Texas CHIP Coalition
Meeting Minutes

July 15, 2016

Present:
Julia Von Alexander, CPPP
Jackie Rodriguez, Community Care
Leah Gonzalez, Women's Healthcare Coalition
Alice Bufkin, Women's Healthcare Coalition
Will Francis, NASW-TX
Kathy Eckstein, CHAT
Laura Guerra-Cardus, CDF-TX
Helen Kent Davis, TMA
Adriana Kohler, Texans Care for Children
Anne Dunkelberg, CPPP
Mary Allen, TACHC
Olga R, TACHC
Erle Winn, Merck
Juliana Kerker, OB/GYNs
Juanita Gutierrez, CommUnity Care
Caroline Young, CDF-TX
Tara McKinley, HHSC
Daniela DeLuna, HHSC
Clare Seagraves, HHSC
Lesley French, HHSC

On the Phone:
Claudia Calderon, Texas Children's Hospital
Erica Laredo, Texas Children's Hospital
Betsy Coats, Maximus
Shannon Lucas, March of Dimes
Mel McChesney, CPPP
Dr. Emilie Becker, HHSC
Denise Rose, Jackson Walker, representing Children's Health System of Texas
Greg Hansch, NAMI
Holly Turner, Merck

Chair: Kathy Eckstein, Children's Hospital Association of Texas
Minutes Scribe: Julia Von Alexander, Center for Public Policy Priorities
Next meeting: August 19, 2016

I. **Overview and Update on the State's Women's Healthcare Initiatives** *(Associate Commissioner of Women's Health Services Lesley French, HHSC)*

- New programs to meet clients' needs, still lots of work to be done to make sure all have access.

- FY15 costs of Medicaid births (slide 4). Costs continuing to increase over the last 5 years. Trying to develop programs so women have a healthy pregnancy/healthy birth outcome.
- www.healthytexaswomen.org is the new website. Also have a one-pager (attached) to distribute to people who need services. HTW is a program and an outreach campaign. Moving forward will need to clear the confusion between the outreach program (which discusses all services available) and HTW program.
- Healthy Texas Women program (HTW) is a combination of Texas Women's Healthcare program and the Expanded Primary Health Care program.
- Can get treatment for reproductive health issues within the program. Also includes screening/treatment for hypertension, diabetes, and cholesterol. Main purpose is reproductive health and family planning.
- Crucial change- increased eligibility, serves women up to 200% FPL, minors with parental consent.
- Can apply through YourTexasBenefits
- Helen D.- On minors- those who are enrolled in CHIP (i.e. most minors) are not eligible. Confusion here for providers. Need to be clear on this in the advertisements. Want to help address this issue in interim/next session.
- Lesley F.-Issue is the IT system due to how the system was built. Would need legislative direction for minors on CHIP to access benefits through family planning. However, lots of contractor applications for family planning program (FPP)! List of contractors to come soon.
- Laura G.- What scenario would there be for a child under 200% to be on the program? Lesley- up to the parent, e.g. they may have access to other coverage besides CHIP. Still I don't think we will see a large number of minors in HTW for now. [clarification- if a child has access to other coverage, they are ineligible for HTW]
- Funding for FPP. Plan to double the size of funding for FPP. Waiting for permission to be able to expend those funds- request at LBB since 2/29. Most of the $50 million to FPP. Goal is to serve women of reproductive age (18-44), but will likely include age 13-64. Confusion and not as much access as would like. Should see an improvement in the program.
- Anne D- Method of finance for the FPP? Has some Title XX (less than 5%- just administrative costs). Contracts fully funded by GR. Subject to expectations of the federal government.
- Automatic enrollment is working well for people so far. But want to hear about problems. Goal is to allow women to keep the provider they've had during pregnancy after having the baby. Will have numbers later this fall/early spring. Only for pregnant women's Medicaid.
- Erica L.- If a pregnant women on Medicaid had a baby on June 30th is she automatically enrolled into HTW? Yes, automatic enrollment depends on when coverage ends (i.e. 60 days after birth). So if that is after 7/1, they will be enrolled into HTW. Erica L.- this is not clearly explained in the providers manual. Lesley- there is a new policy manual on TMHP, healthytexaswomen.org, etc. But we still want feedback on what we need to clarify/add.
- Outreach comes into play for women who deliver while on CHIP-P. Not the same enrollment system as Medicaid for FPP.
- Alice B.- Will a letter go out to these women? Other steps to communicate on coverage options? Yes, both. Trying to include this information in the hospital bag for women who have just delivered. Also, working with TMA/THA to deliver this communication. In prenatal services, giving women this information throughout the pregnancy (similar to postpartum depression education outreach).
- Melissa M.- Is there a renewal process for HTW? Is there a certification period? Yes, all eligibility is valid for 1 year from day auto-enrolled or day submitted application to eligibility office. Working on a renewal build to auto-renew if still qualify financially. Melissa M.- income counting differences in Medicaid and HTW (i.e. child support), may affect some women at renewal.

- Sister JT- Is a client on CHIP-P who is a non-citizen eligible for HTW? Anne D.- No, not eligible for HTW. Legal Permanent Residents are mostly excluded from Medicaid, but there are exceptions in federal law and these are the only women who would be eligible for HTW (i.e. pregnant women on Medicaid, not CHIP-P). FPP is CHIP-P women's current option.
- LARCs are covered in Medicaid, HTW, and FPP. Working to include all LARCs and with Medicaid providers to make sure they are well-informed on LARCs. Recently released the TX LARC toolkit guide for providers. Sent to all MCOs, fee-for-service providers, and family planning providers.
- Kathy E- Medicaid started reimbursing hospitals for postnatal LARC procedure. Are you seeing billing? Yes, see slide 15. According to some large hospitals, coding system doesn't work. Working with TMHP and providers to discuss and fix this issue.
- Olga R- Is there a target based on other states? Rider requires an increase of 10% utilization based on 2014/2015 over 2 years. Trying to do more. Idea is that every woman who enters a HTW/FPP clinic leaves with LARC info. Working closely with other states (CO/SC) who have already implemented. But TX is so big and diverse. Actively soliciting feedback on what's working and what isn't in IT and billing systems.
- Helen D- Physician specialty pharmacy workaround is a good interim step. But MDs would rather just buy, bill and get reimbursed because they have to have clients come back and clients don't. It is a best practice to be able to do it right then and there. Know this is a system fix. Lesley F.- Trying to get to as much same day insertion as possible.
- Holly T.- Considering updating provider reimbursement rates for family planning clinics more often than every 2 years? Yes, and we are currently in discussions.
- Holly T.- Solution for FQHC reimbursement for LARCs outside of Medicaid encounter rate. Done for the rural health centers too? Yes, believe that already went through or will soon.
- Zika questions go to www.texaszika.org. Trying to send clients/providers to this site (most current).
- Office of Population Affairs put out a family planning provider toolkit on Zika. Working with Title X providers on that and they are sending it out.
- Helen D- We also need to acknowledge and educate on the fact that, according to CDC, women to men transmission has now been confirmed.
- Helen D.- Confusion on postpartum depression screening/treatment and what is covered. Screening code isn't included for pregnant women on Medicaid unless mother is under 18 (also not in HTW/FPP). Treatment- what does this mean? Please clarify how to refer and to whom. Forthcoming changes?
- Lesley F./Dr. Becker-MCOs have been told what codes are payable for screening/diagnosis/treatment.
- Lesley F.- Providers use the different screening tools and can bill it as counseling for HTW, FPP, and Medicaid. Treatment- HTW/FPP will only cover pills (not extensive therapy with psychiatrist/therapist).
- Dr. Becker- Going forward hoping to include screening for adults in Medicaid and HTW.
- Rider 54 report will be published in late fall. Counseling code is a short-term fix. Policy book has a section on postpartum depression screening/treatment (including code, screenings to use, etc.). For more intensive therapy (i.e. not solely medication) need to be referred out to a local LMHA or psychiatrist (and won't be covered by HTW/FPP).
- Alice B.- Lots of demand for family planning. $80 million for FPP and $180 for HTW. Hope that there is flexibility to make sure funding goes where it is most needed. Lesley F. - Doing HTW/FPP contracts now. Moving forward will look at the data. Have some flexibility to move money within the strategy.

II. **Zika Response** (Dr. Phillip Huang, Austin-Travis County Health Department, and Clare Seagraves, HHSC)

Local Response (Dr. Phillip Huang, Austin-Travis County Health Department)

- **See slides.**
- No local transmission within the continental U.S. All cases so far were travel related.
- In Austin/Travis County, a third case was hospitalized, still no deaths.
- Kathy- Is there a population more associated with Guillen Barre syndrome? No.
- Lots of planning and coordination with state/national groups and other health departments, TMA Zika Workgroup, Travis Co. Medical Society.
- Testing mosquitos at state lab. Can call 311 if concerned about breeding site and will send environmental health specialists to do a property assessment. Spraying isn't the front line on this, because it won't get to household level and spray isn't residual. Other things are more important (e.g. larvicide to reduce breeding sites). Government/community partnerships to look out for standing water.
- Kathy- Don't spray at parks? No, but have capability and will do if assess and needed. Same with larvicide.
- 1st community to do CASPER- conducted surveys on people's knowledge on mosquito-borne diseases, prevention, where they get information and where they trust getting information. Results to date- government isn't most trusted source, most information from media from government; some people were very knowledgeable and some didn't have any knowledge. Varied greatly by area.
- www.austintexas.gov/zika (videos in Spanish and English)
- Participated in state tabletop exercise for 1st local transmission case. Will work closely with the state. Don't anticipate this will be like Brazil. Will have local transmission, but will likely be in pockets.
- Working closely with the blood blanks, to make sure they are still able to do collection in Texas. Will try to identify the boundary of local transmission. Will look into each situation individually.
- Helen D.- Has it really affected the blood bank? No, because no local transmission yet.
- Anne D.- Cmr. Smith has requested the ability to prescribe repellant from the LBB. No answer yet. For those who can't buy it, do we have programs that can make repellant available to low-income people? Not in a widespread way. When informed of a case, they will assess the situation and may provide it. Anne- Colleagues in the RGV are more concerned and I believe they are planning to provide it there. Dr. Huang- $4.5 million wasn't a lot of money, so will be used to support Zika response teams, not passed out to local departments. Anne- May need to reach out to legislators. Lesley F.- In conversation with Dr. Hellerstedt to address it soon. May be able to fund repellant for women's health programs.
- Anne D.- Time will lapse between when there is local transmission and when we know we have it. Don't wait to use repellant!
- Laura G.- What is the criteria for running the test? For example, male partner traveled to affected area, had mild symptoms and his partner is pregnant. MD prescribed test, but lab wouldn't run the test. Dr. Huang- Lab testing going through the state. Will definitely run the lab for pregnant women who traveled to the area. Looking into a system to allow local health authority to have more of say in allowing a test. But there isn't lab testing capacity for everyone. In the case of local transmission, all pregnant women within 1 mile would be eligible for free testing.
- Laura G-Is the lab overburdened now? Yes, back up of a few weeks. The state is increasing their capacity for testing. More local private lab capability.
- Alice B.-what work are you doing to connect with family planning providers/those who provide reproductive services? Working with physicians and clinicians. Central Health talking about an augmenting campaign for women of childbearing age. Working with state health department for media and MD societies. Lesley F-Working on options to get out to family planning providers at DSHS.
- Some county health departments don't have capability. DSHS regional office would be the local health authority and has less capability. Strike teams to go to those areas since they have no local resources.

- Adriana K.- Outreach to family planning is critical to eliminate transmission. Would ask that you include the OPA toolkit in outreach to providers and reach out to all providers serving men and women of reproductive age.

Update on Medicaid Covering Insect Repellant (Clare Seagraves & Tara McKinley, HHSC)

- CMS bulletin issued on 6/1 on what Medicaid benefits could be provided for Zika.
- HHSC submitted a request to provide insect repellant for prevention of Zika. Waiting on the response.
- Focus on pregnant women, women of childbearing age (10-45). Biggest risk for microcephaly.
- Olga R.- How will it work? Tara M- CMS required that Medicaid cover it via prescription only. How it gets to pharmacy is up to provider, they don't have to require an office visit. HHSC is researching the ability to create a standing order to open access and eliminate extra steps.
- Olga- As soon as LBB says yes, are you ready to go? Will likely need about a week to make sure to coordinate with MCOs. Will also need an education campaign to physicians. Standing order may come after LBB approval. Education needed on which products acceptable- not covering every product.
- Kathy E-CMS doesn't have to approve the standing order? No, they said go forward.
- Clare S.- Looking into how other states are doing it. FL, LA, OH plan to provide as a Medicaid benefit.
- Kathy-Fiscal note didn't assume a standing order? Noted that they are assessing feasibility. Most likely all would be included. 1 can/month with one refill would be available. Kathy-Lasting through when? July-end of October 2016.
- Lesley F.- This request is just for 2016. Likely much more discussion during session.
- Alice B.- Will pharmacies be able to stock sufficient repellant? Tara M.- Independent pharmacies will need to order/stock it. Pharmacies will be able to order with a day to a week turnaround.
- Helen- Will HHSC request continuation as part of exceptional items? Lesley- We are having those conversations now.

Update on Implementing the Medicaid and CHIP Managed Care Final Rule (*Daniela DeLuna-Olivares, HHSC)*

- Continuing to read the rules. Managed_care_initiatives@hhsc.tx.us for questions and recommendations. Will come back when they have an implementation plan.
- Initial scan- Already in compliance with some of the rules on managed care. Implementation dates vary: immediately, July 2016, September 2017 and September 2018.
- Aligning CHIP with Medicaid requirements.
- Can enroll client into MCO immediately, as long as they can change/chose. Not planning to do that.
- Network adequacy- due in Sept 2018. Looking into differences between SB760 and CMS rules. CMS rules require time and distance standards.
    - CMS has specific provider types and differentiates between adult/pediatric populations. HHSC looking into LTSS and home health care requirements. Working to develop standards.
    - Some challenges with time standards (e.g. medical transportation vs. public transit vs. driving), would welcome recommendations. Have geomapping standards in the contract but they aren't easy to find. Developing a public facing website.
- Working on standards and contract language around availability of services to all members including those with physical/mental disabilities, or language barriers.
- Must submit network adequacy information at least annually to CMS. Currently submit it quarterly.
- Olga R.- What are you looking at in the quarterly reports? Self-reported data from MCOs. Health Plan Management prepares reports on providers in-network, etc. Look at trends to make sure MCOs are in compliance. Non-compliant MCOs must provide a reason and if HHSC doesn't accept it, put on compliance plan.

- Provider directories- Must list if provider has cultural competence training, facility is accessible, etc. by 9/2017. Working with MCOs to capture that data, and include it. Changing contracts/handbooks. HHSC is part of an initiative to develop standards for online provider directory.
- STAR Plus- Robust service coordination, minimum encounters. General requirements on service management. By 9/2017, all MCOs will need to do a health risk assessment within 90 days of enrollment for all new enrollees.

III. Improving Medical Care for Children in Foster Care *(Kathy Eckstein, CHAT)*

- Position paper attached. Background on medical problems with kids in foster care.
- Would like to align health care standards with national American Academy of Pediatrics (AAP) standards. HHSC uses EPSTD guidelines for frequency of visits for children, which requires a health assessment within 30 days. For children in foster care, AAP recommends a health assessment within 72 hours. The state doesn't even meet the current standard. Only 50% get assessment within 30 days.
- Helen D.-Have any states adopted AAP standards? Yes, Will F to follow up.
- Whenever kids have a change in placement, doctors would like to see them.
- Need to improve the use of the Passport for providers. It has 2 years of Medicaid claims data. Prescription drug information is useful, but isn't good for medical information. Takes a lot of digging and is very time-consuming.
- People don't always upload stuff into it. Many behavioral health assessments aren't loaded, because physicians aren't paid for that and it takes a lot of time.
- Rural doctors don't use it, since it is confusing unless used regularly. Doesn't connect to MDs own electronic health records.
- MDs want the trauma histories of their patients, but Passport doesn't provide this. CASA got some of the foster care info from IMPACT, but had lots of issues with the system.
- Children's hospitals would like to avoid placement disruption and lengthy stays in hospitals that aren't' medically necessary. There are cases where kids lived in the hospital for a year, not paid by DFPS nor Superior. Want in-home supports for foster care families so they can take the kids back after a hospitalization. Many of the affected kids were denied in-home services (by Superior). Helen D. What is the criteria? Unsure.
- STAR FISH- DFPS does have a process to review the placement of kids with challenging placement needs. DFPS placement team meets to solve, but it is only a few kids per week.
- Helen D.- How many affected? Don't know, requested data from HHSC in March on how many kids have extended hospital stays and the number of days denied for medical necessity. Helen- Has a lawmaker requested that data? Don't believe so, but HHSC says they are close to getting the report to us.
- Having a CPS worker in the hospital has worked out well. May be a good model.
- Superior could do a NAIP project for a specialized foster care center of excellence. But with $500 million in NAIP, HHSC wants to stop new NAIP projects. Currently no foster care NAIP projects are operational.
- Olga R- Is that $500 million DSRIP? Or other program through CMS? Not DSRIP, this is another CMS funding stream. Involves hospitals partnering with MCOs to improve access.
- Improving care coordination- Hard to know who all of the players are. Provider community doesn't understand the avenue they are supposed to use. DFPS is studying it to better understand the problem.
- Working on these issues and may come forward with proposals.

IV. Update on the Legislative Agenda

- Narrow agenda- Only items that many members are committed to working on with the coalition brand.
- The Legislative Agenda working group will meet again within the next few weeks. Items discussed so far are on the next page and were emailed out.
- A group working on an agenda around maternal and infant health will also meet next week.
- Please email any items you would like to add to the list to Julia Von Alexander and cc Laura Guerra-Cardus **by COB 8/2**.

General topics discussed at the last working group call are as follows:

Budget:

- Monitor Appropriations process to advocate for adequate funding for Medicaid and CHIP, and to identify and oppose proposals to reduce services or payments that will adversely affect children's and mothers' access to care.

Outreach and Enrollment:

- Seek ongoing modernization and streamlining of eligibility and enrollment for children and pregnant women. Seek legislation if needed to improve on current policy.
- Sustain and improve on Texas historical engagement in creating and supporting community-level outreach and application assistance resources to help families enroll eligible children and expectant mothers in coverage. Seek legislation if needed to update or revitalize current systems.

Quality of Care:

- Monitor ongoing implementation of Texas' state-funded women's health care programs to ensure they are designed to maximize maternal and infant health before, during, and after pregnancy. Seek legislation if needed to correct any barriers to optimal care.
- Support legislation to create comprehensive coverage for Texas' low-income adults, to improve maternal health and the ability for parents to do the best job of raising their children and providing for their families.

Additionally, we have the legislative conference center reserved for the **afternoon of January 19th**.

Clayton Travis of Texas Pediatric Society will chair on August 19, which is a 90-minute meeting followed by Outreach and Eligibility Working Group meeting.

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Women's Health Update
CHIP Coalition

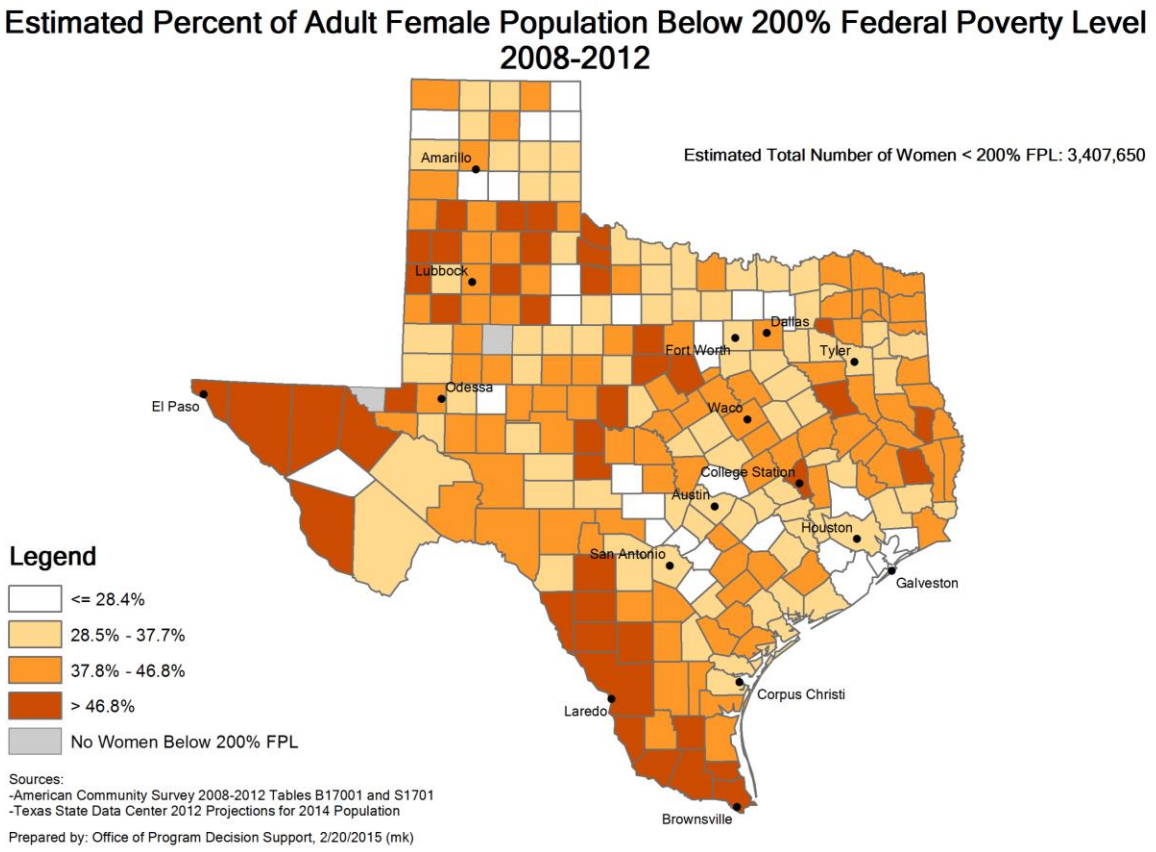
Lesley French
Associate Commissioner
Women's Health Services Division
Health and Human Services Commission

July 15, 2016

TEXAS Health and Human Services Commission

Women's Health in Texas

Approximately 3.4 million women in Texas are below 200% of the Federal Poverty Level (FPL).



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Women's Health in Texas

- Texas is experiencing substantial population growth
  - Between 2000 and 2013, Texas added 1.2 million more residents, more than any other state, and grew by 4.8%, compared to 2.2% growth for the entire country
  - In 2014, 42% of women (5.7 million) were of childbearing age

- Access to healthcare among women in Texas
  - In 2014, 78% of women 19-64 years had health insurance coverage

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Medicaid Costs for Preterm Births

- Approximately 53% of all Texas births (213,253) paid by Medicaid
- Over $3.5 billion per year for birth and delivery-related services for moms and infants in the first year of life
- Medicaid newborn average costs:
  - Very low and extremely low birth weight $ 93,366
  - Prematurity with major complications $ 15,854
  - Full-term birth $ 572
- In FY2015, Medicaid paid over $402 million for newborns with prematurity and low birth weight. Care delivered in the neonatal intensive care unit (NICU) is now the costliest episode of medical care for the non-elderly population.

Preconception and Interconception Care

- Meeting a client's health care needs that directly impact her ability to have a future, healthier pregnancy.
- Preconception - Access to family planning services to promote health and improve birth outcomes
- Interconception - Access to family planning services in the postpartum period has the potential to reduce unwanted pregnancies, promote better birth spacing, and improve birth outcomes.

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HEALTHY TEXAS WOMEN

www.healthytexaswomen.org

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Women's Health Services Division

HHSC launched three women's health initiatives on July 1, 2016:

- Healthy Texas Women
- Family Planning
- Auto-enrollment from Medicaid Pregnant Women into Healthy Texas Women

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Healthy Texas Women

Program Details

Client Eligibility

- Women ages 15-44 (Ages 15-17 with parental consent)
- 200% Federal Poverty Level
- Citizen/Eligible Immigrant
- Not pregnant

Eligibility Determinations

- Client eligibility is determined by HHSC
- Clients may apply through a paper application or online
- Services delivered on a fee-for-service basis

Covered Services

- Pelvic examinations
- Contraceptive Services
- Pap tests
- Screening for hypertension, diabetes, cholesterol
- Sexually transmitted infection (STI) services
- Sterilizations
- Breast and Cervical Cancer Screenings and Diagnostic Services
- Immunizations
- Cervical Dysplasia treatment
- Other preventative services

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Family Planning

Program Details

Client Eligibility

- Women and men
- Age 64 or younger
- 250% of the Federal Poverty Level (FPL)
- Texas residents

Eligibility Determinations

- Must not be eligible for any similar program, including the HTW Fee-For-Service program
- Eligibility is determined at the point of service by family planning contractors

Covered Services

- Pelvic exam
- Contraceptive services
- Pap tests
- Screening for hypertension, diabetes, cholesterol
- Sexually transmitted infection (STI) services
- Sterilizations
- Breast and cervical cancer screening and diagnostic services.
- Immunizations
- Prenatal services

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Healthy Texas Women

Automatic Enrollment

- Effective July 1, 2016, HHSC's eligibility system has been modified to allow for the automatic transition of Medicaid for Pregnant Women clients to HTW.
- Medicaid for Pregnant Women coverage ends 60 days postpartum.
- HTW enrollment begins the next day following Medicaid termination.
- In addition, clients will be referred to the marketplace for other insurance coverage options.

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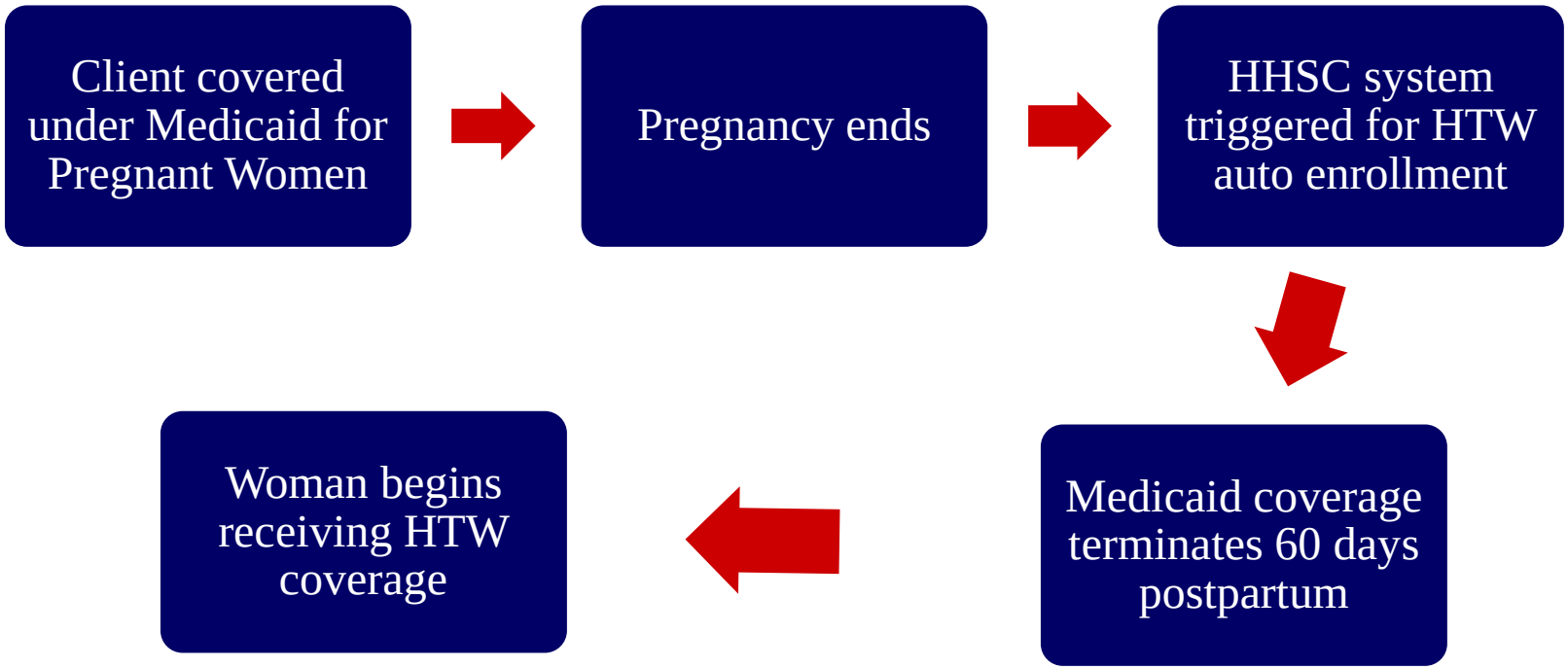
Healthy Texas Women

Automatic Enrollment Process



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Family Planning

CHIP Perinatal Clients

- Clients covered under CHIP Perinatal will not be eligible for automatic enrollment into HTW.
- Once a woman's pregnancy ends, she may be eligible to receive Family Planning Program coverage for reproductive health care services.
- Clients can locate a Family Planning provider at www.HealthyTexasWomen.org

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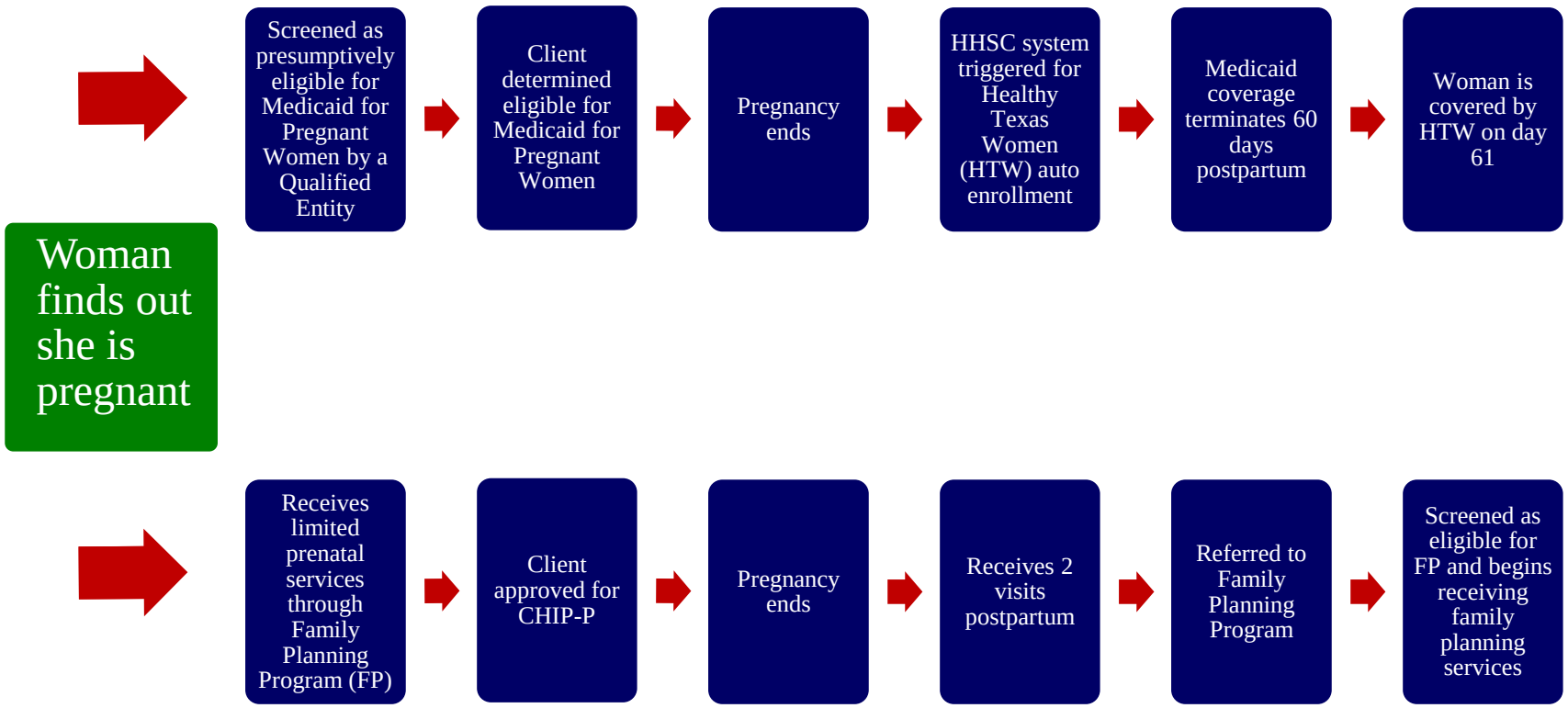
Women's Health Coverage



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Long-Acting Reversible Contraception

- Highly effective method of contraception
- Highest continuation and satisfaction rates
- Can be used by most women
- Increased use may reduce unintended pregnancy rates
- The American College of Obstetricians and Gynecologists (ACOG) recommends offering LARC methods as first-line contraceptive methods and supports post-partum insertion of LARC as safe, effective, and advantageous

Source: American College of Obstetricians and Gynecologists. Committee Opinion No. 539, "Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices," October 2012.

American College of Obstetricians and Gynecologists. Practice Bulletin No. 121, "Long-Acting Reversible Contraception: Implants and Intrauterine Devices," July 2011.

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Long-Acting Reversible Contraception

Long-acting reversible contraception (LARC, such as IUDs and contraceptive implants) is a safe and highly beneficial contraceptive. LARCs reduce the risk of unplanned pregnancies and improve the health of newborns and mothers by facilitating healthy spacing between pregnancies.

Women served who received LARC

(of total women receiving contraceptives)

Program	FY 2012	FY 2013	FY 2014	FY 2015
Medicaid Clients	6.5% 31,094	5.9% 28,805	6.7% 31,980	7.5% 37,760
Texas Women's Health Program Clients	6.9% 5,958	7.2% 5,023	9.2% 5,316	10.8% 5,926
Family Planning Clients	5.1% 3,113	7.8% 2,798	13.8% 3,200	13.3% 2,918
Expanded Primary Health Care Clients			9.1% 5,680	12.2% 6,856

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LARC Effectiveness

	INTRAUTERINE DEVICE (IUD)				IMPLANT
	Mirena	**ParaGard**	**Skyla**	**Liletta**	**Nexplanon**
Active ingredient	Hormonal (levonorgestrel)	Copper-releasing	Hormonal (levonorgestrel)	Hormonal (levonorgestrel)	Hormonal (etonogestrel)
Effective time	Up to 5 years	Up to 10 years	Up to 3 years	Up to 3 years	Up to 3 years
Failure rate	0.2%	0.8%	0.2%	0.55%	0.05%
Year method was FDA approved	2000	1984	2013	2015	2011

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Zika in Texas

For information about Zika, please visit:

www.texaszika.org

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Future Goals

- Increasing access to women's health and family planning services throughout the state
  - New women's health programs
  - Outreach
  - Provider training

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Questions?

HEALTHY TEXAS WOMEN

A strong Texas woman understands the importance of taking care of herself from her physical and emotional health to her spiritual and financial wellbeing. At HealthyTexasWomen.org, you can find physicians and clinics in your area that provide a wide range of free and affordable health care services.

HOW IT WORKS

The process is simple.

1

Go to:
www.HealthyTexasWomen.org

2

Pick the health-care issues that you're interested in

3

SUBMIT

Click the
"Submit" button

4

Connect with doctors and programs that are a match

AVAILABLE SERVICES

Log onto HealthyTexasWomen.org now to find local doctors and clinics that offer affordable services for:

- General health
- Birth control or once-a-year family planning exam
- Breast and cervical cancer screening
- Treatment for breast or cervical cancer
- Pregnancy testing/prenatal care
- Sexually-transmitted infections
- Mental health treatment
- Smoking
- Family violence

DID YOU KNOW?

- Scheduling regular doctor's visits and taking care of your personal health can help you stay healthy and detect serious medical conditions early.
- Eligible Texas women can receive family planning services, including prenatal care and birth control, at little to no cost through Healthy Texas Women programs.
- Regular breast and cervical cancer screenings increase your chances of finding and preventing health risks early.
- There are programs and helplines available across Texas that provide mental health screenings, counseling and support groups.
- Finding low cost health care programs and doctors in your area is simple. Visit HealthyTexasWomen.org to learn more.

To find a physician or clinic in your area today, visit www.HealthyTexasWomen.org or dial 2-1-1.

Brought to you by: Texas Department of State Health Services and Texas Health and Human Services Commission

HEALTHY TEXAS WOMEN

Una mujer fuerte comprende la importancia de cuidarse a sí misma, desde su salud física y emocional hasta su bienestar espiritual y económico. En HealthyTexasWomen.org puede encontrar doctores y clínicas en su área que ofrecen una amplia variedad de servicios de salud sin costo o al alcance de los bolsillos.

CÓMO FUNCIONA

El proceso es muy sencillo.

1

Vaya a ***www.HealthyTexasWomen.org*** y haga clic en el enlace que dice "En Español" en la parte superior derecha.

2

Escoja los temas de salud en los que esté interesada

3

Haga clic en el botón de **Enviar**

4

Comuníquese con los proveedores de servicios de salud y programas estatales de su área que cubran sus necesidades.

SERVICIOS DISPONIBLES

Entre al sitio HealthyTexasWomen.org hoy mismo para encontrar doctores y clínicas locales que ofrecen servicios al alcance del bolsillo para:

- Salud en general
- Control natal o un examen de planificación familiar anual
- Pruebas para detectar cáncer de seno y cáncer cervical
- Tratamiento para cáncer de seno o cáncer cervical
- Pruebas de embarazo y atención prenatal
- Infecciones de transmisión sexual
- Dejar de fumar
- Violencia intrafamiliar
- Tratamiento de la salud mental

¿LO SABÍA?

- Programar visitas periódicamente con el doctor y cuidar su salud personal puede ayudarla a mantenerse sana y a detectar enfermedades médicas graves a tiempo.
- Las mujeres de Texas que sean elegibles pueden recibir servicios de planificación familiar, incluidos la atención prenatal y el control natal, a un costo muy bajo o sin costo alguno, por medio de los programas de Healthy Texas Women.
- Las pruebas para detectar cáncer de mama y cáncer cervical aumentan sus posibilidades de encontrar y prevenir riesgos de salud a tiempo.
- Existen programas y líneas telefónicas de apoyo en todo Texas que ofrecen exámenes de salud mental, terapia y grupos de apoyo.
- Encontrar programas y doctores que brinden atención médica a bajo costo en su área es sencillo. Visite ***HealthyTexasWomen.org*** para obtener más información.

Para encontrar un doctor o una clínica en su área hoy mismo, visite *www.HealthyTexasWomen.org* o llame al 2-1-1.

Presentado por: Texas Department of State Health Services y Texas Health y Human Services Commission

ZIKA STATUS AND LOCAL RESPONSE

Philip Huang, MD, MPH

Health Authority/Medical Director
Austin/Travis County Health and Human Services Department

Texas CHIP Coalition
July 15, 2016

ZIKA STATUS - U.S. and Texas

- Local vector-borne transmission of Zika virus has NOT been reported in the continental U.S.
- Nationally, a total of 1306 laboratory-confirmed Zika virus disease cases have been reported
  - 1305 travel associated
  - 14 sexually transmitted
  - 5 Guillain-Barré syndrome
  - 1 laboratory acquired
- Texas has 63 Zika virus disease cases
  - One microcephaly case in Harris County

ZIKA STATUS – Austin/Travis County

- Staff identified 206 persons (60 percent are pregnant women) in the City of Austin and Travis County for whom clinical specimens have been submitted for testing

- Three persons have been tested positive for Zika, two for Dengue, two for Chikungunya, and one was inconclusive

- There are no reported severe illnesses, hospitalizations, or deaths from Zika virus

Zika Virus Key Facts

- **Transmission:**
  - Primarily through Aedes species of mosquito bites
  - From pregnant mother to baby
  - Sexual contact
  - Possibly through infected blood products
- **Symptoms:**
  - Usually within 2-7 days, fever, rash, joint pain, and conjunctivitis (red eyes). Also muscle pain and headache.
  - Four out of 5 people infected with Zika virus won't even know they have the disease
  - Usually mild with symptoms lasting for several days to a week.
- **Key Concerns:**
  - Microcephaly
  - Guillain-Barre Syndrome

Prevention and Control

- There is no vaccine to prevent Zika virus disease. There is no cure or treatment
- Focus is on PROTECTING PREGNANT WOMEN
- The best way to prevent diseases spread by mosquitoes is to prevent mosquito bites. (Four D'S)
  - Dress - Wear long-sleeved shirts and long pants.
  - Drain – Standing water Stay in places with air conditioning and window and door screens to keep mosquitoes outside.
  - DEET – or other EPA recommended insect repellents. Always follow the product label instructions.
  - Daytime (as well as Dusk to Dawn)
- During the 1st week of infection, Zika virus can be found in a person's blood and can pass from an infected person to a mosquito through mosquito bites. Strictly follow steps to prevent mosquito bites during the first week of illness.
- Integrated Vector/Mosquito Management

Planning Efforts

- Coordinate planning efforts at the local, state and federal levels with:
  - Texas Department of State Health Services
  - CDC
  - Texas Association of City and County Health Officials
  - Texas Medical Association
  - Travis County Medical Society, and other groups
- Developed *Zika Virus Strategic Action Plan*
- Preparations for first local transmission

Integrated Mosquito Management

- Collect mosquito specimens throughout Travis County and send to the State lab for testing
- Conduct property assessments
- Investigate mosquito complaints
- Engage in larviciding activities to reduce the number of breeding sites
- Assess the need for other mosquito control activities

Communications with Area Healthcare Providers

- Ongoing contact with the physicians through the Travis County Medical Society and with other area healthcare providers about Zika and other novel conditions.

- Share medical guidance on testing, recommendations for patients who are currently pregnant, symptoms to check, and a reminder to report “notifiable conditions” to us, the local health department, as required by law

Investigation of Human Cases

- Follow up and investigate suspect cases of Zika infection
- Work with local physicians and other healthcare providers to assess the need for laboratory testing and facilitate collection of lab specimens

Partnerships

- Partnership with multiple City Departments (Parks and Rec, Code Compliance, Resource Recovery, Public Works, Austin Water, etc.) on clearing of mosquito habitat
- Community partnerships:
  - Keep Austin Beautiful, UT, WIC, Central Health, and others
- **Community Assessment for Public Health Emergency Response (CASPER**) –Conducted door-to-door surveys on June 17th and 18th to ask Travis County residents about their knowledge of mosquito-borne diseases, mosquito prevention, and household emergency preparedness.

Education

- Travel advisory information
- General press releases
- Weekly situation updates
- Web and social media
- Videos
- Flyers

https://www.austintexas.gov/zika

QUESTIONS?

Addressing the Health and Safety of Children in Foster Care

by the Rees-Jones Center for Foster Care Excellence at Children's Medical Center

MAY 2016
Version 2

The Texas foster care system is an integral part of the safety net for the state's most vulnerable children, and is charged with the daunting task of providing safe homes to thousands of children who are in crisis. Systemic deficiencies remain in the foster care system despite numerous initiatives developed to address the challenges. Children and youth in foster care still face persistent barriers when they interact with the health system, which blunt the effectiveness of reform initiatives and potentially create lifelong harms for children in the program. Addressing disparities in the areas of physical health, mental health, educational attainment and special health care needs is integral to improving safety, stability and permanency for every child across the foster care system.

The Rees-Jones Center for Foster Care Excellence at Children's Medical Center applauds the hardworking men and women who dedicate their lives, careers and homes to make life better for children in the state's foster care system. Texas is fortunate to have a robust infrastructure that includes dedicated families, Child Protective Service (CPS) staff and leaders within Department of Family Protective Services (DFPS), STAR Health, concerned judges and attorneys, and court advocates and volunteers.

Despite these advantages, it is clear after serving thousands of children in foster care at the Rees-Jones Center that **perpetual systemic gaps are creating alarming clinical patterns, such as preventable health declines, non-medical hospitalizations and moves from home to home, putting at risk the most vulnerable children in Texas.** It should bring some hope, then, that almost every concerning pattern and challenge we observe is avoidable by adopting systemic reforms that target health care delivery.

"Almost every concerning pattern and challenge we observe is avoidable by adopting systemic reforms that target health care delivery."

The information presented below is based on the extensive experiences of the Rees-Jones Center's clinical care teams, who together serve more than 1,350 children in foster care each year. While these experiences are drawn from one Center, our facility serves children from across Texas; thus, we believe the observations are indicative of broader statewide challenges and opportunities. **This paper outlines a series of recommendations in the areas of quality, infrastructure, integration, caregiver support, and safety that, if taken together, can significantly improve health outcomes, well-being, and successful permanency that will make Texas foster care a model for the nation.**

About Texas Foster Care

- More than **47,000** children were in DFPS custody during state fiscal year (FY) 2015, which includes all children under age 18 for whom DFPS has legal custody, regardless of their placement, and youth who have aged out of DFPS legal responsibility but remain in substitute care.[1]

- **31,200** of these children lived in a verified foster care placement at some point during 2015. Of these, **7,305** live in DFPS Region 3, the largest region in the state, which encompasses a 19-county area in north central Texas (including Dallas, Tarrant, Collin and Denton Counties).

- The vast majority of children enter foster care due to abuse or neglect.

- Of all children in DFPS custody, approximately one in eight (5,900 children) are considered to be "high needs children," meaning they have special medical, behavioral or emotional indicators, or are in the IDD (intellectual and developmental disabilities) population.[2]

- National studies indicate that up to 80 percent of children in foster care have at least one chronic medical condition, while 25 percent have three or more chronic conditions.[3]

Concerns About Heath Care Access

Access to timely and effective pediatric and mental health care is particularly critical for children in foster care given the growing body of science documenting the short and long-term impacts of abuse and neglect on the developing brain, immune system, disease potential and adult health and behavioral outcomes.[4]

Children routinely come to the Center experiencing physical distress, missed diagnoses, overlooked symptoms, and missing prescribed medications and medical equipment. These observations are consistent regardless of a child's living arrangement, county or region of residence or length of time in care. They range from individuals with readily treatable conditions such as asthma, anxiety or developmental delays, to complex conditions such as traumatic brain injury or serious mental illness. These disparities are often the result of inadequate health assessments, transition planning and monitoring as children enter, move through, and exit foster care — and they occur despite universal health insurance coverage, current policies and a strong advocacy community. In fact, every child in the Texas foster care system has health care coverage through Texas' STAR Health program, which provides Medicaid and other benefits from entry through exit from foster care.

These gaps result in chronically unmet health care needs that affect children's ability to function at their full potential, creating lifelong disadvantages. **We observe a series of concerning patterns, including worsening disease status, declines in mental and behavioral health, unnecessary and prolonged hospitalizations, unsafe foster care transitions, placement disruptions, adoption dissolutions, and poor educational outcomes.** These observations hold true regardless of the child's level or type of medical or mental health complexity. **We believe these health disparities can be markedly reduced by following the recommendations outlined below.**

The Center has conducted more than 200 case reviews with local and regional CPS leaders since 2010. We consistently find that CPS staff, health care providers and courts almost always uniformly follow existing policies and used resources to the best of their knowledge. **Thus, we are convinced current health care requirements within Texas Health Steps, Medicaid and DFPS policies do not include necessary safeguards to address the high rate of trauma, transition, co-morbid physical and mental health conditions, and chronic conditions among children in foster care.**

The American Academy of Pediatrics (AAP) has endorsed 24 health supervision standards for children in foster care.[5] According to a new report by the Texas Pediatric Society's Foster Care Committee, Texas completely meets only one of the 24 standards, and partially aligns with only eight.[6] Aligning Texas state policies with the AAP standards would standardize how children are assessed, treated and monitored. This will greatly improve trauma-informed care, child abuse recovery, mental health supports and overall child health.

"We are convinced current health care requirements within Texas Health Steps, Medicaid and DFPS policies do not include necessary safeguards to address the high rate of trauma, transition, co-morbid physical and mental health conditions, and chronic conditions among children in foster care."

Recommendations

The Rees-Jones Center for Foster Care Excellence recommends the following policy changes. We believe that these steps, taken together, will significantly improve the Texas foster care system — for children, caregivers, parents, and the agencies and advocates serving them.

Enhance Health Care Quality Standards

1. Implement community-based and hospital-based health care standards for children in foster care from entry through permanency that are distinct and enhanced from traditional Medicaid or Texas Health Steps (THSteps) requirements, and are consistent with principles included in the AAP standards. State standards should include:

    - Adoption of an enhanced THSteps visit schedule, beginning with an immediate pediatric health assessment upon entering foster care. To support CPS workers in the field who identify abused and neglected children entering foster care, the state could adopt an immediate technology-supported field health triage, followed by an appropriately-timed in-person health assessment by a STAR Health provider within a few days of entering care.

    - Expansion of THSteps requirements to include trauma-informed components including specific monitoring of trauma symptoms, caregiver needs, child development, mental health symptoms, normalcy, disabilities, infectious disease and emerging chronic conditions.

    - Requirements should also address access to health care and reassessments after planned and unplanned transitions. These expansions help children and families avoid delays and interruptions in health care, reduce placement disruptions and unnecessary hospitalizations, as well as avoid declines in health as children move from family to family to permanency.

2. Enhance statewide standards for health care transition planning including caregiver preparation, continuity of health care, safe and necessary transportation and CPS-healthcare communication when children experience any disruption or change in residence, including discharge from hospital or residential treatment settings.

    - Primary medical needs staffing calls do not require participation by the child's current treating hospital-based or community-based health care/medical providers. Lack of health care provider participation contributes to miscommunication, delays effective planning, delays identification of foster homes, and contributes to poor transition planning.

    - Currently, no policy standardizes medical assessment of the child's comfort, cardiopulmonary status, and pain control during long-distance medical transport.

"Lack of health care provider participation contributes to miscommunication, delays effective planning, delays identification of foster homes, and contributes to poor transition planning."

3. Consider the incorporation of telemedicine and telemonitoring to supplement the face-to-face and in-person care that children in foster care receive, particularly for children with complex medical and mental health conditions that would benefit from active monitoring.

Ensure Safety and Reporting

4. Children should receive a comprehensive reassessment upon each placement disruption and findings should be recorded and any corrections to the health record made. Placement disruptions — including adoption dissolutions — are not reviewed to identify contributing factors. Often, disruptions are due to untreated or undertreated medical or behavioral health problems.

5. Establish one telephone number for concerns from health care providers, schools and others regarding children in foster care. The "warmline" would enable easier contact with CPS, as well as earlier reporting of concerns with caregiving, neglect, transitions or problems with access to care.

6. Create a separate Residential Child Care Licensing (RCCL) hotline, investigation and communication process for children in foster care. Components should include sharing of past investigation outcomes with each CPS worker involved with a child in the home. The system should include a trauma-informed health assessment of every child's safety and health status in consultation with health care providers when a report involves a home with children with special health care needs.

Expand Infrastructure to Support Child Protection/Health Care Collaboration

7. Assign a nurse coordinator to each child from entry to permanency to assist with regular monitoring of unmet health needs, updating active health histories, responding to health declines or delays in care, reaching out to treatment teams, communicating complete and relevant health histories with court teams during hearings and permanency decisions, and training and supporting caregivers.

8. Create regional medical and mental health consult teams to provide health consultation to CPS, Child Placing Agencies, hospitals and court teams when there are questions or concerns regarding a child's health status, quality of care and healthcare needs, particularly for children with complex medical needs or comorbid medical and mental health conditions.

9. Establish non-punitive, protected, regional foster care quality improvement boards or entities linked to a state quality improvement process. The process would allow forums to review concerning cases with root causes analysis to identify training needs, identify local versus statewide trends and contribute to early, targeted practice and policy improvements, when necessary. Current review processes exclude health care professionals serving children.

10. Establish an accessible, secure electronic child welfare-medical record with real-time information across all parties who have legal access to health information including a child's trauma history, strengths, health status, active health issues, unmet medical needs, treatment plans and recommendations. This lack of information risks duplication of painful and costly procedures, delays in care, and declines in physical health, mental health and educational attainment.

    - Currently, key health histories — newborn screens, immunization records, active diagnoses and treatment plans, hospital discharge summaries, and laboratory results — require extensive researching, which is time prohibitive and costly.

    - Often, psychological assessments are not shared by psychologists due to legal constraints which delays access to necessary behavioral and educational services.

11. The federally-required health care oversight committee under Fostering Connections should include individuals and entities representing each region, and be led by state officials.

Integrate Health Care Professionals into Decision Making

12. Consult licensed medical and mental health professionals and include them when child welfare and courts make decisions that affect a child's treatment options for medical, mental, developmental or other health issues.

    - CPS, foster parents, Court Appointed Special Advocates, judges, and attorneys do not have access to health consultation/medical expertise to interpret health information when assessing current health status, adequacy of health care services, adequacy of caregiving, as well as when making decisions to restrict or require health care services.

    - CPS and courts identify new caregivers without uniform standards to safely assess a family's readiness to meet the child's emotional or physical health issues or ability to secure necessary health care supports, including medications and equipment. Lack of uniformity contributes to placement disruptions when caregivers are ill-prepared for known medical and mental health diagnoses.

13. Court-ordered health care treatment or restrictions of health care treatment should require consultation with licensed medical and mental health professionals and include a report of the child's health status from the child's health care provider.

Improve Caregiver Education & Support

14. Provide foster families with full, necessary in-home assistance to support children with developmental disabilities, complex medical conditions, and mental health conditions to help ensure permanency and child well-being. Adequate in-home supports can help improve health and mental health outcomes,

15. Reconfigure hospital discharge planning to ensure new caregivers are formally assessed for reasonable knowledge, skills and parenting behaviors needed to safely care for a child with special health care needs, including those with complex medical and mental needs. Currently, Child Placing Agencies and CPS do not require that new caregivers meet a hospitalized child in person prior to discharge — both when caregivers live in town or out of town — unless a child has a tracheostomy.

16. Consider a uniform reimbursement model that promotes caregiver training and education at a child's bedside. Current policy does not establish a caregiver payment structure until a child arrives in a foster home, creating a barrier to early education and training.

17. Allow families caring for neurologically-devastated or profoundly disabled children regular in-home respite to increase placement options, avoid disruptions and promote permanency.

18. Implement pre-placement assessment standards to determine caregiver capacity and support to meet a child's health and mental health treatment needs with consideration of caregiver experience, number of children and level of complexity of other children residing in the potential home.

"While the observed disparities among the foster care population are troubling, the Rees-Jones Center staff believe the solutions are achievable and within our capacity to deliver."

Conclusion

The institutional and systemic challenges outlined in this paper require state-level action to truly improve the health and safety of children in foster care. Regional, local and provider efforts are creating pockets of success drawn from local strengths and capacities that provide ideas for a statewide model; yet without state-level support, these efforts will fall short of the broad-based institutional changes that are required. While the observed disparities among the foster care population are troubling, the Rees-Jones Center staff believe the solutions are achievable and within our capacity to deliver.

About the Rees-Jones Center for Foster Care Excellence

The Rees-Jones Center for Foster Care Excellence at Children's Medical Center is a partnership between the Children's Health System of Texas and the University of Texas Southwestern Medical Center. Thanks to a generous grant from the Rees-Jones Foundation in 2014, the Center transformed its 25 year foster care medical home program into a multifaceted Center with clinical, academic, and community development experts dedicated to improving the well-being and long-term outcomes of children and youth in Texas Foster Care. The Center is home to the only integrated foster care clinical program in North Texas. This innovative healthcare model brings together child welfare, pediatric, early childhood, and mental health professionals, as well as nurse coordination, to ensure every child receives rehabilitative and recovery-focused, community-based services that promote optimal health, mental health, educational attainment, permanency and long-term well-being.

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[5]"Health Care Standards," American Academy of Pediatrics and Child Welfare League of America, accessed February 23, 2016. Available online at https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Health-Care-Standards.aspx. See also, "Texas Pediatric Society Foster Care Committee 2016 Report: Comparison of National vs. Texas Foster Care Health Standards for Health Supervision of Children in Foster Care Served in Community-Based Health Care Settings," Texas Pediatric Society, February 18, 2016. See also Department of Health and Human Services, Office of the Inspector General, "Not All Children in Foster Care Who Were Enrolled in Medicaid Received Regional Health Screenings," OEI-07-13-00460, March 2015.

[6]"Texas Pediatric Society Foster Care Committee 2016 Report: Comparison of National vs. Texas Foster Care Health Standards for Health Supervision of Children in Foster Care Served in Community-Based Health Care Settings," Texas Pediatric Society, February 18, 2016.

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