Spring 5-2017

Case Study: Healthy Texas Women program in the Abilene-Taylor County Public Health District

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ABSTRACT

The public healthcare system faces continuous transformations and challenges of constant adjustments to the increasing usage of fee for service revenue and the decrease of federal investment to women's healthcare services and to the safety net healthcare providers (Meit, 2013; Weisman, 1997). In 2016, the Texas 84th Legislation Session determined to consolidate two existing women's healthcare service programs into one a single program: the Healthy Texas Women (HTW) program. The new women's program is a preventative care program that provides services of family planning and chronic illness care under a complete fee for service reambursement system as its sourse to create revenue. This case study was conducted to explore the effects of the Texas 84th Legislation Session changes on women's healthcare services had on Local Health Department in Abilene, Taylor County, Texas. Official documentation from the Abilene Taylor County Public Health District (ATCPHD) was collected explore the overall effects on volume of services provided, volume of population served, and to identify any gaps in services left by the implementation of the new women's healthcare program. Results of this research document how the ATCPHD experienced an increase in services pertaining to patient's age, outreach activities, family planning services, and physical exams while experiencing a decrease in service areas in client services, client exams, and in refill services and refill clients. The findings in this research provide a significant overview to HTW providers to understand trends and gaps in services related to preventative and chronic care in women's health.

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A Thesis

Presented to

The Faculty of the Graduate School

Abilene Christian University

In partial Fulfillment

Of the Requirements for the Degree

Master in Science in

Social Work

By

Saul Francisco Delgado

May 2017

This thesis, directed and approved by the candidate's committee, has been accepted by the Graduate Council of Abilene Christian University in partial fulfillment of the requirements for the degree

Master of Science in Social Work

Assistant Provost of Graduate Programs

Date

4-28-2017

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To my Lord and Savior, God the Father, God the Son, and God the Holy Spirit

Thank you, for this thesis could have not been possible without your strength, wisdom, presence, and love in my heart and in my life.

To my parents, Saul and Benita Delgado

Thank you for all of your emotional and spiritual support, encouragement, unconditional love, and unending prayers.

Dedicado a mis padres Saúl y Benita Delgado

Gracias por todo su apoyo emocional y espiritual, ánimo, amor incondicional y por sus continuas oraciones.

ACKNOWLEDGEMENTS

With honor and pleasure I would like to acknowledge my thesis committee, Dr. Kyeonghee Jang, Amy Kalb, and Nike Neuvenheim, for their assistance, time, and dedication in supporting me complete this research project. A warm thanks to the Abilene Taylor County Public Health District's Leadership Team, especially the Nursing Manager, Kay Durilla, for giving me the privilege to work with them. I would also like to thank my thesis chair Dr. Kyeonghee Jang for her advice and encouragement. Lastly, I would like to thank God for blessing me with my loving and supportive parents, Saul and Benita Delgado, for their unending support and prayers in this process.

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ASTHO – Association of State and Territorial Health Officials

ATCPHD – Abilene Taylor County Public Health District

CDC – Centers for Disease Control and Prevention

CMS – Centers for Medicare and Medicaid Services

DHHS – Department of Health and Human Services

DHS – Department of Homeland Security

EPA – Environmental Protection Agency

EPHC – Expanded Primary Health Care

FDA – Food and Drug Administration

HHSC – Health and Human Services Commission

HRSA – Health Resources and Services Administration

HTW – Healthy Texas Women

LHD – Local Health Department

MCR - Monthly Count Reports

MORN – Monthly Operating Report Numbers

NAACHO – National Association of City and County Health Officials

NHEA – National Health Expenditure Accounts

NIH – National Institutes of Health

OECD – Organization for Economic Cooperation and Development

RBRVS – Resource-Based Relative Value Scale

TWHP – Texas Women's Health Program

US – United States

USDA – Department of Agriculture

WHO – World Health Organization

WHP – Women's Health Program

CHAPTER I

INTRODUCTION

Problem Statement

Public health in the United Stated faces significant challenges due to constricting budget legislations and reduction of funding. As a result of the significant cuts in funding and rise in cost of services, public healthcare providers have faced increasing challenges to provide public health services, or prepare for new challenges in providing services in the future (Blendon & Desroches, 2003; Meit, 2013). From 2005 through 2010 the federal public health spending budget did not increase, rather than it remained flat; however, states around the country cut approximately $392 million from public health programs in 2009, despite increasing demands on the public health system (Krisberg 2010; Trust for America's Health 2010). In 2014, it was found that the discretionary health programs pertaining to public health services accounted only for 1.61 percent of the federal budget (Kaszuba, 2016).

The financial challenges reach all the levels of public health in the United States which include the state, tribal, and local health departments, as well as the community-based organizations that provide public health services such as immunizations, environmental inspections, and tracking of diseases, among others (Meit, 2013). From all the public health systems, it is the Local Health Departments (LHD) that serve as safety net healthcare providers in small jurisdiction (average population of 25,000 or less) that are more likely to have less access to funding sources, amplifying the consequences of

budget cuts in personal health services (Luo, Sotnikov, & Winterbauer, 2015). Therefore, it is a continuous challenge in how the safety net healthcare providers must constantly seek for new ways to serve their patients with fewer resources and more complex patients in comparison to other traditional healthcare service providers (Hacker, Santos, Thompson, Stout, Bearse, & Mechanic, 2014).

Similar to other public health systems, the LHDs receive a fraction of their funding by the federal Department of Health and Human Services (DHHS) in which the funding is provided through grants and contracts. Meit (2013) declares that a contributing factor of the uprising challenge faced by public healthcare providers is the historical dependency of federal funds where the finances tend to be allocated through categorical grants leaving public health providers with limited capacity to address local health needs. In regards to this up growing financial challenge, Meit (2013, p. 66) states: "The prescriptive nature of federal funding streams has led many health departments to develop and implement programs based on what is funded, rather than need." In addition to federal resources, LHDs may also receive funding from state and local sources. Another contributing factor to the financial challenges faced by the safety net healthcare providers can be attributed to the significant influence that the state or local government might have when allocating the distribution of funds (Meit, 2013). A state or local government may have the authority to make specific funding decisions, and whether revenues are retained at the state or local level.

Problem Statement in Abilene, Texas

In the state of Texas, the safety net healthcare providers also faced significant challenges as a result of budget legislations and reduction in funding. In 2011, the Texas

82nd Legislative Session cut two-thirds of funding for its 2010-2011 biennium budget for uninsured women with basic needs for preventative healthcare services (Texas Health and Human Services Commission, 2012). The services provided were estimated to have attended over 211,000 women in the prior year, whereas the budget cut led to only an average of 75,000 women being served after the budget legislation in the 2012 (Texas Health and Human Services Commission, 2012; Smith, 2013; Texas Women's Healthcare Coalition, 2013).

The safety net healthcare providers suffered from the severe funding cuts and many healthcare service providers who attended women services had to close their clinics. In response to the severe funding losses and reduction of services for Texas women, the Texas Women's Healthcare Coalition (2013) has stated the importance of quickly rebuilding its women's safety net healthcare providers to forestall a progression of undetected breast and cervical cancer, prevent complications of undetected diabetes and high blood pressure, reduce the occurrence of unplanned pregnancy, and improve the health of women and their families.

In response to target the severe budget cuts of the Texas 82nd Legislative Session, the Texas 84nd Legislative Session developed a new women's health program by combining two existing programs: the Texas Women's Health Program (TWHP) and Expanded Primary Health Care (EPHC). The new program, the Healthy Texas Women (HTW), was launched in July 1, 2016. The HTW program is primarily a family planning preventative program and will include breast and cervical cancer services, and limited primary care services related to reproductive health and chronic care. In addition of the

changes in services, the new women's program faced a change in its primary funding stream.

Instead of implementing a categorical grant, the HTW program will transition to a complete fee for service reimbursement system as the funding stream to create revenue. A fee for service reimbursement system compensates the healthcare providers based on an established rate for each individual service provided given to a patient (Drossos, 2002). With a fee for service reimbursement system, the more patients a healthcare provider sees in a given period of time, the more they will be compensated. By transitioning to this system, it is expected that the new women's program could enter into cost reimbursement contracts to conduct additional activities, increasing their range of services provided, and enhance the clinical outcomes for clients through the grogram (Traylor, 2016).

As a result of the 84th Texas Legislation Session, the implementation of the HTW program, with the fee for service reimbursement system, has had an impact around the state. In the City of Abilene, one of the LHDs that has experienced the transition to the new women's healthcare program has been the Abilene-Taylor County Public Health District (ATCPHD). The Agency is a division within the City of Abilene's Community Services Department. It serves as a LHD that provides a range of healthcare programs and services within the Abilene Taylor County area, and it is responsible for protecting and improving the community's well-being by providing preventative services for disease, illness, and injury. Also, the ATCPHD has the responsibility to educate and create awareness of public health, its benefits, and to impact the social, economic and environmental factors fundamental to public health.

The ATCPHD operates in partnership between the City of Abilene and Taylor County who establishes the terms in which the Agency administrates the community-wide public healthcare system, forms of monetary responsibility, and determines the involvement of the Health Advisory Board. Within the Fiscal Year 2015 the District operated under a budget of 4.9 million dollars, with an estimated of 1.1 million from the city of Abilene, 2.3 million from the Texas Department of State Health Services DSHS, 1.4 million from fee for services (i.e., Medicaid, private insurance, private pay feed for dental, immunizations and STC services), and $163,790.00 from Taylor County.

The ATCPHD provided its women's health services through the both the Texas Women's Health Program (TWHP) and Expanded Primary Health Care (EPHC) program. As of July 1, 2016, the Agency transitioned its women's healthcare services to the new women's program, HTW program, and transitioned to a complete fee for service reimbursement system as the funding stream to create revenue as established by the Texas 84th legislation directed by the Health and Human Services Commission (HHSC).

Adding to the complexity of studying the impact of financial legislation and budget changes in public health services for women in United States, gaps in available information pertaining to financial data in public health affect the ability to measure effectiveness and efficiency of a decision-making processes in the public health system (Meit, 2013). Also, gaps in information regarding to the impact of financial legislation and budget changes in public health for women may increase the difficulty for identifying the significant role public health plays in providing and sustaining services to the women in our country, and the quantification of its economic impact.

Purpose of Study

This study aims to explore the effects on the Abilene Taylor County Public Health District's HTW program as the result of the Texas 84th Legislation Session changes on women's healthcare services and the Agency's financial adjustments and adaptations in response to the programs' implementation of a complete fee for service reimbursement system. To study the financial effects that the Texas 84th Legislation Session budget change had on the ATCPHD, the research will explore the Agency's response in financial adjustments and adaptations through implementing the new women's health program and the transition to a complete fee for service reimbursement system as the main funding stream for revenue. In addition to exploring Agency's financial adjustments and adaptations, the researcher hopes to identify gaps in services, and populations excluded as a result from the implementation of the HTW program.

In light of the program being recently implemented in Abilene and around the state of Texas, it is crucial for the healthcare service providers, such as the Abilene Tylor County Public Health District, the Health and Human Service Commission, and other providers of the HTW program to have overview of the effects Texas 84th Legislation Session has had in women's healthcare services to better understand gaps women's health and prepare for new challenges in providing services in the future.

Research Question

What have been the effects on the Abilene Taylor County Public Health District's Health Texas Women program as the result of the Texas 84th Legislation Session budget change on women's healthcare services and the Agency's financial adjustments and

adaptations in response to the programs' implementation of a complete fee for service reimbursement system?

Significance

This research could have significant impact for the women who receive services through the HTW program by the ATCPHD and other healthcare providers in the State of Texas. This information can be utilized by the agency to help guide and lead further studies in ways to improve quality of healthcare services to women the Agency attends and prepare for new financial challenges that may occur in the future. Providing the Agency with the data collected from this study will help to improve its understanding of trends in services, and will help the Agency better identify any gaps in services by the HTW program. Also, this study can be useful for other HTW programs in the City of Abilene, around the State of Texas, and other women's safety net healthcare providers in the United States that have transitioned to a complete fee for service reimbursement system as their main funding stream to create revenue.

CHAPTER II

REVIEW OF LITERATURE

Introduction

The following literature review locates scholarly studies, federal and governmental reports, and official documents in pertaining to: 1) public health funding in the United States; 2) an description of two key federal funding streams in public health: categorical grant and fee for service; and 3) public health funding in the state of Texas; and 4) women's public health funding and programs in the state of Texas, followed by the importance for women's healthcare services and programs in the State.

Public Health Funding in the United States

Public health funding can be defined as the provision of resources required to provide public health functions and services, and the outcomes of the resources provided on the population's health (Honoré & Amy, 2007). In the United States, public health receives the majority of its funding through federal revenue from federal agencies such as the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), the U.S. Department of Agriculture (USDA), the Environmental Protection Agency (EPA), the Food and Drug Administration (FDA), the Department of Homeland Security (DHS), and finally the U.S. Department of Health and Human Services (DHHS) (Institute of Medicine, 2012; Meit, 2013). However, estimating the level and sum of federal funding, allocated to financially support public health and healthcare service providers, is a difficult and challenging task (Kinner, & Pellegrini,

2009). Independently how public health expenditures are estimated or who funds public health and public healthcare service providers, researchers agree that public healthcare service providers in the United States have constantly faced the challenge of being underfunded (DHHS, 1994; Baker, Potter, Jones, Mercer, Cioffi, Green, Halverson, Lichtveld, & Fleming, 2005). The majority of the Health and Human Services funding, a primary funding source for public health activities, is allocated to fund clinical care (through Medicaid and Medicare) and to fund the National Institutes of Health (NIH) (US Institute of Medicine, 2012). Contrary to the clinical care and NIH funding, a minimum fraction of the Health and Human Services funds are allocated to primary prevention and population-based intervention programs (US Institute of Medicine, 2012). While some researches (e.g., Krisberg 2010; Trust for America's Health 2010) state that the federal funding has been flat over the decades, other researches assert a decline in federal funding (Meit, 2013; Mapes, 2015; Rapaport, 2016).

According to the US Institute of Medicine (2012), a continuous challenge faced by public health and public healthcare service providers, when pertaining to receiving funds to supply the needs and demands of services, can be attributed to several factors. A first challenge when estimating the level of expenditures of public health can be attributed to the differences between definitions of public health. For example, a report published by the National Association of State Budget Officials included how "the promotion of chronic disease control and encouragement of healthy behavior and the protection against environmental hazards" in its definition of health spending (National Association of State Budget Officers, 2005). On the other hand, the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary added "publicly provided health

services such as epidemiological surveillance, inoculations, immunization, vaccination services, disease prevention programs, the operation of public health laboratories, and other such functions" as part of their public health activities (CMS, 2011). Another challenge when estimating the level of expenditures of public health can be attributed to projecting a holistic and inclusive perspective in how governmental bodies should define, consider, and identify public health, its services, and responsibilities (Curry, 2005). Finally, a third challenge faced by public health when estimating the level of funding is the absence of a universal or inclusive method or tool to track expenditures and revenues with accuracy, validity and reliability (US Institute of Medicine, 2012).

In order to calculate funding for public health, the U.S. DHHS annually publishes data presenting estimates in the total national health expenditures known as the National Health Expenditure Accounts (NHEA) (CMS, 2015). The NHEA is a tool utilized to measure the total annual dollar amount of health care consumption in the United States as well as the dollar amount invested in the medical sector in regards to equipment and non-commercial research to procure health services in the future. According to the Centers of Medicare and Medicaid Services (2015), utilizing the expenditures approach to national economic accounting to estimating the cost in Public Health, the NHEA provides a tool to quantifiably estimate consumption of health care goods and services in the US.

However, presenting a holistic, accurate, and reliable estimation of the cost of public health presents to be challenge for agencies, policy makers, and public health care providers (Kinner, & Pellegrini, 2009; US Institute of Medicine, 2012). The estimations of cost are related to the variation in how public health expenditures are defined at all levels of service. Public health expenditures may be reported with different methods. For

example: the NHEA utilizes a percentage of national health expenditures; both the Organization for Economic Cooperation and Development (OECD) and the World Health Organization (WHO) utilize a percentage of national gross domestic product; and organizations such as the Association of State and Territorial Health Officials (ASTHO), National Association of City and County Health Officials (NAACHO), utilize the total of dollars spent to calculate health expenditures (US Institute of Medicine, 2012).

Different methodologies of calculating the cost of public health expenditures can lead to different results and estimations, for example; a recent report has stated that the federal budget for CDC has gradually decreased 0.73 billion dollars in funding from Fiscal Year 2005 to Fiscal Year 2016 (Trust for America's Health, 2016). According to Kinner & Pellegrini (2009), the annual federal public health expenditures are only 0.08 percent of Gross Domestic Product (GDP), 1.5 percent of federal health-related expenditures, and 0.5 percent of total health related US public and private sector expenditures. In 2009, the NHEA estimated 3.1 percent of the country's budget, nearly $2.5 trillion dollars, was spent on government public health activities (Centers for Medicare and Medicaid Services, 2011). In 2014, Kaszuba (2016), estimated that all health programs that compose Public Health Services in the United States accounted for only 1.61 percent of the federal budget in 2014; and finally, researchers (e.g., Turnock 2009; and US Institute of Medicine, 2012) estimate that only 2 percent of DHHS funding is distributed between the HRSA and the CDC that serve as the primary federal sources of funding for local public health activities.

A report published by the US institute of Medicine (2012), reflect the complexity of relying on different definitions and methodologies to calculate the cost of public health

expenditures. The report documents how the National Health Expenditures Accounts states that 14.1 percent is attributed to the federal government and the remaining percent (85.9) was attributed to state and local government spending in regards to public health total spending. However, the percentages do not reflect the federal contributions to public health funding (US Institute of Medicine, 2012).

In the 2010 Fiscal Year report by the NACCHO data shows that federal funding accounted for 23 percent of public healthcare service providers' revenue; indicating that the federal government contributed in a minimum portion to financially support local public health activities (US institute of Medicine, 2012). Meanwhile, study conducted by Beitsch and colleagues estimated the total of public health spending of state and local governments by analyzing the data totaled from ASTHO and NACCHO reports. According to their study "spending of state and local public health agencies constituted 2.37 percent of all U.S. health spending for 2004" and 2.32 percent for 2005 (Beitsch, Brooks, Menachemi, & Libbey, 2006, pp. 917-918). On the other hand, the US institute of Medicine (2012) demonstrated how the Centers of Medicare and Medicaid Service's Office of the Actuary reported how the federal government public health activities accounted for 2.8 percent of the total expenditures for 2004 and 2005. When comparing the reports from the CMS office of the Actuary and the study conducted by Beitsch and colleagues (2006), the public health activities expenditures present similar estimates. According to the US institute of Medicine (2012, p.4-4), the non-uniformity of these estimates "offer another data point to document the growing imbalance between state and local [governments] compared to federal funding of public health."

The financial challenges faced by public health in the United States reach all levels in the public healthcare system including the state and local health care service providers. The growth in public healthcare financing between 1960 and 2001 has been influenced by increasing state and local government expenditures, which have accounted for between 80% and 90% of total public health spending (Himmelstein, Woolhandler, 2016). Dilger (2015) reported that in the Fiscal Year 2015 healthcare accounted for more than half of total (56.4%) expenditures for federal grants that were allocated to state and local governments. The financial struggles have increased the challenges for both state and local healthcare service providers resulting in the public healthcare system staffing cuts and/or reductions of health programs despite the increase of necessity for services (ASTHO, 2011; Meit, 2013; National Association of County and City Health Officials, 2011; Willard, Shah, Leep & Ku, 2012). A report based on a National Longitudinal Survey of Public Health Systems stated that 78 percent of the nation's larger health departments (those serving a population of 100,000 or more) eliminated one or more services between 1997 to 2008 (Hsuan & Rodriguez, 2014). And in 2012, 48 percent of local healthcare service providers reduced or eliminated services in at least one program area (Willard et al., 2012).

Researchers (e.g., Kinner, & Pellegrini, 2009; Meit, 2013; Luo, Sotnikov, Winterbauer, 2015) documented that states and local healthcare service providers face greater challenges for public health funding than federal agencies. Meanwhile, a report published by the US Institute of Medicine (2012), stated how the federal funding for state and local healthcare service providers is significantly lower than the federal funds allocated to other federal programs within the public healthcare system. For example,

"the federal contribution to governmental medical care cost, Medicaid and Medicare, which is 83 percent federal compared with 17 percent state and local funding, and 66 percent federal to 33 percent state and local funding for Medicaid alone" (US Institute of Medicine, 2012, p. 4-5).

Similar to accurately estimating expenditures of public health in the federal system, the state and local level of public healthcare funding is similarly complex. According to a report published in 2010 by the National Association of County and City Health Officials (NACCHO), the leading proportion of local public health department revenue (26 percent) comes from the local government, while 21 percent comes from state direct funding, and 14 percent from federal grant funds. The remaining 39 percent is provided by other financial sources, fees, and reimbursements systems such as Medicaid and Medicare reimbursement (NACCHO, 2011).

Public Health Funding Streams: Categorical Grants and Fee for Service

In the United States, a wide range of funding for public healthcare services and programs is provided by the DHHS. Through the HHS, funding is approved by grants and contracts to support of the public health systems' services provided by the state and/or LHDs (Meit, 2013). From all the different federal finding streams, the most utilized funding stream in the federal grant system are the categorical grants (DHHS, 1995). However, even though categorical grants are the most utilized funding stream from the federal system, public healthcare service providers also can receive funding from state and local sources including their General Fund allocations, and by providing services with fees and fines (Meit, 2013). Because the nature of this research is based on the HTW program, a federal program that transitioned to a complete fee for service reimbursement

system from a half categorical and half fee for service funding stream, the researcher will only focus on the categorical funding and the fee for service reimbursement system for this study.

Categorical grants

A categorical funding stream is defined as a state aid with the purpose of providing financial support for specific programs, operational functions, or financial activities (DHHS, 1995; Hightower, Mitani, & Swanson, 2010). This type of grant is considered to be the most restrictive out of all the grant funding streams due to its explicitly specific purposes defined for funding to be approved. Typically a categorical grant may require mandated federal applications, eligibility requirements, and reporting and outcome requirements to ensure that program and services provided are true to the program description (DHHS, 1995; Richter, 1992).

Beneficiaries of categorical funding spread across all levels in the public healthcare system. Funds can be allocated to a state, local, or at the non-profit level of public healthcare service providers. However, with a categorical funding stream, priorities are set by the state government to target what State Officials view as the most prominent programs in their legislative sessions (Smith, Gasparian, Perry, & Capinpin, 2013). Being considered such a restrictive funding stream, a categorical grant can bring upon both benefits and challenges for public healthcare providers and for the public health system in general around the US.

Because of its restrictive nature, a categorical grant can seem beneficial when the healthcare provider has a clear benchmark in projected health outcomes through the program or services being funded (Meit, 2013). A report published by the US Advisory

Commission on Intergovernmental Relations (1977), stated that a categorical grant is the funding stream that provides the most efficient and direct means for providing accurate accountability for federal funds and securing any national health objective. Being a federal funding stream that is determined by the State, State Officials might incline to prefer categorical grants over other approaches because they are viewed as an affective instrument for state and local healthcare service providers to deliver certain services (Advisory Commission on Intergovernmental Relations, 1978).

Keeping a strict accountability on public healthcare providers might seem as the most efficient way to target public health needs in the US; however, public health providers, services, and programs may face numerus challenges because categorical funds can only be used for strict grant purposes. Researchers (e.g., Advisory Commission on Intergovernmental Relations, 1978; DHHS, 1995; Meit, 2013) have stated that because of the restrictive nature of the categorical grant, states and local health care providers have faced the challenge of inflexible findings leaving many public healthcare providers with limited capacity to address local health needs. A DHHS report on categorical grants (1995, p. 7) stated that most "federal grants assume that national concerns are complementary to State and local needs".

Targeting a specific need can be challenging for healthcare programs in providing services to populations in need of the service(s) but do not qualify with the grant requirements. Since categorical federal funds are designated for a specific public healthcare program or service, it prevents service providers from using those funds to fill in gaps in population's health needs (Hulme, Hanlon, Barrientos, 2012; Meit, 2013). Because of the restrictive nature of the categorical grant, the federal grant system

fragments the ability of government at all levels to address people's needs and made government at all levels less effective (Gore, 1994).

Fee for service

Even though categorical grants are a common funding stream from the federal system, public healthcare providers also can receive funding from state and local sources, including their General Fund allocations, and by providing services with fees and fines through other health care systems such as Medicaid. Meit (2013) explains how Medicaid can be of great significance in funding public health services through the reimbursement for their services. The Health Insurance Glossary (1994) defines the fee for service reimbursement as a system of health insurance payment in which a doctor or other health care provider is paid a fee for each particular service rendered. In a fee-for-service reimbursement system, healthcare providers are rewarded for the volume of services provided.

Opposite from a categorical grant, where the funding allocations are precise, direct and strict, a fee for service reimbursement system is a relative, open, and an adjusted financial system. A fee for service system establishes the value of services provided utilizing a federal standard of physician payment schedule called Resource-Based Relative Value Scale (RBRVS). A report published by the Medicaid and CHIP Payment and Access Commission (2016) described how the RBRVS system is utilized in Medicare and it assigns every physician service a relative value based on the complexity of the service, practice expense, and malpractice expense. The relative value is fixed to a dollar amount that determines the amount of payment. Therefore, a State Medicaid

program that uses Medicare to generate revenue may establish relative value units to the physician services and even may set its own conversion factor.

Financial systems that include fees and fines for services are becoming more important revenue sources for healthcare service providers (Meit, 2013). However, healthcare service providers face a continuous challenge when they find themselves with financial gaps to cover start-up costs for practices such as patient follow-up, education, and outreach and offsite visits. To address the financial gaps left by the fee for service system, healthcare providers may tend add new payments to help offset these added costs (Friedberg, Chen, White, Jung, Raaen, Hirshman, & Tutty, 2015). Another challenge healthcare service providers face with fee for service is the uncertainty to strategically plan for future cost of their program or services. The cost of services being relative to physicians, public healthcare providers can only relay on the certainty of cost of services after the contract is signed, creating a greater challenge for preparing for future adjustments (Friedberg et al., 2015). Many healthcare providers around the Unites States have reported that the fee amounts in local services often do not keep pace with rising cost of programs and services creating a greater challenge to prepare for future financial needs and future healthcare legislations (Meit, 2013).

Public Health Funding in State of Texas

Because of the financial challenges in the public health system, state and local healthcare service providers face the uncertainty if their revenue projections will meet or exceed any grant stipulation (National Governors Association, 2008). State and local policy makers must balance the competing fiscal and budgetary pressures, including the growth of cost in services, and demographic changes amongst their state population. For

example: if expenditures exceed state revenues, State Officials may have to increase taxes or cut services (Kinner & Pellegrini, 2009). Legislative consideration in determining what is an appropriate funding to health care service providers demonstrate variance in funding according to emerging needs (Meit, 2013). By federal funds being allocated on an annual basis, legislative officials, states, and local healthcare service providers face a greater challenge to plan strategically, show results of newer programs, and face the risk of not being able to easily replace declining federal funding for core public health activities in the long term (Kinner, & Pellegrini, 2009). Also, state budget legislations and financial distribution amongst healthcare service providers are greatly influenced by policies at the national level, such as the Affordable Care Act. The complexity in balancing state budgets, including the requirement to balance state budgets annually and the rising cost of health care services, can be a contributing factor to the reduction of financial resources available for public health (National Conference of State Legislatures, 2007).

In the state of Texas, policy makers and State Officials have the responsibility of balancing the financial distribution, and managing the revenues and expenditures state wide. Because federal funds are allocated at an annual basis, State budgets present themselves to be complicated and fluid as they depend on uncertain revenues and planned expenditures, which may change over the course of a fiscal year (Kinner, & Pellegrini, 2009). The main source of federal funding for state and local healthcare providers in Texas is provided by the DHHS, through the CDC and the NIH (Texas Health Institute, 2012). The state government receives aid from the federal government to fund variety healthcare activities, mainly in the form of grants, for programs such as Medicaid

(National Association of State Budget Officers, 2012). Between 2010 and 2014, the Texas state budget spent on Medicaid increased from 24.6 percent in 2010 to 30.1 percent in 2014 (National Association of State Budget Officers, 2015). And between Fiscal Year 2014 and 2015, the State of Texas experienced an increase of 3.6 percent in government spending (Crawford, Church, & Akin, 2015; National Association of State Budget Officers, 2015).

In Texas, public healthcare service providers are supported through a combination of revenue streams from the federal, state, and local funding sources (Texas Health Institute, 2012). In cases where federal funds do not cover the totality of a service, especially when providing healthcare and preventative services, governments utilize the State General Funds as a source of funding (Meit, 2013). A report developed by the Texas Health Institute (2012, p. 21) stated that the "State General Revenue (GR) and local revenue directed to local public health represent the backbone of public health financing in Texas." Maintaining and economic health in the State could decrease the risk and challenges faced by public health care service providers and the public health care system as a whole (Adler & Newman, 2002). However, there is a sector in the Texas public healthcare system that has suffered significant funding reduction: women's healthcare and preventative services.

Funding for Women's Health in Texas

In 2007, the HHSC, under the authority of the Texas Legislature, initiated as a five-year Medicaid pilot program, called the Women's Health Program (WHP), which would serve as a preventive care and birth control program for low-income adult women. The WHP covered preventative healthcare services for women ages 18 through 44 with

incomes at or below 185 percent of the Federal Poverty Level. As a result, it was estimated that the program served an unduplicated total of 292,680 women enrolled in the WHP. The WHP enrollment increased from 92,000 women in 2007 (the first full year of the Program's operation) to 183,537 women in 2010 (Texas Health and Human Services Commission, 2011). According to the 2011 Annual Savings and Performance Report published by the HHSC (2012), the WHP, as a Medicaid program, had significantly expanded access to preventive care for Texas women, while reducing federal and state tax costs.

The Texas government had combined several sources of federal funding in order to provide uninsured women with basic preventative and reproductive healthcare services such as: cancer screenings, and birth control (Texas Women's Healthcare Coalition, 2013). Until 2011, over 300,000 low-income women received essential healthcare from the Department of State Health Services Family Planning program and the WHP (Texas Women's Healthcare Coalition, 2013). In the Texas 82nd Legislative Session, in 2011, the Department of State Health Services reduced funds that were allocated to the Texas Family Planning Program who provided services to the women around the State (Texas Health and Human Services Commission, 2012). The services provided were estimated to have attended over 211,000 women in the prior year, whereas the budget cut led to only an average of 75,000 women being served after the budget legislation in the 2012 (Texas Health and Human Services Commission, 2012; Smith, 2013; Texas Women's Healthcare Coalition, 2013). As a result, more than 50 women's healthcare clinics suffered a termination of their services which included preventive care, examinations,

breast and cervical cancer screenings, and contraception over 145,000 low-income women (Pogue, 2013; Texas Women's Healthcare Coalition, 2013).

The WHP and women's healthcare services continued to experience a decrease in federal funding. To prevent the loss of this program for Texas women the program transitioned to be federally funded to be a State funded program known as the TWHP (Pogue, 2013b; Texas Health and Human Services Commission; 2015). As a result of the reduction in funding in women's healthcare and preventative services, reports have stated that there was a decrease of 9.1 percent in the total number of enrolled women in the program (Smothers, 2015; Texas Health and Human Services Commission; 2015; Berlin, 2016). A report published by the DeLuna (2015) described that in the State of Texas, the WHP grew up to 130,000 women served from 2007 until 2011. Since the legislative budget cut in 2011 the WHP and the TWHP continuously declined; by 2012 there was an enrollment of 120,600 and in July 2013 only 99,300 women were enrolled to receive these services.

With the goal to improve access to preventive health care to women, the Texas Department of State Health Services lead the Texas 83rd Legislative Session, in 2013, and created the EPHC grant (Pogue, 2013b; Texas Department of State Health Services, 2015b). The grant was established to be a hybrid grant pertaining to Non-Contraceptive Prescription Services that would include the same fees from both a categorical from grant and fee for service reimbursement contracts (Texas Department of State Health Services, 2015a). In addition to women's preventative reproduction healthcare services, the EPHC program also included a focus for preventative chronic illnesses. The Primary Health Care and EPHC Services FY 2015 Annual Report published by the Texas Department of

State Health Services (2016, p. 3) established that the EPHC program aimed to "reduce the number of preterm births; and reduce the number of cases of potentially preventable hospitalizations related to hypertension and diabetes."

In response to target the severe budget cuts established in the Texas 82nd Legislative Session and the reduction of enrollment to services presented at the Texas 83rd Legislative Session, the Texas 84th Legislative Session determined that the Health and Human Service Commission will consolidate the TWHP and the EPHC into a single program: the Healthy Texas Women (HTW) program. In addition of the State Government legislating for a change in services, there was also a change in funding stream for the HTW program. Instead of implementing a categorical grant as the funding stream, the HTW program will transition to a complete fee for service reimbursement system. It was expected that by providing services under a complete fee for service system, the HTW program could enter into cost reimbursement contracts to conduct additional activities that will enhance the clinical outcomes for clients seen under the new women's program (Traylor, 2016).

The new women's program, the HTW, was launched in July 1, 2016. The HTW program includes preventative healthcare services such as testing and counseling, family planning, immunizations, breast and cervical cancer screenings, and chronic care including screenings and treatment for diabetes, hypertension, and high cholesterol (Berlin, 2016; Smith, 2016; Traylor, 2016). The HTW program will also provide services to women aging between 15 to 44, have an income at 200 percent of the federal poverty level or below, are U.S. citizens or legal immigrants, and for women who are not bearing pregnancy (Traylor, 2016). The eligibility requirements for the HTW program

were established to broaden intake of clients and make women's health, preventative and chronic-care services more accessible. It is expected that the new 200 percent of the federal poverty level or below income requirement allows for greater eligibility for low-income women contrary to the TWHP who only allowed eligibility for women at or below 185 percent of the federal poverty level (Berlin, 2016). According to the Health and Human Services Executive Commissioner, Charles Smith, more than 5,000 healthcare providers all across the state are now part of HTW resulting in a 30 percent increase in providers state wide (Smith, 2016).

Importance of Women's Healthcare Services in Texas

Balancing legislative budgets and the rising cost of health care services are contributing factors of limiting the access of public health (National Conference of State Legislatures, 2007). Even before the funding reduction occurred in 2011, hundreds of thousands of low-income Texas women who needing preventive care did not receive it threatening the health of Texas' women and children (Texas Women's Healthcare Coalition, 2013). According to the US Census Bureau, in 2006, approximately 13% of all pregnant women in the US were uninsured. It was estimated that in 2006, 12.6 million women in child bearing age (27.2% of all the uninsured population in the U.S) (U.S. Census Bureau, 2007). Approximately half of all sexually active women of reproductive age are estimated to be in need of publicly funded services, and only 50% of them are served under a health care provider system (Gold, Sonfield, Richards, & Frost, 2009; Guttmacher Institute, 2009). Research as shown that women with lack of health coverage or have limited access to a public health care provider are 30% less likely to use prescription contraception methods contributing to a higher risk in health disparities and

an elevated rate unintended pregnancies (Culwell & Feinglass, 2007; Dehlendorf, Rodriguez, Levy, Borrero, & Steinauer, 2010). Women with unintended pregnancies have are more likely to receive poor prenatal care and suffer from disparity health outcomes increasing the risk for the mother and child Kost, Landry, & Darroch, 1998).

During 2009 through 2011 the uninsured women in Texas averaged 34.2% percent, while the need for public women's preventive care increased 12% percent between 2000 and 2008 (March of Dimes Foundation, 2012). According to Kingsley (2010), nearly half, 47%, of the pregnancies in the state were unplanned. This amounts to an average of 180,000 births each year in the State with higher at-risk health outcomes for both mother and baby. In 2015 it was estimated that that one in three Texas women of childbearing age are uninsured and over one million Texan women, aging from 20-44 years old, are in need of public preventive care and birth control (Frost, Henshaw, & Sonfield, 2010).

During 2013, the state of Texas was the highest percentage of uninsured adults with over 22% of the total state population in need of health care insurance (Smith & Madelia, 2014). Today, Texas continues to be the State with the highest rate of uninsured adults averaging at 30% from the State's total population that lack from health care insurance (DeLuna Castro, 2015). A study conducted by the Kaiser Family Foundation (2016) found that 21% of Texan women were uninsured.

In cases of pregnancy, women who suffer from chronic illness may intensify the risk to their health (Gupton, Heaman, & Cheung, 2001). Unattended women with chronic disease during pregnancy can suffer from cumulative degeneration of the body on a woman during pregnancy where they may be more at risk for health alterations

(McCoy, Beal, Saunders, Hill, Payton, & Watson, 2008). Attending and identifying symptoms is important to improve overall maternal and fetal well-being and family health. Unless women suffering from chronic illnesses during pregnancy are attended by a health provider it can be assumed that there will be effects on the mother and child's health during and possibly after pregnancy (Mishra, Dobson, & Schofield, 2000).

Consequences such as low rates in preventative care, greater probabilities in death, and high rates of unplanned pregnancies are correlated with the risk of not having access to health insurance (Culwell, & Feinglass, 2007; Institute of Medicine, 2009; National Immigration Law Center, 2014). Uninsured women were found to have lower use of important health care and preventative services and are more likely to reject medical services due to cost (Salganicoff, Ranji, Beamesderfer, & Kurani, 2014). Texas ranks as the state with the highest percentage of women who have not seen a doctor in the past year due to cost (James, 2009). The elevated cost or limited access to public health care prevents women to gain access to both essential preventative services and chronic illness treatments.

Recognizing the challenges faced by healthcare service provides to facilitate access to women's health; Texas policy makers recognize the importance and need to for women to have access to healthcare, preventative and chronic-care services at little or no cost (Smith, 2016). By combining two existing health and preventative service programs (the TWHP and EPHC) the HTW can be a tool to make women's health, preventative and chronic-care services more accessible to women in the state of Texas. In Taylor County Texas, the Country Health Rakings report published by the Robert Wood Johnson Foundation (2016) identified that 22 percent of Taylor County's population did not relay

on an insurance plan and 18 percent of the County's population was considered to live at a Poor or fair health conditions.

As part of the public healthcare system in Taylor County, the Abilene-Taylor County Public Health District, a LHD, is a local healthcare service provider that also transitioned its women's healthcare services to the new HTW Program as required and established by the Texas 84th Legislation directed by the HHSC.

CHAPTER III

RESEARCH METHODOLOGY

Research Design

An exploratory case study design should be considered when a researcher cannot manipulate behaviors or events involved in the study, and when a researcher desires to cover contextual conditions because they are relevant to the phenomenon under study (Baxter & Jack, 2008; Zainal, 2007). In this case study, the researcher aims to explore the effects on the Abilene Taylor County Public Health District's HTW program as the result of the Texas 84th Legislation Session changes on women's healthcare services and the Agency's financial adjustments and adaptations in response to the programs' implementation and transition to a complete fee for service reimbursement system.

To explore these effects, the researcher explored two main categories of study: first, the research will explore the Agency's response in financial adjustments and adaptations through implementing the new women's health program and the transition to a complete fee for service reimbursement system as the main funding stream for revenue. Second, the researcher explored the effects of the program's implementation in regards to the volume of services provided, volume of population served, cost effectiveness and methods of payments most utilized by patients. Because the nature is this research is to explore the two categories of study; the nature of this study will be a non-experimental case study research.

In addition to the case study design, this research is a longitudinal single case study. According to Yin (2003) a longitudinal single case study is utilized to when studying the same single case at two or more different points in time. According to the Texas 84th Legislation, the HTW program became effective in July 1, 2016; therefore, in order to complete the longitudinal single case study for this research, the comparison is in contrast with the two prior programs providing similar services before the HTW program: the EPHC and the TWHP. To better identify and understand the two categories of study within the ATCPHD, data was compared from two different time periods, 2015 with 2016. Because the HTW program became effective in July 1, 2016, the time periods analyzed, from which the data was collected, was the six months from July through December of 2015 (Time Period 1) and from July through December of 2016 (Time Period 2).

The research question the researcher is seeking to answer is: What have been the effects on the Abilene Taylor County Public Health District's Health Texas Women program as the result of the Texas 84th Legislation Session budget change on women's healthcare services and the Agency's financial adjustments and adaptations in response to the programs' implementation of a complete fee for service reimbursement system?

In addition to the main research question, and to further explore the study categories in this case study, additional research questions the researcher is seeking to answer are: Does the HTW program provide greater amount of services than the former women's health programs (TWHP and EPHC)?; Is the Health Texas Women program providing services to a greater volume of population than the former women's health programs? If not, what populations seem to be excluded from receiving these services?;

Has the HTW program proven to be more cost effective to its consumers?; What are the payment methods utilized by clients receiving these services?; and What were the major organizational financial adjustments and adaptations through implementing the new women's health program and the transition to a complete fee for service reimbursement system as the main funding stream for revenue?

Data Collection

Under the supervision of the administrative staff of the Abilene-Taylor County Public Health District, the researcher utilized Official Documentation in order to explore the categories of study. Specifically, the documentation was retrieved through the ATCPHD Monthly Count Reports (MCR) and the ATCPHD Monthly Operating Report Numbers (MORN) provided by the ATCPHD Nursing Manager for both Time Period 1 and Time Period 2.

To the overall effects of the HTW program, the researcher explored if the new women's program provided a greater amount of services, increased their population served. The researcher will obtain the data in regards to services, patients demographic, and payment method(s) from the ATCPHD EPHC program and TWHP monthly service reports of Time Period 1, and from the HTW program monthly service reports of Time Period 2.

In order to explore any financial adjustments and adaptations through implementing the new women's health program and the transition to a complete fee for service reimbursement system as the main funding stream for revenue; the researcher will collect the information from the ATCPHD monthly financial reports in regards to

women's healthcare and preventative services provided during Time Period 1 and Time Period 2.

Complications in the data collection process did not allow the researcher to collect data pertaining to patient's demographics, payment method(s) most utilized, nor any financial adjustments and adaptations through implementing the new women's health program and the transition to a complete fee for service reimbursement system.

Data Collection Approval

With the approval of the Abilene Christina University IRB (Appendix A), the research was approved as a Non-Human research. With the consent of the ATCPHD (Appendix B) and under the supervision of the administrative staff, the researcher will gather and analyze any data collected in this study. It is not expected that any level of confidentiality will be breached or at risk during this proses of data collection by reason that the service and monthly financial reports are organizational reports and public documents which exclude any personal information from the clients who have received the services provided by the Agency.

Data Analysis

The analysis strategy for this longitudinal single-case study was an embedded rationale design. According to Yin (2003), an embedded rationale is utilized when the same case study involves more than one unit of analysis and the study categories may consist of subcategories or subunits. To better identify the effects on the ATCPHD's HTW program as the result of the Texas 84th Legislation Session changes on women's healthcare services and the Agency's financial adjustments and adaptations in response to the programs' implementation and transition of a complete fee for service reimbursement

system, the researcher divided the data into two categories. Category 1 will analyze the effects on the program's services; the subcategories in Category 1 will be: volume of services provided, volume of population served, client's race/ethnicity, client's age, income (level of poverty), cost effectiveness and payment methods utilized client. Category 2 will analyze the Agency's financial adjustments and adaptations in response to the programs' implementation and transition of a complete fee for service reimbursement system.

Category 1 was analyzed by the researcher and aimed to identify and compare the main trends in volume of population served, cost effectiveness and patient's payment methods utilized from both Time Period 1 and Time Period 2 utilizing a single time series analysis. The method(s) utilized for the data analysis of Category 1 will be data tabulation and other comparative analysis methods as appropriate to further explore all three categories of study. Quantitative data from Category 1 will enter into Statistical Package for Social Science (SPSS) for analysis.

CHAPTER IV

RESULTS

The following chapter presents the results of an exploratory case study research on and services provided by ATCPHD in response to the 84th Texas Legislation which implemented the Heal Texas Women program. Because the HTW program became effective in July 1, 2016, data from the two time periods were analyzed: the six months from July through December of 2015 (Time Period 1) and July through December of 2016 (Time Period 2). In this case study, the researcher presents Expanded Primary Health Care, TWHP, and the HTW programs' outputs in the ATCPHD according to the results of the program's volume of services provided and volume of population served. This section presents services according to patient age ranges, exams and refill services, outreach activities, family planning methods most utilized, and physical exams of physical assessment by doctor provided at the ATCPHD. To better identify and understand the volume of services provided and volume of population served presented in this study, the results from each time period are presented first and followed by the comparison between them.

Time Period 1 (July 2015 – December 2015)

Patient Age

The age ranges of patients who were seen for family planning services during Time Period 1 (TP1) were reported in the ATCPHD MCR. Table 1 reflects the count of

patients served per month, the total counts and percentage of patients served according to age range, and the average of patients served per month and by age range.

The total 139 patients were served in this time period and 23.1 patients served per month. The greatest age range of population served was 23-34 years old with a total of 80 patients served during the six months (57.5%) and 13.3 patients served per month. The lowest age range of population served was the 'Under 14' group with a total of 1 patient served (.7%) meaning 0.1 patients served per month.

Table 1

Age of Clients Served: Time Period 1

Age	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	Total # served	%	# served per month
Under 14	1	0	0	0	0	0	1	.7	0.1
15-17	3	0	2	0	1	1	7	5	1.1
18-21	13	6	9	5	3	1	37	26.6	6.1
23-34	19	10	13	12	8	18	80	57.5	13.3
35+	0	0	5	1	1	7	14	10	2.3
Total	36	16	29	18	13	27	**139**	**100**	**23.1**

Exams, Refills, and Outreach Activities

The exams and refills services provided during TP1 were reported in the ATCPHD MORN. Table 6 reflects the numbers of for exams provided to patients (Client Exams), exam services (Client Series), refills provided to clients (Refill Clients), and refill services (Refill Services). The values in the Client Services are 14 times of Client Exams because 14 services were provided as part of the examination process of each client. In regards to refills provided; the values in the Refill Services are 4 times of the

Refill clients because 4 services were provided as part of the examination process of each client.

The total of Client Exams provided in TP1 was 335 and 55.8 client exams provided per month; a total of 4,720 client services and 786.6 services provided per month in TP1. In regards to the refills and refill services, the ATCPHD provided a total of 361 and 60.1 client refills per month; and a total of 1,387 refill services and 231.1 refills provided per month. Finally, the ATCPHD provided a total of 7 and 1.1 outreach activities per month.

Table 2

Exams, Refills, and Outreach Activities: Time Period 1

Variable	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	Total # served	# served per month
Client Exams	118	33	69	43	35	37	335	55.8
Client Services	1652	462	996	602	490	518	4720	786.6
Refill Clients	63	56	85	59	46	52	361	60.1
Refill Services	252	224	340	236	127	208	1387	231.1
Outreach activities	0	1	2	4	0	0	7	1.1

Family Planning Methods

The family planning methods served in TP1 were reported in the ATCPHD MCR. Table 3 reflects the different types of family planning methods provided by the ATCPHD, and the total counts and percentage of family planning methods served in TP1.

As Table 3 indicates, the total of family planning methods served TP1 was 53. Of the total of family planning methods served in TP1, the greatest method utilized was the pill with 18 (33.9%), and 3 pill servings per month. The lowest method utilized in TP1

was the path method with 0 patches served during this time. The ACTPHD provided an overall average of 9.4 family planning methods services per month throughout TP1.

Table 3

Family Planning Methods: Time Period 1

Variable	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	Total # served	%	# served per month
Pill	4	0	0	5	5	2	18	33.9	3
Depo	1	3	4	3	0	1	12	22.6	2
Ring	0	0	1	0	0	0	1	1.8	0.1
Patch	0	0	0	0	0	0	0	0	0
IUD	0	0	0	1	2	1	4	7.5	0.6
Condoms	0	1	2	1	0	0	4	7.5	0.6
Other	7	0	2	0	3	2	14	26.4	2.3
Total	12	4	11	10	10	10	**53**	**100**	**9.4**

Physical Exam of Physical Assessment by Doctor

The physical exams of physical assessment by doctor provided by the ATCPHD were reported in the ATCPHD MCR. Table 4 reflects the different types of physical exams provided by the ATCPHD, the total counts and percentage of family planning methods served in TP1.

As Table 4 indicates, the total of physical exams of physical assessment by doctor provided in TP1 was 138. Of the total of physical exams of physical assessment by doctor provided in TP1, the physical exams of physical assessment by doctor most provided were the general exams with 110 (79.7%) and 18.3 services provided per month. The least physical exams of physical assessment by doctor was the Intra Uterine Device (IUD) with 2 (1.4%) and 0.3 IUD per month provided during TP1. The ACTPHD

provided an overall average of 23 physical exams of physical assessment by doctor services per month throughout TP1.

Table 4

Physical Exam of Physical Assessment by Doctor: Time Period 1

Variable	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	Total # served	%	# served per month
Exams	27	10	26	17	11	19	110	79.7	18.3
IUD	1	0	1	0	0	0	2	1.4	0.3
Other	8	6	1	1	2	8	16	11.5	4.3
Total	36	16	28	18	13	27	**138**	**100**	**23**

Time Period 2 (July 2016 – December 2016)

Patient Age

The age ranges of patients who were seen for family planning services during Time Period 2 (TP2) were reported in the ATCPHD MCR. Table 5 reflects the count of patients served per month, the total counts and percentage of patients served according to age range, and the average of patients served per month and by age range.

The total 187 were served in this time period and 31.1 served per month. The greatest age range of population served was 23-34 years old with a total of 107 patients served during the six months (57.2%) and 17.8 patients served per month. The lowest age range of population served was the ‘Under 14’ group with a total of 0 patient served (0%) meaning 0 patients served per month.

Table 5

Client age: Time Period 2

Age	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	Total # served	%	# served per month
Under 14	0	0	0	0	0	0	0	0	0
15-17	3	0	1	2	0	2	8	4.2	1.3
18-21	11	8	9	10	4	6	48	25.6	8
23-34	14	23	18	20	14	18	107	57.2	17.8
35+	5	2	3	6	1	7	24	12.8	4
Total	33	33	31	38	19	33	**187**	**100**	**31.1**

Exams, Refills, and Outreach Activities

The count for exams provided to patients (Client Exams), number of exam services (Client Series), refills provided to clients (Refill Clients), and number of refill services (Refill Services) were reported in the ATCPHD MORN. Table 6 reflects the total count and monthly average for each variable for exams and refills. For every one client examined, 14 services were provided as part of the examination process. In regards to refills provided, for every one client refill, four services were provided as part of the refill process.

As Table 6 indicates, the total of client exams provided in TP2 was 213and 35.5 client exams per month; and a total of 3,024 client services provided and 504 services per month in TP2. In regards to the refills and refill services, the ATCPHD provided a total of 169, and 28.1 client refills per month; and a total of 676 refill services and 112.6 refills per month. Finally, the ATCPHD provided a total of 8 and 1.3 outreach activities per month.

Table 6

Exams, Refills, and Outreach Activities: Time Period 2

Variable	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	Total # served	# served per month
Client Exams	58	34	31	38	19	33	213	35.5
Client Services	812	476	486	580	290	380	3024	504
Refill Clients	56	39	44	12	6	12	169	28.1
Refill Services	224	156	176	48	24	48	676	112.6
Outreach activities	0	0	1	5	1	1	8	1.3

Family Planning Methods

The family planning methods served in TP2 were reported in the ATCPHD MCR. Table 7 reflects the different types of family planning methods provided by the ATCPHD, and the total counts and percentage of family planning methods served in TP2.

As Table 7 indicates, the total of family planning methods served TP2 was 77. Of the total of family planning methods served in TP2, the greatest method utilized was condoms with 25 (33.4%) and 4.1 condoms servings per month. The lowest method utilized in TP1 was the path method with 0 patches served during TP2. The ACTPHD provided an overall average of 12.8 family planning methods services per month throughout TP2.

Table 7

Family Planning Methods: Time Period 2

Variable	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	Total # served	%	# served per month
Pill	2	8	1	5	1	2	19	33.9	3.1
Depo	3	2	1	3	2	0	11	22.6	1.8
Ring	1	1	1	0	0	0	3	1.8	0.5
Patch	0	0	0	0	0	0	0	0	0
IUD	2	0	0	1	0	1	4	7.5	0.6
Condoms	1	9	8	3	2	2	25	32.4	4.1
Other	7	0	6	4	1	4	15	26.4	2.5
Total	9	20	17	16	6	9	**77**	**100**	**12.8**

Physical Exam of Physical Assessment by Doctor

The physical exams of physical assessment by doctor provided by the ATCPHD were reported in the ATCPHD MCR. Table 8 reflects the different types of physical exams provided by the ATCPHD, the total counts and percentage of family planning methods served in TP2.

As Table 8 indicates, the total of physical exams of physical assessment by doctor provided in TP2 was 184. Of the total of physical exams of physical assessment by doctor provided in TP2, the physical exams of physical assessment by doctor most provided were the general exams with 105 (57.6%) and 17.6 services provided per month. The least physical exams of physical assessment by doctor were the breast exams and Pap smear exams with 0 breast exams and 0 Pap smear exams provided during TP2. The ACTPHD provided an overall average of 30.6 physical exams of physical assessment by doctor services per month throughout TP2.

Table 8

Physical Exam of Physical Assessment by Doctor: Time Period 2

Variable	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	Total # served	%	# served per month
Exams	20	18	16	24	7	21	106	57.6	17.6
IUD	2	2	0	0	3	2	9	4.8	1.5
Other	9	12	15	14	9	10	69	37.5	11.5
Total	31	32	31	38	19	33	**184**	**100**	**30.6**

Comparison between TP1 and TP2

Client Age

Figure 1 visualizes the comparisons of clients' age between Time Period 1 (Table 1) and Time Period 2 (Table 5). Based on the values from the tables, the number of clients served changed from 139 at TP1 to 187 at TP2, indicating an increase of 34.5 percent in total patients served throughout the months of July through December. However, the patterns remained the same for both time periods: the highest age range served being 23-34 and the lowest age range served being the population of Under 14 years of age.

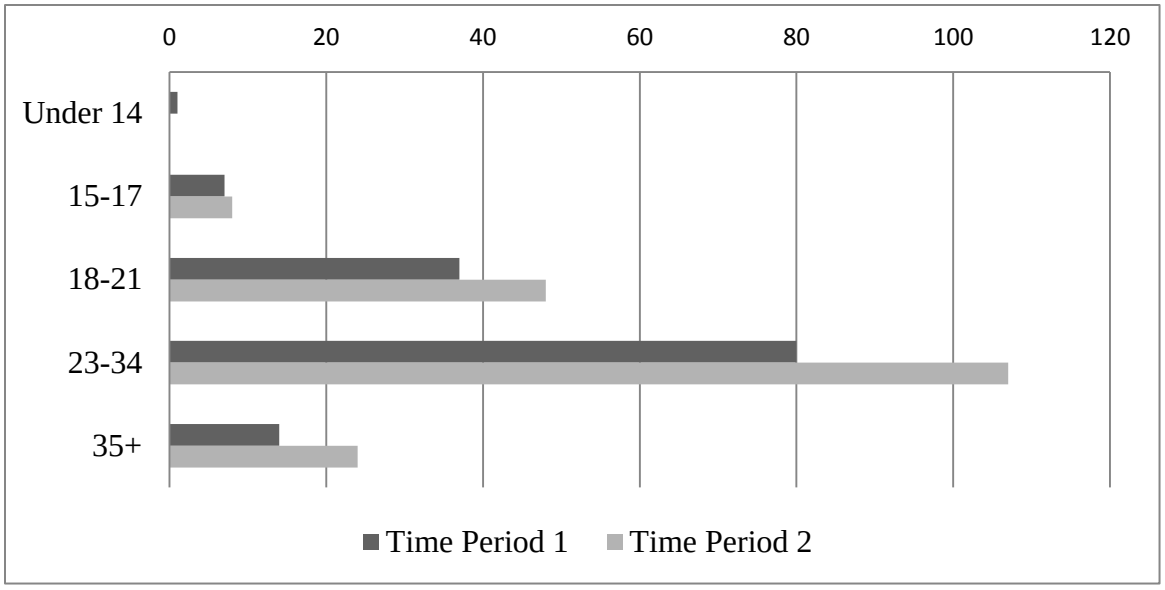

Figure 1. Patient age range.

Exams, Refills, and Outreach Activities

Client exams and services. Figure 2 and Figure 3 visualize the comparisons of client services exams and client services between Time Period 1 (Table 2) and Time Period 2 (Table 6). Based from the values of the tables, the number of client exams changed from 335 at TP1 to213 at TP2, indicating a decrease 36.4 percent in total client exams provided throughout the months of July through December. Correspondingly, the number of client services also changed from 4,720 at TP1 to 3,024, indicating a decrease of 35.9 percent in total client services provided throughout the months of July through December. Figure 2 and Figure 3 visualize how both time periods experienced a decrease of client exams and client services through the months of July through August. Between the months of August and September, TP1 experience an increase in client exams and client services and a decrease between September and October. Meanwhile, TP2 experienced a slight decrease in client exams and client services between August and September and minor increase between September and October. Both time periods

demonstrated similar dynamics between the months of October through December experiencing a decrease of client exams and client services between October and November and an increase in client exams and client services between November through December.

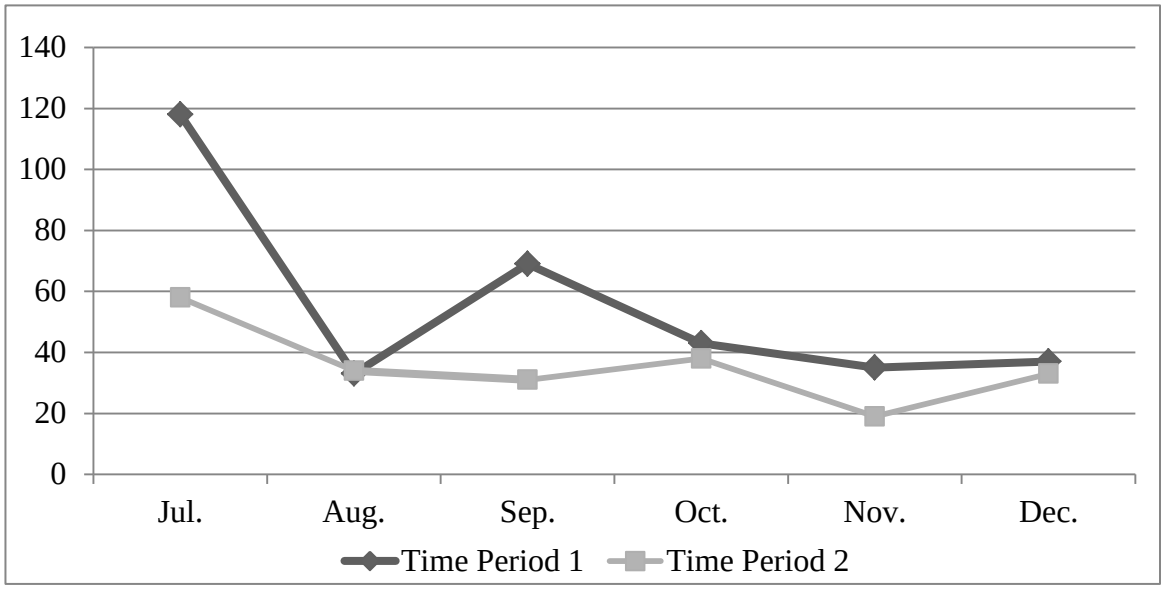

Figure 2. Client Exams.

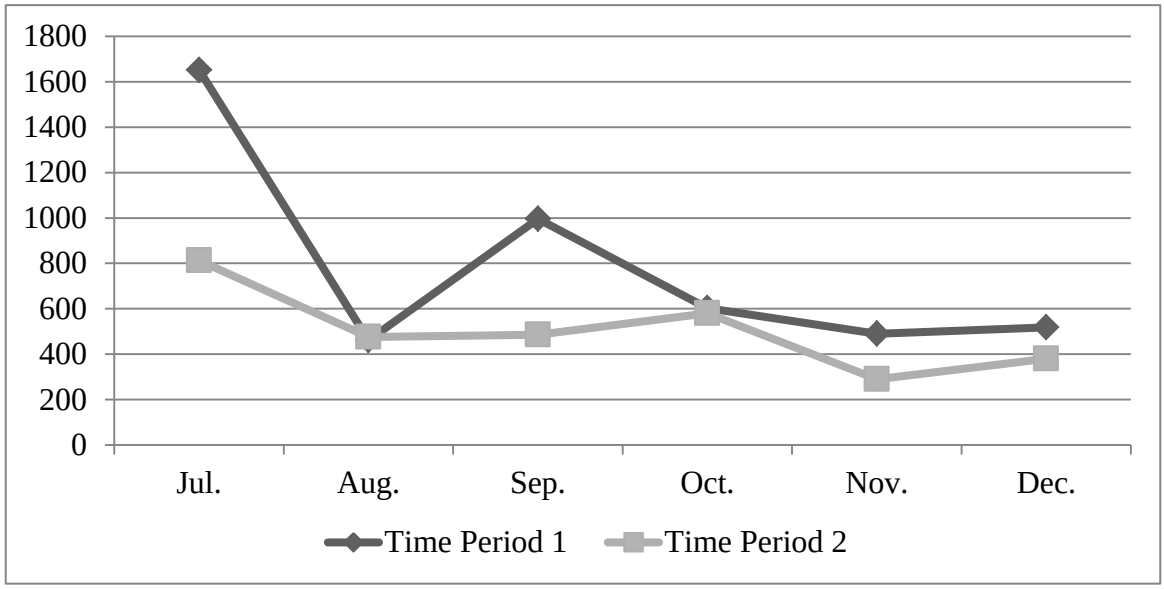

Figure 3. Client services.

Refill clients and services. Figure 4 visualize the comparisons of refill client, and Figure 5 visualize the comparisons of refill services between Time Period 1 (Table 2) and Time Period 2 (Table 6). Based from the values of the tables, the number of refill clients changed from 361 at Time Period 1 to 169 at Time Period 2, indicating a decrease of 53.1 percent in refill clients served throughout the months of July through December. Correspondingly, the number of refill services provided also changed from 1,387 at Time Period 1 to 676 at Time Period 2, indicating a decrease of 51.2 percent in refill services provided throughout the months of July through December.

Figure 4 and Figure 5 visualize how both time periods experienced refill client and refill service dynamics between the months of July through December. For Refill Clients and Refill Services, both time periods experienced: a decrease in client intake between the months of July through August; an increase in client intake between August through September; a continuous decrease in client intake between September through November; and finally an increase in client intake between November and December.

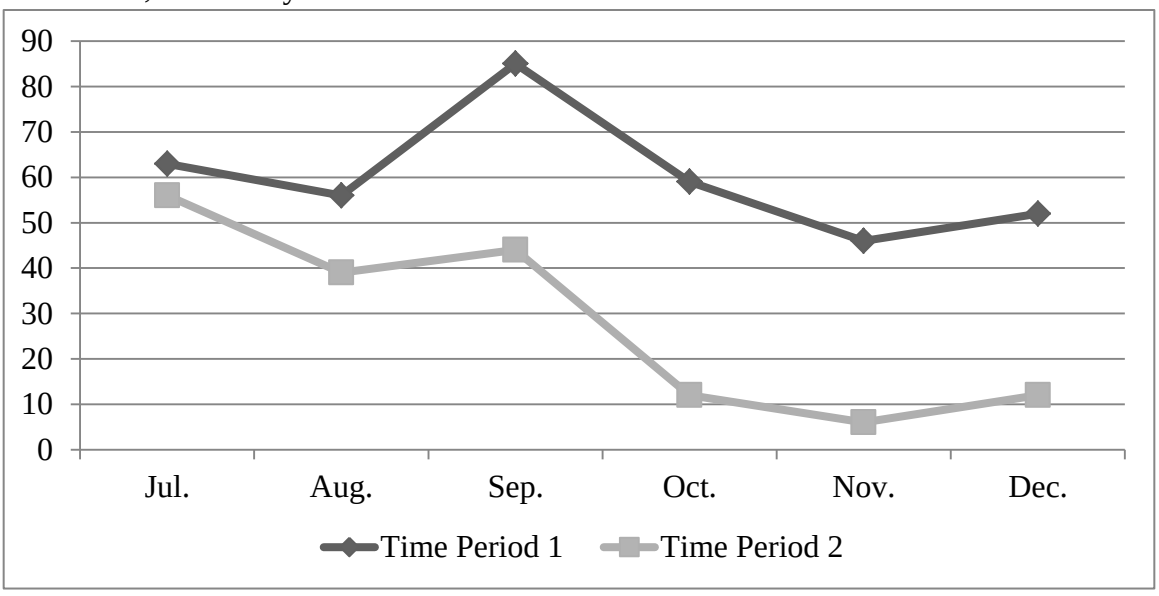

Figure 4. Refill client.

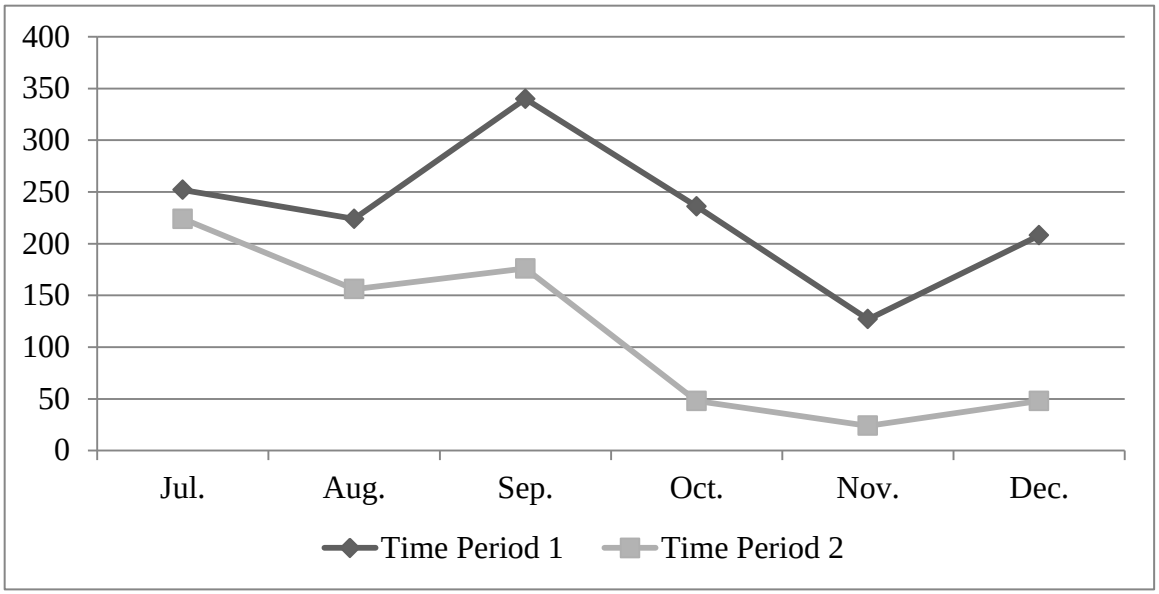

Figure 5. Refill services.

Outreach activities. Figure 6 visualizes the comparisons of outreach activities provided in Time Period 1 (Table 2) and Time Period 2 (Table 3). Based on the values from the tables, the number of outreach activities provided changed from 7 at TP1 to 8 at TP2, indicating an increase of 14.2 percent in total family planning methods served throughout the months of July through December.

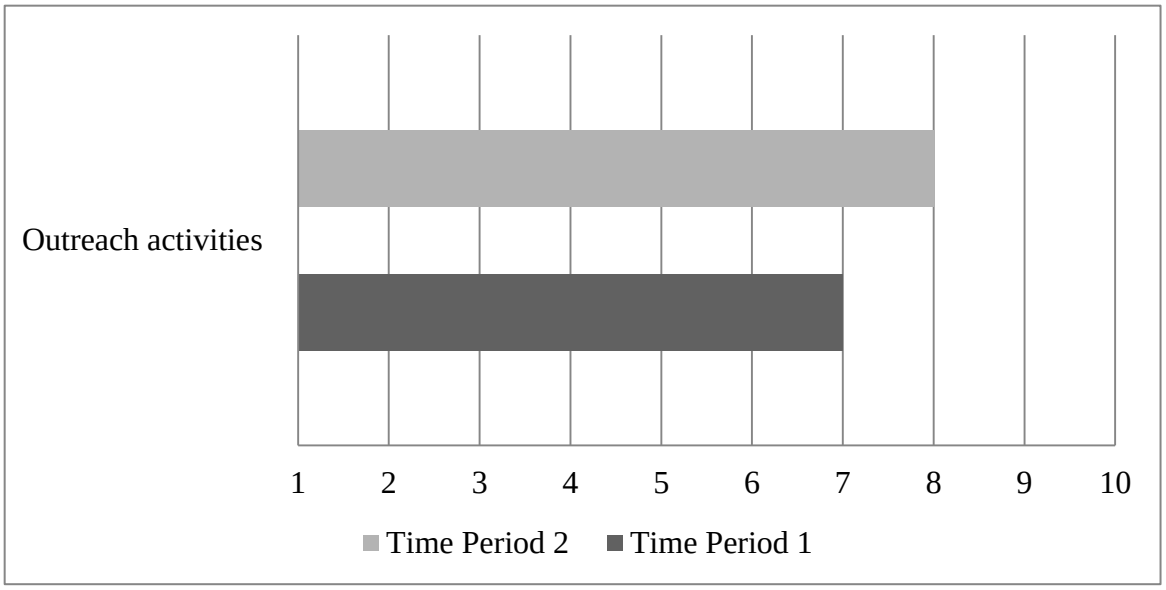

Figure 6. Outreach activities.

Family Planning Methods

Figure 7 visualizes the comparisons of family planning methods served between Time Period 1 (Table 3) and Time Period 2 (Table 7). Based on the values from the tables, the number of family planning methods served changed from 53 at TP1 to 77 at TP2, indicating an increase of 45.2 percent in total family planning methods served throughout the months of July through December. Figure 6 demonstrates that family planning method most served in TP1 was the Pill while Condoms became the most utilized family planning method provided in TP2. However, both time periods continued to present the Ring as the family planning method least provided following the Patch method which is presented to not be served in either time period.

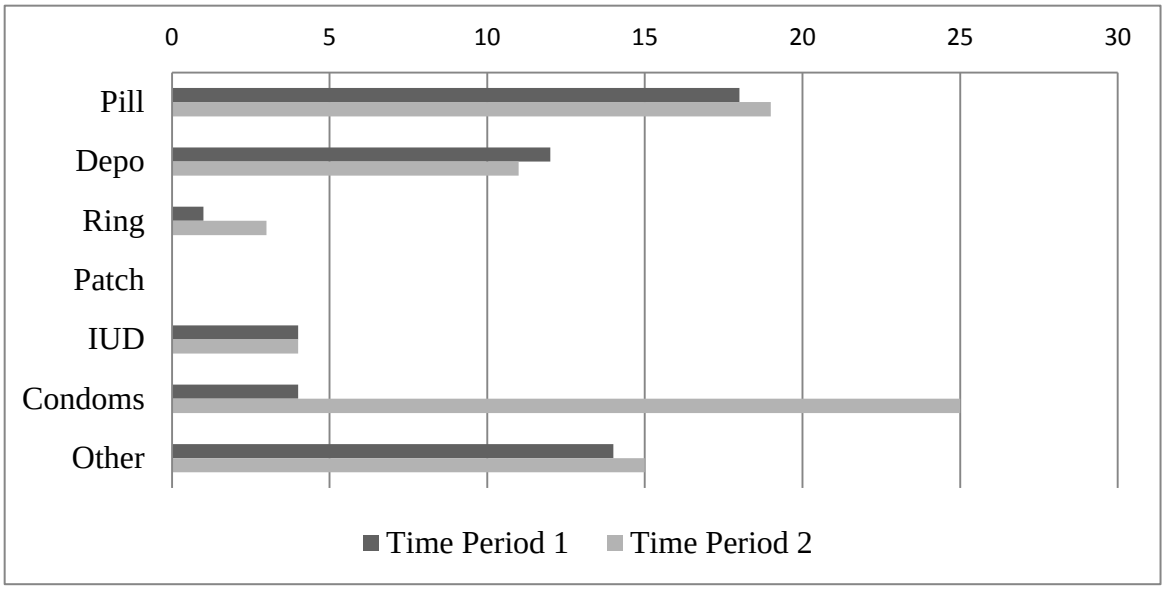

Figure 7. Family planning methods.

Physical Exam of Physical Assessment by Doctor

Figure 8 visualizes the comparisons of physical exams of physical assessment by doctor provided between Time Period 1 (Table 4) and Time Period 2 (Table 8). Based on the values from the tables, the number of physical exams of physical assessment by doctor provided changed from 138 at TP1 to 184 at TP2, indicating an increase of 31.4 percent total physical exams of physical assessment by doctor provided the months of July through December. However, the patterns remained the same for both time periods: the highest physical exam of physical assessment by doctor being the general exams and the least physical exam of physical assessment by doctor being the IUD.

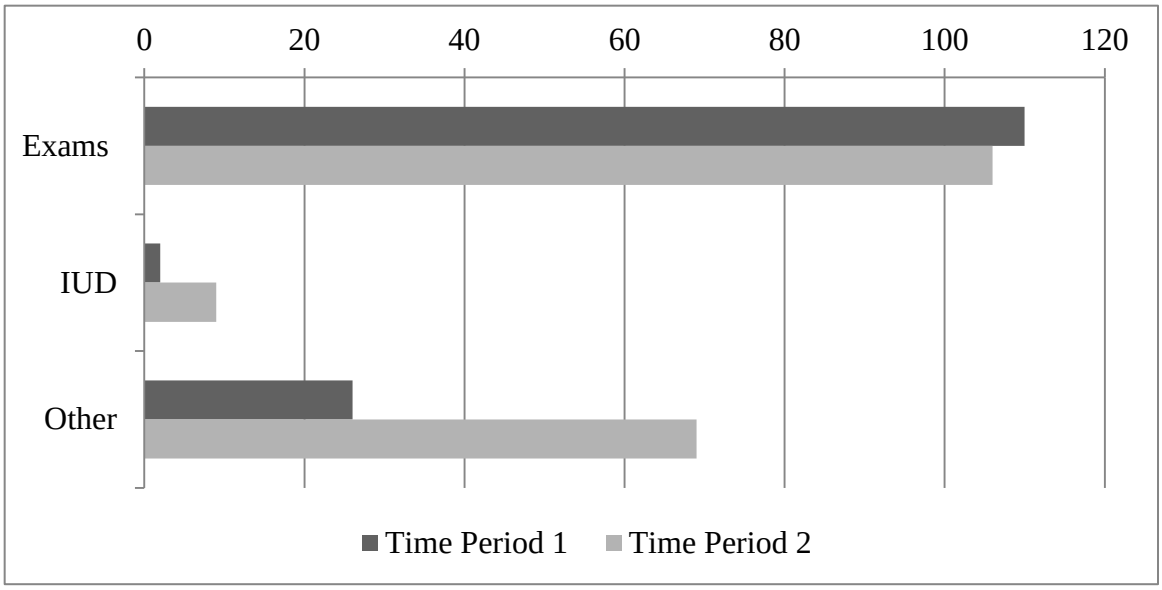

Figure 8. Physical exam of physical assessment by doctor.

CHAPTER V

DISCUSSION

This research aimed to explore the effects on the Abilene Taylor County Public Health District's (ATCPHD) Healthy Texas Women (HTW) program as the result of the Texas 84th legislation budget change on women's healthcare services and the Agency's financial adjustments and adaptations in response to the programs' implementation of a complete fee for service reimbursement system. The data was collected by the ATCPHD Monthly Count Reports and the ATCPHD Monthly Operating Report Numbers presented the volume of services provided unto four main variables: patient's age; exams, refills and outreach activities; family planning methods provided; and physical exam of physical assessment by doctor.

Within the new women's healthcare program, the results indicated that the ATCPHD experienced a 34.5 percent increase in patients who were seen for family planning services In relation to the Client Exams and Client Services, the Agency experience: a 36.4 percent decrease client exams; a 35.9 decrease in Client Services provided; a 53.1 percent decrease in refill clients; and a 51.2 percent decrease in refill services. Finally, the ATCPHD experienced a 45.2 percent increase in family planning methods provided, and a 31.4 percent increase in physical exam of physical assessment by doctor.

Relationship to Literature

The information was found to be both consistent and inconsistent with the literature and statistical finding in public health nationwide. Literature suggests that various factors such as the change in funding streams (from half categorical and half fee for service to a complete fee for service reimbursement system), in the program (i.e., combining TWHP and EPHC program into HTW Program), and social environmental factors all have effects on the results presented in this study.

Change in Funding Stream: Fee for Service

The 84th Texas Legislation determined that the financial stream for the new women's preventative healthcare program, HTW program, would be a complete fee for service reimbursement system. Within the new women's healthcare program, the results of this study document that while some areas of service, such as patients seen, outreach activities, family planning methods provided, and physical exam of physical assessment by doctor experienced an increase; other areas of services provided, such as client exams and service, and refill client and services, experienced a significant decrease. The effects on the volume of services and services provided may be the result of the shifting to a complete fee for service reimbursement funding streams.

Some researchers (e.g. Berenson & Rich, 2010; Meit, 2013) support that a fee for service reimbursement system would provide more benefits to the healthcare providers and the patients receiving the services, and are becoming an important source of revenue for the healthcare system. Berenson and Rich (2010) support that a fee for service reimbursement system benefits a healthcare provider in being a flexible health insurance to patients and providing accessibility to physicians. According to the Texas Health and

Human Services Executive Commissioner, Chris Traylor, the new women's healthcare program would allow a healthcare provider to conduct additional activities that will enhance the clinical outcomes for clients served (Traylor, 2016).

However, contrary to the benefits mentioned above, researchers (e.g., Calsyn & Lee, 2012; Friedberg, Chen, White, Jung, Raaen, Hirshman, & Tutty, 2015; Knox, 2009) suggest that fee for service reimbursement system may provide more harm than good to the healthcare system, healthcare providers, and patients receiving services. Calsyn & Lee (2012), suggest that a fee for service reimbursement system drives up health care costs and lowers the value of services provided to patients. Contrary to Traylor's belief, Friedberg et al., (2015) suggest that healthcare providers tend to reduce or eliminate practices, such as patient follow-up, and offsite visits, because of financial challenges for being under a fee for service reimbursement system.

The results in this research document both beneficial and harmful outcomes to the agency and services provided. On one hand, the Agency experienced a 34.5 percent increase in patients who were seen for family planning services, 14.7 percent increase in outreach activities, 45.2 percent increase in family planning methods provided, and a 31.4 percent increase in physical exam of physical assessment by doctor throughout Time Period 1 to Time Period 2. On the other hand, the Agency experienced a 36.4 percent decrease client exams, 35.9 decreases in Client Services provided, 53.1 percent decrease in refill clients, and a 51.2 percent decrease in refill services throughout Time Period 1 to Time Period 2.

Interestingly, with the exception of the outreach activities, the new women health program experienced an increase in all services related exclusively to family planning

services. One of the previous programs, Texas Women Health Program, provided family planning service based on an all fee for service program. However, the new women's health program experienced decreases in client services, client exams, and in refill services and refill clients. These services are directly related with services of chronic care provision. One of the previous programs, EPHC program, provided the client exams, client services, refill client, and refill services, which were funded by a half categorical and half fee for service program. The effects on the volume services provided in these specific areas may be the result the change in funding streams to a complete fee for service reimbursement system of the current program. More detailed explanations about the change in each area are discussed in the following sections: Change in program; Patient's age; Family Planning methods; and Exams and Refills.

Change in Program

Within the new women's healthcare program, the results suggest that while some areas of service experienced an increase, other areas of service experienced a significant decrease. These findings are not consistent with the program's original expectation proposed by Texas Health and Human Services Executive Commissioner, Chris Traylor (2016). According to Traylor, the new women health program would be completely beneficial to both healthcare providers and patients by allowing healthcare providers to broadened client intake, make services more accessible, increase the range of services, and enhance the clinical outcomes for patients. However, these results document several very important trends in regards to three main areas of service provided by the new women's healthcare program: patient's age; family planning methods; client exams and refill services.

Patient's age. Eligibility age to receive services in the HTW program is between 15-44 years of age. The results in this research document that the leading age of patients receiving family planning services are between the 23-34 years of age in both time periods. These finding seem to be consistent with the national trend in age range of women utilizing contraceptives. The National Health Statistics Report, published by the DHHS (2013), stated that throughout the years the age range amongst women who utilized contraceptive method has increased from 35% among teenagers aged 15–17, to 69% at ages 18–19, to 89% at ages 20–24, and to 97.7% at ages 25–44. As presented in the DSHS report, the highest age range of women utilizing contraceptives is between 20-44 years of age (Daniels, Mosher & Jones, 2013). Therefore, the results of this research align with the national trend of women's age range utilizing contraceptive methods.

Family planning methods. The main family planning methods provided by the agency were the pill, depo, ring, patch, IUD, condoms and others. The results in this research support that the highest contraceptive most served in Time Period 1 was the Pill while Condoms became the most utilized family planning method provided in Time Period 2. However, both time periods continued to present the ring following the patch. These trends in usage of contraceptives are consistent with the literature on contraceptive usage. In prior studies it has been reported that the condom and the pill were the contraceptives the most have been utilized with sexually active women, while the patch or ring have been the least contraceptive utilized (Daniels, Daugherty, Jones, & Mosher, 2015; Jones, 2011; Lindberg, Santelli & Desai, 2016; Martinez, Copen & Abma, 2011).

Exams and refills. The results of this study show that with the exception of the outreach activities, the new women health program experienced an increase in all

services related exclusively to family planning services. Before the implementation of the new women's program, patients who sought for family planning and chronic care had to be treated exclusively under one program. By combining the two prior programs (i.e., TWHP and Expanded Primary Health Care) the HTW program can provide a greater range of services for patients seeking for both family planning and chronic simultaneously. Given the HTW program was created with the aim to include women's preventative services in family planning and chronic care (Traylor, 2016) the findings suggest the implementation of the current program has partially met the original expectation.

Even though the agency experienced both beneficial changes with the implementation of the new women's health program, the greatest changes related to chronic care illnesses were negative. Services related to chronic care illnesses such as client exams and services, and refill clients and refill services all experienced from 35.9 percent up to 53.1 percent decrease in services provided. The decrease in services related to chronic care can be attributed to the reduction of chronic care illnesses provided by the HTW program. The previous program, EPHC program, provided the preventative services related to chronic care based on the objectives of the program. According to the official government documentation, the EPHC program was aimed to services of preventative chronic illnesses which include illnesses such as arthritis, asthma, cancer, diabetes, hypertension, high cholesterol, and viral diseases such as hepatitis C and HIV/AIDS, and aimed to "reduce the number of preterm births; and reduce the number of cases of potentially preventable hospitalizations related to hypertension and diabetes" (Texas Department of State Health Services, 2016, p. 3). By implementing the new

women's health program and reducing the chronic care services to only three (diabetes, hypertension, and high cholesterol) may be the result the change in funding streams to a complete fee for service reimbursement system.

Social Environmental Factors

Health and health services can be determined and influenced by several factors including access to quality health care, and by the external ecological and/or social environment conditions (Blazer & Hernandez, 2006). Without a doubt, social environment conditions have an influence in the services provided by the Agency between the data collection periods of this study: July through December 2015 and 2015. Three important social environment factors that may have influenced in the results of this study are: managing a program through different fiscal calendars; the newness of the program; and other competitor within the healthcare system.

In this research, the researcher discovered that the fiscal calendar for the State of Texas begins in September, while the fiscal calendar for the City of Abilene begins in October. According to Pinard & Kemper (2002), different fiscal calendars or fiscal structures create difficulty in accurately reporting of earning, net income, or services of an agency or program. Therefore, it is unknown if the number of patients served or services provided accurately report the response of the new women's program as oppose to studying the program in the middle of the fiscal calendar.

Also, the newness of the program may have had an effect in the results presented in this study. For this research, data was collected from two different time periods: July through December of 2015 and 2016. However, the time periods of the data collection process do not reflect the same duration time of the programs explored in this study. On

one hand, the TWHP and EPHC had been implemented since 2013. Therefore, the data collected from Time Period 1 (July through December 2015) reflect the results of two programs both within 2 years of their initial implementation. On the other hand, the HTW program became effective in July 1, 2016. Therefore, the data collected from Time Period 2 (July through December 2016) reflect results of a program immediately after its implementation. Researchers (e.g. Bertram, Blase, Shern, Shea, & Fixsen, 2011; Kitzman, Cole, Yoos, & Olds, 1997; Sadd & Grinc, 1996) strongly support the implementation process of a new service program is almost sure to face challenges in during its implementation process. The newness of a service program may take a toll on the improvement of the program and may turn out to be the deciding factor when a new program faces its first challenge (Harvey, 2010). Some of the challenges a program may face in the implementation process can involve new understanding and activities, the adaptation to new practices, fear of change, and creating awareness of the program and services to the public (Bertram, Blase, Shern, Shea & Fixsen, 2011).

Another environmental factor that may have influenced in this study is competition within the healthcare system. It is clear that the new women's program provided by the ATCPHD faces the challenge of the healthcare competitor market. The HTW website documents a total of 27 other HTW providers, including the recently opened Abilene Community Health Center, within five miles of the ATCPHD Clinic that provides the HTW services. Academic evidence strongly supports the healthcare service providers constantly face the challenges of competing with other healthcare service providers, especially those who offer the same services or manage the same program (Dafny,& Lee, 2016; Dash, Meredith, 2010; Enthoven & Tollen, 2005; Porter &

Teisberg, 2004). The high number of HTW service providers and the influence of healthcare provider competitors are external environmental factors that influence in the results presented in this research.

Implication for the Abilene Taylor County Public Health District

The results in this research also provide a significant overview to HTW providers to understand trends and gaps in services related to preventative and chronic care in women's health. For HTW providers, the researcher suggests several measurements to be taken by the healthcare service providers to minimize the impact where the program suffered a significant decrease in services.

First, continue keeping track of the patient count reports and the progress the HTW program experiences following the trends presented in this research. Second, improve methods to track patient intake or maintaining a consistent counting method could decrease the risk of duplicating patient count and increase the validity of the of the service and patient monthly reports. Third, apply for external funding to cover the gaps in preventative and chronic care services left by the new women's program. Another measurement to be taken to minimize the impact where the program suffered a significant decrease in services could be to increase the programs methods of outreach to the community, especially amongst the populations of most clients served: ages 23 - 34. Some service programs problems can be addressed with an effective outreach strategy. Implementing or increasing outreach methods and activities (beyond paid advertising) can contribute in creating awareness and target certain populations with limited access to the program (DeChiara, 2001).

Implication for Social Work Practitioners

Based on the ongoing challenges faced by the public healthcare system, the necessity for public health social work continuously grows as a priority within the profession (Jackson, 2015; Ruth, Sisco, Wyatt, Bethke, Bachman, & Piper, 2008). Even though researchers support that public health social work is a growing necessity within the profession, social work research in and articles studying the effects on policy and budgeting have on the public health system, services, and patients is limited. Nevertheless, this study aimed to explore the effects on a HTW program of a LHD as the result of the Texas 84th legislation budget change on women's healthcare services.

The limited studies focused on women's healthcare services and programs invite the active involvement of the Social Work profession in research and policy practice within the public health system. The Social Work profession uniquely qualified to make a significant difference in public health (Jackson, 2015). Practical steps for social work involvement in the public health systems are presented in the NIH Plan for Social Work Research (2003) which suggests social workers should: lead in fundamental creative discoveries and innovate their applications; develop and maintain resources that will assure prevention; and expand the knowledge through research to enhance economic well-being and ensure a positive return of the investment in research to the broad society. With the knowledge and studies in person-environment dynamics, skills in clinical services, advocacy, policy development, case managements, and cultural diversity, social workers have great potential to benefit to contribute with the social dimensions and implications within the public health system.

Implications for Policy

The gap in available public health financing data affects the ability of public health practitioners, researchers, and policymakers to define effective and efficient decision-making processes for public health resource allocations (Miet, 2013, p. 3). This study provides a foundational overview of the effects of a State legislation on a new women's healthcare program within its first six months of implementation. The political reframing of women's healthcare services and programs has important implications on the healthcare providers and delivery of services. The implied necessity is to ensure all women's access to services that incorporate preventative and chronic care services across all life stages. The healthcare system faces continuous transformations and challenges of constant adjustments to the increasing usage of fee for service revenue and the decrease of federal investment to women's health and safety net healthcare providers (Meit, 2013; Weisman, 1997). It is clear that the HTW program was approved by state legislation to ensure access to preventative and chronic care services to women in the state of Texas. However, the results in this study document how the new women's health program is left with significant gaps within some areas of services in comparison to its former programs.

For policy practitioners, the researcher believes in the advocacy of several measurements to be taken in behalf of women's health and women's healthcare preventative and chronic services. First, restore the funds for women's preventive care to increase the access to women's health at least to the levels before the 2011 budget reduction. Until 2011, over 300,000 women received healthcare services provided by the Family Planning program and the WHP (Texas Women's Healthcare Coalition, 2013).

Reinstating the funding allocated to women's health preventative and chronic care could restore access for the thousands of women affected by the 2011 budget reduction.

Another measure to be taken would be to amplify the access to more chronic care services within the HTW program. Within the new women's healthcare program, patients can only be serviced for three chronic care illnesses: diabetes, hypertension, and high cholesterol. Consequently, women in childbearing age who suffer from other chronic illnesses are excluded from receiving family planning and chronic care simultaneously. The absence of chronic care of conditions such as high blood pressure, diabetes, heart disease, and obesity contribute to higher risk of pregnancy complications (Gupton, Heaman, & Cheung, 2001; Kersten, Lange, Haas, Fusch, Lode, Hoffmann, & Thyrian, 2014). According to the report brief published by the Texas Department of State Health Services (2016) more than 600 women die of pregnancy-related causes, and 65,000 have severe pregnancy complications each year in the United States. The results in the research suggest the necessity to close the service gap for women in childbearing age who seek both preventative and chronic care services.

Suggestion for Future Research

This research suggests that future researchers study the effects transitioning to a complete fee for service reimbursement system had on the Agency's financial dynamic and internal funding allocations. Also, the researcher suggest to conduct a study exploring the effects that the 84th Texas Legislation had on services provided according patient demographic information such as: status under the Federal Poverty Line, ethnicity and/or race, zip code, and others. By studying demographic information researcher can have a clearer overview on trends and patterns of populations affected and/or excluded

from the implementation of the HTW program. In addition, the researcher suggests studying the payment methods most utilized by patients while receiving the services of the HTW. With the information based on payment methods most utilized future researcher can identify if the new women's healthcare program is financially more beneficial to the patients it serves. Another research topic should be conducted a longitudinal study exploring service and financial dynamics throughout the whole year instead of six month. Finally, the researcher suggests studying the progress of effectiveness and efficiency of the new HTW program throughout the duration of the program.

Strengths and Limitations

While developing this research, the researcher was faced with several circumstances in the data collection process. Developing a case study, there is not much control over the data collection environment in comparison with other research methods (Yin, 2013). Even though many attempts were made to minimize the impact of these circumstances there were numerous limitations to this study.

First, because this research aimed to explore the effects of the 84th Texas Legislation on a women's health program, it is not possible to imply neither the effectiveness nor quality of the new women's healthcare program or its services. Second, this research was an exploratory case study; therefore, the present study does not suggest any causal inference. Because this research was a case study, the ability to generalize the findings is limited. Third, the deficiency of primary and official documentation and the overwhelming amount of third and non-official sources, the statistical data provided in the literature review presents to be inconsistent. Therefore, statistical data provided in the

literature review may have affected the accuracy of the information presented in Chapter II. Fourth, no financial data was collected in this study. Without financial data collected the research was not able to present the financial dynamics of the Agency or the effects of adopting a complete fee for service reimbursement system in the new women healthcare program. Fifth, no demographic nor income data was collected in this study. Without demographic or income data such as race, ethnicity, or percentage under the Federal Poverty Line, the researcher was not able to determine patterns of populations affected and/or excluded from the implementation of the HTW program. Also, no information pertaining to patient's most utilized payment methods. Without payment methods most utilized information the researcher was not able to identify if the new women's healthcare program is financially more beneficial to the patients it serves.

Another concern is a measurement issue. The change in staff, change in counting methods, and change in reporting instruments may have influenced the exclusive count in the report counts under each program. There was no way to guard exclusive count for each program report resulting in a possible duplication report counts. While analyzing the data, the research noticed inconsistencies between totalities in client intakes between the different variables studied. Finally, the women enrolled in the Texas Women Health Program were to be automatically enrolled in the HTW program (Traylor, 2016). However, the enrollment to the HTW program takes place at the first visit under the new program. It is unknown if the number of patients that have not yet been automatically enrolled to the new women's program continue under the ATCPHD healthcare services or have opted for another healthcare provider.

In spite of the limitations encountered in this study, strengths that support this research mainly involve having the support of the Agency's staff and management team including the Health Director, Health Program Manager, Health Manager Coordinator, and Health Administration Specialist. The research did not seem to encounter any complications with gathering data; the management team was enthusiastic to provide any data available. The research has strong relationship and significance for the Abilene Taylor County Public District and the women's health care program provided at the Agency. Finally, this study provides an overview of a new women's program that can be utilized by the agency to help guide and lead further studies in ways to improve quality of healthcare services to women the Agency attends and prepare for new financial challenges that may occur in the future.

CHAPTER VII

CONCLUSION

Public healthcare service providers in the United States constantly face the challenge of being underfunded (Baker, Potter, Jones, Mercer, Cioffi, Green, Halverson, Lichtveld, & Fleming, 2005; DHHS, 1994). The financial challenges faced by public health in the United States reach all levels in the public healthcare system including the state and local health care service providers. Unfortunately, a sector in the Texas public healthcare system that has suffered significant funding reduction is the women's healthcare and preventative services. This study aimed to explore the effects on the Abilene Taylor County Public Health District's HTW program as the result of the Texas 84th Legislation Session changes on women's healthcare services.

This study documents an overview of the effects of a State legislation on a new women's healthcare program within its first six months of implementation. It is clear that the HTW program was approved by state legislation to ensure access to preventative and chronic care services to women in the state of Texas. However, the results in this study document how the new women's health program is left with significant gaps within some areas of services in comparison to its former programs, and demonstrate how political reframing of women's healthcare services and programs can impact the healthcare service providers, delivery of services, and the health of the patients and broad society.

Even though access to women's healthcare services may seem uncertain in the present federal policy developments, it is up to the public healthcare service providers,

communities, universities, and helping professionals to do take the job of educating, creating awareness, advocating and developing policies that can guarantee access of public healthcare services to all women in the United States.

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APPENDIX A

IRB Approval Letter

ABILENE CHRISTIAN UNIVERSITY
Educating Students for Christian Service and Leadership Throughout the World

Office of Research and Sponsored Programs
320 Hardin Administration Building, ACU Box 29103, Abilene, Texas 79699-9103
325-674-2885

1/26/2017

Saul Fransico Delgado
Department of Social Work
ACU Box #27866
Abilene Christian University

Dear Mr. Delgado

On behalf of the Institutional Review Board, I am pleased to inform you that your project titled

(IRB# 17-005)is exempt from review under Federal Policy for the Protection of Human Subjects as:

- ☐ Non-research (45 CFR 46.102(d))
- ☑ Non-human research (45 CFR 46.102(f)

Based on:

If at any time the details of this project change, please resubmit to the IRB so the committee can determine whether or not the exempt status is still applicable.

I wish you well with your work.

Sincerely,

Megan Roth

Megan Roth, Ph.D.
Director of Research and Sponsored Programs

APPENDIX B

Consent Form

Appendix: Consent Form

Consent Form for Participation in Research Study

Case Study: Healthy Texas Women (HTW) program in the Abilene-Taylor County Public Health District (ATCPHD)

The Abilene-Taylor County Public Health District is invited to participate in a research study conducted by a graduate student in the Masters of Science in Social Work program at Abilene Christian University. The purpose of this study is to explore: [1] the effectiveness of the Healthy Texas Women program in the ATCPHD as a result of the Texas 84th legislation on women's healthcare services; and [2] the agency's financial adjustments and adaptations in response to the programs' implementation of a fee for service reimbursement system.

Participation

In order to complete this research, the researcher will be under the supervision of the administrative staff of the ATCPHD. To measure the effectiveness of the Healthy Texas Women program, the researcher requires access to: [1] monthly service reports of both the Expanded Primary Health Care program and Texas Women's health program from Time Period 1 (July 2015 to December 2015); [2] monthly service reports of the Healthy Texas Women from Time Period 2 (July 2016 to December 2016); [3] organizational financial monthly reports from both Time Period 1 and Time Period 2.

Potential Benefits

This research could have significant impact for the women who receive services through the Healthy Texas Women program by the Abilene Taylor County Public Health District and other health care providers in the State of Texas. This information can be utilized by the agency to help guide and lead further studies in ways to improve, and to improve the quality of healthcare services to women the agency serves and prepare for new financial challenges that may occur in the future.

Confidentiality and Risks

It is not expected that any level of confidentiality will be breached or at risk during this proses of data collection by reason that the monthly financial reports are organizational reports and public documents which exclude any personal information from the clients who have received the services provided by the ATCPHD.

Informed Consent

By signing this consent form, the ATCPHD agrees to grant the information required to proceed with this study and grants authorization to the researcher, Saul Francisco Delgado and the Masters of Science in Social Work program at Abilene Christian University, to publish the any findings and analysis as a result of this investigation.

Contact person/researcher:

Saul Francisco Delgado
ACU School of Social Work Graduate Student
Sfd15a@acu.edu
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Annette Ferma
Signature
Health Program Manager

1-23-17
Date

Mike Neuvenheim
Signature
Health Manager Coordinator

1-23-17
Date