

1. HB1549 requires DSHS to develop trainings for Justice of the Peace and Medical Examiners on inquests in child deaths, provide child fatality review teams with electronic access to prelim death certificates for child deaths, and evaluate child fatality data for public health preventive strategies. It also requires the members of a child fatality review team to reside in the review team's jurisdiction and reflect the county's diversity.

2. HB2848 requires DSHS to ensure that MEDCARES providers have the ability to obtain consultations with specialists in unique health conditions, specifically bone-tissue disorders. It also requires MEDCARES providers to use a blind peer review process in the event of disputed cause of injury or disputed condition diagnosis.

3. SB1599 requires DSHS to post on their website information regarding the systematic protocol for pregnancy-related death investigations and the best practices for reporting pregnancy-related deaths. The website information should include information on toxicology screening determinations, when a death should be reported or investigated by a Medical Examiner or Justice of the Peace, and how to correctly complete a death certificate when the death is pregnancy related.

4. HB2466 requires the state's Medicaid program to cover a postpartum depression screening and access to mental health referrals for an enrollee's mother, regardless of whether the mother is also an enrollee, during a covered office-visit before the enrollee's first birthday.

5. HB62 prohibits the use of a wireless communication device while operating a motor vehicle throughout the state of Texas unless being used with a hands-free device. This includes reading, writing, or sending an electronic message.

Zika

Zika remains a public health priority in Texas and efforts continue at DSHS to ensure a comprehensive Zika response. In November 2016 Texas became the second state in the continental US to confirm a locally transmitted case of the Zika virus; six cases of locally transmitted Zika virus disease have been confirmed in Cameron County, the southernmost county in Texas. From December 2015 to December 2016 a total of 320 cases were reported, with the majority being travel-related. As of May 19, 2017, 12 cases have been reported in 2017. As of May 3, 2017, 192 pregnant women and 10 of their infants have been identified with evidence of Zika virus infection. Due to the risk that Zika posed to the Rio Grande Valley along the Texas-Mexico border, a health alert was issued by DSHS on April 7, 2017, which included recommendations around testing pregnant residents within certain Texas counties.

A multidisciplinary team of DSHS staff, including the MCHS Medical Director and Associate Commissioner of FCHS, continue to meet weekly with the DSHS Commissioner and other executive leadership to provide ongoing planning and communication related to the disease. A Zika Operations group was formed to ensure implementation and oversight of key response activities. DSHS participates in ongoing communication with key partners including the CDC and LHDs in the Rio Grande Valley. MCHS provided funding to support the US-Mexico Border Health Commission's *Binational Forum on Emerging Mosquito-borne Infectious Diseases along the US-Mexico Border* in El Paso in June 2017. The meeting will be attended by the FCHS Associate Commissioner and MCHS Infant Mortality Reduction Specialist.

Efforts continue to provide education and resources for health care professional and Texas residents, including the website www.TexasZika.org. The site was visited over 139,000 times in the first half of FY17 and in April 2017 a new Zika GovDelivery topic was added to provide email updates on new information and resources related to Zika. As of May 24, 2017 256 stakeholders had subscribed to the Zika GovDelivery topic. MCHS has begun the process of updating the website's provider page and developing resources to help providers navigate Zika testing and clinical management. Additional resources are available for download from the website and through the DSHS warehouse.

MCHS began providing these resources at conference exhibits including the TxP2P Annual Conference, Texas Pediatric Society Annual Conference, Partners in Prevention Conference, March of Dimes Prematurity Summit, and DSHS Injury Prevention Conference.

DSHS is implementing a communication plan to increase provider knowledge of Zika virus, particularly related to Zika screening and testing for pregnant women and infants born to women with possible Zika virus exposure. MCHS has coordinated messaging to Texas' Medicaid providers and other publicly-funded health care providers, including specific guidance to the Medicaid Managed Care Organizations regarding coordinating care for these populations, and the provision of Medicaid insect repellant benefit.

The DSHS Commissioner presented Grand Rounds special sessions on Zika in April and November of 2016 and was featured in a THSteps podcast on Zika. Another Grand Rounds session will be held in July 2017 with presentations from two physicians in Texas with direct experience treating pregnant women and infants affected by the virus. The DSHS Commissioner also participated in TMA telehealth townhalls in September 2016 and April 2017 to provide education to Texas physicians. The MCHS Medical Director presented at the Department of Family and Protective Services' 2016 Partners in Prevention Conference and to a University of Texas School of Public Health class. The MCHS Medical Director and CSHCN Director contributed to a forthcoming Navigate Life Texas webpage on Zika for families. The DSHS campaign Don't Give Zika a Biting Chance continues with radio and TV public service announcements, digital advertising, media interviews, and other materials and outreach. The DSHS Commissioner serves as the Director of the Governor's Task Force on Infectious Disease Preparedness and Response which developed a specific workgroup in response to Zika.

CSHCN SDG convened key partners in FY16 to develop the Texas Plan for System of Services for Children with Congenital Zika Syndrome to ensure the linkage to necessary services and supports. The workgroup included representatives from key programs at DSHS and HHSC, including MCHS, BDES, WIC, ECI, Medicaid, and Case Management programs. Documents depicting and describing the plan have been shared with key partners within the state and nationally. To aid in BDES' referral and outreach efforts and to determine the efficacy of the plan, DSHS will be conducting a pilot to connect families to services. The pilot will be limited to statewide cases of severe microcephaly (< 3rd percentile head circumference) and Congenital Zika Syndrome.

Funds for responding to Zika virus in Texas have been awarded by the CDC and are centered on public health prevention of and testing for Zika virus and mosquito control activities. BDES has received funding for surveillance, intervention, and referral to services activities for infants in Texas with microcephaly or other adverse outcomes linked to the Zika virus. A portion of this grant focuses on family outreach and connection to services for infants born with severe microcephaly and congenital Zika syndrome. DSHS convened key partners to establish a process to identify these infants and their families and ensure access to care coordination, including connection to TxP2P.

In addition, the DSHS Zoonosis Control Branch and Laboratory Services Section has received funding through the Building and Strengthening Epidemiology, Laboratory, and health Information Systems Capacity in State and Local Health Departments grant to increase laboratory and epidemiology capacity, support locally based vector control and other key response activities.

Within Texas, CHWs remain uniquely positioned to bring timely information and resources regarding the Zika Virus Disease in a way that is culturally tailored and linguistically proficient to at-risk communities in South Texas and other areas. Along the Texas/Mexico border, CHW programs are increasing education activities using a revised Zika training curriculum and tools. In collaboration with MCHS and through Title V funding, the DSHS Border Services is training CHW instructors and programs to use the new curriculum and tools with a focus on prevention and access to testing. The goal is to train 500 of the 831 CHWs along the Texas-Mexico border. Through CMS and Title V funding, CHWs and CMs will be deployed to LHDs in Cameron, Hidalgo, and Laredo Counties. Additional teams will be funded in DSHS HSR 8/Val Verde County and the City of El Paso through Title V. This will result in at least 11 teams in 5 counties along the Texas-Mexico border. Activities will focus on three areas: counseling on and access to contraception, Zika testing, and supportive services for families affected by the virus. Ongoing support and education of these teams will be provided through Border Services. In addition, grant efforts will focus on increasing provider capacity and capability through training and education. MCHS will partner with the March of Dimes, the Texas Pediatric Society, and TCHMB to develop and implement provider training. Pediatric provider education efforts will be supported through the AIM Learning Collaborative, a project of AMCHP and seven other national organizations to increase maternal and child health outcomes. Texas was invited to participate in Cohort 3 of the Collaborative and the team includes the MCHS Medical Director, CSHCN Director, FCHS Associate Commissioner, HHSC Health, Developmental and Independence Services Associate Commissioner, HHSC Medicaid Policy Director, and two pediatricians representing the Texas Pediatric Society. As part of the project, the Texas team will increase pediatric provider capacity and capability and enhance services within current family support systems related to Zika.

Texas has also participated in national Zika efforts. The MCHS Medical Director attended a meeting in FY16 convened by the CDC in collaboration with the AAP to obtain individual input from experts and partners to inform the

development of guidance for the evaluation and management of infants with congenital Zika virus infection. The MCHS Medical Director was a contributor to the Morbidity and Mortality Weekly Report, "Update: Interim Guidance for the Evaluation and Management of Infants with Possible Congenital Zika Virus Infection — United States, August 2016." She also serves as a member of the Advisory Committee for the AAP Project ECHO Zika. Project ECHO is a virtual telementoring project that connects clinical experts with primary care providers who may see infants with Congenital Zika Syndrome. MCHS participated in CDC site visits to LHDs in Corpus Christi and Harris County, where the CDC will be providing CDC staff assignees to assist local health departments with their Zika response. The April 2017 edition of AMCHP's PULSE newsletter included an article written by the MCHS CSHCN Director about Texas' Zika activities. DSHS has also promoted the CDC's Zika Care Connect project.

Neonatal Abstinence Syndrome

Also increasing in the state and nation is the use of opioids, including during pregnancy, and the resultant uptick in rates of Neonatal Abstinence Syndrome (NAS). In Texas, approximately one out of four pregnant women is admitted to DSHS-funded treatment services dependent on opioids. Currently, Bexar, Harris and Dallas counties have the highest report of NAS in the state with Bexar county accounting for approximately 30% of diagnosed NAS cases in the state. Per the CHS Hospital Inpatient Discharge Public Use Data Files between 2008 and 2012, the rate of NAS has increased from 1.3 to 1.9 per 1,000 live births in Texas. Data analyzed by the Texas Maternal Mortality and Morbidity Task Force revealed that overdose was the second leading cause of maternal death in 2011-2012—the most recent year of data available—and most those deaths involved licit or illicit prescription opioids.

To address this issue, Texas has implemented several initiatives and appropriated funds to reduce the incidence and severity of opioid use and NAS in the state. The Texas Legislature appropriated $11.2 million in General Revenue funds to the Health and Human Services Commission (HHSC) to create and expand new and existing services aimed at reducing incidence, severity, and costs associated with NAS. These efforts take a multi-pronged approach to addressing NAS by: 1) increasing targeted outreach services to engage women earlier in care, 2) increasing the availability of intervention and treatment services to pregnant and postpartum women to improve birth outcomes, and 3) implementing specialized programs to reduce the severity of NAS.

The Behavioral Health and Intellectual and Developmental Disabilities Services/ Substance Use Disorders Unit oversees a number of initiatives to reduce the incidence, severity and costs associated with NAS, which the additional funding has helped expand. The Pregnant, Postpartum Intervention (PPI) program provides intervention services for pregnant and postpartum adult and adolescent women at risk for substance abuse. The programs offer on-site, gender specific, community-based outreach, intervention, motivational counseling, case management, treatment referral and support for at risk women. The Mommies Program is an integrated and collaborative model of care that has shown to reduce NICU stays and supports family preservation. The model has been replicated in the five highest counties of NAS (Bexar, Dallas, Tarrant, Harris and Nueces) and is supported by continued online training, statewide annual symposium, and intensive technical assistance. Educational events in FY16 included an NAS symposium, and Opioid Overdose Prevention Trainings. The NAS symposium had 212 participants and Continuing Education (CE) credits were offered. The Opioid Overdose Prevention Trainings had 700 attendees and were scheduled in the highest counties of NAS, including: Tyler, Corpus Christi, El Paso, Houston, Lubbock, San Antonio, Waco, and Dallas. There will additionally be Opioid Overdose Prevention Trainings targeted to pharmacists scheduled soon through the Texas Targeted Opioid Response. The Substance Use Disorder Unit and MCHS are forging partnerships to collaborate on initiatives to improve the quality of services and increase continuity of care for women with substance use disorders. Further, through participation in an NAS Workgroup led by the Substance Use Disorder Unit, MCHS provides education and resources related to women's preconception and interconception health and health care.

Human Trafficking

Regional staff have responded to calls from the community for additional education on domestic minor sex trafficking, a problem that plagues Texas because of its many interstate highways, international ports and proximity to the border. Staff from DSHS HSR 1 participated in the development of the 2016 Texas Human Trafficking Prevention Task Force Report to the Texas Legislature. The report highlighted trainings conducted by DSHS regional staff in HSRs 1, 4/5N, 6/5S, 7 and 9/10 to increase awareness of human trafficking among health care providers and social services professionals, improve identification of potential victims and increase referral to appropriate resources. The SCFRT heard presentations from law enforcement and DFPS on human trafficking at two quarterly meetings. This topic will be considered for legislative recommendations for the FY18 biennial SCFRT report. A presentation on human trafficking was given at the 2017 Texas Injury Prevention conference. All CSHCN SDG Community-Based Contractors are required have a written policy on human trafficking, which includes annual staff training.

Hurricane Harvey

On August 25, 2017, Hurricane Harvey made landfall on the Texas coast causing catastrophic damage and flooding

to Texas. MCH populations are among those who were affected and displaced. As emergency rescue efforts diminished in the days and weeks following the storm, recovery activities became the primary focus. DSHS will continue providing affected residents with necessary support, and MCHS will continue to assess MCH needs related to the storm in FY18.

II.F.6. Public Input

The draft FY18 Application/FY16 Annual Report was posted to the DSHS MCH site (http://www.dshs.texas.gov/mch/) from June 9, 2017 through June 22, 2017 for public comment. Stakeholders, providers, consumers, HHS system staff, and other MCH partners were notified of the public comment opportunity through announcements sent to the MCH and CSHCN GovDelivery lists maintained by MCHS. The announcements were sent to more than 10,000 subscribers of the GovDelivery lists. Public comments included funding recommendations for MCH activities related to legislation passed in the 2017 85th Texas legislative session. 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. Past Title V Block Grant Applications as well as the current and past Five-Year Needs Assessments are also linked on the site.

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. In FY17, MCHS hosted Quarterly Partner Meetings for key MCH colleagues and experts. The purpose of these meetings is to convene partners, provide an opportunity to share updates, and explore opportunities to collaborate. 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. In FY16, MCHS began conducting annual 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.

II.F.7. Technical Assistance

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 Assistance with identification of other states with the same SPMs as Texas would be helpful and allow Texas to connect with other state colleagues to share best practices and lessons learned. Additionally, federal technical assistance related to obesity prevention, infant mortality, community integration, and adolescent quality care (the four Texas SPMs) would also very beneficial.

Maternal and Child Health Disparities The continued provision of learning opportunities to operationalize activities to address health disparities and the social determinants of health 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 the April, 2016 AMCHP Technical Assistance meeting. This method of grouping states was 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 Assistance with statewide workforce development would be useful in order to enhance regional MCH capacity and improve efficiency in implementation of activities throughout the Health Service Regions in Texas.

III. Budget Narrative

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$31,213,037	$33,850,560	$33,355,483	$34,063,619
Unobligated Balance	$3,932,132	$0	$12,008,165	$0
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	$75,353,897	$74,059,288	$85,572,376	$74,272,347
Other Federal Funds	$546,757,096		$573,975,574	$1,733,016
Total	$622,110,993	$74,059,288	$659,547,950	$76,005,363

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$33,850,560	$33,958,965	$33,899,658	
Unobligated Balance	$5,415,582	$0	$0	
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	$79,474,870	$74,167,693	$74,108,386	
Other Federal Funds	$2,749,532	$2,476,025	$2,759,792	
Total	$82,224,402	$76,643,718	$76,868,178	

	2018	
	Budgeted	Expended
Federal Allocation	$33,958,965	
Unobligated Balance	$0	
State Funds	$40,208,728	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$74,167,693	
Other Federal Funds	$3,527,463	
Total	$77,695,156	

III.A. Expenditures

The set of Budget Forms (2, 3a, and 3b) were prepared in collaboration with the DSHS Grant Coordination and Funds Management Branch and the Community Health Improvement Division fiscal oversight team members to provide a complete updated set of budget and expenditure data for FY16 as of 5/31/17. Field Notes have also been added to update the individual form cells where needed. 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 FY16, 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. Funding to support Zika programming began in FY16 and included the provision of education and information by way of presentations, outreach and the development of the TexasZika.org website. Population-based and public health systems programs continued to be a focus in FY16. Federal Expenditures noted in Form 2 amounts to $33,958,965 and reflects 47.2% of funds expended for preventive and primary care for children ($16,037,783), 39.8% for Children with Special Health Care Needs ($13,534,270), and 7.9% expended for Title V Administrative Costs ($2,656,265). Non-federal MCH expenditures totaled $40,208,728, per the state required match. In FY16, 900 clients were removed from the CSHCN SP health care benefits waitlist resulting in increased federal and non-federal client service expenditures. Due to HHSC reorganization, the women's prenatal and dental fee-for-service program, the children's health and dental fee-for-service program, and CSHCN SP health care benefits client services moved to HHSC from DSHS on September 1, 2016. Expenditure information and budget planning is coordinated through ongoing communication and monthly in-person meeting between DSHS and HHSC budget and program personnel.

III.B. Budget

The budgeted federal amount for FY18 is consistent with the actual FY16 expenditure amount and the budgeted amount for FY17. The DSHS commitment of general revenue for FY18 remains limited to the 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. 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 in general, and particularly, to establish internal controls to monitor expenditures of federal funds. The Budget Office's Grants Coordination and Funds Management Unit prepares financial reports on compliance with the 30% - 30% requirement on a monthly basis. The Community Health Improvement Division and Title V program leadership review reports, provide feedback, and adjust service delivery as needed to maintain the required spending proportions. The same vigorous monitoring process is in place to comply with the 10% cap on administrative expenditures which are budgeted at $1,856,607.

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 FY18, the projected budget shows that $13,111,196 of the federal Title V awarded funds are specifically marked for preventive and primary care for children while $13,269,457 are earmarked directly for children with special health care needs. These dollar amounts, based on the projected FY18 federal allocation, will ensure that Texas compliance with federal requirements. Texas receives other federal, state, and private grants related to women and children, including the Rape Prevention and Education (RPE) Program and Project LAUNCH. The Pregnancy Risk Assessment Monitoring System (PRAMS) and the State Systems Development Initiative (SSDI) are now also under the control of the Title V program administrator and have been added to the list of other federal funds budgeted for FY18 on Form 2. Title V is planning for implementation of new efforts, and continuing impactful existing efforts, to address the national and state performance measures. Zika activities will continue into FY18 using federal funding. To maximize federal funds for public health programming, the majority of MCH initiatives planned for FY18 will utilize federal funds, while staff and support infrastructure will use MOE funding. Funds for programming in the Maternal/Women’s health domain and the Infant/Perinatal health domain will see an increase in FY18 compared to previous years. Texas will continue to provide the MOE amount of $40,208,728 as required.

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 - Healthy Texas Babies and PRAMS Databooks.pdf

Supporting Document #02 - V. Supporting Document - DSHS Presentations and Publications - OPDS and Birth Defects.pdf

Supporting Document #03 - V. Supporting Document - 2016 MMMTF and CHW Legislative Reports.pdf

Supporting Document #04 - V. Supporting Document - DSHS Breastfeeding Initiatives.pdf

Supporting Document #05 - V. Supporting Document - Glossary and Organizational Charts.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Texas

	FY18 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 33,958,965	
A. Preventive and Primary Care for Children	$ 13,111,196	(38.6%)
B. Children with Special Health Care Needs	$ 13,269,457	(39%)
C. Title V Administrative Costs	$ 1,856,607	(5.5%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0	
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 (Same as item 18g of SF-424)	$ 74,167,693	
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)	$ 3,527,463	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 77,695,156	

OTHER FEDERAL FUNDS	FY18 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 2,092,386
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	$ 665,934
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 78,045
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 155,536
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Zika Health Care Services Program	$ 535,562

	FY16 Annual Report Budgeted		FY16 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 33,850,560		$ 33,958,965	
A. Preventive and Primary Care for Children	$ 17,395,803	(51.4%)	$ 16,037,783	(47.2%)
B. Children with Special Health Care Needs	$ 12,835,000	(37.9%)	$ 13,534,270	(39.8%)
C. Title V Administrative Costs	$ 2,538,792	(7.5%)	$ 2,656,265	(7.9%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 5,415,582		$ 0	
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 (Same as item 18g of SF-424)	$ 79,474,870		$ 74,167,693	
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)	$ 2,749,532		$ 2,476,025	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 82,224,402		$ 76,643,718	

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	$ 667,243	$ 339,770
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 2,082,289	$ 2,136,255

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**2. UNOBLIGATED BALANCE**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Unobligated balances are expended first under prior-year previously reported awards, rather than carrying forward unobligated funds. Therefore, there will be no budgeted unobligated balance for the second year of the budget period.	
2.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Due to agency reorganization, this grant will be under the control of the Title V program administrator beginning in the fall of 2017.	
3.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Due to agency reorganization, this grant will be under the control of the Title V program administrator beginning in the fall of 2017.	
4.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Zika Health Care Services Program**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: This is a three year grant from 7/1/2017 through 6/30/2020 for a total of $1,800,000. The fiscal year runs from July 1 through June 30 and does not align with the Title V federal fiscal year. The year one total is $535,562.00; the year 2 total is $632,218.00; and the year 3 total is $632,220.00. The entry on this form reflects the year one total.	

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	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 4,440,711	$ 1,242,958
2. Infants < 1 year	$ 1,280,994	$ 487,689
3. Children 1-22 years	$ 13,111,196	$ 16,037,783
4. CSHCN	$ 13,269,457	$ 13,534,270
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 32,102,358	$ 31,302,700

IB. Non Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 7,063,316	$ 7,219,687
2. Infants < 1 year	$ 922,486	$ 977,378
3. Children 1-22 years	$ 5,625,996	$ 3,436,946
4. CSHCN	$ 24,684,515	$ 24,224,647
5. All Others	$ 1,912,415	$ 4,350,070
Non Federal Total of Individuals Served	$ 40,208,728	$ 40,208,728
Federal State MCH Block Grant Partnership Total	$ 72,311,086	$ 71,511,428

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Form 3b
Budget and Expenditure Details by Types of Services

State: Texas

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	$ 13,005,000	$ 17,322,748
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 7,005,000	$ 6,657,655
C. Services for CSHCN	$ 6,000,000	$ 10,665,093
2. Enabling Services	$ 3,926,240	$ 3,997,941
3. Public Health Services and Systems	$ 17,027,725	$ 12,638,276
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		$ 5,567,079
Physician/Office Services		$ 3,463,465
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 2,769,425
Dental Care (Does Not Include Orthodontic Services)		$ 4,605,734
Durable Medical Equipment and Supplies		$ 449,401
Laboratory Services		$ 434,303
Other		
Home Health		$ 33,341
Direct Services Line 4 Expended Total		$ 17,322,748
Federal Total	$ 33,958,965	$ 33,958,965

IIB. Non-Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	$ 17,506,915	$ 14,006,335
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,401,158	$ 1,574,998
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 16,105,757	$ 12,431,337
2. Enabling Services	$ 0	$ 2,608,020
3. Public Health Services and Systems	$ 22,701,813	$ 23,594,373
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		$ 6,650,434
Physician/Office Services		$ 2,256,509
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 3,228,069
Dental Care (Does Not Include Orthodontic Services)		$ 508,653
Durable Medical Equipment and Supplies		$ 523,826
Laboratory Services		$ 661,834
Other		
Low-Protein Foods		$ 138,147
Home Health		$ 38,863
Direct Services Line 4 Expended Total		$ 14,006,335
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: 406,132

1. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	399,333 (98.3%)	18,594	676	676 (100.0%)

Program Name(s)				
Propionic acidemia	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Isovaleric acidemia	3-Methylcrotonyl-CoA carboxylase deficiency
3-Hydroxy-3-methyglutaric aciduria	Holocarboxylase synthase deficiency	ß-Ketothiolase deficiency	Glutaric acidemia type I	Carnitine uptake defect/carnitine transport defect
Medium-chain acyl-CoA dehydrogenase deficiency	Very long-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	Argininosuccinic aciduria
Citrullinemia, type I	Maple syrup urine disease	Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I
Primary congenital hypothyroidism	Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)	S,C disease	S, βeta-thalassemia
Biotinidase deficiency	Cystic fibrosis	Severe combined immunodeficiences	Classic galactosemia	

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing Screening	392,488 (96.6%)	11,502	2,037	1,164 (57.1%)
Secondary RUSP Conditions	399,333 (98.3%)	1,091	129	129 (100.0%)

3. Screening Programs for Older Children & Women

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Vision Screening	2,702,794	254,117	221,083	102,745
Hearing Screening	2,633,591	54,571	44,361	17,415
Spinal Screening	759,750	22,292	22,292	7,557

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 - Referred For Treatment**
	Fiscal Year:	**2016**
	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 - Receiving At Lease One Screen**
	Fiscal Year:	**2016**
	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 - Positive Screen**
	Fiscal Year:	**2016**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens for several secondary RUSP conditions were included with the number of presumptive positive screens 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 - Confirmed Cases**

Fiscal Year:	**2016**
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 5a
Unduplicated Count of Individuals Served under Title V

State: Texas

Reporting Year 2016

		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	90,492	46.0	0.0	46.4	7.6	0.0
2. Infants < 1 Year of Age	89,874	46.0	0.0	46.4	7.6	0.0
3. Children 1 to 22 Years of Age	69,223	35.2	0.0	51.9	12.9	0.0
4. Children with Special Health Care Needs	63,482	39.5	0.0	55.7	4.8	0.0
5. Others	2,748	8.0	0.0	68.7	23.3	0.0
Total	315,819					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2016**

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 may have also received the Parent's Guide to Raising Happy Healthy Children. Therefore, the number of total individuals who were provided Information for Parents of Newborns was reduced by 50%. Primary source of coverage for pregnant women was estimated using 2015 birth data.

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2016**

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, and therefore, the individuals served were infants. In addition, it is estimated that 50% of the individuals who received the Information for Parents of Newborns were enrolled in Medicaid and may have also received the Parent's Guide to Raising Happy Healthy Children. Therefore, the total number of infants served by the Information for Parents of Newborns was reduced by 50%. Primary source of coverage for infants was estimated using 2015 birth data.

3.	**Field Name:**	**Children 1 to 22 Years of Age**
	Fiscal Year:	**2016**

Field Note:
Programs and services for children include Oral Health Program, School Health, MEDCARES, Genetics Fee-for-Service, and MCH Fee-for-Service. Primary source of coverage for children was estimated using 2015 American Community Survey data.

4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2016**

Field Note:
Programs and services for children with special health care needs include CSHCN SP Health Care Benefits, CSHCN Systems Development Group, and CSHCN Regional Case Management. Primary source of coverage for CSHCN was estimated using 2011/2012 National Survey of Children's Health data.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2016**

Field Note:
Programs and services for other populations include the Peer Dad Program. Primary source of coverage for others was estimated using 2015 American Community Survey data.

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Texas

Reporting Year 2016

Types Of Individuals Served	Total Served
1. Pregnant Women	408,173
2. Infants < 1 Year of Age	418,709
3. Children 1 to 22 Years of Age	3,808,543
4. Children with Special Health Care Needs	115,890
5. Others	802,505
Total	5,553,820

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2016**
	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, Tobacco Provider Education, 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.	
2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2016**
	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, Texas Collaborative for Healthy Mothers and Babies, and Healthy Texas Babies Coalitions. It is estimated all infants residing in the state of Texas were served by Title V through universal Newborn Screening.	
3.	**Field Name:**	**Children 1 to 22 Year of Age**
	Fiscal Year:	**2016**
	Field Note: Programs and services for children include Oral Health Program, School Health, MEDCARES, Genetics Fee-for-Service, MCH Fee-for-Service, Rape Prevention and Education, Tobacco Provider Education, Suicide Prevention, School Screening, Strengthening Youth & Families Conference, GovDelivery, Project LAUNCH, Texas Health Steps Online Provider Education, Youth Engagement Project, and 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.	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2016**
	Field Note: Programs and services for children with special health care needs include CSHCN SP Health Care Benefits, CSHCN Systems Development Group, and CSHCN Regional Case Management.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2016**

Field Note:
Programs and services for other populations include Peer Dad Program, Healthy Texas Babies, Suicide Prevention, Texas Mother Friendly Worksites, Community Health Workers, GovDelivery, Regional Population Based Services, TexasZika.org, and 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. To calculate the reach of the Community Health Workers program, the number of individuals who took the DSHS-approved training course was added to the number of individuals who applied for certification and did not take the DSHS-approved training course.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Texas

Reporting Year 2016

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	408,173	295,152	49,679	1,011	21,538	553	5,988	34,252
Title V Served	5,752	4,911	238	11	103	6	0	483
Eligible for Title XIX	210,580	113,371	30,125	850	4,402	339	784	60,709
2. Total Infants in State	418,709	309,499	46,588	917	18,120	469	5,497	37,619
Title V Served	406,132	293,669	49,253	1,009	21,456	541	5,976	34,228
Eligible for Title XIX	259,035	80,563	20,364	625	2,748	266	1,371	153,098

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	212,130	195,733	310	408,173
Title V Served	4,886	866	0	5,752
Eligible for Title XIX	76,164	124,728	9,688	210,580
2. Total Infants in State	199,739	218,970	0	418,709
Title V Served	211,025	194,799	308	406,132
Eligible for Title XIX	50,598	82,365	126,072	259,035

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Data source: CHS Provisional 2016 Natality File and CHS Provisional 2016 Fetal Mortality File	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Data source: Title V MCH FFS Program	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Data source: Data Quality Team, Center for Analytics & Decision Support, HHSC	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Data source: Texas Demographic Center 2014 Projections for 2016 Population. State population data do not distinguish between race without considering ethnicity. Therefore, race-specific numbers for this row have been estimated using state population data along with racial identification information for Hispanics and other/unknown racial groups in the CHS Provisional 2016 Natality File.	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Data source: CHS Provisional 2016 Natality File	
6.	**Field Name:**	**2. Eligible for Title XIX**

Fiscal Year:	**2016**
Column Name:	**Total All Races**

Field Note:
Data source: 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	2018 Application Year	2016 Reporting 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"	Ryan Ward	Ryan Ward
4. Contact Person's Telephone Number	(512) 483-5117	(512) 483-5117
5. Number of Calls Received on the State MCH "Hotline"		53,697

B. Other Appropriate Methods	2018 Application Year	2016 Reporting Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	http://www.dshs.texas.gov/mch/	http://www.dshs.texas.gov/mch/
4. Number of Hits to the State Title V Program Website		14,966
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:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Texas

1. Title V Maternal and Child Health (MCH) Director	
Name	Manda Hall, MD
Title	Title V Maternal and Child Health Medical Director
Address 1	Texas Department of State Health Services
Address 2	PO Box 1922, MC 1922
City/State/Zip	Austin / TX / 78714
Telephone	(512) 776-2567
Extension	
Email	Manda.Hall@dshs.texas.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Rachel Jew, MPAff
Title	Title V CSHCN Director; CSHCN Systems Development Group Manager
Address 1	Texas Department of State Health Services
Address 2	PO Box 1922, MC 1922
City/State/Zip	Austin / TX / 78714
Telephone	(512) 776-2184
Extension	
Email	rachel.jew@dshs.texas.gov

3. State Family or Youth Leader (Optional)	
Name	Carol Harvey
Title	Family Delegate; State Adolescent Health Coordinator
Address 1	Texas Department of State Health Services
Address 2	PO Box 1922, MC 1922
City/State/Zip	Austin / TX / 78714
Telephone	(512) 776-6965
Extension	
Email	carol.harvey@dshs.texas.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Texas

Application Year 2018

No.	Priority Need
1.	Children and Youth with Special Health Care Needs receive family-centered, coordinated care within a medical home model.
2.	Children and Youth with Special Health Care Needs and their families have the services and supports necessary to transition to adulthood.
3.	Advance Community Integration efforts.
4.	Reduce health disparities for maternal and child health populations.
5.	Promote collaborations including family professional partnerships (to enhance Maternal and Child Health programming).
6.	Bolster access to quality statewide data, screening, and surveillance (to inform Maternal and Child Health programming).
7.	Improve coordination of care for Maternal and Child Health populations.
8.	Provide support to promote quality in primary care, women's health, and specialty services.
9.	Ensure use of culturally and linguistically appropriate Maternal and Child Health education and outreach efforts.
10.	Increase Maternal and Child Health safety programming.

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Children and Youth with Special Health Care Needs receive family-centered, coordinated care within a medical home model.	New	
2.	Children and Youth with Special Health Care Needs and their families have the services and supports necessary to transition to adulthood.	New	
3.	Advance Community Integration efforts.	New	
4.	Reduce health disparities for maternal and child health populations.	New	
5.	Promote collaborations including family professional partnerships (to enhance Maternal and Child Health programming).	New	
6.	Bolster access to quality statewide data, screening, and surveillance (to inform Maternal and Child Health programming).	New	
7.	Improve coordination of care for Maternal and Child Health populations.	New	
8.	Improve access to and quality of primary care, women's health, and specialty clinical services.	New	
9.	Ensure use of culturally and linguistically appropriate Maternal and Child Health education and outreach efforts.	New	
10.	Increase Maternal and Child Health safety programming for birth to 19 year olds.	New	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 5

Field Note:
Family Professional partnerships are an key components of all Title V programming and is integrated throughout the strategic planning of the block grant cycle.

Field Name:

Priority Need 6

Field Note:
Data serves as the foundation for programming and ongoing evaluation and quality improvement of all Title V programs. Therefore, this priority need is integrated into all aspects of strategic planning for all performance measures.

Field Name:

Priority Need 7

Field Note:
Coordination of care is a key component of medical home and effective transition to adulthood for CYSHCN. The focus of additional performance measures, including those related to adolescent and women's health support this priority need.

Form 10a
National Outcome Measures (NOMs)

State: Texas

Form Notes for Form 10a 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
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%, 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
2014	182.3	2.3 %	6,691	367,025
2013	177.3	2.3 %	6,293	355,021
2012	183.1	2.3 %	6,491	354,581
2011	181.7	2.3 %	6,442	354,507
2010	174.8	2.2 %	6,299	360,401
2009	171.5	2.2 %	6,410	373,740
2008	156.9	2.1 %	5,818	370,708

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
2011_2015	34.2	1.3 %	668	1,950,896
2010_2014	31.5	1.3 %	609	1,933,396
2009_2013	28.3	1.2 %	547	1,935,607
2008_2012	25.0	1.1 %	489	1,953,821
2007_2011	20.7	1.0 %	410	1,978,719
2006_2010	18.3	1.0 %	366	2,000,877

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 4.1 - 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
2015	8.3 %	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%, or >10% missing data and should be interpreted with caution

NOM 4.1 - Notes:

None

Data Alerts: None

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	1.4 %	0.0 %	5,683	403,460
2014	1.4 %	0.0 %	5,722	399,625
2013	1.4 %	0.0 %	5,322	387,204
2012	1.5 %	0.0 %	5,591	382,636
2011	1.4 %	0.0 %	5,340	377,333
2010	1.4 %	0.0 %	5,531	385,982
2009	1.5 %	0.0 %	5,906	401,831

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.2 - Notes:

None

Data Alerts: None

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	6.8 %	0.0 %	27,592	403,460
2014	6.8 %	0.0 %	27,022	399,625
2013	6.9 %	0.0 %	26,837	387,204
2012	6.8 %	0.0 %	26,016	382,636
2011	7.1 %	0.0 %	26,678	377,333
2010	7.0 %	0.0 %	26,955	385,982
2009	7.0 %	0.0 %	28,231	401,831

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.3 - Notes:

None

Data Alerts: None

NOM 5.1 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	10.2 %	0.1 %	41,019	403,443
2014	10.4 %	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%, or >10% missing data and should be interpreted with caution

NOM 5.1 - Notes:

None

Data Alerts: None

NOM 5.2 - Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	2.8 %	0.0 %	11,460	403,443
2014	2.9 %	0.0 %	11,575	399,607
2013	2.8 %	0.0 %	11,011	387,192
2012	3.0 %	0.0 %	11,300	382,584
2011	2.9 %	0.0 %	11,068	377,299
2010	3.0 %	0.0 %	11,432	385,985
2009	3.0 %	0.0 %	12,045	401,804

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.2 - Notes:

None

Data Alerts: None

NOM 5.3 - Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	7.3 %	0.0 %	29,559	403,443
2014	7.5 %	0.0 %	29,770	399,607
2013	7.6 %	0.0 %	29,329	387,192
2012	7.6 %	0.0 %	28,879	382,584
2011	7.8 %	0.0 %	29,310	377,299
2010	8.0 %	0.0 %	30,685	385,985
2009	8.1 %	0.0 %	32,469	401,804

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.3 - 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
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%, 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
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:

Indicator results were based on a shorter time period than required for reporting

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
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
2014	5.9	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	6.2	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
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
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
2014	186.4	6.8 %	745	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 - Sleep-related 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
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 - The percent of infants born with fetal alcohol exposure 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
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 has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	4.7	0.1 %	1,733	367,392
2013	4.1	0.1 %	1,445	355,257
2012	3.5	0.1 %	1,254	354,625
2011	3.2	0.1 %	1,135	354,539
2010	2.9	0.1 %	1,036	360,430
2009	2.6	0.1 %	960	373,764
2008	2.1	0.1 %	789	371,148

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)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

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 12 months

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	20.9 %	1.5 %	1,346,452	6,456,525

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% 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
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
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
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
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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.7 %	1.4 %	1,371,315	6,946,024
2007	17.4 %	1.5 %	1,141,616	6,579,611
2003	19.0 %	1.0 %	1,179,167	6,217,276

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% 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) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	17.8 %	1.7 %	151,633	852,029

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children 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
2011_2012	1.6 %	0.5 %	93,010	5,817,615
2007	1.3 %	0.6 %	72,442	5,430,930

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children 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
2011_2012	8.5 %	1.1 %	491,308	5,804,703
2007	4.5 %	0.9 %	243,967	5,426,374

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children 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
2011_2012	60.2 %	6.6 %	307,260	510,622
2007	42.2 %	8.2 %	147,616	350,191
2003	44.6 %	5.4 %	178,996	401,726

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children 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
2011_2012	82.0 %	1.4 %	5,697,388	6,945,902
2007	78.2 %	1.6 %	5,141,109	6,576,608
2003	77.2 %	1.1 %	4,797,216	6,213,401

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	36.6 %	2.8 %	1,020,599	2,787,964
2007	32.2 %	2.9 %	805,996	2,502,408
2003	32.4 %	1.9 %	765,505	2,364,143

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	30.4 %	0.1 %	93,535	307,498
2012	32.2 %	0.1 %	108,343	336,178
2010	34.3 %	0.1 %	123,931	361,823
2008	34.3 %	0.1 %	108,794	317,047

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	31.2 %	1.4 %	406,991	1,302,698
2011	31.6 %	1.3 %	404,132	1,280,539
2009	28.5 %	1.6 %	349,840	1,229,339
2007	30.8 %	1.2 %	342,773	1,114,648
2005	28.4 %	1.4 %	321,147	1,129,791

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	71.2 %	2.1 %	404,445	568,417
2014	64.0 %	2.6 %	359,406	561,796
2013	72.5 %	2.6 %	404,961	558,691
2012	64.8 %	2.1 %	371,810	573,708
2011	72.7 %	2.0 %	429,854	591,196
2010	58.6 %	2.3 %	350,074	597,183
2009	40.7 %	2.7 %	239,803	589,412

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children 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
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 95% confidence interval half-width/estimate > 0.6

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 (Female)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	60.1 %	2.6 %	582,248	968,632
2014	50.7 %	3.6 %	482,649	952,218
2013	56.2 %	3.8 %	520,870	926,326
2012	51.2 %	3.0 %	461,211	900,624
2011	48.8 %	3.4 %	433,840	888,332
2010	47.5 %	3.6 %	406,933	856,654
2009	37.6 %	3.4 %	323,271	859,178

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Teen (Male)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	41.4 %	2.4 %	417,227	1,008,515
2014	36.6 %	3.3 %	364,915	998,082
2013	34.1 %	3.3 %	331,387	971,014
2012	24.0 %	2.6 %	226,620	944,936
2011	10.4 %	1.7 %	96,967	933,425

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 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
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 half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 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
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 half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: Texas

NPM 1 - Percent of women with a past year preventive medical visit

Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	61.6
Annual Indicator	59.9
Numerator	3,003,165
Denominator	5,016,691
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	62.5	63.4	64.3	65.2	66.1	67.0

Field Level Notes for Form 10a NPMs:

None

NPM 4 - A) Percent of infants who are ever breastfed

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	79.1
Annual Indicator	81.9
Numerator	302,196
Denominator	368,965
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	82.7	83.4	84.1	84.8	85.5	86.2

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	17.8
Annual Indicator	21.0
Numerator	75,605
Denominator	360,397
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	22.4	23.8	25.2	26.6	28.0	29.4

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	67.9
Annual Indicator	66.0
Numerator	240,305
Denominator	364,373
Data Source	PRAMS
Data Source Year	2010

State Provided Data	
	2016
Annual Objective	67.9
Annual Indicator	69.4
Numerator	263,609
Denominator	379,932
Data Source	PRAMS
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	69.9	71.9	73.9	75.9	77.9	78.9

Field Level Notes for Form 10a 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.

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	30.4
Annual Indicator	30.4
Numerator	559,623
Denominator	1,839,623
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	32.2	34.4	36.6	38.8	40.0	41.2

Field Level Notes for Form 10a NPMs:

None

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Child Health)

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - CHILD	
	2016
Annual Objective	132
Annual Indicator	125.3
Numerator	4,981
Denominator	3,974,223
Data Source	SID-CHILD
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	122.0	117.0	112.0	107.0	102.0	97.0

Field Level Notes for Form 10a NPMs:

None

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Adolescent Health)

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - ADOLESCENT	
	2016
Annual Objective	219.3
Annual Indicator	194.7
Numerator	7,599
Denominator	3,902,181
Data Source	SID-ADOLESCENT
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	188.9	181.4	173.9	166.4	158.9	151.4

Field Level Notes for Form 10a NPMs:

None

NPM 11 - Percent of children with and without special health care needs having a medical home

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	55
Annual Indicator	53.9
Numerator	706,631
Denominator	1,310,061
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	55.0	55.2	55.4	55.6	55.8	56.0

Field Level Notes for Form 10a NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	37
Annual Indicator	35.4
Numerator	101,253
Denominator	286,298
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	37.0	37.2	37.4	37.6	37.8	38.0

Field Level Notes for Form 10a NPMs:

None

NPM 14 - A) Percent of women who smoke during pregnancy

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	4.3
Annual Indicator	3.6
Numerator	14,521
Denominator	403,518
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	3.5	3.3	3.2	3.0	2.9	2.7

Field Level Notes for Form 10a NPMs:

None

NPM 14 - B) Percent of children who live in households where someone smokes

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	21.8
Annual Indicator	21.9
Numerator	1,510,537
Denominator	6,900,294
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	21.3	20.8	20.3	19.8	19.3	18.8

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: Texas

SPM 1 - Percent of CYSHCN and their families who received the supports and services necessary to be integrated into their communities

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	37.5
Numerator	224
Denominator	598
Data Source	Annual CYSHCN Outreach Survey
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	37.5	38.0	38.5	39.0	39.5	40.0

Field Level Notes for Form 10a SPMs:

None

SPM 2 - Percent of Texas WIC participants, ages 2-5, in the overweight/obese range

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	28.5
Numerator	113,597
Denominator	398,359
Data Source	Texas WIC client data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	27.8	27.1	26.4	25.8	25.1	24.5

Field Level Notes for Form 10a 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%

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	2.2
Numerator	10.9
Denominator	4.9
Data Source	Texas natality and mortality data
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.1	2.1	2.1	2.0	2.0	2.0

Field Level Notes for Form 10a 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

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
Annual Objective	
Annual Indicator	49.2
Numerator	1,421,277
Denominator	2,888,775
Data Source	Texas Behavioral Risk Factor Surveillance System (
Data Source Year	2015
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	57.6	57.9	58.2	58.5	58.8	59.1

Field Level Notes for Form 10a 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.

Form 10a
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Texas

ESM 1.1 - Number of preconception health tools accessed from DSHS infant mortality reduction public awareness campaign website Someday Starts Now and the Health and Human Services (HHS) Warehouse

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	10,236
Numerator	
Denominator	
Data Source	Google Analytics and HHSC Warehouse
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	5,500.0	5,570.0	5,640.0	5,710.0	5,780.0	5,850.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.2 - Number of Texas Health Steps Online Provider Education (OPE) users completing preconception and prenatal health modules

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1,566
Numerator	
Denominator	
Data Source	Texas Health Steps Online Provider Education (OPE)
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	385.0	390.0	395.0	400.0	405.0	410.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.3 - Number of additional Historically Black Colleges and Universities (HBCUs) that implement the Preconception Peer Educators Program (PPE)

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	2
Numerator	
Denominator	
Data Source	UNTHSC Ft. Worth
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	2.0	2.0	2.0	1.0	0.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.4 - Establishment of support infrastructure for the Texas Collaborative for Healthy Mothers and Babies (TCHMB)

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	University of Texas System
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	No	No	No	No	No

Field Level Notes for Form 10a ESMs:

None

ESM 1.5 - Create joint report with the Maternal Mortality and Morbidity Task Force (MMMTF) to the Texas Legislature on findings and recommendations to prevent severe maternal morbidity and mortality in Texas

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	Texas DSHS
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	Yes	No	Yes	No	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 1.6 - Preconception health strategic plan developed

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	Yes	No	No	No	No

Field Level Notes for Form 10a ESMs:

None

ESM 1.7 - Texas Collaborative for Healthy Mothers and Babies (TCHMB) health and health care quality improvement projects conducted

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 1.8 - Texas Collaborative for Healthy Mothers and Babies (TCHMB) educational forum for health professionals held

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 1.9 - Communication of case reviews findings from maternal overdose deaths developed in partnership with the Maternal Mortality and Morbidity Task Force (MMMTF)

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	Yes	No	No	No	No

Field Level Notes for Form 10a ESMs:

None

ESM 4.1 - Breastfeeding support assessment findings available

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	Texas WIC Infant Feeding Practices Survey
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 4.2 - DSHS Infant Feeding Workgroup Strategic Plan available in 2017

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	DSHS Infant Feeding Workgroup
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	Yes	No	No	No	No

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
In development during 2016. Draft to be complete in 2017. Final release planned for 2018.

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
Annual Objective	
Annual Indicator	143
Numerator	
Denominator	
Data Source	DSHS Texas Ten Step Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	140.0	145.0	150.0	155.0	160.0	165.0

Field Level Notes for Form 10a ESMs:

None

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
Annual Objective	
Annual Indicator	458
Numerator	
Denominator	
Data Source	DSHS Mother Friendly Worksite Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	400.0	400.0	400.0	400.0	400.0	400.0

Field Level Notes for Form 10a ESMs:

None

ESM 4.5 - DSHS Infant Feeding Position Statement reviewed, revised and updated in FY2018

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	Yes	No	No	No	No

Field Level Notes for Form 10a ESMs:

None

ESM 5.1 - Interagency Safe Sleep Messaging Strategic Communication Plan available in 2017

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Safe Sleep Messaging Interagency Workgroup
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	Yes	No	No	No	No

Field Level Notes for Form 10a 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.

ESM 5.2 - Complete community assessments and infant mortality prevention strategic plans in Healthy Texas Babies (HTB) Coalition communities

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	Yes	Yes	No	No	No

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	6,429
Numerator	
Denominator	
Data Source	Texas Health Steps Online Provider Education (OPE)
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	6,750.0	7,087.0	7,441.0	7,831.0	8,222.0	8,633.0

Field Level Notes for Form 10a ESMs:

None

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
Annual Objective	
Annual Indicator	27
Numerator	
Denominator	
Data Source	Project LAUNCH
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	300.0	100.0	73.0	0.0	0.0	0.0

Field Level Notes for Form 10a ESMs:

None

ESM 7.1 - Number of Texas Health Steps Online Provider Education (OPE) users completing injury prevention modules.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	12,279
Numerator	
Denominator	
Data Source	Texas Health Steps Online Provider Education (OPE)
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	12,893.0	13,538.0	14,215.0	14,926.0	15,672.0	16,456.0

Field Level Notes for Form 10a ESMs:

None

ESM 7.2 - 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
Annual Objective	
Annual Indicator	40
Numerator	
Denominator	
Data Source	DSHS School Health Program Gov Delivery
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	25.0	25.0	25.0	25.0	25.0	25.0

Field Level Notes for Form 10a ESMs:

None

ESM 7.3 - Lead a statewide comprehensive injury prevention conference.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Texas DSHS
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	No	No	No	No	No

Field Level Notes for Form 10a ESMs:

None

ESM 7.4 - Train Child Fatality Review (CFR) teams on injury prevention

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Texas DSHS
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	No	Yes	No	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 7.5 - Percent of child deaths reviewed by Child Fatality Review Teams (CFRT)

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Child Fatality Review Teams and Vital Statistics
Data Source Year	2014
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	37.0	37.5	38.0	38.5	39.0	39.5

Field Level Notes for Form 10a 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.

ESM 7.6 - Percent of youth reporting connection to at least one caring adult

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	YRBSS
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	68.0	70.0	70.0	70.2	70.2	70.5

Field Level Notes for Form 10a 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.

ESM 11.1 - Percent of families receiving professional care coordination for their child

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	35.7
Numerator	218
Denominator	610
Data Source	Texas 2016 CSHCN SP Outreach Survey
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	37.5	38.0	38.5	39.0	39.5	40.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.2 - Percent of physicians demonstrating knowledge of medical home characteristics

Measure Status:	Inactive - Replaced

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	16.0	17.0	18.0	19.0	20.0	

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
A survey for providers which included medical home topics was developed and distributed during FY16. A low response rate led to reformatting and disseminating two separate surveys. Due to this low response rate, this ESM has been revised to use another data source and measure to assess knowledge of medical home characteristics.

ESM 11.3 - Distribution of Medical Home and Transition Physician Surveys

Measure Status:	Inactive - Replaced

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
A survey for providers which included medical home and transition topics was developed and distributed during FY16. A low response rate led to reformatting and disseminating as two separate surveys. Due to this low response rate, this ESM has been revised to allow TVMCH to meet with partners and formulate strategic goals to increase the number of physicians and other providers engaged in TVMCH activities for CYSHCN. Increased engagement will improve needs assessment response rates and increase TVMCH's reach to providers across the state.

ESM 11.4 - Percent increase in medical home provider education

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4.0	8.0	12.0	16.0	20.0	24.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.5 - Meet with clinical champions for provider engagement

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	Yes	No	No	No	No

Field Level Notes for Form 10a ESMs:

None

ESM 11.6 - Create a provider engagement strategic plan

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	No	No	Yes	No	No

Field Level Notes for Form 10a 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
Annual Objective	
Annual Indicator	19.8
Numerator	46
Denominator	232
Data Source	Texas 2016 CSHCN Outreach Survey
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	19.5	20.0	20.5	21.0	21.5	22.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.2 - Percent of physicians demonstrating knowledge of the transition from pediatric to adult health care

Measure Status:	Inactive - Replaced

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	21.0	22.0	23.0	24.0	25.0	

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
A survey for providers which included health care transition and medical home topics was developed and distributed during FY16. A low response rate led to reformatting and disseminating two separate surveys. Due to this low response rate, this ESM has been revised to use another data source and measure to assess provider education on health care transition best practices.

ESM 12.3 - Distribution of CYSHCN Outreach Survey

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	DSHS CSHCN Systems Development Group
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 12.4 - Percent increase in transition provider education

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	4.0	6.0	8.0	10.0	12.0

Field Level Notes for Form 10a ESMs:

None

ESM 14.1 - Number of health care service providers who adopt an electronic medical record (EMR) interface to electronically refer caregivers who smoke to the Texas Tobacco Quitline

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Data Not Available
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	500.0	600.0	5,000.0	5,500.0	6,000.0	6,500.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2016**

Column Name: **State Provided Data**

Field Note:
This activity began in FY17 and no data is available for FY16. Data from FY17 pilot test sites will be available for FY18 block grant application.

Form 10b
State Performance Measure (SPM) Detail Sheets

State: Texas

SPM 1 - Percent of CYSHCN and their families who received the supports and services necessary to be integrated into their communities
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To improve awareness and utilization of resources, including respite, by CYSHCN and their families, to promote community integration.
Definition:	**Numerator:** Number of CYSHCN families surveyed indicating awareness of and utilization of family supports and community resources. **Denominator:** Total number of CYSHCN families surveyed per state fiscal year **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	This SPM is related to several HP2020 objectives: DH-9(Developmental) Reduce the proportion of people with disabilities who encounter barriers to participating in home, school, work, or community activities DH-10(Developmental) Reduce the proportion of people with disabilities who report barriers to obtaining the assistive devices, service animals, technology services, and accessible technologies that they need DH-12.2 Reduce the number of children and youth with disabilities aged 21 years and under living in congregate care residences DH-13(Developmental) Increase the proportion of people with disabilities who participate in social, spiritual, recreational, community and civic activities to the degree that they wish DH-17 Increase the proportion of adults with disabilities who report sufficient social and emotional support DH-20 Increase the proportion of children with disabilities, birth through age 2 years, who receive early intervention services in home or community-based settings
Data Sources and Data Issues:	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 Title V and community-based contractors in both English and Spanish formats. The survey will be promoted through email communication, newsletters and webpages. Baseline data will be obtained during FY16. Data Issues: Challenges associated with surveying a convenience sample of youth and families include the potential to underrepresent subsets of CYSHCN families in Texas according to geographical location, language spoken, and race/ethnicity. Title V 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.
Significance:	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. 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 integration. The CYSHCN Outreach Survey identified 52% of Texas parents indicated the need for respite. Only 34% of families surveyed received the needed support. Barriers included lack of knowledge about respite 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 integration 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 Texas WIC participants, ages 2-5, in the overweight/obese range
Population Domain(s) – Cross-Cutting/Life Course

Measure Status:	Active
Goal:	To reduce the prevalence of overweight and obesity in Texas.
Definition:	**Numerator:** Number of Texas WIC participants, ages 2-5, with a body mass at or above the 85th percentile (in the overweight/obese range) in a specific calendar year **Denominator:** Total number of Texas WIC participants, ages 2-5, in a specific calendar year **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Associated HP2020 objective: Reduce the proportion of children aged 2 to 5 years who are considered obese (NWS-10.1)
Data Sources and Data Issues:	Data Source: Texas WIC client data As secondary analyses, we also plan to calculate several other measures of overweight/obesity for both adults and children, using other data sources. Results for these additional measures will be provided in the Notes section in future years, as available. Additional measures include: a) the percent of infants born to mothers with pre-pregnancy BMI in the overweight/obese range (using state birth file data); b) the percent of Texas children with a BMI in the overweight/obese range (using Texas SPAN survey data); c) the percent of Texas adolescents with a BMI in the overweight/obese range (using YRBSS data); and d) the percent of Texas adults with a BMI in the overweight/obese range (using BRFSS data). Data Issues: WIC client data are only available for those children ages 2-5 who participate in WIC. Approximately 26% of all children in Texas in this age group are WIC participants. Results may not be generalizable to children ages 2-5 who are not served by WIC.
Significance:	Obesity and chronic diseases that are associated with obesity are top health concerns within the state. Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer, some of the leading causes of preventable death. The estimated annual medical cost of obesity in the U.S. was $147 billion in 2008 U.S. dollars; the medical costs for people who are obese were $1,429 higher than those of normal weight. Among non-Hispanic black and Mexican-American men, those with higher incomes are more likely to have obesity than those with low income. Higher income women are less likely to have obesity than low-income women. Among the parents who responded to the Title V community outreach survey, 54.0 percent chose obesity as a top health concern and 39.9 percent chose chronic disease. Additionally, 40.5 percent chose lack of exercise and physical activity as a top five health concern in their community. Among the Title V Focus Groups, all groups listed obesity as a top health concern and cited its links to heart disease, diabetes, and hypertension. There is wide awareness about the negative health effects of obesity on health in the state.

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:	**Numerator:** Rate of Black infant mortality among Texas residents in a specific calendar year. **Denominator:** Rate of White infant mortality among Texas residents in a specific calendar year. **Unit Type:** Ratio **Unit Number:** 1
Healthy People 2020 Objective:	Related to MICH-1.3 Reduce the rate of all infant deaths (within 1 year) (Baseline: 6.7 infant deaths per 1,000 live births occurred within the first year of life in 2006, Target: 6.0 infant deaths per 1,000 live births) Related to MICH-1.1 Reduce the rate of fetal deaths at 20 or more weeks of gestation (Baseline: 6.2 fetal deaths at 20 or more weeks of gestation per 1,000 live births and fetal deaths occurred in 2005, Target: 5.6 fetal deaths per 1,000 live births and fetal deaths)
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 - Percent of young adults (ages 18-24) who visited a doctor for a routine checkup in the past year
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	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.
Definition:	**Numerator:** 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 **Denominator:** Total number of young adults ages 18-24 in Texas during a specific calendar year **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Associated HP2020 objective: Increase the proportion of adolescents who have had a wellness checkup in the past 12 months (AH-1)
Data Sources and Data Issues:	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.
Significance:	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.

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: Texas

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Texas

ESM 1.1 - Number of preconception health tools accessed from DSHS infant mortality reduction public awareness campaign website Someday Starts Now and the Health and Human Services (HHS) Warehouse
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Active
Goal:	To increase the public's knowledge of and self-efficacy in practicing preventive health behaviors that will improve their preconception health and prevent or reduce health risks in future pregnancies.
Definition:	**Numerator:** Total number of preconception health tools downloaded from the DSHS Someday Starts Now public awareness campaign website or ordered from the HHS warehouse per state fiscal year **Denominator:** N/A **Unit Type:** Count **Unit Number:** 30,000
Data Sources and Data Issues:	Data Source: Someday Starts Now DSHS website and public awareness campaign. The public awareness campaign Someday Starts Now (SomedayStartsNow.com/ AlgunDiaEmpiezaAhora.com) provides educational information, tools, outreach activities and additional content in both English and Spanish to enhance public awareness of the impact of preconception health, maternal health, and infant health behaviors on birth and infant health outcomes. The site also features tools intended to augment patient health literacy and open the lines of communication between provider and patient about the role of preconception planning in assurance of healthy birth outcomes. Formative research on appropriate media and target audiences was conducted through two separate contracts to inform the public awareness campaign. The site's aesthetics were developed after extensive testing and formative research on the key demographic most negatively impacted by infant mortality–African-American women and men 18-44 years old. Website tools include a Life Planning Tool, a My Health Priorities Worksheet, and Women's Wellness Health Tips. Materials can be downloaded and ordered for free from the Someday Starts Now website and the HHS warehouse. Data Issues: Someday Starts Now is a public website with accessible content for various audiences including men, women, health care providers, and stakeholders working in the community on health promotion. It is not possible to determine the demographics of the population downloading materials on the website, nor of those ordering materials from the warehouse. Nonetheless, the tool was developed for use by women of childbearing age to promote the key tenets of preconception health, including pregnancy intendedness, healthy diet and exercise, avoidance of tobacco, and promotion of dental and well woman checkups, among other things. The intent and target population of the tool remain the same regardless of who downloads/orders the tool.

Significance:	Preconception health refers to the health of women during their reproductive years. Optimal health during these years is essential to improve health outcomes, and preconception health care has been recognized as a critical component of a comprehensive health package to improve pregnancy- and birth-related outcomes as well as women's health overall. The preconception/inter-conception period is an opportunity to provide risk assessment, management and counseling on positive health behaviors to improve the mother's health and reduce risks in future pregnancies. Educating women on leading a healthy lifestyle and encouraging them to seek preventive care where they can receive risk assessment and management of conditions as needed is critical to improving health outcomes of current and future generations.

ESM 1.2 - Number of Texas Health Steps Online Provider Education (OPE) users completing preconception and prenatal health modules
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Active
Goal:	To increase the number of health care providers and other health professionals accessing education on providing quality preventative care (preconception care) to women of childbearing age.
Definition:	**Numerator:** Total number of unduplicated users completing one or more Texas Health Steps Online Provider Education (OPE) Preconception and Prenatal Care Health modules per year **Denominator:** N/A **Unit Type:** Count **Unit Number:** 5,000
Data Sources and Data Issues:	Data Source: Texas Health Steps OPE The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is Medicaid's comprehensive preventive child health service (medical, dental, and case management) for individuals from birth through 20 years of age. In Texas, EPSDT is known as Texas Health Steps, which includes preventive care components. Texas Health Steps OPE offers free continuing education courses for primary care providers and other health professionals (www.txhealthsteps.com). These courses offer updated clinical, regulatory, and best practice guidelines for a range of preventive health, oral health, mental health, and case management topics. In 2015, OPE launched five modules focused on different components of preconception and prenatal health, with the goal of equipping providers and other health care professionals to improve the preconception and prenatal health of Texas women. The target audience for these modules are primary care providers and other health professionals who treat adolescent and adult female patients who may become pregnant again or for the first time. Completion of any one of the following four OPE modules will be assessed for this measure (the fifth module has greater relevance to prenatal care): 1. Preconception and Prenatal Health: Overview 2. Preconception and Prenatal Health: Managing Chronic Health Issues Before and During Pregnancy 3. Preconception and Prenatal Health: Identifying and Intervening in High-Risk Behaviors 4. Preconception and Prenatal Health: Promoting and Maintaining Women's Oral Health Data Issues: Texas Health Steps OPE modules offered may be subject to change, which could impact analysis of trends over time.
Significance:	Optimal health during the reproductive years is essential to improve health outcomes, and preconception health care has been recognized as a critical component of a comprehensive health package to improve pregnancy- and birth-related outcomes as well as women's health overall. The preconception/inter-conception period is an opportunity to provide risk

assessment, management and counseling on positive health behaviors to improve the mother's health and reduce risks in future pregnancies. Educating women on leading a healthy lifestyle and encouraging them to seek preventive care where they can receive risk assessment and management of conditions as needed is critical to improving health outcomes of current and future generations. This measure will look at the number of individuals who viewed preconception health-related OPE modules that will give them knowledge and tools to assess and mitigate risks prior to pregnancy.

ESM 1.3 - Number of additional Historically Black Colleges and Universities (HBCUs) that implement the Preconception Peer Educators Program (PPE)
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Active
Goal:	To increase knowledge and self-efficacy on preconception health and health care among African American college-age students.
Definition:	**Numerator:** Total number of HBCUs to establish a new PPE program on their campus per state fiscal year. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Data Source: University of North Texas Health Science Center (UNTHSC) PPE is a national OMH initiative to reduce infant mortality in the African American community. Young men and women at HBCUs are trained on a peer educator model to educate their peers and members of their community on the importance of preconception health behaviors and seeking regular preventive care, having a reproductive life plan, and the impact of social determinants of health on their wellbeing. MCHS, in partnership with the University of North Texas Health Science Center (UNTHSC), will engage Texas HBCUs and other interested organizations through a strategic implementation plan of the PPE program. A community readiness assessment will be conducted by students on their respective campuses to ensure programs are implemented in ways that best serve the needs of individual HBCU, and a student advisory council will be created to secure student engagement in the decision-making processes associated with the program. DSHS will collaborate closely with UNTHSC to conduct peer educator trainings and establish the program infrastructure at HBCUs in the state.
Significance:	Optimal health during the reproductive years is essential to improve health outcomes, and preconception health care has been recognized as a critical component of a comprehensive health package to improve pregnancy- and birth-related outcomes as well as women's health overall. The preconception/inter-conception period is an opportunity to provide risk assessment, management and counseling on positive health behaviors to improve the mother's health and reduce risks in future pregnancies. Educating women on leading a healthy lifestyle and encouraging them to seek preventive care where they can receive risk assessment and management of conditions as needed is critical to improving health outcomes of current and future generations. This measure will look at the number of HBCUs that establish the PPE program on their campuses, exposing young adults to preconception health concepts and encouraging adoption of positive health behaviors that may translate to increased rates of pregnancy intendedness and improved pregnancy and birth outcomes in future pregnancies.

ESM 1.4 - Establishment of support infrastructure for the Texas Collaborative for Healthy Mothers and Babies (TCHMB)
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Active
Goal:	To support development of infrastructure for the Texas Collaborative for Healthy Mothers and Babies as the state perinatal quality collaborative.
Definition:	

Numerator:	Yes: Development and implementation of strategic plan, bylaws, governance structure, website, pilot projects, and an annual meeting have occured in 2017 No: These development activities have not occurred in 2017
Denominator:	N/A
Unit Type:	Text
Unit Number:	Yes/No

Data Sources and Data Issues:	Data Source: Texas Collaborative for Healthy Mothers and Babies (TCHMB) TCHMB emerged in 2013 as a core component of Healthy Texas Babies, Texas DSHS' comprehensive infant mortality reduction initiative. TCHMB's mission is to advance health care quality and patient safety for all Texas mothers and babies through the collaboration of health and community stakeholders in the development of joint quality improvement (QI) initiatives, the advancement of data-driven best practices, and the promotion of education and training. TCHMB is composed of three standing committees focused on promoting education and best practices related to: obstetrics, neonatal, and community health. In FY16, DSHS established a partnership with the University of Texas System (UT) through its Population Health Initiative to provide administrative and support services for TCHMB. DSHS will work closely with UT in development of infrastructure-building activities for TCHMB as the state perinatal quality collaborative.
Significance:	Optimal health during the reproductive years is essential to improve health outcomes, and preconception health care has been recognized as a critical component of a comprehensive health package to improve pregnancy- and birth-related outcomes as well as women's health overall. The preconception/inter-conception period is an opportunity to provide risk assessment, management and counseling on positive health behaviors to improve the mother's health and reduce risks in future pregnancies. Educating women on leading a healthy lifestyle and encouraging them to seek preventive care where they can receive risk assessment and management of conditions as needed is critical to improving health outcomes of current and future generations. Educating and supporting providers on best practices and evidence-based tools will improve the quality of care for women, children and families.

ESM 1.5 - Create joint report with the Maternal Mortality and Morbidity Task Force (MMMTF) to the Texas Legislature on findings and recommendations to prevent severe maternal morbidity and mortality in Texas
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Active
Goal:	To support the MMMTF in development and dissemination of its findings and recommendations, to improve the quality of care for mothers and to ultimately improve pregnancy and birth outcomes.
Definition:	

Numerator:	Yes: A report is produced for the Texas Legislature on severe maternal morbidity and mortality findings and potential areas for prevention in Texas No: No maternal morbidity and mortality report is produced for the Texas Legislature
Denominator:	N/A
Unit Type:	Text
Unit Number:	Yes/No

Data Sources and Data Issues:	Data source: MMMTF task force data The MMMTF is a legislatively mandated multidisciplinary advisory committee charged with identifying causes of maternal mortality and making recommendations to reduce severe maternal morbidity and prevent maternal death. In conducting its work, the task force ensures that all aspects of women's care and associated factors - including health disparities, clinical, and psychosocial matters - are represented and considered. To improve women's and maternal health safety programming, MCHS supports the MMMTF in its analysis of maternal death cases and severe maternal morbidity trends in Texas, as well as in the development of a report to the state legislature stating findings and recommendations to prevent adverse health outcomes. The maternal morbidity and mortality report to the Texas Legislature is produced once every other year, so reports will be written and submitted to the Legislature in 2018 and 2020.
Significance:	Optimal health during the reproductive years is essential to improve health outcomes, and preconception health care has been recognized as a critical component of a comprehensive health package to improve pregnancy- and birth-related outcomes, as well as women's health overall. The preconception/interconception period is an opportunity to provide risk assessment, management, and counseling on positive health behaviors to improve the mother's health and reduce risks in future pregnancies. Educating and supporting providers on best practices and evidence-based tools will improve the quality of care for women, children and families. MCHS' work with stakeholders across the state to perform severe maternal morbidity and mortality review will support development and uptake of recommendations to improve women's and maternal care practices that reduce risk and prevent maternal and feto-infant harm.

ESM 1.6 - Preconception health strategic plan developed
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Active
Goal:	To improve preconception health in Texas by increasing coordination, synergy and collective impact of efforts around preconception and interconception health and health care, and ensure efforts are aligned with the latest evidence-based research.
Definition:	

Numerator:	Yes: a preconception strategic action plan is developed, reviewed and approved by DSHS leadership in FY2018. No: a strategic plan is not developed in FY2018.
Denominator:	N/A
Unit Type:	Text
Unit Number:	Yes/No

Data Sources and Data Issues:

Data Source:
MCHS subject matter experts will work during the Summer of 2017 with a two-person intern team placed at DSHS through the National MCH Workforce Development Center Title V MCH Internship Program to conduct a gap analysis to learn about opportunities and barriers within DSHS' direct sphere of influence for improving PCHHC. This gap analysis will include literature review, as well as communication and information collection through interviews, listening sessions, and/or focus groups with an array of DSHS public health partners. This work will assist DSHS in focusing strategic planning efforts and will inform development of a state action plan for improving PCHHC during FY2018.

By contributing to a larger landscape assessment for PCHHC in Texas, this work will support Strategy 1 for National Priority Measure 1, focused on assessing the landscape for support of preconception health initiatives throughout the state and to partner with public and private organizations, coalitions, clinicians, health plans, family advocates and other stakeholders to increase capacity, synergy and collective impact of initiatives to improve women's health and health care delivery. This strategy also serves to address the State Priority Need to provide support to promote quality in primary care, women's health, and specialty services.

Data Issues: none anticipated

Significance:

Optimizing health during the reproductive years reduces risk for poor health, pregnancy, and birth outcomes in the future. Preconception health care is recognized as a critical component of a comprehensive health package to improve pregnancy- and birth-related outcomes as well as women's health overall. The preconception/interconception periods are an opportunity to provide risk assessment, management and counseling on positive health behaviors to improve the woman's health and reduce risks in future pregnancies. Educating women on health promotion activities and leading a healthy lifestyle and encouraging them to seek preventive care where they can receive risk assessment, early diagnoses, prompt treatment, and ongoing management of conditions as needed, are critical components for improving health outcomes of current and future generations. Educating and supporting providers on best practices and evidence-based tools will improve the quality of care for women, children and families. A strategic plan will be developed to provide a roadmap for action to improve women's health with a focus on the preconception/interconception periods.

ESM 1.7 - Texas Collaborative for Healthy Mothers and Babies (TCHMB) health and health care quality improvement projects conducted

NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Active
Goal:	To improve the quality of maternal and women's health and health care by supporting TCHMB quality improvement projects.
Definition:	

Numerator:	Yes: 4 or more research and quality improvement projects conducted by TCHMB annually. No: Less than 4 research and quality improvement projects conducted by TCHMB annually.
Denominator:	N/A
Unit Type:	Text
Unit Number:	Yes/No

Data Sources and Data Issues:	Data Source: TCHMB Monthly and Annual Reports TCHMB emerged in 2013 as a core component of Healthy Texas Babies, Texas DSHS' comprehensive infant mortality reduction initiative. TCHMB's mission is to advance health care quality and patient safety for all Texas mothers and babies through the collaboration of health and community stakeholders in the development of joint research and quality improvement (QI) projects and initiatives, the advancement of data-driven best practices, and the promotion of education and training. Research and quality improvement projects are categorized as: • Type I Projects: literature reviews, secondary analysis of administrative or survey data, needs assessments, gap analysis, or resource analysis; • Type II Projects: QI projects or evaluations of specific TCHMB subcommittee projects; • Type III Projects: products that represent a view or position taken by or endorsed by the TCHMB, which may include toolkits, educational materials, editorial, or position statements. TCHMB is composed of an Executive Committee, which provides leadership, governance, oversight, and support for the overall collaborative, and four standing committees focused on promoting education and best practices related to: obstetrics, neonatal, community health, and data. In FY2016, DSHS established a partnership with the University of Texas System (UT) through its Population Health Initiative to provide administrative and support services for TCHMB. DSHS will work closely with UT in development of infrastructure-building activities for TCHMB as the state perinatal quality collaborative. The TCHMB Monthly and Annual Reports submitted by UT will be used to confirm the number of new research and quality improvement projects initiated by the TCHMB committees. Data Issues: None anticipated
Significance:	Optimizing health during the reproductive years reduces risk for poor health, pregnancy, and birth outcomes in the future. Preconception health care is recognized as a critical component of a comprehensive health package to improve pregnancy- and birth-related outcomes as well as women's health overall. The preconception/interconception periods are an opportunity to provide risk assessment, early detection, treatment and management and counseling on positive health behaviors to improve the woman's health and reduce risks in future pregnancies. Educating and supporting providers on best practices and evidence-based tools will improve the quality of care for women, children and families. TCHMB projects will be implemented to support improvements in health and health care services for mothers and women of childbearing age.

ESM 1.8 - Texas Collaborative for Healthy Mothers and Babies (TCHMB) educational forum for health professionals held
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Active
Goal:	To improve the quality of maternal and women's health care by holding an annual educational forum for health- and health care professionals to advance evidence-based women's and perinatal health efforts around the state.
Definition:	**Numerator:** Yes: At least one educational forum is held by TCHMB annually. No: No TCHMB educational forum is held annually. **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Data Source: TCHMB Monthly and Annual Reports TCHMB emerged in 2013 as a core component of Healthy Texas Babies, Texas DSHS' comprehensive infant mortality reduction initiative. TCHMB's mission is to advance health care quality and patient safety for all Texas mothers and babies through the collaboration of health and community stakeholders in the development of joint quality improvement (QI) initiatives, the advancement of data-driven best practices, and the promotion of education and training. TCHMB is composed of four standing committees focused on promoting education and best practices related to: obstetrics, neonatal health, community health, and data. In FY16, DSHS established a partnership with the University of Texas System (UT) through its Population Health Initiative to provide administrative and support services for TCHMB. DSHS will work closely with UT in development of infrastructure-building activities for TCHMB as the state perinatal quality collaborative. The TCHMB Monthly and Annual Reports submitted by UT will be used to confirm that TCHMB held one or more educational forum(s) each fiscal year throughout the block grant cycle. Data Issues: None anticipated
Significance:	Optimizing health during the reproductive years reduces risk for poor health, pregnancy, and birth outcomes in the future. Preconception health care is recognized as a critical component of a comprehensive health package to improve pregnancy- and birth-related outcomes as well as women's health overall. The preconception/interconception periods are an opportunity to provide risk assessment, management and counseling on positive health behaviors to improve the woman's health and reduce risks in future pregnancies. Educating and supporting providers on best practices and evidence-based tools will improve the quality of care for women, children and families. An educational forum will be held by TCHMB each year for TCHMB members and other relevant stakeholders to strengthen the capacity of health professionals to address issues relevant for women of childbearing age.

ESM 1.9 - Communication of case reviews findings from maternal overdose deaths developed in partnership with the Maternal Mortality and Morbidity Task Force (MMMTF)
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Active
Goal:	To support the dissemination of findings related to maternal mortality resulting from overdose of licit or illicit substances to raise awareness among practitioners, consumers, and other stakeholders and to identify opportunities for prevention.
Definition:	

Numerator:	Yes: Communication of findings from maternal overdose deaths developed in FY2018. No: Communication of findings from maternal overdose deaths not developed in FY2018.
Denominator:	N/A
Unit Type:	Text
Unit Number:	Yes/No

Data Sources and Data Issues:	Data Source: MMMTF The MMMTF is a legislatively mandated multidisciplinary advisory committee charged with identifying causes of maternal mortality and making recommendations to reduce severe maternal morbidity and prevent maternal death. In conducting its work, the task force ensures all aspects of women's care and associated factors—including health disparities, clinical and psychosocial matters—are represented and considered. To improve women's and maternal health safety programming, MCHS supports the MMMTF in its analysis of maternal death cases and severe maternal morbidity trends in Texas, and in development of a biennial report to the state legislature stating finding and recommendations to prevent adverse health outcomes. The MMMTF has reviewed all 2012 maternal deaths that were associated with overdose. These reviews will provide the basis for the task force to identify and compile findings, themes, and recommendations for prevention and public health- and health care improvements to address this type of death. The task force will develop a communication to disseminate findings related to maternal mortality resulting from overdose of licit or illicit substances to raise awareness among practitioners, consumers, and other stakeholders and to inspire action. The format and dissemination methods for the communication will be determined by the task force. A Joint Report to the Texas Legislature is produced biennially by the MMMTF and DSHS. Information used to develop the communication of case reviews findings from maternal overdose deaths will also be incorporated into the Joint Biennial Report submitted to the Legislature in FY2019. Data issues: None anticipated
Significance:	Prescription drug use is rising in the United States and can lead to use of illegal opioids. In Texas, overdose by ingestion of drugs was the second leading cause (11.6 percent; source: CHS Death File) of maternal death during 2011-2012.

Optimizing health during the reproductive years reduces risk for poor health, pregnancy, and birth outcomes in the future. Preconception, prenatal and postpartum health care are recognized as critical components of a comprehensive health package to improve pregnancy- and birth-related outcomes as well as women's health overall. The preconception, prenatal, postpartum and interconception periods are opportunities to provide risk assessment, treatment, management and counseling on positive health behaviors to improve the woman's health before and during pregnancy while reducing risks for the postpartum period and for future pregnancies. Educating women on health promotion activities and leading a healthy lifestyle, and encouraging them to seek preventive care where they can receive risk assessment, early diagnoses, prompt treatment, and ongoing management of conditions as needed, are critical components for improving health outcomes of current and future generations.

Educating and supporting providers on evidence-based tools for screening for substance use disorder and best practices for treatment before conception, as well as during pregnancy and in the postpartum period, will improve the quality of care for women, children and families.

MCHS' work with stakeholders across the state will include examination of the impact of social determinants of health in these cases, which will support development and uptake of recommendations to improve women's and maternal care practices that reduce risk for overdose and prevent maternal and feto-infant harm.

ESM 4.1 - Breastfeeding support assessment findings available
NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase availability of data to inform public health strategies for breastfeeding support.
Definition:	

Numerator:	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
Denominator:	N/A
Unit Type:	Text
Unit Number:	Yes/No

Data Sources and Data Issues:	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.
Significance:	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.

ESM 4.2 - DSHS Infant Feeding Workgroup Strategic Plan available in 2017
NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To establish a strategic direction and plan of action for allocation of efforts and resources to increase breastfeeding support.
Definition:	**Numerator:** Yes: A DSHS Infant Feeding Workgroup Strategic Plan to Support Breastfeeding—including goals, SMART objectives, and a five-year action plan – is developed, reviewed, and approved by DSHS leadership in FY17. No: A DSHS Infant Feeding Workgroup strate **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
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 data-informed strategic plan will build upon successes of the previous 5-year plan and provide a roadmap for action and measurement to maximize improvement on infant feeding outcomes. 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, >900 excess child deaths in the United States per year, and an estimated annual loss in the U.S. of >$31 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).

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 and 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:	**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:** N/A **Unit Type:** Count **Unit Number:** 500
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).

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 and 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:	

Numerator:	Number of Texas employers receiving information and technical assistance annually through the Texas Mother-Friendly Worksite Technical Assistance and Support Program
Denominator:	N/A
Unit Type:	Count
Unit Number:	1,000

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.

ESM 4.5 - DSHS Infant Feeding Position Statement reviewed, revised and updated in FY2018
NPM 4 – A) Percent of infants who are ever breastfed and 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:	

Numerator:	Yes: The DSHS Position Statement on Infant Feeding is reviewed and updated in FY2018 No: The DSHS Position Statement on Infant Feeding is not reviewed and updated in FY2018
Denominator:	N/A
Unit Type:	Text
Unit Number:	Yes/No

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.

ESM 5.1 - Interagency Safe Sleep Messaging Strategic Communication Plan available in 2017
NPM 5 – Percent of infants placed to sleep on their backs

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:	

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:	N/A
Unit Type:	Text
Unit Number:	Yes/No

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.

ESM 5.2 - Complete community assessments and infant mortality prevention strategic plans in Healthy Texas Babies (HTB) Coalition communities
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Active
Goal:	To complete community assessments and infant mortality prevention strategic plans in HTB Coalition communities with excess sleep-related infant deaths.
Definition:	**Numerator:** 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 **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Data Source: HTB Evaluation Reports HTB currently supports four (4) Community Coalitions (HTB-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 HTB Technical Assistance Contractor (HTB-TAC) in early FY18 to support HTB-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 HTB-TAC will support each HTB-CC in developing a strategic plan to address excess feto-infant mortality. The 4 currently contracted HTB-CCs are expected to draft assessments and plans in FY2018. The additional 4 HTB-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.
Significance:	Disparities in feto-infant mortality persist across the state. HTB-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 HTB-CCs, and organizations to be recruited for development of additional HTB-CCs, are based within 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 HTB-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 HTB-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 the HTB CCs for optimal coordination, synergy, collaboration and impact.

ESM 6.1 - Number of Texas Health Steps Online Provider Education (OPE) users completing developmental screening modules
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Measure Status:	Active
Goal:	To increase the number of providers accessing education on early childhood developmental screening guidelines.
Definition:	

Numerator:	Number of individual users completing one or more Texas Health Steps Online Provider Education (OPE) developmental screening modules per year
Denominator:	N/A
Unit Type:	Count
Unit Number:	10,000

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 and ASD: Diagnosis and Management 2. Developmental Surveillance and Screening 3. Newborn Hearing Screening 4. Newborn Screening 5. 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:	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 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 additional individuals trained in early childhood developmental screening and referral in the Texas LAUNCH communities
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Measure Status:	Active
Goal:	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.
Definition:	**Numerator:** 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. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 3,000
Data Sources and Data Issues:	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.
Significance:	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.

ESM 7.1 - Number of Texas Health Steps Online Provider Education (OPE) users completing injury prevention modules.
NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 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:	

Numerator:	Number of individual users completing one or more Texas Health Steps Online Provider Education (OPE) injury prevention modules per year
Denominator:	N/A
Unit Type:	Count
Unit Number:	50,000

Data Sources and Data Issues:

Data Source: DSHS Texas Health Steps Online Provider Education (OPE) website data
Texas Health Steps OPE module data will be utilized to measure providers trainings on injury prevention. 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 injury prevention modules will be assessed for this measure:
1. Adolescent Health Screening
2. Adolescent Substance Use
3. Childhood Trauma and Toxic Stress
4. Identifying and Treating Young People with High-Risk Behaviors
5. Interpersonal Youth Violence
6. Pediatric Head Injury: Abusive Head Trauma
7. Pediatric Head Injury: Concussion
8. Pediatric Head Injury: Overview
9. Preventing Unintentional Injury: 13 to 18 Years
10. Preventing Unintentional Injury: 5 to 12 Years
11. Preventing Unintentional Injury: Birth to 4 Years
12. Preventing Unintentional Injury: Overview

Data Issues:
Texas Health Steps 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 childhood unintentional 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. In order 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 the risk. This measure will examine the number of individuals who completed injury prevention-related OPE modules.

ESM 7.2 - Number of School Health Friday Beat newsletters per fiscal year with at least one injury prevention resource provided
NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

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:	**Numerator:** Number of School Health Friday Beat bi-weekly newsletter issues per year that include at least one injury prevention resource. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 40
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 7.3 - Lead a statewide comprehensive injury prevention conference.
NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Measure Status:	Active
Goal:	To lead a Texas injury prevention conference in the spring of 2017 to convene partners from around the state to educate, inform, build, and discuss injury prevention best practices, data, partnerships, and intervention strategies.
Definition:	

Numerator:	Yes: MCHS led a statewide injury prevention conference in the spring of 2017. No: MCHS did not lead an injury prevention conference in the spring of 2017.
Denominator:	N/A
Unit Type:	Text
Unit Number:	Yes/No

Data Sources and Data Issues:	Data Source: DSHS Maternal and Child Health Section (TMCHS)
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, professionals need to increase their knowledge of the potential risks impacting this population. Texas will lead an injury prevention conference in spring of 2017 to convene partners from around the state to educate, inform, build, and discuss injury prevention best practices, data, partnerships and intervention strategies.

ESM 7.4 - Train Child Fatality Review (CFR) teams on injury prevention
NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Measure Status:	Active
Goal:	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.
Definition:	

Numerator:	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.
Denominator:	N/A
Unit Type:	Text
Unit Number:	Yes/No

Data Sources and Data Issues:	Data Source: DSHS Maternal and Child Health Section (MCHS). TVMCH will be leading trainings for regional CFR teams. Data Issues: None anticipated.
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.

ESM 7.5 - Percent of child deaths reviewed by Child Fatality Review Teams (CFRT)
NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Measure Status:	Active
Goal:	Increase the percentage of child death reviews completed by Child Fatality Review Teams.
Definition:	**Numerator:** Number of child deaths reviewed by Child Fatality Review Teams (CFRT) per calendar year **Denominator:** Total number of child deaths in Texas per calendar year **Unit Type:** Percentage **Unit Number:** 100
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.

ESM 7.6 - Percent of youth reporting connection to at least one caring adult
NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 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:	**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 **Unit Type:** Percentage **Unit Number:** 100
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 (which should be available in FY18), 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 that 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. Furthermore, response rates to the YRBSS are lower than ideal and declining. YRBSS findings are intended for population surveillance and have only limited generalizability to specific geographic subgroups such as counties or cities. In 2015, Texas YRBSS did not receive enough data for results to be considered representative of youth across the state, so 2013 YRBSS data were used as a baseline to estimate annual objectives. In the 2013 YRBSS, only information about whether youth ate dinner at home with parents/guardians 4 of the last 7 days was available.
Significance:	New research is showing 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. Positive youth development (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 having a medical home

Measure Status:	Active
Goal:	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.
Definition:	**Numerator:** Number of CYSHCN families surveyed who indicated they received professional care coordination for their child **Denominator:** Total number of CYSHCN families surveyed **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Source: Annual CYSHCN Outreach Survey Responses to the CYSHCN Outreach Survey are collected on an annual basis. The survey is mailed out and dispersed electronically to families served by the HHSC CSHCN SP 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 data gathered as part of the 2015 Title V Five Year Needs Assessment, 255 of 923 survey respondents (38.5%) 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 areas of need for additional ongoing needs assessment activities including focus groups and interviews.
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 NS-CSHCN 2009/10 identified that 40.1% of Texas CYSHCN met all criteria for the medical home outcome, and less than one quarter 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 CYSHCN Outreach Survey showed 71.6% of respondents reporting that they coordinate their child's care themselves. This finding was supported by parent focus groups and stakeholder groups, who noted gaps in care that exist when care is not coordinated among providers, including specialists. The number of families who indicate they received professional care coordination for their child will be derived from the CYSHCN Outreach Survey. Data collected will reflect the number of survey respondents who indicate that someone at the child's doctor's office, or a

case manager or social worker, or someone at the child's school helps the child or youth receive all of the care needed.

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.

ESM 11.2 - Percent of physicians demonstrating knowledge of medical home characteristics
NPM 11 – Percent of children with and without special health care needs having a medical home

Measure Status:	Inactive - Replaced
Goal:	Assess level of CYSHCN physicians' understanding of medical home characteristics to evaluate education and outreach to providers and inform the support of medical home best practices.
Definition:	

Numerator:	Number of physicians surveyed and polled during interactive presentations who demonstrated knowledge of the medical home characteristics
Denominator:	Total number of physicians surveyed plus total number of physicians polled in interactive presentations
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	Data Source: Annual Medical Home and Transition Physician Surveys and physician poll data collected from interactive presentations. Responses to the Medical Home and Transition Physician Surveys will be collected on an annual basis. Surveys will be dispersed electronically to physicians providing HHSC CSHCN health care benefits, members of the MHWG and TTVTW, and members of medical and health professional organizations. The surveys will be promoted through email communication, newsletters, and webpages. The online survey responses will be combined with data collected from polling during interactive presentations at provider-focused conferences and events. Baseline data will be finalized during FY17. Data Issues: Challenges associated with surveying a convenience sample of physicians include the potential to underrepresent subsets of the physician population in Texas according to geographical location, type of practice, or specialty. Another challenge includes the strain on physician's time posed by a survey. Revisions to the original Medical Home and Transition Physician Survey seek to combat these challenges by splitting content into separate, smaller surveys. The new surveys include two separate question sets related to provider knowledge and provider implementation of medical home and transition best practices. Additionally, responses gathered using audience response systems during interactive presentations will be utilized to augment the poor survey response rate observed during FY16. Geographical and practice-specific data are gathered in order to examine areas of need for additional education and ongoing needs assessment activities.
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 have further operationalized these characteristics for health care providers as best practices. In order for physicians to support care coordination across all elements of the complex health care system and community, they must possess implementation skills related to the core medical home characteristics. The NS-CSHCN 2009/10 identified that 40.1% of Texas CYSHCN met all criteria for the

medical home outcome. Children who received their care within a medical home were more likely to meet the other core system outcomes. The CYSHCN Outreach Survey showed 71.6% of respondents reporting that they coordinate their child's care themselves. This finding was supported by parent focus groups and stakeholder groups, who noted gaps in care that exist when care is not coordinated among providers, including specialists.

The percent of physicians who demonstrate knowledge of the medical home characteristics defined by the AAP Policy Statement and Joint Principles of a PCMH will be derived from the annual Physician Surveys. Data collected will reflect the number of survey respondents who correctly identify five of the seven medical home characteristics.

Successful education and outreach to physicians will lead to improved physician knowledge and attitudes towards providing medical home services for CYSHCN in Texas. Changes in provider knowledge of medical home characteristics, in combination with support and the promotion of medical home best practices, will lead to increased provider implementation skills and improved medical home outcomes for CYSHCN and families.

ESM 11.3 - Distribution of Medical Home and Transition Physician Surveys
NPM 11 – Percent of children with and without special health care needs having a medical home

Measure Status:	Inactive - Replaced
Goal:	To engage physicians in continued needs assessment.
Definition:	

Numerator:	Yes: Medical Home and Transition Physician Surveys and presentations were distributed/held and responses were collected No: Medical Home and Transition Physician Surveys and presentations were not distributed/held or responses were not collected
Denominator:	N/A
Unit Type:	Text
Unit Number:	Yes/No

Data Sources and Data Issues:	Data Source: Annual Medical Home and Transition Physician Surveys and physician poll data collected from interactive presentations. Responses to the Medical Home and Transition Physician Surveys will be collected on an annual basis. Surveys will be dispersed electronically to physicians providing HHSC CSHCN health care benefits, members of the MHWG and TTVTW, and members of medical and health professional organizations. The surveys will be promoted through email communication, newsletters, and webpages. The online survey responses will be combined with data collected from polling during interactive presentations at provider-focused conferences and events. Baseline data will be finalized during FY17. Data Issues: Challenges associated with surveying a convenience sample of physicians include the potential to underrepresent subsets of the physician population in Texas according to geographical location, type of practice, or specialty. Another challenge includes the strain on physician's time posed by a survey. Revisions to the original Medical Home and Transition Physician Survey seek to combat these challenges by splitting content into separate, smaller surveys. The new surveys include two separate question sets related to provider knowledge and provider implementation of medical home and transition best practices. Additionally, responses gathered using audience response systems during interactive presentations will be utilized to augment the poor survey response rate observed during FY16. Geographical and practice-specific data are gathered in order to examine areas of need for additional education and ongoing needs assessment activities.
Significance:	The Medical Home and Transition Physician Surveys and interactive presentations will include questions on best practices as they relate to caring for children with and without special health care needs in Texas. The surveys and presentation polls will provide a consistent source of data from FY16 – FY20, enabling Title V to monitor improvements in physician knowledge and the implementation of medical home and transition services. Information gathered will be utilized to develop education and outreach efforts targeting physicians in order to improve the system of care for CYSHCN in Texas and to advance medical home and transition outcomes for all children. Results from the surveys and presentation polls will build upon existing knowledge of

barriers and challenges related to providing medical home and transition services to CYSHCN in Texas. 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 typically seen by young adults whose medical needs are complex. Many adult providers cite a lack of training, time, and adequate payment as barriers to providing care to transitioning young adults with special health care needs.

Discussions with providers will be facilitated to gain further insight into areas of need identified by the surveys and presentation polls.

The Medical Home and Transition Physician Surveys, interactive presentations and follow up provider discussions will result in valuable data to inform ongoing provider education and outreach across Texas. Increased physician knowledge, attitudes, and implementation skills will facilitate improvements in medical home and transition services, which will impact health outcomes for children and youth with and without special health care needs.

ESM 11.4 - Percent increase in medical home provider education
NPM 11 – Percent of children with and without special health care needs having 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:	

Numerator:	Unduplicated number of users who completed the Texas Health Steps Medical Home Online Provider Education (OPE) module each fiscal year
Denominator:	(Baseline) Unduplicated number of users who completed the Texas Health Steps Medical Home OPE module during FY16 (371 users)
Unit Type:	Percentage
Unit Number:	100

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 TVMCH 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 will expire on 06/17/2018 and require content updates which will 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 NS-CSHCN 2009/10 identified that 40.1% of Texas CYSHCN met all criteria for the medical home outcome, and less than one quarter 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 MCHS, will lead to increased provider implementation of medical home best practices and improved outcomes for CYSHCN and their families.

ESM 11.5 - Meet with clinical champions for provider engagement
NPM 11 – Percent of children with and without special health care needs having a medical home

Measure Status:	Active
Goal:	To assemble a group of clinical Title V partners committed to increasing the number of physicians and other providers engaged in MCHS activities for CYSHCN in 2018.
Definition:	

Numerator:	Yes: A group of clinical Title V partners have been recruited and a meeting of this group has occurred in 2018 No: A meeting of the group of clinical Title V partners has not occurred in 2018
Denominator:	N/A
Unit Type:	Text
Unit Number:	Yes/No

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. 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 that “state programs such as Title V can provide technical assistance and support to medical practices implementing the medical home model.” The NCMHI also suggests that “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. Due to a low response rate in FY17, the survey was reformatted. However, a statistically valid sample could still not be obtained. Responses gathered using audience response systems during interactive presentations, while successful, were unable to stand alone as usable data without survey data. MCHS will continue to focus on assessing its CSHCN-related provider engagement efforts through the formation of a champion workgroup to assist in the development of a strategic plan for engaging providers. 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.

ESM 11.6 - Create a provider engagement strategic plan
NPM 11 – Percent of children with and without special health care needs having a medical home

Measure Status:	Active
Goal:	To collaborate with a group of clinical Title V partners to develop a strategic plan to increase the number of physicians and other providers engaged in MCHS activities by 2020.
Definition:	**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:** N/A **Unit Type:** Text **Unit Number:** Yes/No
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 that “state programs such as Title V can provide technical assistance and support to medical practices implementing the medical home model.” The NCMHI also suggests that “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. Due to a low response rate in FY17, the survey was reformatted. However, a statistically valid sample could still not be obtained. Responses gathered using audience response systems during interactive presentations, while successful, were unable to stand alone as usable data without survey data. MCHS will continue to focus on assessing its CSHCN-related provider engagement efforts through the formation of a champion workgroup to assist in the development of a strategic plan for engaging providers. 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.

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 who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	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.
Definition:	**Numerator:** Number of families of transition-aged youth with special health care needs (12 years+) surveyed who indicated they received professional help with transition services **Denominator:** Total number of families of transition-aged youth with special health care needs (12 years+) surveyed **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Source: CYSHCN Outreach Survey Responses to the CYSHCN Outreach Survey will be collected on an annual basis. The survey will be mailed out and dispersed electronically to families served by HHSC CSHCN SP 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 Title V Five Year Needs Assessment, 38 of 454 respondents with transition-aged youth (8.4%) indicated they received professional help with four or more of the seven areas of transition services. Data Issues: Due to a low response rate to the Medical Home and Transition Physician Surveys in FY17, the survey content was divided into smaller surveys to encourage greater participation. However, a statistically valid sample could still not be obtained. Responses gathered using audience response systems during interactive presentations, while successful, were unable to stand alone as usable data without survey data. Consequently, this ESM has been inactivated. MCHS will focus on assessing its CSHCN-related provider engagement efforts through the formation of a champion workgroup to assist in the development of a strategic plan for engaging providers.
Significance:	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 2009/10 NS-CSHCN, Texas ranked in the bottom quartile of states and territories in the outcome of children receiving the services necessary to make the transition to adult health care (35.4% in Texas compared to 40% nationally). Only 20 percent of respondents to the CYSHCN Outreach Survey felt prepared for their child to transition to adulthood. Further, over 40 percent of respondents indicated that they had not prepared for transition. Most respondents who indicated that they had prepared for their child's transition

had done so by themselves.

A key finding from the focus groups of parents with CYSHCN was that participants had a wide range of ideas about when transition planning should start, when the transfer of care should happen, and of the various aspects of transitioning to adulthood, including health care, education, social supports and legal transition.

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 - Percent of physicians demonstrating knowledge of the transition from pediatric to adult health care
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Inactive - Replaced
Goal:	Assess level of CYSHCN providers' understanding of transition from pediatric to adult health care to evaluate provider education and outreach efforts.
Definition:	

Numerator:	Number of physicians surveyed and polled during interactive presentations who demonstrated knowledge of the transition from pediatric to adult health care
Denominator:	Total number of physicians surveyed plus total number of physicians polled in interactive presentations
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	Data Source: Annual Medical Home and Transition Physician Surveys and physician poll data collected from interactive presentations. Responses to the Medical Home and Transition Physician Surveys will be collected on an annual basis. Surveys will be dispersed electronically to physicians providing HHSC CSHCN health care benefits, members of the MHWG and TTVTW, and members of medical and health professional organizations. The surveys will be promoted through email communication, newsletters, and webpages. The online survey responses will be combined with data collected from polling during interactive presentations at provider-focused conferences and events. Baseline data will be finalized during FY17. Data Issues: Challenges associated with surveying a convenience sample of physicians include the potential to underrepresent subsets of the physician population in Texas according to geographical location, type of practice, or specialty. Another challenge includes the strain on physician's time posed by a survey. Revisions to the original Medical Home and Transition Physician Survey seek to combat these challenges by splitting content into separate, smaller surveys. The new surveys include two separate question sets related to provider knowledge and provider implementation of medical home and transition best practices. Additionally, responses gathered using audience response systems during interactive presentations will be utilized to augment the poor survey response rate observed during FY16. Geographical and practice-specific data are gathered in order to examine areas of need for additional education and ongoing needs assessment activities.
Significance:	The AAP outlined components 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 through the establishment of evidence-based tools for use by primary care and specialty care providers. According to the 2009/10 NS-CSHCN, Texas ranked in the bottom quartile of states and territories in the outcome of children receiving the services necessary to make the transition to adult health care (35.4% in Texas compared to 40% nationally). In the CYSHCN Outreach Survey in 2014, only 20 percent of respondents felt prepared for their child to transition to

adulthood. Further, over 40 percent of respondents indicated that they had not prepared for their child's transition.

Respondents in stakeholder meetings noted that few doctors have the passion or willingness to take on the primary care role and coordinate the many specialists typically seen by young adults whose medical needs are complex. Many adult providers cite a lack of training, time, and adequate payment as barriers to providing care to young adults with special health care needs.

The percentage of physicians who demonstrate knowledge of the transition from pediatric to adult health care will be derived from the annual Medical Home and Transition Physician Surveys and presentation polls. Data collected will reflect the number of survey respondents respondents and physicians polled during interactive presentations who correctly identify five of the seven medical home characteristics.

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.

ESM 12.3 - Distribution of CYSHCN Outreach Survey
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	To engage young adults with special health care needs and families of CYSHCN in continued needs assessment.
Definition:	

Numerator:	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.
Denominator:	N/A
Unit Type:	Text
Unit Number:	Yes/No

Data Sources and Data Issues:	Data Source: CYSHCN Outreach Survey Responses to the CYSHCN Outreach Survey will be collected on an annual basis. The survey will be mailed out and dispersed electronically to families served by the HHSC CSHCN SP 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 will be obtained during FY16. 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.
Significance:	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 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 Community 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 integration. The 2016 CYSHCN Community Outreach Survey will establish 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 integration, medical home, and transition outcomes throughout Texas.

ESM 12.4 - Percent increase in transition provider education
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	To increase the number of providers educated on health care transition best practices.
Definition:	

Numerator:	Unduplicated number of users who completed the Texas Health Steps Transition Online Provider Education (OPE) module each fiscal year
Denominator:	(Baseline) Unduplicated number of users who completed the Texas Health Steps Transition OPE module during FY16 (1,340 users)
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	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 expired and was updated during Spring 2017 which will impact trend analysis.
Significance:	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 NS-CSHCN 2009/10, 35.4% of Texas children received the services necessary to make the transition to adult health care, compared to 40.0% nationally. In the CYSHCN Outreach Survey in 2014, only 20% of respondents felt prepared for their child to transition to adulthood. Further, over 40% of respondents indicated that they had not prepared for their child's transition. 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, 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 healthcare 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.

Changes in provider knowledge of transition, in combination with support and technical assistance from MCHS, will lead to increased provider implementation of transition best practices and improved outcomes.

ESM 14.1 - Number of health care service providers who adopt an electronic medical record (EMR) interface to electronically refer caregivers who smoke to the Texas Tobacco Quitline
NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Measure Status:	Active
Goal:	Assess smoking prevention and cessation efforts to inform outreach and interventions targeted at reducing smoking within the home.
Definition:	

Numerator:	Number of individual health care service providers who adopt an electronic medical record (EMR) interface to electronically refer caregivers who smoke to services provided by the Texas Tobacco Quitline per state fiscal year.
Denominator:	N/A
Unit Type:	Count
Unit Number:	10,000

Data Sources and Data Issues:	Data Source: Tobacco Research and Evaluation Team (TRET), University of Texas at Austin The DSHS Office of Title V & Family Health is partnering with the DSHS Tobacco Prevention and Control Branch (TPCB) to pilot a systems-level intervention to increase quit attempts among parents/caregivers and reduce rates of household smoke exposure. Through a contractual agreement with The University of Texas at Austin, this proposed project would work to address pediatric patient needs by building a tool to electronically refer parents/caregivers who smoke around the pediatric patient to services provided by the Texas Tobacco Quitline (QL). We will work with developers to incorporate an Electronic Tobacco Referral Protocol (eTP) template into the health care providers' existing electronic medical record (EMR) interface. The eTP template is an evidence-based electronic QL referral tool shown to increase volume of QL referrals from healthcare providers. Data Issues: As a pilot project, we do not yet have baseline data; therefore, estimates of the number of providers expected to participate per year are guesses and could change considerably after the first year of project implementation.
Significance:	There is no safe level of exposure to tobacco smoke, yet nearly 60% of children aged 3 to 11 in the United States are exposed to secondhand smoke (SHS), and almost 1 in 4 lives in a home with at least one smoker. These children are at greater risk of sudden infant death syndrome (SIDS), more severe and frequent asthma attacks, respiratory illness, middle ear infections, and slowed lung growth. Tobacco dependence is a pediatric disease; nearly 90% of smokers start before the age of 18. Children whose parents/caregivers smoke and who grow up in homes where smoking is allowed are also more likely to become smokers themselves. Pediatricians and pediatric nurses are in a unique position to eliminate pediatric SHS exposure by addressing parental tobacco use. Despite recommendations from both the American Academy of Pediatrics and the American Academy of Family Physicians to place higher importance on screenings and counseling services for every child visit, both screening and counseling for parental tobacco use remains low. Providing tobacco cessation assistance to individuals who use tobacco products around children is a crucial component to the process. Child healthcare visits may provide a unique opportunity for physicians to address parental cessation and for parents to access cessation resources, as caregivers may not be seeing a physician for their own benefit; and experiencing discomfort due to parental and smoker role conflict is likely to result in increased motivation to quit.

Form 11
Other State Data

State: Texas

The Form 11 data are available for review via the link below.

Form 11 Data

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

Abbreviated State Action Plan Table

State: Texas

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Provide support to promote quality in primary care, women's health, and specialty services.	NPM 1 - Well-Woman Visit	ESM 1.1 ESM 1.2 ESM 1.3 ESM 1.4 ESM 1.5 ESM 1.6 ESM 1.7 ESM 1.8 ESM 1.9	
Reduce health disparities for maternal and child health populations.	NPM 1 - Well-Woman Visit	ESM 1.1 ESM 1.2 ESM 1.3 ESM 1.4 ESM 1.5 ESM 1.6 ESM 1.7 ESM 1.8 ESM 1.9	

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce health disparities for maternal and child health populations.	NPM 4 - Breastfeeding	ESM 4.1 ESM 4.2 ESM 4.3 ESM 4.4 ESM 4.5	
Ensure use of culturally and linguistically appropriate Maternal and Child Health education and outreach efforts.	NPM 5 - Safe Sleep	ESM 5.1 ESM 5.2	
Reduce health disparities for maternal and child health populations.	NPM 5 - Safe Sleep	ESM 5.1 ESM 5.2	
Reduce health disparities for maternal and child health populations.			SPM 3
Reduce health disparities for maternal and child health populations.			SPM 3
Reduce health disparities for maternal and child health populations.			SPM 3

Child Health

State Priority Needs	NPMs	ESMs	SPMs
Bolster access to quality statewide data, screening, and surveillance (to inform Maternal and Child Health programming).	NPM 7 - Injury Hospitalization	ESM 7.1 ESM 7.2 ESM 7.3 ESM 7.4 ESM 7.5 ESM 7.6	
Increase Maternal and Child Health safety programming.	NPM 7 - Injury Hospitalization	ESM 7.1 ESM 7.2 ESM 7.3 ESM 7.4 ESM 7.5 ESM 7.6	
Improve coordination of care for Maternal and Child Health populations.	NPM 6 - Developmental Screening	ESM 6.1 ESM 6.2	
Provide support to promote quality in primary care, women's health, and specialty services.	NPM 6 - Developmental Screening	ESM 6.1 ESM 6.2	

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Increase Maternal and Child Health safety programming.	NPM 7 - Injury Hospitalization	ESM 7.1 ESM 7.2 ESM 7.3 ESM 7.4 ESM 7.5 ESM 7.6	
Promote collaborations including family professional partnerships (to enhance Maternal and Child Health programming).	NPM 7 - Injury Hospitalization	ESM 7.1 ESM 7.2 ESM 7.3 ESM 7.4 ESM 7.5 ESM 7.6	
Bolster access to quality statewide data, screening, and surveillance (to inform Maternal and Child Health programming).	NPM 7 - Injury Hospitalization	ESM 7.1 ESM 7.2 ESM 7.3 ESM 7.4 ESM 7.5 ESM 7.6	
Increase Maternal and Child Health safety programming.	NPM 7 - Injury Hospitalization	ESM 7.1 ESM 7.2 ESM 7.3 ESM 7.4 ESM 7.5 ESM 7.6	
Provide support to promote quality in primary care, women's health, and specialty services.			SPM 4

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Children and Youth with Special Health Care Needs receive family-centered, coordinated care within a medical home model.	NPM 11 - Medical Home	ESM 11.1 ESM 11.2 *Inactive* ESM 11.3 *Inactive* ESM 11.4 ESM 11.5 ESM 11.6	
Children and Youth with Special Health Care Needs receive family-centered, coordinated care within a medical home model.	NPM 11 - Medical Home	ESM 11.1 ESM 11.2 *Inactive* ESM 11.3 *Inactive* ESM 11.4 ESM 11.5 ESM 11.6	
Children and Youth with Special Health Care Needs receive family-centered, coordinated care within a medical home model.	NPM 11 - Medical Home	ESM 11.1 ESM 11.2 *Inactive* ESM 11.3 *Inactive* ESM 11.4 ESM 11.5 ESM 11.6	
Children and Youth with Special Health Care Needs and their families have the services and supports necessary to transition to adulthood.	NPM 12 - Transition	ESM 12.1 ESM 12.2 *Inactive* ESM 12.3 ESM 12.4	
Children and Youth with Special Health Care Needs and their families have the services and supports necessary to transition to adulthood.	NPM 12 - Transition	ESM 12.1 ESM 12.2 *Inactive* ESM 12.3 ESM 12.4	
Children and Youth with Special Health Care Needs and their families have the services and supports necessary to transition to adulthood.	NPM 12 - Transition	ESM 12.1 ESM 12.2 *Inactive* ESM 12.3 ESM 12.4	
Advance Community Integration efforts.			SPM 1
Advance Community Integration efforts.			SPM 1

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Reduce health disparities for maternal and child health populations.	NPM 14 - Smoking	ESM 14.1	
Reduce health disparities for maternal and child health populations.			SPM 2
Reduce health disparities for maternal and child health populations.			SPM 2