

2014
beyond



Assessing Children's Health in the
North Texas Corridor





Making life better for children since 1913

On behalf of Children's Health System of Texas (Children's HealthSM), we are pleased to present the 13th edition of *Beyond ABC: Assessing Children's Health in the North Texas Corridor*, a comprehensive report on the quality of life for children in North Texas. The report examines four factors — children's health care, education, economic security and safety — that shape a child's quality of life today and influence their opportunities tomorrow.

Without a doubt, the latest report reveals some disheartening statistics. For example, Texas' uninsured rate for children remains among the highest in the nation. However, we are encouraged with the steady and continuous improvements in other measures. The rays of hope throughout the report make us even more determined to continue our efforts to meet the needs of children in North Texas.

For more than a century, we have been on the forefront of serving children in North Texas. We have grown from four tents on the lawn of Old Parkland Hospital to become one of the leading pediatric health care systems, providing a full continuum of wellness and care for children in North Texas. Children's Health includes the flagship hospital Children's Medical Center Dallas, as well as Children's Medical Center Plano and Children's Health Specialty Centers in Southlake and the Park Cities, 18 pediatric primary care centers, home health, physician practices, a pediatric research institute and professional services. At Children's Health, we care for the whole child, since we understand that their health is not shaped in a vacuum.

As a state-of-the-art health system, we understand that the first step is to appropriately identify and diagnose issues. In addition to assessing the quality of life for children in North Texas, the report includes a set of community recommendations. It is our hope that the information and recommendations will be a catalyst for action across the state.

We are committed to our mission to make life better for children. However, we cannot do it alone. We encourage you to read this report and consider how you can help implement the community recommendations. We are encouraged by your interest, and Children's Health looks forward to working by your side to make life better for all children.

Sincerely,



Christopher J. Durovich
President and Chief Executive Officer
Children's Health System of Texas



En nombre de Children's Health System of Texas (Children's HealthSM), nos complace presentar la 13.º edición de *Beyond ABC: Assessing Children's Health in the North Texas Corridor*, un completo informe sobre la calidad de vida de los niños del norte de Texas. El informe examina cuatro factores — cuidado de la salud de los niños, educación, seguridad económica y seguridad — que forjan la calidad de vida de los niños hoy en día e influyen en sus oportunidades futuras.

Sin lugar a dudas, el último informe revela algunas estadísticas desalentadoras. Por ejemplo, la tasa de niños sin seguro en Texas permanece entre las más elevadas de la nación. Sin embargo, nos estimula la mejora constante en otras medidas. Los rayos de esperanza del informe nos comprometen aún más a seguir con nuestros esfuerzos para satisfacer las necesidades de los niños del norte de Texas.



Durante más de un siglo, hemos estado al frente de la atención de los niños del norte de Texas. Hemos crecido desde las cuatro carpas en el césped del hospital Old Parkland hasta convertirnos en uno de los sistemas de salud pediátrica líderes, que brinda bienestar y atención de manera ininterrumpida a los niños del norte de Texas. Children's Health incluye los hospitales insignias Children's Medical Center de Dallas, Children's Medical Center de Plano y Children's Health Specialty Centers de Southlake y Park Cities, 18 centros de atención primaria pediátrica, servicios de atención médica en el hogar, profesionales médicos, un instituto de investigación pediátrica y servicios profesionales. En Children's Health, nos preocupa el niño en su totalidad, ya que entendemos que su salud no funciona de manera aislada.

Como sistema de salud de última generación, entendemos que el primer paso es identificar y diagnosticar problemas adecuadamente. Además de evaluar la calidad de vida de los niños del norte de Texas, el informe incluye un conjunto de recomendaciones para la comunidad. Esperamos que la información y las recomendaciones se utilicen como catalizadores para tomar medidas en todo el estado.

Estamos comprometidos con nuestra misión de mejorar la vida de los niños. Sin embargo, no lo podemos hacer solos. Le sugerimos leer este informe y pensar en cómo puede ayudar a implementar estas recomendaciones para la comunidad. Children's Health se siente alentado por su interés y espera trabajar a su lado para mejorar la vida de todos los niños.

Atentamente.

A handwritten signature in blue ink that reads "Christopher J. Durovich". The signature is fluid and cursive.

Christopher J. Durovich
Presidente y Director ejecutivo
Children's Health System of Texas

2014
beyond 

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North Texas Corridor

Published by



Michele Chulick, Executive Vice
President, Chief Administrative
Officer

Keri Kaiser, Vice President,
Marketing and Communications

Delia Jasso, Senior Director,
Community Relations

Debbie Hancock, Project
Manager, Community Relations

Jane Hogan, Specialist,
Community Relations and
Governance

Advisory Board for 2014
Beyond ABC

Data Collection by

The University of Texas at
Dallas, Institute for Urban
Policy Research

Dr. Timothy M. Bray, Director

Anthony M. Galvan, Senior
Research Associate

Sara A. Mokuria, Senior
Research Associate

Lauren A. Villa, Research
Assistant

Alexis J. Harper, Graduate
Research Associate

Sheila N. Dang, Research Intern

Design by

Anne Humes, AHHA Graphics

Illustration by

Mary Erikson Washam

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Beyond ABC Online

In addition to the material printed in this report, you can access previously published information about children's lives in Dallas County and the North Texas region by visiting: www.childrens.com/beyondabc

The link will take you to reports (in .pdf format) issued since 2010 that provide comprehensive information on the quality of life for children in Dallas, Collin, Cooke, Denton, Fannin and Grayson counties.

Contact us online at: beyondabc@childrens.com

Acknowledgments

The 2014 Advisory Board for *Beyond ABC: Assessing Children's Health in the North Texas Corridor*

Sandy Barber
Fannin County Children's Center

Maria Berry
Plano ISD

Shirletta Best
City of McKinney

Candy Blair
Collin County Health Care Services

Yvonne Booker
Assistance Center of Collin County

Scott Braddock
Eleos

Ashley Brundage
United Way of Metropolitan Dallas

Nicole S. Burse
Frisco Family Services

Rock Carpenter
Collin County City of Hope

Tonia Cunningham
Frisco Police Department

Gordon Echtenkamp
YMCA of Metropolitan Dallas

Rebecca Egelston-Caso
Community Volunteer

Susan Etheridge
CASA of Collin County

Haley Feuerbacher
Redeemer Covenant Church

Sarah Feuerbacher
SMU Center for Family Counseling

Niccole Frazier
Allen Police Department

Jana Garner
Bonham ISD

Linda Goodman
City House

Brenda Hayward
Child & Family Guidance Center
of Texoma

Marilyn Herrick
March of Dimes, Texas Chapter
Dallas Division

PJ Holland
McKinney ISD

Linda Horton
Texoma Community Center

Kristin Jenkins
DFWHC Foundation

Karen Kaighan
Texas Women's University

Graciela Katzer
Plano ISD Council of PTAs

Diane Kazlow
ECI of LifePath Systems

Glenda May
Allen Community Outreach

Dr. Randy McBroom
Texoma Council of Governments

Janetta Michaels
Children's Advocacy Center of
Collin County

Jessica Noel
CHILDREN AT RISK

Dr Sandeepa Rajadhykasha
Children's Health Pediatric Group

Erica Simon
Minnie's Food Pantry

Pat Tosi
Hope's Door

Duncan Webb
Collin County Commissioners Court

Kate Whitfield
Community Volunteer

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We would also like to thank the 2013 Beyond ABC board for continuing to lend their time and efforts to implement the 2013 recommendations.

About Children's Health System of Texas

Children's Health System of Texas (Children's HealthSM) is the pediatric healthcare system which is proud to have Children's Medical Center Dallas as its flagship hospital, along with Children's Medical Center Plano, numerous specialty and primary care locations, and health and wellness programs and initiatives for children. For 100 years, the mission of Children's Medical Center has been to make life better for children. Our beginnings in 1913 were humble, starting with four donated tents set up as an open-air clinic. But our vision even then was big, thanks to one nurse who dreamed of a hospital dedicated exclusively to children. Today, our team of 6,000 takes great pride in being the sixth-largest pediatric healthcare provider in the country, and the only academically affiliated pediatric hospital in the area.

Children's HealthSM considers it a privilege and a responsibility to serve as an ardent advocate for children. Through a combination of programmatic initiatives, organizational affiliations and community events, Children's Health spreads its influence throughout the region and provides North Texas children with much-needed access to an improved quality of life. Advocacy efforts extend into the areas of children's health insurance (Medicaid and CHIP), child abuse, childhood obesity, asthma, immunizations and community health. Children's Health also leads the Safe Kids Dallas Area Coalition, spearheading local efforts to raise awareness about childhood injury prevention.

AT A GLANCE

- Private, not-for-profit pediatric healthcare system that doesn't receive any state or county tax dollars.
- Children's Medical Center Dallas was the first pediatric hospital in Texas designated as a Level I Trauma Center.
- The only pediatric medical center in the nation with seven disease-specific management program certifications by The Joint Commission.
- The primary pediatric teaching facility for UT Southwestern Medical Center, the top medical school in the region.
- The Children's Medical Center Research Institute at UT Southwestern focuses on the discovery of transformative advances related to the understanding and treatment of metabolic disease.
- In December 2013, Children's HealthSM accepted \$18.9 million from the Rees-Jones Foundation to establish the Rees-Jones Center for Foster Care Excellence at Children's Medical Center, the state's first center dedicated to the advancement of health for children in the foster system.
- The Health and Wellness Alliance for Children, founded by Children's Health is a coalition of community organizations established to improve the health and well-being of children in Dallas County. The Alliance, using a "collective impact" approach, encourages collaboration across sectors to create large-scale positive change.

RECOGNITION

- Children's Medical Center is ranked among the top pediatric hospitals in the country by U.S. News & World Report.
- Among only 5 percent of the nation's hospitals named a Magnet Recognition Program by the American Nurses Credentialing Center.
- Accredited by the National Cancer Institute.
- In 2013, Hospital and Health Networks magazine named Children's as a "Most Wired" hospital for the ninth time.
- Selected by Becker's Hospital Review as one of its "100 Great Places to Work in Healthcare" in 2013.
- Texas Diversity Council recognized Children's with a DiversityFIRSTTM Corporate Leadership Achievement Award for outstanding accomplishments and sustained commitment in promoting appreciation for diversity, inclusion, and cultural understanding in the workplace and community.
- Children's HealthSM Pediatric Group was recognized as Level III National Committee for Quality Assurance (NCQA) Certified Patient-Centered Medical Homes.

SERVICES

- Children's Medical Center is licensed for 591 inpatient beds at two campuses.
- Children's Medical Center has more than 50 specialty and subspecialty programs, serving children through more than 760,000 patient encounters in 2013.
- Emergency Department logged 163,661 patient visits in 2013 making it the second busiest pediatric emergency department in the nation.
- Children's Medical Center Dallas has 77 dedicated pediatric intensive care unit beds, making it one of Texas' largest ICUs just for children.
- Children's Medical Center Dallas features 28 of the largest, most technologically advanced operating rooms available in pediatrics today.
- Children's Medical Center Dallas boasts a 20-bed dedicated pediatric cardiac intensive care unit, the largest heart center for children in North Texas.
- The first TeleNICU in Texas providing physicians at other hospital neonatal intensive care units (NICUs) with 24-hour access to the highly trained, board-certified UT Southwestern neonatologists on Children's Medical Center medical staff.
- School-based Telehealth is a coordinated strategy that increases the availability of health care and improves access to health care resources in schools.
- Children's Medical Center Dallas is a major pediatric kidney, liver, heart and bone marrow transplant center.
- Children's Health Pediatric Group has 18 locations offering primary care medical homes.



recommendations

The 2014 *Beyond ABC* Advisory Board identified the following recommendations to help make life better for children in North Texas:

health

- **Enhance Access to Care by Reauthorizing the Children’s Health Insurance Program.** The average number of new CHIP enrollees per month has increased every year in every county. Since 2006, the number of CHIP enrollees in Denton and Collin counties has tripled. The program is set to expire on October 1, 2015. This critical safety net program should be reauthorized to ensure children have continued access to care.

economic security

- **Address the Impact of Poverty on Asthma by Establishing a Renter’s “Health Bill of Rights.”** With asthma being a leading cause of both school absences and ER visits, asthma management is critical to a child’s health, education, and future successes. Many factors can trigger asthma reactions, including the home environment. A “Health Bill of Rights” should be established to ensure landlords provide a healthy environment for tenants.

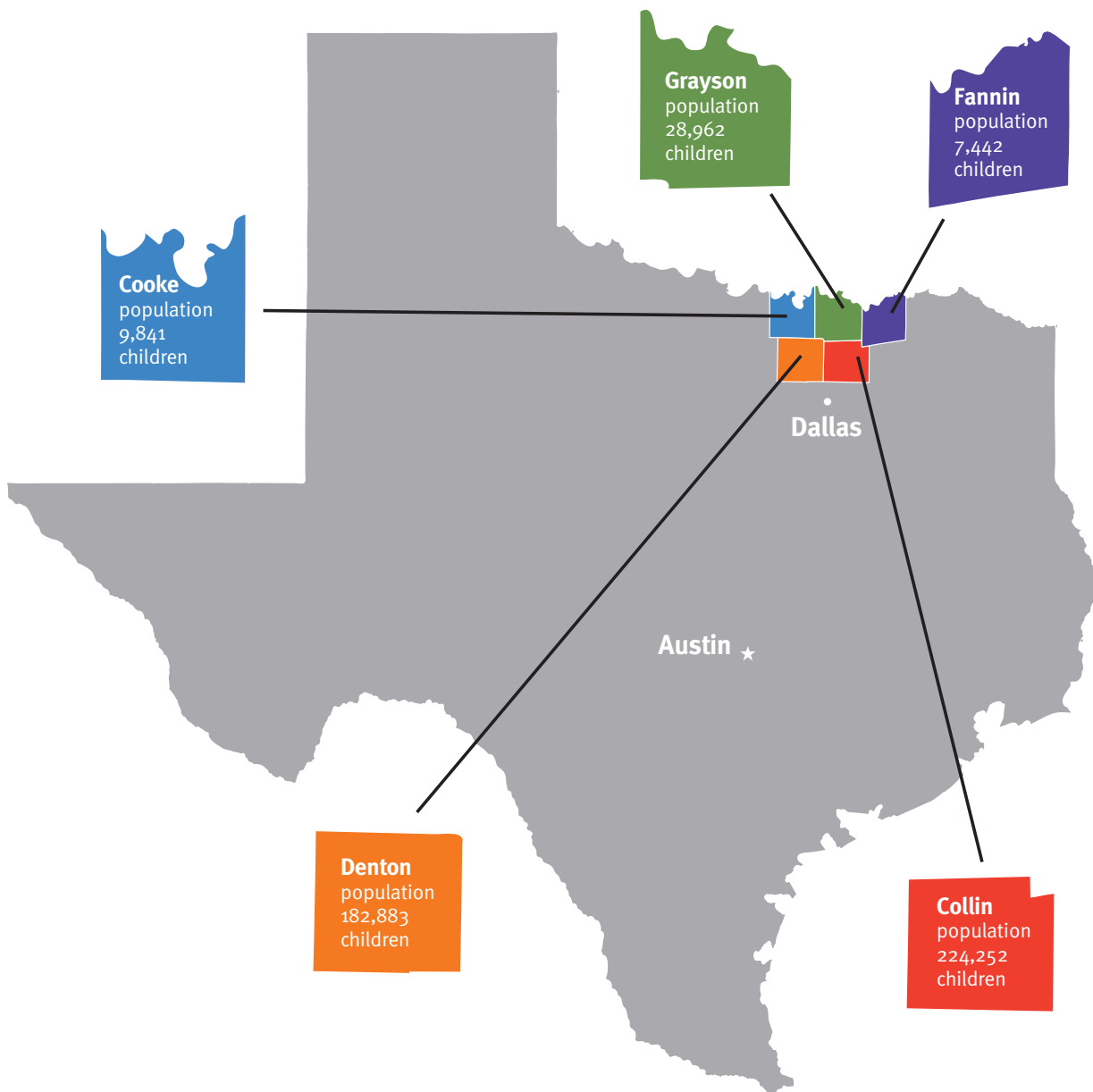
education

- **Improve Literacy by Supporting Reading Initiatives Sponsored by Medical Homes.** A readiness gap in early childhood education is often created by disparities in development and socialization. Low-income families often lack early interactions, such as a parent reading to a child, that promote linguistic development. As years progress, this readiness gap becomes an achievement gap. Medical providers across the state are prescribing books to encourage families to read together. The North Texas providers and community organizations should partner together to establish, expand and support reading initiatives through medical homes.

safety

- **Protect and Provide Better Care for Victims of Child Abuse.** CPS workers in all five counties continue to be assigned more than the recommended number of caseloads. Collin, Denton and Grayson counties each average more than double the recommended number of 12 cases. Additionally, retention rates remain low with 24 percent of caseworkers in 2013 having been employed for only a year. In order to allow caseworkers the time required to perform necessary due-diligence and attention to each case, the Department of Family and Protective Services should follow the Sunset Commission’s recommendation to consolidate its existing workforce management functions under one operational unit and add additional critical functions to better support employees and systemically identify root causes of turnover. In addition, CPS would benefit from creating a mentoring program using existing caseworker positions to better support new CPS caseworkers.

demographic summary



Over the past 50 years, the counties of the North Texas corridor have grown in relationship to Dallas County. Considered agrarian neighbors in the 1960s and 1970s, Dallas' northern neighbors are now more integrally connected. From 2010 to 2011, just over 23,000 persons moved from the five counties of the North Texas corridor to Dallas County, and more than 30,000 moved from Dallas to the five-county region.¹ Of the 782,767 employed residents in the five-county region, 33 percent worked in Dallas County, while 7 percent of the employed residents in Dallas County worked in the five-county region.²

Since 2000, the five-county region's population has grown by 146,796 children, an increase of more than 48 percent. Numerically, white or Caucasian children are the largest growing racial group, increasing by 86,659 children over the 12-year period. The number of Hispanic children grew by 55,952 children – an increase of 137 percent. Asian children experienced the largest relative growth at 163 percent, or 24,076 children. Four out of the five counties experienced a growth in child population, with only Cooke County experiencing a nominal decrease of 101 children. While Cooke County experienced a net decrease, the county's population of Hispanic children mirrored those of other counties, with an increase of more than 1,000 children.³

In 2012, the five-county region was home to 47,529 children living at or below the poverty line. This number represents a 111 percent increase in children in poverty, more than double the 2000 levels. With a child population increase of only 48 percent during the same time period, the 111 percent increase in child poverty indicates that poverty is outpacing overall population growth – the region's children are becoming poorer. In fact, the 2000 poverty rate for children in the five-county region was 7 percent. By 2012, the child poverty rate increased to 11 percent.

Poverty is outpacing overall population growth.

¹ Institute for Urban Policy Research analysis of U.S. Internal Revenue Service Statement of Income county to county migration data for the 2010 and 2011 tax years.
² Institute for Urban Policy Research analysis of American Community Survey 5-year Estimates 2006-2010.
³ Institute for Urban Policy Research analysis of American Community Survey 5-year Estimates 2008-2012.



COLLIN COUNTY

TOTAL YOUTH POPULATION	PERCENT WHITE/ CAUCASIAN	PERCENT BLACK/ AFRICAN- AMERICAN	PERCENT AMERICAN- INDIAN	PERCENT ASIAN	PERCENT PACIFIC- ISLANDER	PERCENT OTHER OR MULTIPLE RACES	PERCENT HISPANIC/ LATINO	PERCENT OF ALL CHILDREN LIVING IN POVERTY	PERCENT OF WHITE/ CAUCASIAN, NON- HISPANIC/ LATINO CHILDREN LIVING IN POVERTY	PERCENT BLACK/ AFRICAN- AMERICAN CHILDREN LIVING IN POVERTY	PERCENT OF HISPANIC/ LATINO CHILDREN LIVING IN POVERTY
224,252	70.5%	9.1%	0.5%	11.9%	0.1%	7.9%	19.1%	9.1%	4.2%	15.1%	3.5%

In 2012, 224,252 children lived in Collin County, up 82,945 from the county's 2000 child population. White or Caucasian children saw the largest numerical growth, with an increase of 46,307 children since 2000. Within the white and Caucasian child population there has been a sizeable increase among those identifying as Hispanic. In 2000, roughly 8 percent of Collin County's white child population identified as Hispanic. In 2012, 33,107 white Hispanic children accounted for 21 percent of the county's white child population and 15 percent of the county's Hispanic child population. An additional 9,678 Hispanic children identified as some other race. Altogether, the 42,785 Hispanic children in Collin County represented 19 percent of the county's child population. This increase makes Hispanics the second largest growing child population.¹

Collin
population
224,252
children

Aside from Native Hawaiian or Pacific-Islander children, whose 183 percent increase from 2000 to 2012 was driven, in part, by a base of only 59 children in 2000, Asian and Black or African-American children were the fastest growing racial groups in 2012. They were also the second and third largest groups, respectively. The county's 16,912 Asian children and 20,372 African-American children in 2012 both represented 172 percent increases over their 2000 populations.¹

Since 2000, the number of children living below the poverty line in Collin County has increased by 12,632, with the 20,355 children in 2012 representing a 164 percent increase over 2000 levels. This growth in poverty has slightly outpaced the growth in overall child population, with the county's child poverty rate increasing from 6 percent in 2000 to 9 percent in 2012. Moreover, children are increasing in ranks among the poor. In 2000, 32 percent of those living in poverty in Collin County were children. By 2012, children had grown to represent 34 percent of those living in poverty.¹

In 2012, 82 percent of Collin County children lived in married-couple families, with the remaining 18 percent living in single-parent families. Those living in single-parent families were more likely to reside in a single-mother household (14 percent, compared to 4 percent living with a single father).² The growth in child population in Collin County has accompanied a growth in single-parent families. The percentage of children living in married-couple families is down from 87 percent in 2000 to 82 percent, and percent of children living in single-parent families is up to 18 percent from 13 percent in 2000. While the number of children living in married-couple families has increased by 50 percent, the number living in single-mother families has more than doubled (an increase of 123 percent), as has the number living in single-father families (increasing by 111 percent).¹

From 2010 to 2013, the total population of Collin County grew by 72,247.³ Two-thirds of that growth (67 percent) was due to net migration into the county. The majority of migration (accounting for a population increase of 39,112) was domestic migration from elsewhere in the United States. Natural population growth accounted for the remaining third of the population change, with 33,735 births and 10,944 deaths occurring during the 3-year period accounting for a net change of 22,791 due to natural changes.

¹ To improve comparability of estimates between counties, all discussion of population changes, poverty, and family structure are based on IUPR analyses of U.S. Census Bureau American Community Survey 5-Year Estimates for 2012 and Decennial Census Summary File 1 Estimates for 2000. For that reason, figures in the demographic summary may not be directly comparable with those produced elsewhere in the report.

² The phrase "single mother" is a colloquialism; the U.S. Census Bureau refers these as single female-headed households with no husband present, which could include a grandmother or other female relative as head of household. The phrase "single-mother" and "single-father" have been adopted here for ease of reference.

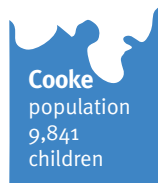
³ IUPR Analysis of U.S. Census Bureau Population Estimates and Components of Change, 2010-2013.

COOKE COUNTY

TOTAL YOUTH POPULATION	PERCENT WHITE/CAUCASIAN	PERCENT BLACK/AFRICAN-AMERICAN	PERCENT AMERICAN-INDIAN	PERCENT ASIAN	PERCENT PACIFIC-ISLANDER	PERCENT OTHER OR MULTIPLE RACES	PERCENT HISPANIC/LATINO	PERCENT OF ALL CHILDREN LIVING IN POVERTY	PERCENT OF WHITE/CAUCASIAN, NON-HISPANIC/LATINO CHILDREN LIVING IN POVERTY	PERCENT BLACK/AFRICAN-AMERICAN CHILDREN LIVING IN POVERTY	PERCENT OF HISPANIC/LATINO CHILDREN LIVING IN POVERTY
9,841	82.7%	4.2%	1.3%	0.4%	0.0%	11.4%	26.4%	9.6%	16.6%	16.7%	29.6%

From 2000 to 2012, the child population of Cooke County remained relatively stable, dropping by 101 children from 9,942 to 9,841, a roughly 1 percent drop. The white or Caucasian and black or African-American populations remained relatively stable at 83 percent and 4 percent of the child population, respectively. While the balance of racial groups has remained largely unchanged, the number of children identifying as Hispanic has increased by more than 1,000, from 1,558 children in 2000 to 2,598 children in 2012. Those identifying as Hispanic represented 16 percent of the child population in 2000, and 26 percent of the child population in 2012. Of the white or Caucasian child population, those identifying as Hispanic grew by 183 percent.¹

Looking at the total population changes for the period from 2010 to 2013, the decrease of 400 in net migration (more people moving out than moving in) was offset by the increase of 424 in net natural changes (more births than deaths). The population decrease of 400 from net migration reflects a population gain of 85 from international migration offset by an actual loss of 485 due to domestic migration (within the U.S.).²



Child poverty in Cooke County has remained stable, with 20 percent of children living in poverty in 2000 and 2012.¹ The balance of family structure in Cooke County has slightly shifted since 2000. The percent of children living in married-couple families has dropped from 81 percent to 74 percent, while the percent living in single-parent families has increased from 19 percent to 26 percent, with 20 percent of those children living in single-mother families.^{1,3}

¹ To improve comparability of estimates between counties, all discussion of population, poverty, and family structure changes are based on IUPR analyses of U.S. Census Bureau American Community Survey 5-Year Estimates for 2012 and Decennial Census Summary File 1 Estimates for 2000. For that reason, figures in the demographic summary may not be directly comparable with those produced elsewhere in the report.

² IUPR Analysis of U.S. Census Bureau Population Estimates and Components of Change, 2010-2013.

³ The phrase "single mother" is a colloquialism; the U.S. Census Bureau refers these as single female-headed households with no husband present, which could include a grandmother or other female relative as head of household. The phrase "single-mother" and "single-father" have been adopted here for ease of reference.



DENTON COUNTY

TOTAL YOUTH POPULATION	PERCENT WHITE/ CAUCASIAN	PERCENT BLACK/ AFRICAN-AMERICAN	PERCENT AMERICAN-INDIAN	PERCENT ASIAN	PERCENT PACIFIC-ISLANDER	PERCENT OTHER OR MULTIPLE RACES	PERCENT HISPANIC/ LATINO	PERCENT OF ALL CHILDREN LIVING IN POVERTY	PERCENT OF WHITE/ CAUCASIAN, NON-HISPANIC/ LATINO CHILDREN LIVING IN POVERTY	PERCENT BLACK/ AFRICAN-AMERICAN CHILDREN LIVING IN POVERTY	PERCENT OF HISPANIC/ LATINO CHILDREN LIVING IN POVERTY
182,883	74.0%	8.4%	0.5%	6.5%	0.0%	10.6%	24.5%	20.2%	4.2%	18.0%	18.5%

From 2000 to 2012, Denton County experienced a 52 percent growth in the number of children, from 120,110 in 2000 to 182,883 in 2012. During that time frame, only two population groups more than doubled in number. Asian children in Denton County grew in number by 152 percent, from 4,702 in 2000 to 11,866 in 2012, while the number of Hispanic children grew by 144 percent, from 18,373 in 2000 to 44,860 in 2012. Hispanic children also saw the second largest numeric increase in the county, with a net increase of 26,487 during the 12 year time period. While white or Caucasian children saw the largest numerical growth, with an increase of 40,607 (43 percent) from 2000 to 2012, a majority of that growth was among Hispanics who identified as white or Caucasian for their race. From 2000 to 2012, the non-Hispanic white population of Denton County grew by 16,914 children, a 20 percent growth. The Hispanic white population grew by 23,693 children — a growth of 274 percent — representing 58 percent of the growth in the population of white children.¹

Denton
population
182,883
children

Growth in the population of children of other races was not quite as large, with the population of black or African-American children growing by 98 percent, from 7,752 to 15,372. Those children reporting some other race, or two or more races, grew by a similar amount — 7,189 — representing a 59 percent increase from 2000.¹ Examining the overall recent growth in population from 2010 to 2013, 68 percent of the net growth of 66,195 persons was from migration. Most of the migration (85 percent) was from domestic migration — migration to and from places in the U.S. The remaining one-third of Denton’s 3-year population growth

was from net natural increases, with the excess of births over deaths contributing 20,478 to the county’s population growth.²

From 2000 to 2012, the number of children living in poverty in Denton County increased by almost 10,000, from 7,638 to 17,410, an increase of 128 percent. The poverty rate for children rose from 6 percent in 2000 to 10 percent in 2012. Likewise, children increased in the ranks of the poor, with children representing 27 percent of the poor in 2000, and 31 percent of the poor in 2012.¹

In 2012, 80 percent of Denton County children were living in families with two parents, down from 84 percent in 2000. Of the 20 percent of children living in single-parent families, 16 percent were in single-mother families, while the other 4 percent were in single-father families.³ The number of children in single-parent families has nearly doubled since 2000, from 18,314 to 34,450, with most of the increase coming from those living in single-mother families.¹

¹ To improve comparability of estimates between counties, all discussion of population, poverty, and family structure changes are based on IUPR analyses of U.S. Census Bureau American Community Survey 5-Year Estimates for 2012 and Decennial Census Summary File 1 Estimates for 2000. For that reason, figures in the demographic summary may not be directly comparable with those produced elsewhere in the report.

² IUPR Analysis of U.S. Census Bureau Population Estimates and Components of Change, 2010-2013.

³ The phrase “single mother” is a colloquialism; the U.S. Census Bureau refers these as single female-headed households with no husband present, which could include a grandmother or other female relative as head of household. The phrase “single-mother” and “single-father” have been adopted here for ease of reference.

FANNIN COUNTY

TOTAL YOUTH POPULATION	PERCENT WHITE/ CAUCASIAN	PERCENT BLACK/ AFRICAN- AMERICAN	PERCENT AMERICAN- INDIAN	PERCENT ASIAN	PERCENT PACIFIC- ISLANDER	PERCENT OTHER OR MULTIPLE RACES	PERCENT HISPANIC/ LATINO	PERCENT OF ALL CHILDREN LIVING IN POVERTY	PERCENT OF WHITE/ CAUCASIAN, NON- HISPANIC/ LATINO CHILDREN LIVING IN POVERTY	PERCENT BLACK/ AFRICAN- AMERICAN CHILDREN LIVING IN POVERTY	PERCENT OF HISPANIC/ LATINO CHILDREN LIVING IN POVERTY
7,442	87.5%	4.9%	1.4%	0.0%	0.0%	6.2%	14.3%	20.2%	16.7%	62.4%	24.7%

The child population of Fannin County remained relatively stable from 2000 to 2012. The county's 2012 child population of 7,442 represented an increase of only 3 percent (192 children) from 2000. By race, white or Caucasian children had the largest increase, with 276 more children in 2012 than 2000. The number of black or African-American children decreased by 20 percent (93 children). The number of children identifying as Hispanic nearly doubled, growing by 94 percent from 547 in 2000 to 1,061 in 2012.¹

In 2012, 74 percent of Fannin County children lived in married-couple families, while 26 percent lived in single-parent families. This pattern was largely unchanged from 2000. Over the same period, the number of children living in married-couple families decreased by 3 percent, while the number of children living in single-parent households increased by 9 percent. While the number of children living



in single-mother families decreased by 10 percent, from 1,119 to 1,002, the number living in single-father families increased by 61 percent, from 407 to 655.² Among the five counties in the North Texas report, Fannin was the only one to experience a decrease in children living in single-mother families.¹

Poverty has remained relatively stable in the county, rising from 18 percent to 20 percent from 2000 to 2012. Though the rates slightly increased, children were less prevalent among the poor, representing 34 percent of the poor in 2000, and only 29 percent of the poor in 2012.¹

¹ To improve comparability of estimates between counties, all discussion of population, poverty, and family structure changes are based on IUPR analyses of U.S. Census Bureau American Community Survey 5-Year Estimates for 2012 and Decennial Census Summary File 1 Estimates for 2000. For that reason, figures in the demographic summary may not be directly comparable with those produced elsewhere in the report.

² IUPR Analysis of U.S. Census Bureau Population Estimates and Components of Change, 2010-2013.



GRAYSON COUNTY

TOTAL YOUTH POPULATION	PERCENT WHITE/CAUCASIAN	PERCENT BLACK/AFRICAN-AMERICAN	PERCENT AMERICAN-INDIAN	PERCENT ASIAN	PERCENT PACIFIC-ISLANDER	PERCENT OTHER OR MULTIPLE RACES	PERCENT HISPANIC/LATINO	PERCENT OF ALL CHILDREN LIVING IN POVERTY	PERCENT OF WHITE/CAUCASIAN, NON-HISPANIC/LATINO CHILDREN LIVING IN POVERTY	PERCENT BLACK/AFRICAN-AMERICAN CHILDREN LIVING IN POVERTY	PERCENT OF HISPANIC/LATINO CHILDREN LIVING IN POVERTY
28,962	78.6%	6.3%	1.2%	0.5%	0.0%	13.3%	18.7%	22.3%	16.0%	45.6%	33.9%

In 2012, 28,962 children lived in Grayson County, up 4 percent from the 27,975 living there in 2000. By race, the single notable increase was among those children identifying as “other or two or more races,” with an addition of 1,611 children – a 72 percent increase over the number of children in 2000. Children of “other or two or more races” represent 13 percent of Grayson County’s children. All other racial groups saw decreases in the child population, except for Asian children, whose number remained relatively stable over the time period. The number of children of Hispanic ethnicity nearly doubled, from 2,937 in 2000 to 5,427 in 2012, an increase of 85 percent. Among children who racially identified as white or Caucasian, the number identifying as Hispanic grew by 1,670. The remaining Hispanic children are likely represented among those racially identifying as two or more races or some other race.¹

Grayson
population
28,962
children

The number of children living in poverty in Grayson County increased by 2,421, from 3,920 in 2000 to 6,341 in 2012, an increase of 62 percent. Such a dramatic increase in children living in poverty, coupled with a relatively small 4 percent increase in child population, yields an

increase in the poverty rate among children, rising from 14 percent of children in 2000 to 22 percent of children in 2012.¹

Examining changes in the total county population from 2010 through 2013, the county’s population rose by 1,476 persons. Migration accounted for roughly 58 percent of this growth, with a little more than half due to domestic migration from elsewhere in the country.²

With regard to family structure, the percent of children living in married-couple families dropped by 10 percentage points, from 76 percent to 66 percent, from 2000 to 2012. Concomitantly, children living in single-mother families increased by 9 percentage points, from 17 percent to 26 percent of children, and those living in single-father families grew from 6 percent to 9 percent of children.^{1,3}

¹ To improve comparability of estimates between counties, all discussion of population, poverty, and family structure changes are based on IUPR analyses of U.S. Census Bureau American Community Survey 5-Year Estimates for 2012 and Decennial Census Summary File 1 Estimates for 2000. For that reason, figures in the demographic summary may not be directly comparable with those produced elsewhere in the report.

² IUPR Analysis of U.S. Census Bureau Population Estimates and Components of Change, 2010-2013.

³ The phrase “single mother” is a colloquialism; the U.S. Census Bureau refers these as single female-headed households with no husband present, which could include a grandmother or other female relative as head of household. The phrase “single-mother” and “single-father” have been adopted here for ease of reference.



health



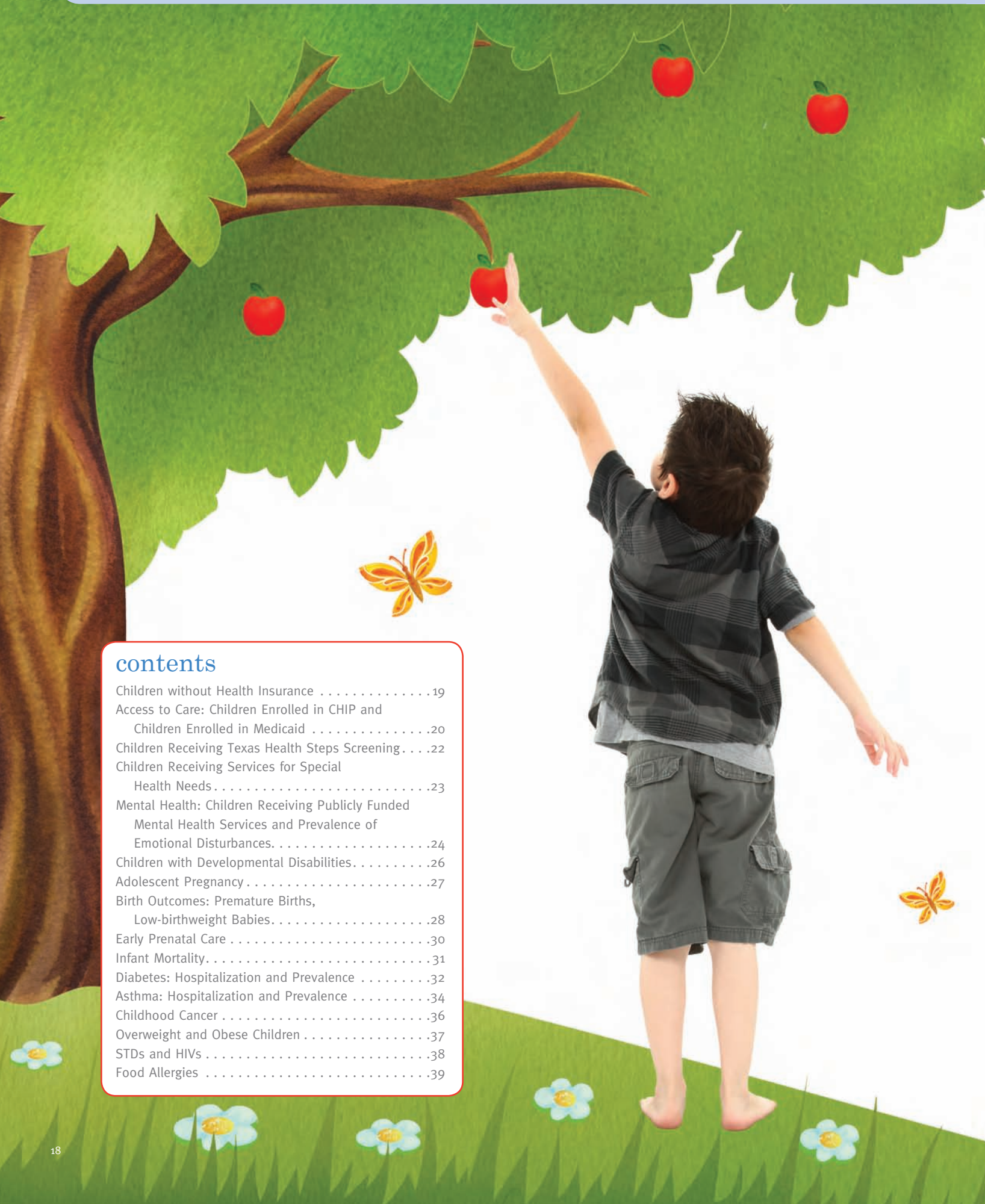
While health indicators include topics from insurance coverage to birth outcomes and the prevalence and incidence of specific diseases, some factors impact the entirety of the health landscape in the region. Chief among them are indicators of access to care and preventive health. Recent research suggests that consistently visiting the same doctor or doctor's office is beneficial to all children and increases their likelihood to receive preventive care, avoid hospitalization, and adopt healthy behaviors.¹ Moreover, preventive care is linked to reduced hospitalizations among children, especially hospitalizations for conditions considered in research to be preventable or avoidable.²

Although each of the five counties report rates of uninsured children at or above the national average, recent trends show that the proportion of children without health insurance is decreasing across the region. Similarly, enrollment in CHIP and children's Medicaid is generally trending upward. As a result, more and more children in the region have some form of health insurance, and an upward trend in the number of children receiving Texas Health Steps screening indicates more children are utilizing that coverage for preventive care. Early prenatal care also provides an important indicator of overall health because it has been linked with increased preventive care utilization and immunization rates among the children of mothers who receive such care.³ With regards to prenatal care, the region has seen some improvement, but significant disparities exist among counties. Overall, the five-county region has seen progress in areas of health care access and preventive care, but there remains room for improvement and opportunity to address regional disparities.

¹ Long, W. E., Bauchner, H., Sage, R. D., Cabral, H. J., & Garg, A. (2011). The Value of the Medical Home for Children Without Special Health Care Needs. *Pediatrics*, 87-98.

² Gadomski, A., Jenkins, P., & Nichols, M. (1998). Impact of a Medical Primary Care Provider and Preventative Care on Pediatric Hospitalization. *Pediatrics*.

³ Kogan, M.D., Alexander, G. R., Jack, B. W., & Allen, C. M. (1998). The Association Between Adequacy of Prenatal Care Utilization and Subsequent Pediatric Care Utilization in the United States. *Pediatrics*, 25-30.



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Children without Health Insurance

Percent of children (under age 18) without health insurance

	2008	2009	2010	2011	2012	2013
COLLIN	13.1	11.5	9.1	9.2	9.8	NA
COOKE	NA	NA	23.9	21.0	18.2	NA
DENTON	10.3	10.1	10.0	8.4	10.5	NA
FANNIN	NA	NA	16.3	13.4	14.8	NA
GRAYSON	15.9	20.8	19.1	11.2	9.7	NA

Data Source: U.S. Census Bureau; American Communities Survey, 1Y Estimates (Collin, Denton, Grayson) 3Y Estimates (Cooke, Fannin).

In the United States, Texas ranks third worst for children lacking health insurance, with 16 percent not covered. Of those, 9 percent are under the age of 18.¹ Across the five-county region, only Cooke County failed to outperform the state, but none of the five counties matched the national rate, although Collin and Grayson came close. For all counties, the rate of uninsured children is generally downward, and Grayson County has seen the largest decreases over the time period measured.

Texas ranks third worst in the nation with 16 percent of children lacking health insurance.

One of the more important issues related to health insurance is consistent access to a medical home. A recent study published by the American Academy of Pediatrics demonstrates a consistent medical home is associated with greater

health care utilization and a greater likelihood of adopting healthy behaviors. For example, children with a medical home were more likely to visit their doctor for preventive care, less likely to require sick visits, and less likely to visit the emergency room.²

The Affordable Care Act (ACA) has had some impact on the uninsured in Texas, but since the state opted not to expand Medicaid, options are somewhat limited for adults, even those with children. Parents who live in poverty but earn more than 19 percent of federal poverty level do not qualify for Medicaid or tax credits in the Health Insurance Marketplace for themselves. Still, families that do not qualify for Children's Health Insurance Program or Medicaid, but earn less than 400 percent of the federal poverty level will be able to receive tax credits in the Health Insurance Marketplace if they do not have access through an employer but only to cover their children.³

Another effect the ACA may have on families revolves around the "shared responsibility payment for not maintaining minimum essential coverage." The regulation applies to any parent who can claim a dependent child on their tax return. If an eligible child goes without minimum coverage for at least one month out of the year, the responsible parent or parents are liable for the shared responsibility payment without regard to whether or not the parent actually claims the child on their tax return.⁴

¹ The Henry J. Kaiser Family Foundation. (2014). *Health Insurance Coverage of Children 0-18*. Retrieved from KFF.org: <http://kff.org/other/state-indicator/children-0-18/>

² Long, W. E., Bauchner, H., Sage, R. D., Cabral, H. J., & Garg, A. (2011). The Value of the Medical Home for Children Without Special Health Care Needs. *Pediatrics*, 87-98.

³ The Henry J. Kaiser Foundation. (2014, January 6). *How Will the Uninsured in Texas Fare Under the Affordable Care Act?* Retrieved from KFF.org: <http://kff.org/health-reform/fact-sheet/state-profiles-uninsured-under-aca-texas/>

⁴ Department of Treasury: Internal Revenue Service. (2013). *Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage*. Retrieved from IRS.gov: <http://www.irs.gov/PUP/newsroom/REG-148500-12%20FR.pdf>

Access to Care

Children Enrolled in CHIP

Number of children enrolled in the Children’s Health Insurance Program (CHIP)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	4,131	3,448	3,665	3,791	4,802	7,073	8,386	9,507	10,723	11,294	10,624
COOKE	514	430	395	410	422	591	672	735	679	689	641
DENTON	4,957	3,831	3,944	3,850	4,634	6,933	8,077	9,377	10,281	11,156	10,273
FANNIN	536	413	357	363	365	459	501	518	551	572	560
GRAYSON	1,770	1,354	1,230	1,216	1,335	1,563	1,649	1,932	2,064	2,147	2,199

Data Source: Texas Health and Human Services Commission; Research and Statistics, Texas CHIP Enrollment Statistics.

Children Enrolled in Medicaid

Number of children younger than 19 enrolled in Medicaid

	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	14,077	17,225	18,063	22,256	27,998	31,334	31,859	33,973
COOKE	2,338	2,420	2,285	2,538	2,938	3,160	3,140	3,456
DENTON	14,572	17,483	17,268	22,582	27,013	30,884	31,510	34,584
FANNIN	1,767	1,950	1,882	2,204	2,463	2,542	2,436	2,618
GRAYSON	6,946	7,311	7,053	8,090	9,638	10,265	10,463	10,906

Data Source: Texas Health and Human Services Commission; Research and Statistics, Texas Medicaid Enrollment Statistics.

From 2012 to 2013, enrollment in the Children's Health Insurance Program (CHIP) decreased in every county except for Grayson; despite this recent decrease, all of the counties have seen a general upward trend since 2006. Denton and Collin counties have seen the most drastic increases, as their number of enrollees has nearly tripled since 2006. Similarly, the number of children enrolled in Medicaid has steadily risen since 2006 in all five counties, with few exceptions. As with CHIP enrollment, the most significant increases have occurred in the two largest counties where the number of enrollees has more than doubled.

Not only are overall enrollment numbers generally trending upward, from 2010 to 2013, the average number of new CHIP enrollees per month has increased every year in every county. Despite this fact, over the same time period, the renewal rates in Collin, Denton, and Fannin counties have decreased. While these numbers are not conclusive, they suggest the region has been successful at enrolling new participants, but less successful at retaining them.¹

Although Medicaid and CHIP are somewhat different in scope, both programs primarily serve children. The income requirements imposed for children's Medicaid are signifi-

cantly lower than those for CHIP. In order to qualify for services under children's Medicaid, a family of four must have an annual income less than \$32,921, or a monthly income less than \$2,743. On the other hand, the income threshold for the same family to qualify for CHIP is \$49,143 annually, or \$4,095 per month.²

The number of CHIP enrollees in Denton and Collin counties has tripled since 2006.

Since its passage in 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) has provided federal grants to local agencies committed to increasing enrollment or simplifying enrollment in both CHIP and Children's Medicaid. Across the three grant cycles since 2009, agencies in Texas have received more than \$5 million for outreach efforts, most of which have been concentrated in the Rio Grande Valley

and Houston areas. However, there has been some investment in the North Texas region. The North Texas CHIP and WIC Project was created with nearly \$900,000 in CHIPRA funding in 2011, and received a similar amount in 2013.^{3,4} The program centers aims to provide CHIP and Medicaid enrollment assistance through existing WIC office. Although the program bears the name "North Texas," most of the efforts have been coordinated through the City of Dallas WIC offices.⁵

¹ Institute for Urban Policy Research analysis of data from: Texas Health and Human Services Commission. (2014, April). *CHIP Enrollment Statistics*. Retrieved from Texas Health and Human Services Website: <http://www.hhsc.state.tx.us/research/CHIP/ChipDataTables.asp>

² Texas Health and Human Services Commission. (2014). *Can I Get It?* Retrieved from CHIP | Children's Medicaid: <http://chipmedicaid.org/en/Can-I-Get-It>

³ U.S. Department of Health and Human Services. (2011). *CHIPRA Cycle II Grant Summaries*. Retrieved from InsureKidsNow.gov: http://www.insurekidsnow.gov/professionals/outreach/get_covered_campaign/CHIPRA-Cycle-II-Grant-Summaries.pdf

⁴ Centers for Medicaid and Medicare Services. (2013, July 2). *Fact sheets: Connecting Kids to Coverage Outreach and Enrollment Grants*. Retrieved from Centers for Medicaid and Medicare Services website: <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-07-02.html>

⁵ Community Council for Greater Dallas. (2011, September). *Funds Expand North Texas CHIP Outreach*. Retrieved from Community Council of Greater Dallas website: <http://www.ccgd.org/news/fundsexpandnorthtexaschipoutreach.html>



Children Enrolled in Medicaid Receiving Texas Health Steps Medical Screening Services

Number of children who received medical screening services through Texas Health Steps (Medicaid)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	7,143	9,056	10,501	11,244	12,663	12,092	13,904	17,423	20,698	23,022	23,559
COOKE	1,573	1,770	1,705	1,961	2,043	1,805	2,135	2,479	2,433	1,872	1,385
DENTON	6,446	10,054	10,378	12,510	12,325	12,314	13,980	17,864	20,965	22,635	24,259
FANNIN	1,096	1,151	1,153	1,168	1,318	1,248	1,504	1,628	1,621	1,484	1,672
GRAYSON	4,274	4,522	4,706	4,745	5,020	4,815	4,767	6,402	6,806	6,362	6,573

Data Source: Texas Health and Human Services Commission; Research and Statistics, Texas CHIP Enrollment Statistics.

With the exception of Cooke, each county in the five-county region saw an increase in the number of children receiving medical screening services through Texas Health Steps. The rate of enrolled children in Cooke County has decreased steadily since 2010, even while the population has remained much the same.¹ Denton County had the largest increase with about 35 percent more children receiving services since 2010.

Rising participation in Texas Health Steps is significant because it reveals utilization of care.

Through Texas Health Steps, participating children can receive regular medical and dental services as part of their Medicaid benefits, at no additional cost. Qualifying

medical services include vision and hearing screenings, immunizations, and some medicines, which participants can receive until age 20. Case managers can help with school and education issues, locate nearby health services, and even assist with transportation to and from visits to a doctor or dentist.² Rising participation in Texas Health Steps is a significant positive development because it speaks not only to access to care, but utilization of care; children receiving Texas Health steps screenings are receiving important preventive care that not only improves their health, but also potentially lower long-term medical costs.

Those enrolled in Texas Health Steps are also entitled to receive medical services as part of the Comprehensive Care Program, under which federally-mandated

preventive care services for children must be made available to eligible Texas Health Steps clients even if they are not regularly available through the state’s Medicaid plan.³ Some of the treatments covered include occupational or physical therapy, nutrition counseling services, orthotic and prosthetic services, and other corrective services for disabilities and chronic conditions.⁴

¹ U.S. Census Bureau. (2010). *State & County Quickfacts: Cooke County, Texas*. Retrieved from U.S. Census Bureau website: <http://quickfacts.census.gov/qfd/states/48/48097.html>

² Texas Department of State Health Services. (2014, January 9). *About Texas Health Steps*. Retrieved from Texas Department of State Health Services website: <http://www.dshs.state.tx.us/thsteps/about.shtm>

³ Texas Medicaid and Healthcare Partnership. (2011). *TMPPM 2011 > Children’s Services Handbook > THSteps Medical > THSteps Medical and Dental Administrative Information > Overview*. Retrieved from Texas Medicaid and Healthcare Partnership: <http://www.tmhp.com/HTMLmanuals/TMPPM/2011/2011TMPPM-19-317.html>

⁴ Texas Medicaid and Healthcare Partnership. (2013). *CCP Overview*. Retrieved from the Texas Medicaid and Healthcare Partnership website: http://www.tmhp.com/HTMLmanuals/TMPPM/Current/Vol2_Children%27s_Services_Handbook.17.007.html

Children Receiving Services for Special Healthcare Needs

Number of children who receive services through the state's Children with Special Healthcare Needs Services Program

		2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	Clients Served	17	26	35	32	39	39	38	32	24	25	24
	Waiting List	17	26	35	32	39	39	38	32	24	25	24
COOKE	Clients Served	1	0	0	0	0	0	1	1	1	1	1
	Waiting List	0	0	0	1	1	0	1	3	3	0	0
DENTON	Clients Served	15	28	28	30	36	36	36	30	27	22	20
	Waiting List	15	7	22	25	26	13	11	13	13	14	10
FANNIN	Clients Served	0	2	4	5	6	2	1	0	0	0	1
	Waiting List	2	1	1	1	1	1	1	1	0	0	0
GRAYSON	Clients Served	9	8	8	7	7	6	7	4	3	1	1
	Waiting List	6	4	4	2	2	1	1	7	3	2	3

Data Source: Texas Department of State Health Services; PHSU Data Team, CSHCN Services Program.

The Children with Special Health Care Needs (CSHCN) Services Program is a state service available to Texas residents under the age of 21, below certain income requirements, who suffer with a medical condition that limits major life activities or requires more health care than a typical child. The condition must also include physical symptoms, as the program does not cover children with only mental, developmental, behavioral, or emotional conditions without physical symptoms. The program assists clients and their families with medical, dental, and mental health care, prescriptions, special therapies, case management, family support services, travel to health care visits, and insurance premiums, among other services. In addition to children, the program serves individuals of any age with cystic fibrosis.¹

In the more populous counties of Collin and Denton, the number of children receiving services for special health care needs increased from 2003 to 2007, but declined during the last five years. Since 2000, the number of children in Grayson County receiving these services reduced from 16 to just one.

In a recent survey, only 58 percent of families had adequate private and/or public insurance to pay for the services needed by their CSHCN.

However, the smaller counties serve too few children to spot a clear trend in number of children being served.

Unlike the state of Texas, the U.S. Department of Health and Human Services does include children

without physical symptoms in their calculation of children with special health care needs and estimates that 13.4 percent of the children in Texas have special health care needs. In a recent survey, only 58 percent indicated they had adequate private and/or public insurance to pay for the services needed by their CSHCN. In the same survey, 1 in 4 family members responded that they had to cut back or stop working in order to take care of their CSHCN. Furthermore, only 35 percent of families said that youth with special health care needs receive the services necessary to make transitions to adult health care.²

¹ Texas Department of State Health Services. (2014, June 05). *Children with Special Health Care Needs (CSHCN) Services Program*. Retrieved from <http://www.dshs.state.tx.us/CSHCN/>

² U.S. Department of Health and Human Services. (2013). *The National Survey of Children with Special Health Care Needs Chartbook 2009-2010*. Retrieved from Health Resources and Services Administration: <http://mchb.hrsa.gov/cshcn0910/state/pages/tx.html>

Mental Health

Children Receiving Publicly Funded Mental Health Services

Number of children receiving publicly funded mental health services through Medicaid Managed Care

	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN		538	543	583	615	904	1,053	1,151	1,172
COOKE		29	26	20	26	34	50	43	37
DENTON	501	487	483	471	433	467	514	478	389
FANNIN	29	17	19	32	44	43	61	72	68
GRAYSON	80	81	67	67	85	69	81	92	75

Data Source: Texas Department of State Health Services: Mental Health and Substance Abuse, Medicaid Services Unit.

Prevalence of Emotional Disturbance and Addictive Disorders

Number of children ages 9-17 with emotional disturbance and addictive disorders

		2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	Any disturbance or disorder	18,460	19,509	20,655	21,282	23,244	23,289	24,081	25,649	NA
	Serious disturbance or disorder	4,416	4,667	4,941	5,091	5,561	5,571	5,761	6,136	NA
COOKE	Any disturbance or disorder	NA	NA	1,104	1,092	982	1,002	1,006	1,026	NA
	Serious disturbance or disorder	NA	NA	264	261	235	240	241	245	NA
DENTON	Any disturbance or disorder	14,798	16,104	16,154	17,014	17,699	19,571	19,301	20,290	NA
	Serious disturbance or disorder	3,540	3,853	3,865	4,070	4,234	4,682	4,617	4,854	NA
FANNIN	Any disturbance or disorder	NA	NA	722	774	784	794	790	745	NA
	Serious disturbance or disorder	NA	NA	173	185	188	190	189	178	NA
GRAYSON	Any disturbance or disorder	2,878	3,435	3,114	3,043	2,919	3,330	2,977	3,147	NA
	Serious disturbance or disorder	689	822	745	728	698	797	712	753	NA

Data Source: U.S. Surgeon General Report; U.S. Census Bureau, American Communities Survey 1Y Estimates (Collin, Denton, Grayson) 3Y Estimates (Cooke, Fannin).

Since the state of Texas does not include those with mental, behavioral, or emotional conditions in their Children with Special Health Care Needs population, it is necessary for us to estimate the number of those children independently by using the emotionally and seriously emotionally disturbed prevalence rates for children ages 9-17, as provided by the U.S. Surgeon General's Report, which reports 20.9 percent and 5 percent, respectively. Considering the prevalence rates mirror growth patterns of the child population of the respective counties, it is no surprise that Collin County has the largest estimated number of emotionally disturbed children at 25,649, followed by Denton, Grayson, Cooke, and lastly Fannin at 745 emotionally disturbed children.

One of the largest challenges for those obtaining mental health services is access.

As demonstrated by the large disparity between the estimated number of emotionally disturbed children and the number of those children receiving publicly funded mental health services, one of the largest challenges for those obtaining mental health services is access. The Texas Department of State Health Services will serve children ages 3 to 17 who have a diagnosis of mental illness and

exhibit serious emotional, behavioral, or mental disorders and who additionally either have a serious functional impairment, are at risk of disrupting a preferred living or child care environment due to psychiatric symptoms, or who are enrolled in a school system's special education program because of serious emotional disturbance.¹

While the number of children receiving services has increased in Cooke, Fannin, and Collin counties, it may be concerning that the number has decreased in Grayson and Denton counties when little evidence suggests a decline in the number of children needing these services. Through appropriate identification, assessment, and treatment, children living with mental illness can lead successful and fulfilling lives. Ronald Kessler, Ph.D., and colleagues found in a landmark study,

called the National Comorbidity Survey Replication (NCS-R), that half of all lifetime mental disorders start by age 14, suggesting that prevention and early treatment should be targeted for youth.¹ The office of the Surgeon General's conference on *Children's Mental Health: Developing a National Action Agenda* revealed that only 20 percent of youth with mental disorders are identified and receive the proper treatment.² This lack of access to adequate treatment and support systems often has a negative impact on overall quality of life.

¹ Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005;62(6):593-602. doi:10.1001/archpsyc.62.6.593.

² US Department of Health and Human Services; US Department of Education; US Department of Justice. Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington (DC): US Department of Health and Human Services; 2000. Conference Proceedings. Available from: <http://www.ncbi.nlm.nih.gov/books/NBK44232/>



Children with Developmental Disabilities

Estimated number of children with developmental disabilities

	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	25,200	28,634	30,935	32,065	33,359	34,013	34,583	34,859	NA
COOKE	NA	NA	1,488	1,486	1,495	1,497	1,480	1,458	NA
DENTON	20,638	23,537	25,432	26,405	27,052	27,594	28,148	28,650	NA
FANNIN	NA	NA	1,083	1,091	1,117	1,132	1,131	1,116	NA
GRAYSON	3,909	4,341	4,375	4,321	4,429	4,411	4,353	4,315	NA

Data Source: American Academy of Pediatrics; U.S. Census Bureau, American Communities Survey 1Y Estimates (Collin, Denton, Grayson) 3Y Estimates (Cooke, Fannin).

The Centers for Disease Control and Prevention (CDC) describes developmental disabilities as “a group of conditions due to impairment in physical, learning, language, or behavior areas.” According to the CDC, developmental disabilities can develop in utero due to genetics or parental health and behaviors or after birth because of injury, infection, or other environmental factors. They can occur across all racial, ethnic, and socioeconomic groups.¹

A study from 1997-2008 published by the CDC in *Pediatrics* found that over the 12-year period, the prevalence of developmental disabilities in children ages 3-17 increased 17 percent, by about 1.8 million children. The prevalence of autism increased 290 percent to 0.74 percent, while the prevalence of ADHD increased by about 33 percent to 7.57 percent. The study also found that males were twice

as likely as females to have any developmental disability, and the gender differences were greatest for ADHD, autism, learning disabilities, and stuttering. Hispanic children had lower prevalence rates of ADHD and learning disabilities compared to non-Hispanic white and black children, and children insured by Medicaid had nearly two times higher prevalence of any developmental disability compared to those with private insurance.²

In a ranking of how well state Medicaid programs serve those with developmental disabilities, Texas ranked at the bottom for the sixth consecutive year.

Each year, the advocacy group United Cerebral Palsy produces a ranking of how well state Medicaid programs serve those with developmental disabilities. They rank all 50

states and the District of Columbia on their outcomes for Americans with developmental disabilities – how well they are performing overall and which states are implementing policies that should be replicated. The 2013 report ranked Texas as 50th, remaining at the bottom for the sixth year in a row. Furthermore, the report stated that Texas has a waiting list of people hoping to be served that would require the program to grow by 313 percent on average to accommodate the need.³

¹ Centers for Disease Control and Prevention. (2013, December 26). *Facts about Developmental Disabilities*. Retrieved from Developmental Disabilities: <http://www.cdc.gov/ncbddd/developmentaldisabilities/facts.html>

² Centers for Disease Control and Prevention. (2012, August 14). *Key Findings: Trends in the Prevalence of Developmental Disabilities in U.S. Children 1997-2008*. Retrieved from Developmental Disabilities: <http://www.cdc.gov/ncbddd/developmentaldisabilities/features/birthdefects-dd-keyfindings.html>

³ United Cerebral Palsy. (2013). *State Scorecards*. Retrieved from The Case for Inclusion 2013: http://www.ucp.org/the-case-for-inclusion/2013/state_scorecards.html

Adolescent Pregnancy

Number and rate of adolescent pregnancies per 1,000 females 13-17

		2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	Number	201	230	198	218	238	230	217	207	186	160	NA
	Rate	9.4	10.0	8.0	8.1	8.3	7.6	6.9	7.0	6.0	4.9	NA
COOKE	Number	40	33	37	45	46	30	31	21	22	20	NA
	Rate	26.7	21.9	24.9	30.6	32.5	22.1	23.0	16.1	16.5	15.1	NA
DENTON	Number	252	240	250	267	250	278	250	237	208	178	NA
	Rate	14.4	13.2	13.2	13.6	12.4	13.5	11.9	10.1	8.5	6.9	NA
FANNIN	Number	23	22	26	24	26	26	15	16	11	13	NA
	Rate	20.1	18.4	21.4	19.9	21.8	22.3	12.9	15.5	10.3	12.4	NA
GRAYSON	Number	99	92	96	81	101	99	89	83	52	75	NA
	Rate	23.6	21.8	22.9	19.5	25.0	25.7	23.9	21.1	13.2	18.7	NA

Data Source: Texas Department of State Health Services; Center for Health Statistics, Vital Statistics Annual Reports.

Rates of adolescent pregnancy have been consistently declining across the nation and the state, particularly since 2007. Overall, all five counties experienced considerable decline in adolescent pregnancy over the 10-year period; the greatest decline in adolescent pregnancy rates came from Denton County where the rate dropped by 40 percent. Even Grayson County, which had the smallest decline, lowered their rate by about 20 percent. Furthermore, all counties were below the 2011 state adolescent pregnancy rate of 18.5 per 1,000

All five counties experienced considerable decline in adolescent pregnancy rate over a ten year period.

females 13-17, and all but Grayson County were below the 2012 state rate of 16.5 per 1,000 females 13-17.

While the state primarily tracks the rate of pregnancies for the 13-17 age group, the Centers for Disease Control and Prevention reports on the 15-19 and 10-14 age groups. In 2012, the national birth rate for those 15-19 was 29.4 births per 1,000 females. This number leaps to 46.3 and 43.9 for Hispanic and non-Hispanic black females, respectively, and lowers to 20.5 for non-Hispanic white females. As for the younger population throughout the U.S., the birth rate remained the same from 2011 to 2012 for those aged 10-14 years at 0.4 births per 1,000 females.¹

While rates have decreased drastically across the nation and state, there has been increased awareness recently about those teens giving birth to a second, third, or even fourth child. Texas ranks number one among the 50 states for repeat teen births, with 22 percent of teen births reported as at least the mother's second child. Recent studies have shown that 1 in 4 teen mothers receive some type of public assistance before the child's third birthday, and only 38 percent will earn a high school diploma.²

¹ Centers for Disease Control and Prevention. (2013). *Births: Final Data for 2012*. Retrieved from National Center for Health Statistics: http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_09.pdf

² Feibel, C. (2013, May 30). *Teenage Pregnancy in Decline, But Texas Still #1 For 'Repeat Teen Births'*. Retrieved from Houston Public Media: <http://www.houstonpublicmedia.org/news/1369307765/>

Birth Outcomes

Premature Births

Number and percent of live births occurring before 37 completed weeks of pregnancy

		2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	Number	1,052	1,328	1,420	1,474	1,422	1,364	1,242	1241	1,141	1,158	NA
	Percent	11.0	13.4	13.9	13.7	12.9	12.4	11.8	11.7	11.0	11.2	NA
COOKE	Number	65	76	66	78	67	63	64	49	56	55	NA
	Percent	12.8	14.1	11.8	14.0	12.2	12.5	13.0	9.6	11.5	9.8	NA
DENTON	Number	835	1,138	1,138	1,174	1,083	1,033	989	956	899	924	NA
	Percent	10.1	13.6	12.9	12.7	11.7	11.2	10.9	10.6	9.8	9.9	NA
FANNIN	Number	42	68	47	58	47	47	53	37	41	38	NA
	Percent	11.9	17.3	12.0	13.8	11.4	11.8	13.9	10.9	12.0	11.8	NA
GRAYSON	Number	155	217	220	197	179	180	212	192	170	181	NA
	Percent	10.2	13.7	14.1	12.7	11.3	11.6	14.2	12.6	11.5	12.1	NA

Data Source: Texas Department of State Health Services; Center for Health Statistics, Vital Statistics Annual Reports.

Low-Birthweight Babies

Number and percent of infants weighing 2,500 grams (approximately 5.5 pounds) or less at birth

		2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	Number	794	791	804	830	840	868	812	843	801	839	NA
	Percent	7.8	7.6	7.7	7.7	7.6	7.9	7.6	8.0	7.7	8.1	NA
COOKE	Number	38	44	38	56	52	43	44	32	40	31	NA
	Percent	7.4	8.1	6.7	9.2	8.6	7.9	8.3	6.3	8.2	5.5	NA
DENTON	Number	591	632	634	705	641	693	662	622	656	680	NA
	Percent	6.9	7.1	7.0	7.5	6.8	7.4	7.2	6.9	7.1	7.3	NA
FANNIN	Number	33	41	26	30	33	27	34	24	25	23	NA
	Percent	9.1	10.0	6.5	7.1	8.0	6.7	8.8	7.0	7.3	7.1	NA
GRAYSON	Number	120	146	111	107	134	112	136	113	109	112	NA
	Percent	7.6	8.8	7.0	6.9	8.4	7.0	8.8	7.4	7.4	7.5	NA

Data Source: Texas Department of State Health Services; Center for Health Statistics, Vital Statistics.

In 2012, the national percentage of live births occurring prematurely was 11.5, and the Texas percentage was 12.4. All five counties outperformed this state percentage, and only Fannin and Grayson counties reported percentages higher than the nation. Since preterm birth is closely related to prenatal care, it is likely that the lack of early prenatal care in these counties contributes to the relatively higher rates of prematurity. Furthermore, the shortage of practicing obstetricians and gynecologists in Fannin County likely exacerbates the situation.

Lack of early prenatal care contributes to the high rates of premature births.

Nationwide, 40 percent of all births are covered by Medicaid and 50 percent in Texas. The average cost of care required for a preterm hospital birth is 18 times that of the average newborn, adding millions of dollars a year in additional Medicaid spending. In 2012, the Texas Health and Human Services Commission introduced a new

program that included a 24-hour hotline for women who are at risk of premature delivery. While it is no replacement for regular prenatal care, the program may still provide much-needed information and advice on proper health and nutrition during pregnancy. Ultimately, the commission expects that the program will save the state as much as \$32.5 million within two years of its introduction.¹

Not only are those mothers who receive inadequate prenatal care more likely to give birth prematurely, they are also at risk of having a low-birthweight baby. Approximately 70 percent of low-birthweight babies are born premature. These infants do not gain the weight appropriately before birth, either because of the behavior or health factors of the mother, problems with receiving nutrients, or the mother not

gaining enough weight during pregnancy. Because of the relationship between premature birth and low birthweight, many of the potential health issues related to underdevelopment may be experienced by a low-birthweight baby.²

Trends in the rates of low-birthweight babies experienced consistent increases from 2001 to 2006 in both the nation and the state, but have been fluctuating since. In 2012, all five counties outperformed the state rate of 8.3 percent, with only Collin County reporting rates higher than the national average of 8 percent.

¹ Luthra, S. (2012, July 3). *HHSC Targets Premature Births in Quest to Cut Costs*. Retrieved from The Texas Tribune: <http://www.texastribune.org/2012/07/03/hhsc-program-targets-intensive-care-babies/>

² March of Dimes. (2014, March). *Low Birthweight*. Retrieved from Your Premature Baby: <http://www.marchofdimes.com/baby/low-birthweight.aspx>



Early Prenatal Care

Percent of live births in which the mother received prenatal care during the first trimester of pregnancy

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	85.4	84.3	73.7	73.2	71.0	71.1	73.7	72.1	74.0	73.5	NA
COOKE	88.7	84.9	62.2	57.7	55.2	50.3	54.1	52.9	56.5	57.4	NA
DENTON	87.7	86.4	72.2	68.3	67.2	64.9	66.8	66.6	68.6	69.0	NA
FANNIN	75.9	77.8	59.1	58.1	57.6	55.5	53.7	51.6	53.1	59.4	NA
GRAYSON	84.6	86.2	62.2	57.3	55.5	55.7	52.8	57.6	54.7	56.9	NA

Data Source: Texas Department of State Health Services; Center for Health Statistics, Vital Statistics.

In 2012, 74.1 percent of pregnant women in the United States received prenatal care during the first trimester of pregnancy; all of the five counties fell short of the national rate, and only Collin and Denton counties outperformed the 63.6 percent reported for the state of Texas in the same year. Just under 90 percent of pregnant women in Texas received prenatal care in the first or second trimester, which means that about 1 in 10 Texas infants are born to mothers who received late or no prenatal care. Moreover, the March of Dimes suggests that, regardless of its timing, 1 in 4 Texas mothers receive inadequate prenatal care.

Prenatal care services are vital to the health of the mother and child, and typically include screening for medical conditions and identification and interventions for behavioral risk factors associated with poor birth outcomes. Mothers are also

provided with educational information designed to boost the health of their newborn, such as tips on nutrition, breastfeeding, illness prevention, and monitoring for health-compromising conditions. Child Trends Databank reports that babies born to mothers who receive no prenatal care are three times more likely to be underweight and five times less likely to survive infancy.¹ Some of the reasons that a pregnant woman might not receive prenatal care include lack of health insurance, language or cultural barriers, fear of the medical system, and accessibility. Women without a regular health care provider and a high school diploma are least likely to receive prenatal care. In 2010, the Texas Department of State Health Services reported that 70 percent of all white women received services during their first trimester, while just 52.1 and 55.5 percent of African-American and Hispanic women received the same care.²

One in four Texas mothers receive inadequate prenatal care.

Lack of early prenatal care is a notable contributor to prematurity, largely because early care is key to guiding new mothers toward healthy behaviors and educating them about in utero development. A newborn is considered premature if born prior to 37 weeks. The earlier the baby is born, the more likely they are to have health problems due to underdeveloped organs and immune system.³

¹ Child Trends Databank. (2014, January). Retrieved from Late or No Prenatal Care: <http://www.childtrends.org/?indicators=late-or-no-prenatal-care>

² Texas Department of State Health Services. (2013, November 12). *Healthy Texas Babies*. Retrieved from Texas Data: <https://www.dshs.state.tx.us/healthytexasbabies/data.aspx>

³ March of Dimes. (2013, October). *Premature Babies Overview*. Retrieved from Your Premature Baby: <http://www.marchofdimes.com/baby/premature-babies.aspx>

Infant Mortality

Number and rate of infants under 12 months who died per 1,000 live births

		2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	Number	32	33	37	35	42	58	46	48	56	38	NA
	Rate	4.8	5.1	5.3	4.6	3.8	5.2	4.3	4.5	5.4	3.7	NA
COOKE	Number	2	1	3	1	4	7	3	2	4	4	NA
	Rate	11.6	3.7	10.6	3.3	6.6	12.9	5.7	3.9	8.2	7.1	NA
DENTON	Number	36	39	27	34	41	41	40	45	31	43	NA
	Rate	5.9	5.7	4.4	5.0	4.4	4.4	4.3	5.0	3.4	4.6	NA
FANNIN	Number	2	2	0	3	1	3	2	1	0	0	NA
	Rate	5.5	7.3	0	7.1	2.4	7.4	5.2	2.9	0.0	0.0	NA
GRAYSON	Number	3	6	3	3	9	9	6	8	9	9	NA
	Rate	5.7	4.2	3.2	4.5	5.6	5.7	3.9	5.3	6.1	6.0	NA

Data Source: Texas Department of State Health Services; Center for Health Statistics, Vital Statistics Annual Reports.

Early access to prenatal care, premature births, and low birth-weight are all primary contributing factors to the infant mortality rate, which is widely considered to be a leading indicator of a country's overall health. Nationwide, the infant mortality rate in 2010 stood at 6.2 per 1,000 live births, which was one of the worst rates among industrialized nations. The rate has improved slightly since 2010, to 6.1 percent, and since 2005 the rate has decreased by about 12 percent. However, it is still a far cry from the 1970s when the infant mortality rate in the U.S. was among the lowest in the world.^{1,2,3}

In 2011, the Texas Department of State Health Services (DSHS) reported the infant mortality rates of 11.2, 4.8, and 5.2 in Texas for African-American, white and Hispanic babies, respectively. The overall rate per 1,000 births for the state was 5.7, indicating that the overall infant mortality rate could be vastly reduced by increasing rates of prenatal care for African-American mothers. Still, the infant

Cooke County's infant mortality rate remains higher than the national rate, which is one of the worst among industrialized nations.

mortality rate in Texas remains lower than the national average of 6.1 per 1,000 births.⁴

Across the five counties, only Cooke and Grayson reported rates higher than the state average, and only Cooke did not fall below the national rate. Fannin County reported zero infant deaths in both 2011 and 2012, and all counties have decreased or remained stable since 2003.

According to the Centers for Disease Control and Prevention, the leading cause of infant mortality is congenital malformation, followed by premature birth and low birth-weight. Other leading causes include sudden infant death syndrome (SIDS), maternal complications, and unintentional injuries.³

While the state as a whole has achieved the U.S. Department of

Health and Human Services' Healthy People 2020 goal of 6 deaths per 1,000 live births, substantial regional disparities persist within the state. Of the 22 largest communities identified by the DSHS, 14 of them reached the Healthy People 2020 goal; the Dallas-Plano area, which includes Collin and Denton counties, did not meet the goal. The region termed the Dallas-Fort Worth "Outlying," which includes Grayson and Cooke counties, did meet the goal; Fannin County is not included in any of the major regions. Other major regions that failed to meet the goal include Beaumont-Port Arthur, Fort Worth-Arlington, and Longview-Marshall, among others.⁴

¹ Department of State Health Services. (2013, November 12). *Texas Data*. Retrieved from Healthy Texas Babies: <https://www.dshs.state.tx.us/healthytebabies/data.aspx>

² Porter, E. (2013, October 22). *New Front in the Fight With Infant Mortality*. Retrieved from The New York Times: http://www.nytimes.com/2013/10/23/business/health-law-is-a-new-front-in-the-fight-against-infant-mortality.html?_r=2&

³ Centers for Disease Control and Prevention. (2013, April). *Recent Declines in Infant Mortality in the U.S. 2005-2011*. Retrieved from Publications and Information Products: NCHS Data Brief: <http://www.cdc.gov/nchs/data/databriefs/db120.htm>

⁴ Mandell, D.J., Daeva, S. & Kormondy, M. 2013 *Healthy Texas Babies: Databook*. Austin, TX: Division for Family and Community Health Services, Texas Department of State Health Services, 2013.

Diabetes

Diabetes Prevalence in Children

Estimated number of children under 18 with diabetes (Type 1 and Type 2)

	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	284	406	446	476	458	498	498	471	NA
COOKE	NA	NA	21	22	21	22	21	20	NA
DENTON	233	334	366	392	372	404	406	387	NA
FANNIN	NA	NA	16	16	15	17	16	15	NA
GRAYSON	44	62	63	64	61	65	63	58	NA

Data Source: Centers for Disease Control and Prevention: National Health Interview Survey 2003-2012.

Diabetes Hospitalizations

Number of children hospitalized with a primary or secondary diagnosis of Type 1 or Type 2 diabetes

		2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	Type 1	182	182	248	259	262	241	314	250	NA
	Type 2	289	341	332	355	404	360	397	430	NA
	TOTAL	471	523	580	614	666	601	711	680	NA
COOKE	Type 1	9	20	17	16	16	17	16	2	NA
	Type 2	13	32	25	37	40	36	24	23	NA
	TOTAL	22	52	42	53	56	53	40	25	NA
DENTON	Type 1	142	188	200	212	228	185	204	239	NA
	Type 2	268	269	296	387	397	352	422	383	NA
	TOTAL	410	457	496	599	625	537	626	622	NA
FANNIN	Type 1	10	9	14	7	22	23	15	20	NA
	Type 2	29	33	44	33	30	48	42	26	NA
	TOTAL	39	42	58	40	52	71	57	46	NA
GRAYSON	Type 1	66	94	67	65	85	84	60	70	NA
	Type 2	103	115	134	134	138	148	125	148	NA
	TOTAL	169	209	201	199	223	232	185	218	NA

Data Source: Texas Department of State Health Services; Center for Health Statistics, Texas Hospital Inpatient Discharge Public Use Data Files 2000-2012.

The trends in the estimated numbers of children with diabetes across the five-county region are a result of both a growth in counties' child population and an increase in the overall prevalence of diabetes. In the counties that saw significant increases in the childhood population, like Collin and Denton, the estimated number of children diagnosed with diabetes increased steadily despite the limited variance in prevalence rates, decreasing only when the prevalence rate for that year did, as in 2009 and 2012. The smaller counties' trends mirrored more closely that of the diabetes prevalence rates, with very minor fluctuations, due to their mostly stagnant child population numbers.

An overall increase in the number of diabetes hospitalizations occurred in all five counties.

The trends seen in the actual diabetes hospitalizations tell a similar story, although the number of hospitalizations are higher on average than the number of estimated diagnoses, possibly due to children having multiple admittances or simply because the estimates are based on national prevalence rates, not local ones. There was an overall increase in the number of

diabetes hospitalizations in all five counties, albeit minimally in Cooke and Fannin.

The Centers for Disease Control and Prevention (CDC) in the National Diabetes Statistics Report explains that diabetes can be treated and managed by adopting a healthy diet, regular physical activity, and a medical treatment regimen designed to lower blood glucose levels. The report emphasizes patient education and self-care practices are critical aspects of managing diabetes. Children with Type 1 diabetes are at high-risk for adverse outcomes associated with hypoglycemia or low blood glucose, which can lead to such serious consequences as seizures, unconsciousness, or death.¹

The latest numbers published by the CDC regarding the rate of new cases of diabetes among children 10-19 years of age shows that the majority of diabetes diagnoses

for African-American and Asian or Pacific-Islander populations are for Type 2 diabetes. Conversely, Type 2 diabetes represented about 40 percent of diabetes diagnoses in the Hispanic population for the same age range, and about 15 percent of the white population. For children less than 10 years of age, the rate of Type 2 diagnoses is about 1 in 100,000 compared to 22 in 100,000 for Type 1 diabetes.¹ All counties in the North Texas corridor reported higher numbers of Type 2 hospitalizations than Type 1, which could suggest that hospitalizations are more common for children older than 10; on the other hand, it is also possible that children with Type 1 diabetes are simply more likely to control their condition and avoid hospitalization.

¹ Center for Disease Control and Prevention. (2014). *National Diabetes Statistics Report, 2014*. Retrieved from Division of Diabetes Translation: <http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf>



Asthma

Pediatric Asthma

Estimated number of children who currently have asthma or have had asthma during their lifetime

		2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	Lifetime	20,946	22,980	26,266	29,279	30,386	29,400	30,045	29,744	NA
	Current	13,339	15,256	17,511	19,685	19,592	18,846	18,242	18,078	NA
COOKE	Lifetime	NA	NA	1,263	1,356	1,362	1,294	1,286	1,244	NA
	Current	NA	NA	842	912	878	829	781	756	NA
DENTON	Lifetime	17,154	18,889	21,593	24,111	24,642	23,851	24,455	24,446	NA
	Current	10,924	12,540	14,395	16,210	15,888	15,289	14,848	14,858	NA
FANNIN	Lifetime	NA	NA	919	997	1,017	979	982	952	NA
	Current	NA	NA	613	670	656	627	597	579	NA
GRAYSON	Lifetime	3,249	3,484	3,715	3,946	4,034	3,813	3,782	3,682	NA
	Current	2,069	2,313	2,477	2,653	2,601	2,444	2,296	2,238	NA

Data Source: Centers for Disease Control; Behavioral Risk Factors Surveillance System, 2005-2012.

Asthma Hospitalizations

Children who were hospitalized with a primary or secondary diagnosis of asthma

	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	531	562	596	494	695	524	489	539	NA
COOKE	25	63	69	49	42	43	29	20	NA
DENTON	532	616	587	513	614	451	466	528	NA
FANNIN	20	22	32	32	29	32	25	27	NA
GRAYSON	131	122	138	119	124	127	107	87	NA

Data Source: Texas Department of State Health Services: Mental Health and Substance Abuse, Medicaid Services Unit.

According to the American Lung Association, “Asthma is a reversible obstructive lung disease, caused by increased reaction of the airways to various stimuli,” such as cigarette smoke, air pollution, exercise, or allergic reactions.¹ Children with asthma can experience more difficulty breathing due to chronically inflamed airways. Asthma affects more than 25 million people in the United States, and for children, it is a leading cause of both school absences and emergency room visits. While asthma can be a life-threatening disease if not properly managed, deaths due to asthma are rare among children.²

Asthma is a leading cause of both school absences and ER visits.

Although exercise, allergies and cigarette smoke can trigger asthma reactions, other factors beyond a child’s immediate control can exacerbate asthma symptoms. Breathing in high levels of ozone, for example, can cause inflammation of the airways, coughing, wheezing, and shortness of breath, among other things. High daily ozone concentrations can also lead to increased incidences of asthma attacks and asthma-related hospital admissions. Moreover, concentrated exposure to ozone can intensify asthma symptoms and increase overall sensitivity to common asthma triggers.³ According to the American Lung Association, from 2008 to 2010, Collin County averaged four high

ozone days per year, and Denton County averaged nearly 11; both Collin and Denton counties received an air-quality grade of “F” based largely on ozone pollution.⁴

The estimated numbers of children presented in the table who have asthma or have had asthma during their lifetime are based on an annual survey performed by the Centers for Disease Control and Prevention, through which a prevalence rate for each subcategory for each state is obtained. As with other prevalence rates, these trends are largely influenced by growth, or the lack thereof, of the child population. With the exception of the estimated numbers of children who have had asthma in their lifetime in Collin and Denton, all counties follow the trend of both the prevalence rates, increasing until about 2008 before beginning to decline. Many children find that their asthma vanishes or becomes less serious as they age, which could explain why the number of children who currently have asthma is one-third lower than the number of those who have had it at some point in their lives, across all counties.

When looking at the number of asthma-related hospitalizations across the five-county region, all counties increased overall through 2007 before dropping in 2008, and in most cases stayed at this rate or below through 2012, with the exception of Collin and Denton counties. The number of hospitalizations in Collin County increased by 40 percent from 2008 to 2009, and Denton’s by 20 percent, before both decreased and began to level out in 2010. For all counties, the number of hospitalizations pales in comparison to the estimated number of children with asthma, either current or in their lifetime, which may indicate that asthma flare-ups are well monitored and treated by the families and doctors of children with the condition.

¹ American Lung Association. (2012, October). *Asthma & Children Fact Sheet*. Retrieved from Facts and Figures: <http://www.lung.org/lung-disease/asthma/resources/facts-and-figures/asthma-children-fact-sheet.html>

² The Nemours Foundation. (2014, January). *Asthma Basics*. (E. P. Ben-Joseph, & N. A. Green, Editors) Retrieved from kidshealth.org: http://kidshealth.org/parent/medical/lungs/asthma_basics.html?tracking=P_RelatedArticle#

³ United States Environmental Protection Agency. (2014, March 12). *Ozone and Your Patients’ Health: Training for Health Care Providers*. Retrieved from EPA.gov: <http://www.epa.gov/apti/ozonehealth/population.html>

⁴ American Lung Association. (2012). *State of the Air 2012*. New York: Hard Copy Printing



Childhood Cancer Diagnoses

New cancer diagnoses for children and adolescents

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	36	30	48	40	41	44	37	49	69	57	NA
COOKE	3	0	2	6	4	7	6	5	1	3	NA
DENTON	28	17	37	28	35	29	45	41	31	40	NA
FANNIN	2	1	4	0	2	2	2	3	0	1	NA
GRAYSON	3	8	4	6	6	6	4	9	11	7	NA

Data Source: Texas Department of State Health Services; Cancer Epidemiology and Surveillance Branch, Texas Cancer Registry.

Over the 10-year period listed in the table, the overall number of new cancer diagnoses increased in children ages 19 and under in Collin, Denton and Grayson counties. However, Grayson’s diagnoses were more closely aligned with those of Cooke and Fannin County, each of which reported less than 12 new diagnoses for any given year. Despite both Collin and Denton not increasing year-over-year, they did display an overall rising trend, whereas there is no such trend in either direction found in the remaining counties.

Cancer is the second leading cause of death among children aged 5 to 14.

Compared to adults, cancer is much less common among children. According to a report by the

American Cancer Society, a child in the United States has an estimated 0.35 percent chance of developing cancer before age 20. Still, an estimated 10,450 children under 14 will be diagnosed with cancer in 2014, resulting in 1,350 deaths in that age group.¹ According to a recent report by the National Center for Health Statistics, cancer is the second leading cause of death among children aged 5 to 14.²

From 2006 to 2010, white and Hispanic children in the 0-14 age group had moderately higher incidence rates of cancer than those of black and Asian-American/Pacific-Islander children, with the difference being even more pronounced in the 15-19 age group. In addition to having the highest incidence rates, Hispanic children also had the highest mortality rate once diagnosed when compared to other

racial and ethnic groups, regardless of age. Although African-American children have lower incidence rates in both age groups, their mortality rate is similar to that of white and Hispanic children. In other words, African-American children are less likely to be diagnosed, but once diagnosed they are similarly likely to die from the disease. Differences across racial and ethnic groups are difficult to explain, and incidence rates in children tend not to correlate with socioeconomic status like incidence rates for adults. However, it is possible that socioeconomic factors impact survival and mortality rates among children, as well as insurance status, quality of care, and genetic factors.¹

¹ American Cancer Society. (2014). Special Section: Cancer in Children & Adolescents. Retrieved from Cancer Facts & Figures 2014: <http://www.cancer.org/acs/groups/content/research/documents/webcontent/acspc-041787.pdf>

² Murphy SL, Xu J, Kochanek KD. Deaths: Final data for 2010. *National vital statistics reports; vol 61 no 4*. Hyattsville, MD: National Center for Health Statistics, 2013.

Overweight and Obese Children and Teens

Percent of children in 3rd-12th grade who are overweight or obese

	2011	2012	2013
COLLIN	33.7	35.0	36.1
COOKE	45.6	44.3	51.5
DENTON	37.7	37.5	37.5
FANNIN	43.8	46.8	46.4
GRAYSON	43.5	45.9	41.4

Data Source: Texas Education Agency; Physical Fitness Assessment Initiative, BMI Students at Some Risk or High Risk.

A child is considered overweight if their Body Mass Index (BMI) is between the 85th and 94th percentile, and obese if their BMI is greater than or equal to the 95th percentile, for their sex and age. The Childhood Obesity in Texas reports that a third of all Texas children — and nearly one half of Hispanic children — are overweight or obese. This same report continues that today's obese children are poised to triple Texas' current adult obesity rate by 2040, and obesity-related expenses for the individual and the state are projected to skyrocket.¹

In the more populous counties of Collin and Denton, the rates of overweight and obese children somewhat reflect the state rate of 1 in 3 children. However, the rate grows to 2 in 5 in Grayson and 1 in 2 in Cooke and Fannin counties. Since 2011, Collin, Cooke, and Fannin counties have all seen their percentages increase, and Denton and Grayson counties have reduced their percentages of overweight and obese children, albeit minimally.

In 2013, 32 percent of Texas students in the 3rd-12th grades were

A third of all Texas children — and nearly one half of Hispanic children — are overweight or obese.

overweight or obese. Meanwhile, 16 percent of high school students drank soda two or more times each day of the week before the survey. In regards to physical activity, 17 percent did not do any activity to increase their heart rate or make them breathe hard at some time during the previous week. However, 38 percent played video or computer games at least 3 hours each of the seven days, and 33 percent watched television three or more hours each day.² Aside from the myriad of health risks associated with child obesity, ranging from heart disease and high blood pressure to diabetes and sleep apnea, there are also behavioral modification risks of students who wish to lose weight. In 2013, 48 percent of Texas high school students admitted they were trying to lose weight, and 12 percent did not eat for 24 or more hours within the previous 30 days of the survey.²

Research has shown that child obesity can negatively impact attendance, grades and standardized test scores. Ultimately, the aggregate health consequences could lower overall life expectancy within a generation.¹ In 2007, Texas instituted Fitnessgram, a comprehensive evaluation of students' physical fitness consisting of six tests to measure body composition, aerobic capacity, strength, endurance, and flexibility. The resulting data has been analyzed with other educational data sets and produced promising research that demonstrates links between physical fitness and improved academic performance, school attendance, and reduced disciplinary infractions.³

¹ Arons, A. (2011, January). *The Costs, The Policies, and a Framework for the Future*. Retrieved from Childhood Obesity in Texas: <http://www.childhealthtx.org/pdfs/Childhood%20Obesity%20in%20Texas%20Report.pdf>

² Centers for Disease Control and Prevention. (2013). *Texas 2013 Results*. Retrieved from High School Youth Risk Behavior Surveillance System: <http://nccd.cdc.gov/youthonline/App/Results.aspx?LID=TX>

³ Trust for America's Health. (2013, February 22). *Texas Recognizes the Costs of Excess Weight & Tries to do Something About It*. Retrieved from http://healthyamericans.org/health-issues/prevention_story/texas-recognizes-the-costs-of-excess-weight-tries-to-do-something-about-it

Sexually Transmitted Diseases (STDs) and Human Immunodeficiency Virus (HIV)

Number of cases in children younger than 18 years

		2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	Syphilis	2	1	1	3	0	1	4	4	4	4	NA
	Chlamydia	152	145	147	176	186	233	260	241	291	268	NA
	Gonorrhea	23	24	28	37	54	57	32	42	51	54	NA
	HIV	0	0	0	0	1	0	2	1	2	1	NA
COOKE	Syphilis	0	0	0	0	0	0	0	0	0	0	NA
	Chlamydia	12	17	17	16	13	8	17	15	11	16	NA
	Gonorrhea	0	2	10	2	4	1	4	2	3	4	NA
	HIV	0	0	1	0	0	0	0	0	0	0	NA
DENTON	Syphilis	1	2	0	1	0	3	3	2	0	0	NA
	Chlamydia	123	105	100	115	141	170	163	189	176	200	NA
	Gonorrhea	26	22	19	34	33	41	36	34	24	31	NA
	HIV	1	0	0	0	0	1	1	0	2	0	NA
FANNIN	Syphilis	0	0	0	0	0	0	0	0	0	0	NA
	Chlamydia	13	17	20	13	10	9	16	16	3	8	NA
	Gonorrhea	3	3	7	4	4	6	1	0	0	6	NA
	HIV	0	0	0	0	0	0	0	0	0	0	NA
GRAYSON	Syphilis	1	0	3	0	0	0	0	2	0	0	NA
	Chlamydia	52	46	47	50	35	54	65	71	53	52	NA
	Gonorrhea	28	9	16	21	8	15	14	14	7	6	NA
	HIV	0	1	0	0	0	0	0	0	0	0	NA

Data Source: Texas Department of State Health Services; HIV/STD Program, Diagnoses by County.

Over the 10-year period of 2003-2012, chlamydia numbers far outpaced those of the second most common STD, gonorrhea, for almost all years in all counties, with exception to Fannin County in 2011 and 2012. In the larger counties of Collin and Denton, chlamydia numbers increased somewhat steadily, while in Cooke, Fannin, and Grayson they fluctuated rather minimally, with Grayson experiencing a spike in 2010, but returning to its usual rate in the following years.

As for the other STDs, gonorrhea cases increased over time in Collin County, decreased over time in Grayson County, and fluctuated with regularity for the remaining counties, with Denton County experiencing a spike in 2008 that subsequently decreased in the following years.

Fortunately, syphilis has not had much of a presence in the North Texas corridor, with only Collin, Denton, and Grayson documenting cases for any of the 10 years, and none of them experiencing more than four cases in a given year. There were very few documented cases of HIV, a total of seven in Collin County, five cases in Denton County, zero in Fannin, and just one in both Cooke and Grayson counties.

It is worth noting that both Denton and Collin counties are within the top 20 counties with the highest STD case numbers for 2012, though neither are in the top 20 counties with the highest STD rates.¹ As for the impact of race and/or ethnicity on incidence rates, of all syphilis and HIV diagnoses in 2012 in Texas, both the Hispanic and black popula-

Denton and Collin counties are within the top 20 counties with the highest STD case numbers for 2012.

tions made up roughly 37 percent each, whereas as the white population represented about 22 percent for both illnesses. In the case of those diagnosed with gonorrhea, 44 percent were black, 28 percent were Hispanic, and 20 percent were white. For chlamydia, 39 percent were Hispanic, 28 percent were black, and 23 percent were white.^{1, 2}

¹ Texas Department of State Health Services. (2014, February). 2012 Texas STD and HIV Epidemiologic Profile. Retrieved from HIV/STD Program: http://www.borderhealth.org/files/res_2621.pdf

² Texas Department of State Health Services. (2012). *Texas STD Surveillance Report 2012*. Retrieved from HIV/STD Program Reports: <https://www.dshs.state.tx.us/hivstd/reports/>

Food Allergies

Estimated number of children with food allergies

	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	7,444	7,806	9,462	9,807	10,203	11,760	11,957	12,052	NA
COOKE	NA	NA	455	454	457	518	512	504	NA
DENTON	6,096	6,416	7,778	8,076	8,274	9,540	9,732	9,905	NA
FANNIN	NA	NA	331	334	342	392	391	386	NA
GRAYSON	1,155	1,183	1,338	1,322	1,355	1,525	1,505	1,492	NA

Data Source: Centers for Disease Control and Prevention: National Health Interview Survey; U.S. Census Bureau: American Community Survey; 1Y Estimates (Collin, Denton, Grayson) 3Y Estimates (Cooke, Fannin).

From 1997 to 2011, the number of children suffering from food allergies in the United States has increased by an estimated 50 percent.¹ This rising trend can be seen across the North Texas corridor, where numbers are based on prevalence rates collected by the Centers for Disease Control and Prevention's National Health Interview Survey. As with other prevalence calculations, the trends are impacted by the child population. In the larger counties of Collin and Denton, the estimated number of children with food allergies increased by approximately 60 percent. Comparatively, the counties with smaller, more stagnant child populations only grew less than 30 percent in their estimated number of children with food allergies, with Cooke growing the least by about 11 percent.

Allergic conditions, in general, are among the most prevalent medical conditions affecting children today; an estimated 35 percent of children under 18 have been diagnosed with an allergic condition.² Food allergies, specifically, affect about 6 to 8 percent of children nationwide.

Limited treatment options leave strict avoidance as the primary treatment for most food allergies.³ Reactions can range from mild discomfort to anaphylaxis, a potentially life-threatening condition. Anaphylaxis from food allergies is the most prevalent type of anaphylactic reaction among children, with an estimated 150 children dying from food allergy-related anaphylaxis each year.^{4,5}

Allergic conditions are among the most prevalent medical conditions affecting children today.

Since most children receive at least some of their meals outside of their home, it is not surprising that 76 percent of deaths from food allergies occur away from the home. Moreover, approximately 18 percent of children with food allergies experience an allergic reaction while at school.^{6,7} The state of Texas passed two laws in 2011 to address growing concerns about food allergies in schools. One law requires parents to disclose food allergies of enrolled children upon

the school's request, and the other requires public school districts and charter schools to adopt a policy that addresses the care of students diagnosed with food allergies. The Texas Department of State Health Services has provided guidelines for schools and intends to produce sample trainings and policies that schools might adopt.⁸

¹ Jackson, K. D., Howie, L. D., & Akinbami, L. J. (2013, May). *Trends in Allergic Conditions Among Children: United States, 1997-2011*. Retrieved from NCHS Data Brief: <http://www.cdc.gov/nchs/data/databriefs/db121.pdf>

² Friedman, A. H., & Morris, T. L. (2006). Allergies and Anxiety in Children and Adolescents: A Review of the Literature. *Journal of Clinical Psychology in a Medical Setting*, 318-331.

³ Gupta, R. S., Kim, J. S., Springston, E. E., Smith, B., Pongracic, J. A., Wang, X., & Holl, J. (2009). Food allergy knowledge, attitudes, and beliefs in the United States. *Annals of Allergy, Asthma, and Immunology*, 43-50.

⁴ Bolke, K., Davis, R., DeStefano, F., Marcy, S., & Thompson, R. (2004). Epidemiology of anaphylaxis among children and adolescents enrolled in a health maintenance organization. *Journal of Allergy and Clinical Immunology*, 563-542.

⁵ Yocum, M., Butterfield, J., Volcheck, G., Schroeder, D., & Silverstein, M. (1999). Epidemiology of Anaphylaxis in Olmsted County: A Population-based Study. *Journal of Allergy and Clinical Immunology*, 536-542.

⁶ Pumphrey, R. (2000). Lessons for Management of Anaphylaxis from a Study of Fatal Reactions. *Clinical and Experimental Allergy*, 1144-1150.

⁷ Nowak-Wegrzyn, A., Conover-Waler, M., & Wood, R. (2001). Food-allergic Reactions in Schools and Preschools. *Archives of Pediatric and Adolescent Medicine*, 790-795.

⁸ Department of State Health Services. (2013, October 3). *Food Allergies: Background*. Retrieved from Texas Department of State Health Services Website: <http://www.dshs.state.tx.us/Layouts/ContentPage.aspx?PageID=34571&id=8589976181&terms=food+allergies>

economic security



While the data on the percentage of children living below the poverty level gives a broad perspective of the counties' economic conditions, individual indicators, such as WIC enrollment and school meal program eligibility, paint a more in-depth picture of residents' economic security.

Children who grow up in poverty are more likely to experience a multitude of negative outcomes, including lower scores on standardized tests, violent crimes, and are more likely to drop out of school.¹ Numerous studies indicate that chronic poverty can even impact a child's brain development, such as increased activity in parts of the brain associated with anxiety and fear and decreased activity in parts which influence long-term decision-making over impulse.²

Housing instability, defined as the number of children and youth without permanent homes, is one of the starkest physical manifestations of poverty, and while this indicator decreased in Denton County by roughly 27 percent, the number of children without permanent homes increased in all of the other four counties. Moreover, all five counties saw an increase in the percentage of children experiencing food insecurity, or the lack of access to enough food for a healthy lifestyle.

Free and reduced-price school meals are an invaluable resource for many. In Cooke and Grayson counties, almost half of all children were eligible for free or reduced-price meals in 2013. Since 2004, the percentages have climbed steadily in all five counties. However, summer is often a vulnerable time for these students who go without the free meals they receive during the school year. Only a fraction of children who receive school-provided meals nationwide participate in the summer equivalent, the Summer Food Service Program.³

¹ Behrman, Richard E., Lewit, Eugene M., & Terman, Donna L. (1997). Children and Poverty: Analysis and Recommendations. *Children and Poverty*.
² Stromberg, Joseph. (2013, November 25). How Growing Up in Poverty May Affect a Child's Developing Brain.. Retrieved from *Smithsonian.com*: <http://www.smithsonianmag.com/science-nature/how-growing-up-in-poverty-may-affect-a-childs-developing-brain-180947832/?no-ist>
³ Feeding America. (2013). *Millions of Children May Go Hungry This Summer Without School-Provided Meals*. Retrieved from the Feeding America website: <http://feedingamerica.org/press-room/press-releases/children-may-go-hungry-this-summer-without-school-provided-meals.aspx>



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Children Living in Poverty

Number and percent of children living in households with income below the federal poverty level

		2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	Number	13,626	11,026	17,205	19,730	18,337	23,032	23,865	23,645	NA
	Percent	7.5	5.8	8.4	9.3	8.3	10.2	10.4	10.2	NA
COOKE	Number	NA	NA	2,043	1,745	1,810	2,020	1,912	1,822	NA
	Percent	NA	NA	20.7	17.7	18.2	20.3	19.4	18.8	NA
DENTON	Number	10,949	14,484	12,064	10,820	16,779	16,126	22,534	19,305	NA
	Percent	7.4	9.3	7.1	6.2	9.3	8.8	12.0	10.1	NA
FANNIN	Number	NA	NA	1,318	1,386	1,662	1,357	1,802	1,410	NA
	Percent	NA	NA	18.3	19.1	22.4	18.0	24.0	19.0	NA
GRAYSON	Number	4,045	5,756	4,578	5,262	5,797	5,306	6,679	7,506	NA
	Percent	14.4	19.9	15.7	18.3	19.7	18.1	23.1	26.2	NA

Data Source: U.S. Census Bureau; American Communities Survey, 1Y Estimates Collin, Denton, & Grayson, 3Y Estimates Cooke, Fannin.

The U.S. Census Bureau defined poverty income for a two-parent household with two children as \$23,283 in 2012.¹ For the same year, 25 percent of all Texas children were living in poverty, which is 3 percent higher than the national average. The method for calculating poverty has remained unchanged for decades, yet research suggests that most families would need to earn about twice the federal poverty level to meet their basic needs. In 2012, approximately 45 percent of all children in the nation lived below 200 percent of the federal poverty level.²

Although the percentage of children living in poverty found in Collin and Denton counties are considerably lower than that of the state and nation, the varying cost of living across counties affects families regardless of their official poverty status. For example, the MIT Living Wage Calculator suggests an adequate living wage for those in Collin and Denton counties

Poverty is the single greatest threat to a child’s well-being, due to its far-reaching effects on education, mental and physical health, and behavior.

would be about \$40,400 annually, whereas in the three smaller counties it suggests incomes between \$36,300 and \$38,100. For all five counties, the estimated living wage is considerably higher than the poverty level; so, while poverty rates might be lower in the larger suburban counties, the higher cost of living means that families living in poverty may be under even more financial stress in these counties. Regardless of the cost of living for the counties, all but Cooke County have experienced an overall increase in their percentage of children living in poverty, with the largest increase occurring in Grayson County.³

Across the state, significant racial and ethnic disparities exist among children living in poverty. Thirty-

six percent of Hispanic children, 33 percent of African-American children, and 24 percent of American-Indian children are living in poverty in Texas, compared to just 10 percent of white children. About 30 percent of children under the age of 6 and 25 percent of children age 6 or older are living in poverty. Research has shown that poverty is the single greatest threat to a child’s well-being, due to its far-reaching effects on education, mental and physical health, and behavior. The National Center for Poverty suggests the risks are greatest for children who experience poverty when they are young and those who experience deep and persistent poverty.

¹ U.S. Census Bureau: Social, Economic, and Housing Statistics Division. (2014, August 4). *Poverty*. Retrieved from United States Census Bureau: <https://www.census.gov/hhes/www/poverty/data/threshld/>

² National Center for Children in Poverty. (2014, May). *Texas: Demographics of Poor Children*. Retrieved from State Profiles: http://www.nccp.org/profiles/state_profile.php?state=TX&id=7

³ Glasmeier, A. K. (2014). *Living Wage Calculator*. Retrieved from Poverty in America: livingwage.mit.edu

Housing Instability

Number of children and youth without a permanent residence

	2008	2009	2010	2011	2012	2013
COLLIN	923	2,616	3,332	1,971	2,193	2,913
COOKE	40	42	50	19	22	90
DENTON	679	1,562	2,364	1,190	1,615	1,175
FANNIN	29	68	130	49	65	148
GRAYSON	433	1,154	1,240	848	883	1,187

Data Source: University of Texas at Austin; Charles A. Dana Center, Texas Homeless Education Office.

Over the past six years, all five counties experienced an increase in the number of children enrolled in public schools who are living without a permanent residence. The number increased most profoundly in Fannin County by over 400 percent, Collin by over 200 percent, both Cooke and Grayson by over 100 percent, and Denton by approximately 73 percent. For the three more populous counties, the numbers reported in 2010 rivalled, and in most cases surpassed, those of 2013, indicating the toll taken by the recession beginning in 2007. This nationally occurring downturn increased the number of homeless children in the U.S. by 38 percent from 2007 to 2010, affecting the trends of the vast majority of states, with only five reporting decreases in their number of homeless children across the same time period.¹ While there were significant decreases locally in the following year, numbers began to rise once more in 2012, and the

trend has continued through 2013 in all counties listed except Denton.

Over the past six years, all five counties experienced an increase in the number of children enrolled in public schools who are living without a permanent residence.

According to the U.S. Department of Housing and Urban Development (HUD), 23 percent of homeless individuals in 2013 were under the age of 18; the same report states that 5 percent of all Texans – 29,615 individuals – were homeless at the time of the study. Texas had 718 unaccompanied homeless children under 18, the third highest in the nation; combined with California and Florida, the sum represented 58 percent of all unaccompanied children under 18.¹ While HUD’s report is based on a specific point in time study, other studies use the

homelessness definition contained in the McKinney-Vento Homeless Assistance Act. This is the definition used by schools and is reflected in the included table. This definition includes children living with friends or family, in motels or hotels, abandoned in hospitals, those who are migratory, or awaiting foster care placement. Based on this definition, the National Center on Family Homelessness found that as many as 1.6 million children are homeless in a year. Furthermore, in Texas in 2010, there were 131,198 homeless children, which ranked the state as 30th in the nation, with 50th being the largest percentage of homeless children.²

¹ Henry, M., Cortes, A., & Morris, S. (2013). *The 2013 Annual Homeless Assessment Report (AHAR) to Congress: Part 1 Point-in-Time Estimates of Homelessness*. Office of Community Planning and Development. Washington, D.C.: The U.S. Department of Housing and Urban Development. Retrieved from <https://www.onecpd.info/resources/documents/ahar-2013-part1.pdf>

² Bassuk, E. L., Murphy, C., Thompson Coupe, N., Kenney, R. R., & Beach, C. A. (2010). *America’s Youngest Outcasts 2010*. The National Center on Family Homelessness.

Children Receiving Temporary Assistance for Needy Families (TANF)

Average monthly number of children receiving basic and state program benefits under the TANF program

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	1181	977	890	632	673	574	436	595	576	548	443
COOKE	190	138	86	49	74	84	58	64	76	73	55
DENTON	941	736	666	435	337	321	162	343	374	331	344
FANNIN	251	183	151	114	85	88	81	88	74	72	78
GRAYSON	872	609	436	288	258	210	168	249	246	250	245

Data Source: Texas Health and Human Services Commission; Strategic Decision Support, TANF Annual Reports.

Temporary Assistance for Needy Families (TANF) is a cash assistance federal-state program for the extremely impoverished. While the federal government establishes basic rules, states develop their programs and income eligibility limits. Texas has set the income criteria for TANF at less than 50 percent of the poverty level, which means even a family living below the poverty level may not qualify for TANF in Texas. Although states are given considerable discretion for qualification incomes, generally speaking, TANF recipients must meet federal work requirements in order to keep the state from losing some of its federal funding. A 2006 TANF reauthorization tightened the rules in this regard, which may be responsible for some of the drastic reductions in the TANF caseloads across the state.¹

Among the five counties, this reduction is most profound in the smaller Cooke County, already with a small average monthly number of child participants, where it decreased from 2004 to 2006 by 64 percent. For the same time period, the aver-

age number of children receiving TANF per month in Collin, Denton, Fannin, and Grayson counties decreased by 35, 40, 38 and 53 percent, respectively. When looking at the past 10 years as a whole, all five counties have decreased in their number of under 18 TANF recipients by 50 to 60 percent. A large part of this reduction can be attributed to the change in the income limits imposed by the Texas Health and Human Services Commission (HHSC). In 2005 the income limit for a single-parent family of three was \$401 a month²; currently, the income limit for the same family model is \$188 a month, which disqualifies many more families from eligibility than in 2005. In addition to income, HHSC also looks at the family's expenses or assets and the amount the family pays for child care and child support.³

TANF for families can help to pay for food, clothing, housing, and other basic needs. However, the maximum monthly TANF amount is not enough to fully cover these costs, and is primarily supplemental. The maximum monthly TANF

All five counties have decreased in their number of under-18 TANF recipients by 50 to 60 percent due to new income limits imposed by HHSC.

amount a single parent of two children could currently receive is \$277 and for two parents with two children it increases slightly to \$341. In addition to the small amount received, potential TANF families must abide by several rules in order to participate; among them, parents or relatives must agree to be actively looking for work if unemployed, adhere to child support orders, maintain current job if employed, refrain from abusing alcohol or drugs, participate in parenting classes, ensure the child has required vaccines, and confirm their child is attending school.³

¹ National Center for Children in Poverty. (2007, September). *Temporary Assistance for Needy Families (TANF) Cash Assistance*. Retrieved from State Profiles: Texas: http://www.nccp.org/profiles/TX_profile_36.html

² Gretchen Rowe with Jeffrey Versteeg, *The Welfare Rules Databook: State Policies as of July 2005*, Assessing the New Federalism, The Urban Institute, 2006.

³ Texas Health and Human Services Commission. (2014). *TANF Cash Help*. Retrieved from Your Texas Benefits: Programs: <http://yourtexasbenefits.hhsc.state.tx.us/programs/tanf/families.php>

Food Insecurity

Number and percent of children who lack access to enough food for an active, healthy life

		2009	2010	2011	2012	2013
COLLIN	Number	43,120	40,130	39,440	44,530	NA
	Percent	20.9	19.0	18.0	19.9	NA
COOKE	Number	2,710	2,300	2,290	2,410	NA
	Percent	27.0	23.9	23.2	24.5	NA
DENTON	Number	36,120	33,440	32,820	37,230	NA
	Percent	21.5	19.4	18.4	20.4	NA
FANNIN	Number	2,080	1,840	1,950	1,980	NA
	Percent	28.2	25.1	25.8	26.5	NA
GRAYSON	Number	7,780	7,010	7,190	7,670	NA
	Percent	26.8	24.5	24.8	26.5	NA

Data Source: Feeding America; Hunger Research, Map the Meal Gap.

The U.S. Department of Agriculture considers a household food insecure if they are “uncertain of having, or are unable to acquire, enough food to meet the needs of all their members because they have insufficient money or other resources for food.” Nationwide, in 2012, 14.5 percent of all households were food insecure compared to 18.3 percent of households in Texas. For the same year, 20 percent of households with children experienced food insecurity in the nation, compared to 27.4 percent of households with children in Texas.¹ For the period of 2010-2012, Texas was the third-most food insecure state with 18.4 percent of households low or very low food security, just behind Mississippi and Arkansas.²

The rates of food insecure children in the larger counties of Collin and Denton follow those of the nation, hovering around 20 percent in both cases for the four years of data available. The rates of the smaller counties are, on average, 4 to 7 percent higher than those of the

larger counties, with Fannin having the highest rate of child food insecurity for the first three years listed, and Grayson tying it for 2012. For the most part, rates of food insecurity were declining across the region from 2009 to 2011. However, all five counties saw increases in 2012.

For the period of 2010-2012, Texas was the third-most food insecure state in the nation.

Nationally, 35.4 percent of female-headed households with children were food insecure; this compares to 13.2 percent for married-couple households with children. Racial and ethnic disparities are also evident as 24.6 and 23.3 percent of African-American and Hispanic families were food insecure,

compared to 11.2 percent of white families. Of the 14.5 percent of households nationwide who were food insecure in 2012, just over two-fifths were living with very low food security, meaning that “normal eating patterns of one or more household members were disrupted and food intake was reduced at times during the year because of insufficient money or other resources for food.” In Texas, about a third of those who were food insecure fell into the very low food security category.²

¹ Feeding America. (2014). *Data by County in Each State*. Retrieved from Map the Meal Gap: <http://feedingamerica.org/hunger-in-america/hunger-studies/map-the-meal-gap/printable-county-2011.aspx>

² U.S. Department of Agriculture. (2014, April 30). *Food Security in the U.S. Key Statistics & Graphics*. Retrieved from Economic Research Service: <http://www.ers.usda.gov/media/246945/mapdata2012.xls>



Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

Number of women, infants, and children who received WIC services

		2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	Infants and Children	5,465	6,309	5,330	8,200	8,581	8,297	NA	7,696
	Women	1,777	2,158	4,282	2,569	2,819	2,820	NA	2,588
COOKE	Infants and Children	723	721	532	857	852	790	NA	975
	Women	283	267	497	278	285	281	NA	388
DENTON	Infants and Children	6,679	6,950	5,506	8,979	9,601	9,170	NA	8,855
	Women	2,459	2,585	4,420	3,122	3,332	3,219	NA	3,216
FANNIN	Infants and Children	641	702	520	765	796	796	NA	704
	Women	229	236	480	271	253	251	NA	234
GRAYSON	Infants and Children	2,687	2,659	1,982	2,922	2,835	2,872	NA	2,847
	Women	912	930	1,845	1,011	976	976	NA	1,029

Data Source: Texas Department of State Health Services; Clinical Services Branch, WIC Program.

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a federal grant program that provides food subsidies, nutrition education, and breastfeeding promotion and support. Local offices may also make referrals for health care and social services. During FY2013, the average number of women and children receiving WIC benefits in the U.S. per month was over 8.6 million.¹ In Texas, the WIC program is administered by the Department of State Health Services (DSHS) through which federal funds flow to local WIC offices. Among those eligible for services are women who are pregnant, postpartum (within six months), or breastfeeding, infants, and children under the age of 5. Further eligibility requirements include the household income being at or below 185 percent of the federal poverty level, the potential WIC recipients being “at nutritional risk” as determined by a health and diet screening, residing in the state through which they are applying, and applying in person.²

Out of the five counties, Collin County experienced the largest increase of WIC recipients, increasing their number of clients by about 43 percent.

In 2013, the number of infants and children and the number of women receiving WIC services in the North Texas corridor each accounted for just fewer than 3 percent of statewide recipients in their respective populations. Excluding 2012, for which there is no data due to reporting changes, all counties have increased overall in their number of WIC recipients in both subgroups. As with other social service programs, the trends of increasing from 2008 to 2010 are present, reflecting the effects of the recession taking place during that time. The largest increases were found in Collin County with both subgroups increasing their number of clients by about 43 percent.

Some of the topics covered in the WIC Nutrition Education program

include healthy eating during pregnancy, how to monitor your child’s health, getting the most of food dollars, parenting skills, the importance of immunizations, as well as the importance of breastfeeding and how to incorporate it into your lives, with many women receiving free breast pumps. Unlike the Supplemental Nutrition Assistance Program (SNAP) benefits, WIC benefits are very strict in the items that can be purchased, giving detailed amounts of which items can be selected, according to modified packages introduced in 2009 that adhere more closely to national dietary recommendations and infant feeding guidelines established by the American Academy of Pediatrics. Items that can be purchased include fruits and vegetables, meats, formula, milk, cheese, juice, eggs, beans, peanut butter, whole grains, and tuna or salmon for those breastfeeding.²

¹ U. S. Department of Agriculture. (2014, April). *WIC Fact Sheet*. Retrieved from Food and Nutrition Service: <http://www.fns.usda.gov/sites/default/files/WIC-Fact-Sheet.pdf>

² Texas Department of State Health Services. (2014, June 5). *WIC Eligibility*. Retrieved from Women, Infants, and Children Program: www.dshs.state.tx.us/wichd/gj/eligible.shtm

School Meal Eligibility

Number and percent of children eligible to receive free or reduced-priced meals at schools

		2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	Number	18,128	20,742	25,563	26,169	26,027	30,371	35,498	37,658	39,541	41,148
	Percent	16.0	17.2	19.7	18.9	17.7	19.7	22.0	22.4	22.8	23.1
COOKE	Number	2,428	2,626	2,880	2,717	2,783	2,911	3,251	3,340	3,397	3,445
	Percent	39.0	42.0	46.0	43.8	44.9	47.4	53.4	54.5	55.0	55.6
DENTON	Number	16,586	21,522	23,476	25,750	27,587	29,774	32,917	35,455	37,382	39,552
	Percent	20.2	24.9	25.4	26.3	27.0	28.1	30.3	31.6	32.4	33.4
FANNIN	Number	2,362	2,599	2,601	2,678	2,612	2,677	2,822	3,014	3,022	3,067
	Percent	44.4	47.8	48.1	49.3	48.2	49.2	53.0	56.6	57.5	57.6
GRAYSON	Number	8,223	8,690	9,001	9,213	9,250	9,716	10,617	11,037	11,280	11,491
	Percent	39.1	41.4	42.8	43.5	43.9	46.3	50.6	52.6	53.5	54.2

Data Source: Texas Education Agency; Academic Excellence Indicator System (2004-2011) Texas Academic Performance Reports (2012,2013), Economically Disadvantaged Students.

For the 2012-2013 school year, a student from a family of four was eligible to receive reduced-price meals if their family’s income totaled less than \$42,643. In order to receive free meals, the income limit was \$29,965, 130 percent of the poverty level for that year.¹ For this same year, according to the Texas Education Agency, 60.4 percent of students in Texas were considered to be economically disadvantaged, meaning they would have qualified for free or reduced-price lunch.² In addition to income-qualified students, a child can be categorically eligible to receive free meals if they are in foster care, Head Start, homeless, migrant, or living in a household receiving SNAP or TANF benefits.³

The percentage of students for free or reduced-price meals in all five counties across the North Texas corridor increases from year-to-year. Cooke and Fannin counties consistently had the highest rates, most recently around 55 to 58 percent, which may be due to their cost of living and average income being lower than those of the more

populated counties. Grayson’s rates were also significantly higher than the larger counties, but slightly below the smaller counties for each year. One in four children in Collin County were eligible to receive free or reduced-price meals, whereas 1 in 3 children in Denton County were eligible, each county having increased their number of students eligible by over 120 percent over the 10-year period.

All five counties across the North Texas corridor experienced steady increases from year-to-year in the percent of students eligible for free or reduced-price meals.

The Healthy Hunger-Free Kids Act of 2010 introduced changes to the nutritional requirements of meals offered to students in 2012. Some of these changes included offering more fruits, vegetables, whole grains, and low or no-fat milk. Additionally, the changes aim to reduce sodium and trans fat intake; all of these changes are, in part,

intended to combat rising obesity levels among school-aged children.⁴ Some news reports have indicated that these new changes have been met with dissatisfaction from students and schools alike. Reports suggest that fewer students are buying lunches and those who do may be throwing away more food. Moreover, schools have reported increased costs as a result of increased waste and the need to purchase new equipment to comply with the guidelines.^{5, 6}

¹ U.S. Department of Agriculture. (2014, March 6). Income Eligibility Guidelines. Retrieved from School Meals: <http://www.fns.usda.gov/school-meals/income-eligibility-guidelines>

² Texas Education Agency. (2014). Texas Academic Performance Reports. Retrieved from Performance Reporting: ritter.tea.state.tx.us/perfreport/tapr/2013/state.pdf

³ Food Research and Action Center. (2010). *School Meal Eligibility*. Retrieved from Federal Food/Nutrition Programs: <http://frac.org/federal-foodnutrition-programs/national-school-lunch-program/eligibility/>

⁴ Department of Agriculture. (2012). *Nutrition Standards in the National School Lunch and School Breakfast Programs*. Food and Nutrition Services. Department of Agriculture. Retrieved from <http://www.gpo.gov/fdsys/pkg/FR-2012-01-26/pdf/2012-1010.pdf>

⁵ Hellmich, N. (2012, September 28). Students push back on new school lunches. USA Today. Retrieved from <http://usatoday30.usatoday.com/news/nation/story/2012/09/28/kids-push-back-on-new-school-lunch/57842204/1>

⁶ Harrington, E. (2014, March 6). 1M kids stop school lunch due to Michelle Obama’s standards. The Washington Times. Retrieved from <http://www.washingtontimes.com/news/2014/mar/6/1m-kids-stop-school-lunch-due-michelle-obamas-stand/?page=al>

Supplemental Nutrition Assistance Program (SNAP) Enrollment

Average monthly enrollment in SNAP for children under 18

	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	9,441	8,836	10,195	12,638	17,670	21,801	21,525	20,451
COOKE	1,627	1,559	1,622	1,937	2,383	2,309	2,176	2,187
DENTON	9,415	8,272	8,706	12,231	18,253	21,228	21,507	21,411
FANNIN	1,370	1,315	1,398	1,607	1,929	1,907	1,842	1,815
GRAYSON	5,435	5,029	5,498	6,144	7,894	8,169	7,797	7,490

Data Source: Texas Health and Human Services Commission; Research and Statistics, Texas TANF and SNAP Enrollment Statistics.

The Supplemental Nutrition Assistance Program (SNAP) is a federal-state program that “helps people to buy the food they need for good health.” SNAP recipients can also purchase garden seeds with their SNAP benefits, but cannot purchase tobacco, alcohol, inedible items or pay food bills with their benefits. Individuals and families can apply for SNAP, but benefits are limited for adults without children. Recipients must fall below certain income thresholds to qualify: \$18,960 annually for an individual, and \$38,868 for a family of four. The maximum benefit amount that an individual can

From 2006-2013, the average monthly enrollment of children receiving SNAP increased in Collin and Denton County by over 115 percent.

receive per month is \$189, and for a family of four it is \$632.¹

Over the last eight years, all counties in the North Texas corridor experienced an overall increase in their average monthly enrollment of children receiving SNAP. These increases were largest in Collin and Denton, with their average monthly numbers increasing by over 115 percent from 2006 to 2013. The other

counties experienced a more modest increase over that time period, ranging from 34 to 38 percent. A likely explanation is the overall population growth in Collin and Denton counties, particularly the growth in child populations and the increasing likelihood that they are born into low-income families.

The SNAP program was reauthorized by Congress and signed into law on February 7, 2014, as part of “The Agricultural Act of 2014,” often referred to simply as the “Farm Bill.” The latest reauthorization included several reforms designed to “strengthen the integrity and accountability of federal nutrition programs.” For example, the law included \$200 million to create pilot projects with the goal of testing innovative SNAP Employment and Training strategies to help SNAP recipients return to the workforce and increase earning potential.²

¹ Texas Health and Human Services Commission. (2014). *SNAP Food Benefits*. Retrieved from Programs: <http://yourtexasbenefits.hhsc.state.tx.us/programs/snap/>
² United States Senate Committee on Agriculture, Nutrition, and Forestry. (2014). *Agricultural Act of 2014*. Retrieved from Title by Title Summary of 2014 Farm bill: <http://www.ag.senate.gov/issues/farm-bill>



Eligible Children in Subsidized Child Care

Number of children receiving free or reduced-price child care services

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	1,380	1,059	1,127	1,414	1,105	1,001	1,062	2,159	3,065	2,475	2,718
COOKE	63	57	62	36	9	9	0	NA	1	170	181
DENTON	1,597	1,147	1,219	1,490	2,947	2,532	1,643	2,719	3,676	3,083	3,321
FANNIN	1,065	548	644	753	753	976	386	141	170	178	144
GRAYSON	107	96	79	156	125	159	72	864	1061	1123	1122

Data Source: Texas Workforce Commission; Child Care, Number of Children Receiving Services.

In Texas, child care assistance is administered through the Texas Workforce Commission with federal funds from the Child Care and Development Fund. The purpose of the program is to provide assistance to low-income families in obtaining child care in order for parents to work, attend school, or complete job training. Parents may use the subsidies to place their children in licensed child care centers, licensed and registered child care homes, or even relative-provided care. In addition to children in low-income families, subsidies are also available to those transitioning from public assistance or requiring protective services. Qualifying children must be under the age of 13. Additional requirements may vary by Workforce Development Board area as each board may set its own eligibility requirements in addition to the general guidelines outlined above.¹

Without exception, all of the counties in the North Texas corridor

experienced drastic fluctuations over the last 10 years in their number of children receiving free or reduced-price child care services. In Collin, Denton, and Grayson counties there have been generally upward trends, which may be attributed to the fact that while other states were curtailing their subsidies for child care in 2010, Texas not only avoided cuts, but was able to offer more child-care assistance through an additional \$215 million provided by the federal government.² In the smaller counties, Cooke County experienced a decrease over the first half of the decennial period, before seeing a substantial increase in 2012 and 2013. Meanwhile, Fannin County experienced an overall considerable decrease after a peak in 2008.

The cost of licensed child care can demand a significant portion of a family's income, and the burden is especially great in single-parent families due to both lower incomes and a greater need for child care

On average, the annual cost of center-based care for an infant exceeds the cost of tuition and fees at most public four-year colleges in Texas.

to ensure workforce participation. On average, the annual cost of center-based care for an infant exceeds the cost of tuition and fees at most public four-year colleges in Texas. Moreover, the average family spends as much money on child care in a year as they do on groceries and more than they do on gas. In 2012, about 140,000 children in Texas received subsidized child care each month, with a wait list of 17,161 children.³

¹ Texas Workforce Commission. (2013, March 25). *Overview*. Retrieved from Child Care Services: <http://www.twc.state.tx.us/svcs/childcare/child-care-services.html#overview>

² Garrett, R. T. (2010, May 25). *Texas Boosts Child Care Subsidies*. Retrieved from The Dallas Morning News: <http://www.dallasnews.com/news/politics/texas-legislature/headlines/20100525-Texas-boosts-child-care-subsidies-1887.ece>

³ Collaborative for Children. (2012). *Make Quality Care Affordable for All*. Retrieved from Public Policy: <http://www.collaborforchildren.org/make-quality-care-affordable-for-all>

Children Living in Single-Parent Families

Number and percent of children in families living with one parent

		2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	Number	32,964	32,932	37,153	40,575	40,700	44,344	52,667	45,602	NA
	Percent	18.8	17.9	18.6	19.4	18.8	20.1	23.5	20.0	NA
COOKE	Number	NA	NA	2,650	2,458	2,234	2,640	2,644	2,468	NA
	Percent	NA	NA	28.9	27.1	24.9	28.5	28.4	26.6	NA
DENTON	Number	30,473	32,606	32,792	35,090	39,253	41,419	43,850	43,723	NA
	Percent	21.3	21.7	20.2	20.6	22.4	23.1	24.1	23.8	NA
FANNIN	Number	NA	NA	1,582	1,621	1,961	1,893	2,785	2,381	NA
	Percent	NA	NA	24.3	24.5	28.2	26.6	38.5	33.3	NA
GRAYSON	Number	7,774	8,981	7,368	9,102	12,413	9,326	10,541	10,503	NA
	Percent	30.0	34.8	26.5	33.3	44.2	34.7	38.0	41.4	NA

Data Source: U.S. Census Bureau; American Communities Survey, 1Y Estimates (Collin, Denton, & Grayson) 3Y Estimates (Cooke & Fannin).

The number and percent of children living in single-parent families has increased in all counties for the years listed, with the slight exception of Cooke County, who decreased their overall number of children living in single-parent families by about 7 percent. Collin, Denton, and Fannin all experienced their largest number of children in single-parent families in 2011, while Grayson saw its peak in 2009. Overall, Collin, Denton, Fannin, and Grayson counties all increased in their number of children living in single-parent families by 35 to 50 percent. Despite these increases, Collin, Cooke, and Denton counties had lower percentages than both the state and national average for all of the years listed.¹

Over the past four decades, the number of children living in single-mother families has continued to rise. The vast majority of single-parent families continue to be

single-mother families, but single-father families have been on the rise in recent years as well. Single-parent families differ across race and ethnicity as 1 in 4 Hispanic children and half of African-American children live in single-parent families. Comparatively, one-sixth of white children live in single-parent families; however, white children account for the largest share of children living under these circumstances overall.²

With 62 percent of working single mothers in lower-wage jobs, children in single-mother families are less likely to have health insurance that covers preventive care.

While living in a single-parent family is not inherently detrimental to a child, when compounded by limited financial resources, a child living in this situation is more likely to drop

out of school and to become a teen parent. In 2010, 7 in 10 children living with a single mother were poor or low-income. Moreover, three-fourths of all single mothers are in the labor force, with 62 percent working lower-wage retail, service, or administrative jobs that offer few benefits, meaning their children are less likely to have health insurance to cover preventive care.² While child support payments can provide some income for single parent households, in 2011, only about 75 percent of single parents who were due child support received it, with only about 43 percent receiving full payments.³

¹ Annie E. Casey Foundation. (2014). *Children in Single-Parent Families*. Retrieved from Kids Count Data Center: <http://datacenter.kidscount.org/data/tables/106-children-in-single-parent-families>

² Mather, M. (2010, May). *U.S. Children in Single-Mother Families*. Retrieved from Population Reference Bureau: <http://www.prb.org/pdf10/single-motherfamilies.pdf>

³ Grall, T. (2013, October). *Custodial Mothers and Fathers and Their Child Support: 2011*. Retrieved from U.S. Census Bureau: <http://www.census.gov/prod/2013pubs/p60-246.pdf>

Families with All Parents Working

Number and percent of families in which all present parents are employed

		2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	Number	65,158	73,716	71,581	78,029	81,388	78,718	84,425	83,565	NA
	Percent	70.7	72.7	68.5	71.2	73.2	70.3	70.3	70.3	NA
COOKE	Number	NA	NA	3,377	3,588	3,306	3,303	3,205	3,103	NA
	Percent	NA	NA	72.0	72.8	72.6	70.0	75.4	79.9	NA
DENTON	Number	55,218	60,720	58,384	61,355	60,853	67,615	62,295	69,087	NA
	Percent	76.2	75.9	73.4	74.8	73.5	74.2	71.4	71.8	NA
FANNIN	Number	NA	NA	NA	NA	2,660	2,508	2,508	2,330	NA
	Percent	NA	NA	NA	NA	71.9	70.9	79.5	70.0	NA
GRAYSON	Number	NA	NA	10,682	10,808	10,633	8,839	9,568	9,414	NA
	Percent	NA	NA	78.9	77.9	76.7	73.7	71.1	69.5	NA

Data Source: U.S. Census Bureau; American Community Survey, 1Y Estimates Collin, Denton, and Grayson, 3Y Estimates Cooke and Fannin.

The percentage of children living in families with all parents working has decreased over time for all counties in the region, except Cooke County. Fannin County demonstrated the curious trend of having a drastic increase in percentage in 2011, but this is due to a decrease in children under 18, not an actual increase in the number of parents working. This occurrence can also account for the vast increase found in Cooke where the population of children in families working decreased by about 400 children each year from 2010 to 2012, so even though the number of parents working decreased in each of those three years, the overall rate of children living in working families actually increased. Looking solely at the number of children in families with all parents working, only Grayson County actually decreased overall for the years listed.

Half of all parents reported difficulty balancing the responsibilities of both a family and a career.

In 2013, about 68 percent of single mothers in the U.S. were employed, whereas about 81 percent of single fathers were employed. Among married-couple families with children, 59 percent had both parents working.¹ Families with children in which all parents are working face different issues than those married-couple families where only one parent is working. Even if a family benefits from a second income, families with all parents working still experience the strain of balancing work and home life. A recent study found that 1 in 3 parents with young children fear losing pay, or even their jobs, in the event that they must take time off to care for a sick child, with more than half of parents having a lack of flexibility in changing the hours or days they work.²

A nationwide survey found that 16 percent of adults said the ideal situation for a young child is to have a mother who works full time, 42 percent said part-time, and one-third said it's best if mothers do not work outside the home at all. In the same survey, half of all parents reported difficulty balancing the responsibilities of both a family and a career. Additionally, of those with children under 18, nearly half of all fathers said they did not spend enough time with their children, compared with a quarter of all mothers.³

¹ U.S. Department of Labor. (2014, April 25). *Employment Characteristics of Families Summary*. Retrieved from Economic News Release: <http://www.bls.gov/news.release/famee.nro.htm>

² Glynn, S. J. (2012, November 20). *Working Parents' Lack of Access to Paid Leave and Workplace Flexibility*. Retrieved from Center for American Progress: <http://www.americanprogress.org/issues/labor/report/2012/11/20/45466/working-parents-lack-of-access-to-paid-leave-and-workplace-flexibility/>

³ Parker, K. (2013, March 14). *Modern Parenthood*. Retrieved from Pew Research: Social and Demographic Trends: <http://www.pewsocialtrends.org/2013/03/14/modern-parenthood-roles-of-moms-and-dads-converge-as-they-balance-work-and-family/>

Licensed Child Care Slots

Number of slots that meet standards and are licensed, registered, or listed under the Child Care Licensing (CCL) Program within the Texas Department of Family and Protective Services

	2007	2008	2009	2010	2011	2012	2013
COLLIN	43,366	46,734	46,956	46,749	50,574	51,047	53,769
COOKE	940	931	701	756	866	853	862
DENTON	26,897	28,558	29,609	32,741	34,330	35,241	36,066
FANNIN	698	810	785	672	641	664	803
GRAYSON	3,291	3,397	3,302	3,225	3,477	3,612	3,563

Data Source: Texas Department of Family and Protective Services; Annual Report and Data Book, Statistics by Counties.

The number of licensed child care slots in each county increased with the exception of Cooke County. The counties with the largest increases in their number of slots were Collin and Denton, each increasing by 24 and 34 percent, respectively, over the seven years listed. When looking at the state over the same time period, the number of licensed child care slots increased by about 8 percent, from 990,080 to 1,065,667.¹

Research reveals a relationship between higher quality child care and increased academic achievement in high school.

Research suggests early childhood education can produce both short- and long-term benefits for children who participate. With that said, the commonly referenced “model program” – mostly private, evidence-based programs with smaller

class sizes – produce greater positive effects than large-scale public programs. While benefits are less pronounced for large-scale public programs, early childhood education, in general, can still improve cognitive development and overall socialization.² In fact, a 2010 study funded by the National Institute of Child Health and Development found the effects of quality early child care were observed as late as age 15. The study found a relationship between higher quality care and increased academic achievement in high school.³

In 2013, the average annual cost of full-time care in a center in Texas was \$8,619 for an infant, \$6,643 for a 4-year-old, and \$3,165 for a school age child’s before or after school care. For full-time care in a family home, these numbers dropped slightly to \$6,623, \$5,192, and \$2,604, respectively. While these averages are far from the

highest in the nation, the cost of having an infant in a full-time center still accounts for about 12 percent of a married-couple family’s income and 36 percent of a single mother’s income.⁴ For a single mother living below the poverty level, the cost of child care accounts for 42.6 percent of her monthly income.⁵

¹ Department of Family and Protective Services. (2007,2013). Annual Report and Data Book. Retrieved from Budget, Data, and Regulations: http://www.dfps.state.tx.us/About_DFPS/Data_Books_and_Annual_Reports/default.asp

² Barnett, W. S. (1995). Long-Term Effects of Early Childhood Programs on Cognitive and School Outcomes. *Future of Children*, 25-50.

³ Vandell, D. L., Belsky, J., Burchinai, M., Steinberg, L., Vandergrift, N., & NICHD Early Child Care Research Network. (2010). Do Effects of Early Child Care Extend to Age 15 Years? Results From the NICHD Study of Early Child Care and Youth Development. *Journal of Child Development*, 737-756.

⁴ Child Care Aware of America. (2014, March). Texas’ State Fact Sheet. Retrieved from Public Policy: http://www.nac-craa.org/sites/default/files/texas_fact_sheet.pdf

⁵ U.S. Census Bureau. (2011). Who’s Minding the Kids? Child Care Arrangements 2011 Detailed Tables. Retrieved from Child Care: <http://www.census.gov/hhes/childcare/data/sipp/2011/tables.html>

education



The recent transition to the State of Texas Assessment of Academic Readiness (STAAR) has not yet impacted college readiness, which remains a product of exit-level scores from the Texas Assessment of Knowledge and Skills (TAKS), the SAT, and the ACT. In short, students who graduate from high school and meet certain criteria on any of the three tests can be considered college ready. Students are only required to meet the standard on one of the three tests, and while virtually all public school students are required to take the TAKS, 1 in 3 Texas graduates in the class of 2012 took neither the SAT nor the ACT.¹

While college readiness indicators seek to predict college and career success, research suggests the path to college and career readiness begins long before high school. In fact, secondary success can be traced back to third-grade reading ability. Furthermore, quality early childhood education and the cognitive development it fosters is linked to reading on grade level at third and fourth grade.² In other words, quality early childhood education during pre-kindergarten can reduce the chances of a student being held back and increase the likelihood that he or she will complete high school, which decreases the long-term likelihood that he or she will live in poverty.^{3,4} Ultimately, the link from quality early childhood education through third grade reading, high school graduation, and beyond demonstrates the need for investment that is not just focused on secondary results, but also on early interventions leading to long-term success.

¹ Texas Education Agency. (2013). *Texas Academic Performance Report*. Retrieved from TEA website: <http://ritter.tea.state.tx.us/perfreport/tapr/2013/state.pdf>

² Annie E. Casey Foundation. (2010). *EARLY WARNING! Why Reading by the End of Third Grade Matters*. Retrieved from Kids Count Special Report: http://www.aecf.org/m/resourcedoc/AECF-Early_Warning_Full_Report-2010.pdf

³ The Pew Charitable Trusts. (2005). *Why All Children Benefit from Pre-K*. Retrieved from The Pew Charitable Trusts Website: http://www.pewtrusts.org/news_room_detail.aspx?id=19434

⁴ Rumberger, R. W. (2011). *Dropping out: Why students drop out of high school and what can be done about it*. Cambridge, Mass.: Harvard University Press.



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High School Completion Rates

Percent of 9th graders who graduated 12th grade in four years

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	90.7	90.7	92.2	92.0	91.3	91.3	92.2	93.6	94.9	95.8	NA
COOKE	91.7	89.0	88.7	84.7	86.7	87.5	91.3	93.5	96.1	94.5	NA
DENTON	89.5	90.4	89.7	88.3	87.9	89.7	90.7	92.0	92.5	93.0	NA
FANNIN	92.9	91.5	87.9	93.5	92.7	89.2	92.3	94.0	95.7	93.8	NA
GRAYSON	89.3	89.0	87.3	87.5	86.7	84.6	89.1	91.5	93.7	95.3	NA

Data Source: Texas Education Agency; Research Reports and Data, Completion, Graduation, and Dropout Rates.

While all counties' high school completion rates experienced fluctuating trends over the past 10 years, all saw an overall increase, ranging from greater than 5 percentage points in the cases of Collin and Grayson counties to increases as small as less than 1 percentage point in the case of Fannin County. When comparing the North Texas counties to the overall completion rates of the state, all five achieved higher completion rates, with the state having 88 percent of students completing high school in the 2011-2012 school year. By race and ethnicity, 84 percent of both the Hispanic and African-American students in Texas who began the ninth grade completed high school, whereas 93 percent of the white students did the same. Nationwide, 80 percent of the total student population completed high school. By race and ethnicity, 73 percent of Hispanic students, 69 percent of African-American students, and 86 percent of white students accomplished the same.

All five counties beat the state rate of high school completion.

There are many contributing factors, such as demographic, motivation, or performance, to a student not completing high school, but research suggests that several factors can be indicative of a student's potential to dropout. A student is more likely not to complete high school if they are a member of a racial or ethnic minority group, part of a low-income family, or older than the average student in their grade. The lower the grades and attendance a student demonstrates, the further behind they fall. These characteristics can produce a poor learning environment, especially when parents, teachers, or administrators already hold low expectations for these students.¹

According to the National Center for Education Statistics, in 2009, 55 percent of high school dropouts between the ages of 16 and 24 were unemployed.² In 2010, high school dropouts aged 25 and older were three times more likely than college graduates to be unemployed.³ In addition to the economic impact, a 2009 study found that high school drop outs aged 16 to 24 were 63 times more likely than their college-educated peers to be incarcerated.⁴

¹ Burrus, J. (2012, February). *Dropping Out of High School: Prevalence, Risk Factors, and Remediation Strategies*. Retrieved from Educational Testing Service: R & D Connections: www.ets.org/Media/Research/pdf/RD_Connections18.pdf

² Institute of Education Sciences. (2011). *Youth Indicators 2011 America's Youth: Transitions to Adulthood*. Retrieved from National Center for Education Statistics: http://nces.ed.gov/pubst2012/20120206/chapter3_28.asp

³ United States Census Bureau. (2011). *Educational Attainment: Five Key Data Releases From the U.S. Census Bureau*. Retrieved from http://www.census.gov/newsroom/cspan/educ/educ_attain_slides.pdf

⁴ Sum, A., Khatiwada, I., McLaughlin, J., & Palma, S. (2009). *The Consequences of Dropping Out of High School: Joblessness and Jailings for High School Dropouts and the High Cost for Taxpayers*. *Northeastern University*.

Head Start and Public School Pre-Kindergarten Enrollment

Number of children enrolled in Head Start or public school pre-kindergarten

		2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	Head Start	NA	NA	378	NA	NA	379	379	427	427	427	NA
	Public Pre-K	1,656	1,840	1,957	2,206	2,239	2,487	2,539	2,826	2,957	3,022	NA
COOKE	Head Start	NA	NA	70	NA	NA	70	70	70	70	70	NA
	Public Pre-K	190	191	213	216	202	238	232	246	226	224	NA
DENTON	Head Start	NA	NA	193	NA	NA	193	193	193	193	193	NA
	Public Pre-K	1,059	1,224	1,295	1,651	1,835	1,910	1,995	2,173	2,676	2,882	NA
FANNIN	Head Start	NA	NA	139	NA	NA	139	139	139	139	139	NA
	Public Pre-K	186	197	227	256	258	262	299	279	303	322	NA
GRAYSON	Head Start	NA	NA	263	NA	NA	237	253	253	253	271	NA
	Public Pre-K	588	639	691	674	673	684	747	811	828	815	NA

Data Source: Texas Education Agency, Academic Excellence Indicator System; Office of Head Start--Region VI.

Head Start and Early Head Start are federally-funded early childhood intervention programs that serve at-risk children and their families from infancy through pre-school. Local agencies receive 80 percent of their funding directly from the federal government, while the other 20 percent come from local and in-kind sources. During the 2009-2010 program year, the two programs combined served over one million children and another one million pregnant women.¹ In 2014, the "Consolidated Appropriations Act of 2014" added more than \$8 billion for the two programs, which restored funding levels to pre-sequestration levels. Local agencies were expected to use these funds to restore services to their previous levels, as well as provide a modest cost-of-living increase for the agencies.²

In addition to Head Start, public school districts must provide pre-kindergarten if at least 15 students in the district qualify. However, qualifying students are not required to attend pre-kindergarten. Students

may qualify for pre-kindergarten services if they meet the requirements for free or reduced-price lunch, have limited English proficiency, or require special education.³ In 2008, the Texas Education Agency implemented new guidelines for pre-kindergarten education, which significantly increased the standards from the previous 1999 guidelines. For example, the new standards suggest that before beginning kindergarten, a student should be able to write his or her own name, identify at least 20 letters and their sounds, and demonstrate an understanding for 3,000 to 4,000 words – although they may not actually use that many words.⁴

The number of children enrolled in public pre-K has increased across all counties, and Head Start slots remain filled.

The number of children enrolled in Head Start throughout the North Texas corridor remained somewhat stagnant over the most recent five years reported, due to the

fact that it is a program for which only a certain number of slots are made available each year, and these slots are always filled. Collin and Grayson, the two counties in which there were changes, both increased in their number of slots by about 14 percent. The number of children enrolled in public pre-K has increased across all counties, impressively in some cases. Over the time period of 2003-2012, Denton County has increased its public pre-K enrollment by approximately 172 percent, Collin by 83 percent, Fannin by 73 percent, Grayson by 39 percent, and Cooke by 18 percent.

¹ National Head Start Association. (2011). *Basic Head Start Facts*. Retrieved from Cutting Head Start - Get the Facts: http://www.nhsa.org/files/static_page_files/48BADE30-1D09-3519-ADED347C39FA16A4/Basic_Head_Start_Facts_rev02212011.pdf

² U.S. Department of Health and Human Services. (2014, February 10). *FY 2014 Head Start Funding Increase*. Retrieved from Office of Head Start: https://eclkc.ohs.acf.hhs.gov/hslc/standards/pi/2014/resour_pri_001_021014.html

³ Texas Education Agency. (2014, April 24). *Prekindergarten Eligibility and Attendance*. Retrieved from Texas Education Agency: http://www.tea.state.tx.us/index2.aspx?id=2147497182&menu_id=2147483718#1

⁴ Texas Education Agency. (2011, March 29). *Prekindergarten Guidelines - 1999 v. 2008*. Retrieved from Texas Education Agency: http://www.tea.state.tx.us/index2.aspx?id=2147495508&menu_id=2147483718

Third-Grade Reading Levels

Percent of 3rd-graders who met standard criteria on the reading section of the (TAKS) or (STAAR)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	95.7	97.5	96.3	97.4	96.2	96.2	96.4	97.2	95.4	90.8	92.2
COOKE	87.6	94.4	89.7	88.2	86.9	91.1	91.3	88.7	90.0	80.9	81.8
DENTON	92.6	93.7	93.6	94.3	93.5	94.3	95.3	95.8	94.3	86.8	88.5
FANNIN	85.4	89.8	91.1	91.0	91.0	91.6	92.4	93.8	90.7	76.7	82.1
GRAYSON	93.6	94.0	94.8	95.5	94.2	93.3	94.7	94.9	92.4	80.8	87.0

Data Source: Texas Education Agency; Academic Excellence Indicator System (2000-2011) Texas Academic Performance Reports (2012,2013), STAAR Phase-in Level II Grade 3.

A student's third grade reading ability is an important indicator of future success. Once a student enters fourth grade, they begin *reading to learn*, and if a child is behind in their reading skills, it could severely hamper their ability to comprehend the new information they are being presented. Additionally, three quarters of students who are reading poorly in third grade will remain poor readers throughout their educational career. Various research institutes have found that academic success, in the form of high school graduation, can be predicted rather accurately through an individual's reading skill at the end of third grade.¹

Across all five counties, there was a downward trend in the percentage of third graders meeting the reading standard on standardized tests over the past 10 years. Fortunately, it was a relatively small decrease, with the largest change being less

than 13 percent in Cooke County from 2004 to 2013. Even though all counties experienced an initial dip with the introduction of the STAAR test in 2012, the scores bounced back in 2013, demonstrating the potential for continued improvement. In a national evaluation, Texas ranked 12th for the percentage of students meeting the state proficiency fourth grade reading standard in 2009, but ranked 41st for the percentage of fourth grade students meeting the National Assessment of Educational Progress proficiency standard.²

A readiness gap often becomes an achievement gap.

There are a variety of factors contributing to a student reading below grade level, but research suggests a readiness gap in primary education is created by lingering effects of substandard early childhood

education resulting from disparities in development and socialization. Many children in low-income families unfortunately lack early interactions which promote linguistic development, such as being exposed to a breadth of vocabulary through stories, conversations, and songs, or simply a parent reading to a child. As the years progress, this readiness gap becomes an achievement gap, which is exacerbated by low-performing schools, chronic absence and/or illness, summer reading loss, and stress induced by hunger, housing insecurity, and family mobility.²

¹ Annie E. Casey Foundation. (2010). *EARLY WARNING! Why Reading by the End of Third Grade Matters*. Retrieved from Kids Count Special Report: http://www.aecf.org/m/resource/doc/AECF-Early_Warning_Full_Report-2010.pdf

² U.S. Department of Education. (2011, September). *National Assessment of Educational Progress 2009 Reading and Mathematics Assessments*. Retrieved from Institute of Education Sciences, National Center for Education Statistics: http://nces.ed.gov/nationsreport-card/studies/statemapping/2009_naep_state_table.aspx

Students with Limited English Proficiency (LEP)

Percent of students enrolled in public school districts who have Limited English Proficiency

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	7.3	8.1	8.6	8.8	8.9	8.9	8.9	8.8	8.6	8.4	8.6
COOKE	7.3	7.6	7.4	7.8	8.8	9.4	10.5	10.1	9.2	9.3	9.7
DENTON	8.4	9.2	9.6	10.4	10.8	11.3	11.5	11.4	11.5	11.5	11.6
FANNIN	3.1	2.7	2.9	3.6	3.8	4.2	4.2	3.7	4.1	4.2	4.7
GRAYSON	4.2	4.5	5.2	5.5	6.0	6.3	6.6	6.8	6.9	7.0	7.6

Data Source: Texas Education Agency; Academic Excellence Indicator System (2000-2012) Texas Academic Performance Report (2013), Student Information.

The percentages of children enrolled in public schools with Limited English Proficiency (LEP) increased across the last 10 years in all five counties. The increases ranged in size from half a percentage point in Collin County to 3.1 percentage points in Grayson County. However, all five counties remain significantly lower than the state rate of about 17 percent.¹

All five counties remain significantly lower than the state rate.

In Texas, any school district with 20 or more English language learners of the same grade level is required by law to provide bilingual instruction for grades pre-kindergarten through fifth grade. Additionally, any district not required to provide

bilingual education, must provide English as a second language, regardless of the number of students or their grade levels. Districts are also allowed to provide bilingual education in instances in which they are not required by law.²

The challenges faced by these students can be seen in standardized tests scores. Seventy-seven percent of Texas students passed all of their TAKS tests for 2013. Meanwhile, only 53 percent for English language learners (ELLs) accomplished the same, despite a higher than average attendance rate of 97 percent in 2012. This is a potential contributor to the annual high school dropout rate for ELLs in Texas in 2012, which was 5.3 percent, more than twice the rate for the overall student population. As for the high school

completion rate, for those who enrolled in the ninth grade, just 59 percent of ELLs graduated in 2012, compared to 88 percent of the Texas student population.³

According to the Migration Policy Institute, more than 25 million LEP individuals live in the United States, nearly 1 in 10 Americans over the age of 5. Adults with limited English proficiency are roughly half as likely as English proficient adults to have completed college and five times less likely to have completed high school; they are also twice as likely to live in poverty.³

¹ Texas Education Agency. (2014). 2012-2013 Texas Academic Performance Reports. Retrieved from Division of Performance Reporting: <http://ritter.tea.state.tx.us/perfreport/tapri/2013/state.pdf>

² Texas Administrative Code §89.1205

³ Whatley, M. (2013, July 25). Limited English Proficient Population of the United States. Retrieved from Migration Policy Institute Information Source: <http://www.migrationpolicy.org/article/limited-english-proficient-population-united-states>

Students Receiving Special Education in Public Schools

Number of students receiving special education in public schools

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	11,834	12,700	13,218	13,708	14,095	14,461	14,728	15,142	15,647	16,076	16,569
COOKE	838	846	910	877	778	731	647	629	568	526	476
DENTON	9,575	9,756	10,191	10,660	10,776	10,679	10,477	10,518	10,747	10,736	10,931
FANNIN	823	822	870	887	836	796	719	640	620	618	576
GRAYSON	3,329	3,394	3,399	3,324	3,155	2,928	2,792	2,699	2,561	2,373	2,254

Data Source: Texas Education Agency; Academic Excellence Indicator System (2000-2012) Texas Academic Performance Report (2013), Student Information.

The number of students receiving special education in public schools has increased steadily over the last 10 years in Collin County by about 300-500 students each year, for an overall increase of about 30 percent. Denton County also saw an overall increase in number, of about 12 percent over that time period. Conversely, Cooke, Fannin, and Grayson counties all experienced overall decreases for the same 10 year period, by an average of 36 percent. Despite all the fluctuations, the percentages of children receiving special education were well below the national average of 13 percent in all five counties.¹

According to a report from the Thomas Fordham Institute, Texas had one of the lowest rates of special education reporting in the nation for the 2009-2010 school year. Additionally, Texas experienced a significant decline in identification from 2000 to 2010, a 3 percentage point drop that represents about 47,000 fewer students receiving special education. Low rates of special education in Texas are, at least partly, explained by administrative definitions which differ from most other states. For example, Texas schools typically serve students with dyslexia through a service model which falls outside

The number of students receiving public school special education in Collin County increased by 30 percent.

of traditional special education; furthermore, Texas excludes students with developmental delays – including those with mental retardation and autism – from its federal reporting of children with special needs.²

¹ U.S. Department of Education, National Center for Education Statistics. (2013). Digest of Education Statistics, 2012 (NCES 2014-015), Table 48.

² Scull, J., & Winkler, A. M. (2011). *Shifting Trends in Special Education*. The Thomas Fordham Institute. Retrieved from http://www.edexcellencemedia.net/publications/2011/20110525_ShiftingTrendsInSpecialEducation/ShiftingTrendsInSpecialEducation.pdf



Truancy

Number of truancy (failure to attend school) filings in the Justice of the Peace and Juvenile courts

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	1,626	1,687	1,648	2,344	3,289	2,988	2,374	2,622	1,868	1,457
COOKE	15	27	15	23	11	10	12	17	14	15
DENTON	697	1,090	1,516	1,057	1,474	1,396	1,463	1,327	777	838
FANNIN	36	2	0	29	1	29	2	4	0	0
GRAYSON	337	404	398	430	289	367	254	270	357	286

Data Source: Texas Office of Court Administration (OCA); Court Activity Reporting and Directory System, Ad Hoc Search.

According to the Justice of the Peace and Juvenile court truancy filings over the last 10 years, Collin and Denton counties experienced similar rising trends until 2008, with a steady decrease after 2011. Collin County decreased their number of filings overall by about 10 percent, while Denton increased overall by about 20 percent. All three of the smaller counties saw much more fluctuation from year-to-year, with Fannin and Grayson ultimately decreasing overall. Cooke County reported the same number of truancy filings in 2013 as in 2004. While most of the counties rose and fell by a moderate degree,

Fannin saw peaks and valleys from year-to-year with decreases and increases as large as 90 percent for several years, which may be indicative of the student population or the way in which truancy is handled or counted in this county.

In Texas, children are required to attend school from age 6 to 18.¹ The Texas Education Code refers to truancy as a “failure to attend school,” which is defined by both the Texas Education Code and the Texas Family code as missing “10 or more days within a six-month period or three or more days within a four-week period.”² State law

Truancy filings in Denton County increased by approximately 20 percent over the last 10 years.

does, however, allow students to be excused for absences “resulting from any cause acceptable to the teacher, principal, or superintendent of the school in which the person is enrolled.”³

If a student is adjudicated for failure to attend school, they may be required by a judge to participate in counseling services for anger or substance abuse issues. A judge can even require a student to attend job skills training or pursue a GED, rather than continue traditional school enrollment. Parents may also be held responsible for the truancy of a child and be required to attend parenting classes or pay as much as \$500 for each day of school missed.^{4, 5}

¹ Texas Education Code §25.085.
² Texas Education Code §25.094; Texas Family Code §51.03(b)(2).
³ Texas Education Code §25.087.
⁴ Office of the Attorney General of Texas. (2014). *Crime: Truancy*. Retrieved from Teen Resource Center: <https://www.texasattorneygeneral.gov/teens/crime/truancy.shtml>
⁵ Texas Education Code §25.093.



Students Passing all TAKS / STAAR

Percent of children meeting the Texas Assessment of Knowledge and Skills (TAKS) or State of Texas Assessments of Academic Readiness (STAAR) standards

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	84.2	84.8	82.5	85.6	86.2	87.2	88.9	89.1	88.8	89.8	90.4
COOKE	68.6	71.6	63.7	68.1	70.9	71.8	75.7	75.2	73.9	75.9	77.1
DENTON	78.0	78.6	74.4	77.8	79.4	81.7	83.9	85.2	85.2	85.5	85.2
FANNIN	65.8	70.2	63.1	70.1	71.4	73.1	76.1	77.2	76.9	77.3	77.7
GRAYSON	73.8	76.0	71.8	76.7	77.9	77.0	81.4	80.0	80.5	80.6	81.3

Data Source: Texas Education Agency; Academic Excellence Indicator System (2000-2011) Texas Academic Performance Report (2012-2013), STAAR Phase-in Level II All Grades.

In 2012, the Texas Education Agency (TEA) replaced the Texas Assessment of Knowledge and Skills (TAKS) with the State of Texas Assessment of Academic Readiness (STAAR) test. The new assessment, according to TEA, is more rigorous both in terms of difficulty and performance standards. For most grades and subjects, the tests will include a greater number of questions and impose a time limit. The increase in test items and rigor are intended to demonstrate a student's ability in greater depth and will provide for increased variability among students, while capturing a more detailed picture of knowledge and cognitive ability at the individual level.¹

Under the new scheme, grades 3 through 8 are tested in math and reading, grades 4 and 7 are tested in writing, grades 5 and 8

in science, and grade 8 is tested in social studies.² One of the more significant changes under STAAR is the transition away from grade-based assessment. There are now 15 End of Course assessments used to measure high school achievement in each of the following subjects: English I, II, and III, Reading and Writing, Algebra I and II, Geometry, World History, World Geography, U.S. History, Biology, Physics, and Chemistry.^{1, 2}

Cooke County consistently reported the lowest passing percentage of the five counties.

For all 10 years, Collin County had the highest passing rate, and with exceptions in 2004 and 2005, Cooke County consistently reported

the lowest passing percentage of the five counties. Surprisingly, the introduction of the STAAR test did not seem to impact overall passing rates, but the standard for passing the STAAR tests is on a sliding scale which increases in difficulty over time. The table above ends with the 2012-2013 school year, which is the final year of "Phase-in 1" standards. The final performance standards will not take effect until the 2015-2016 school year.³

¹ Texas Education Agency; Student Assessment Division. (2012, March 9). *State of Texas Assessments of Academic Readiness (STAAR) Questions and Answers*. Retrieved from Texas Education Agency: <http://www.tea.state.tx.us/student.assessment/staar/faq.pdf>

² Texas Education Agency. (2013, November). *Glossary for the Texas Academic Performance Report*. Retrieved from Performance Reports: ritter.tea.state.tx.us/perfreport/tapri/2013/glossary.pdf

³ Texas Education Agency; Student Assessment Division. (2013, January 2). *State of Texas Assessments of Academic Readiness (STAAR) Standard Setting Questions and Answers*. Retrieved from Texas Education Agency: <http://www.tea.state.tx.us/student.assessment/STAAR-Standard-Setting-QA.pdf>

College Readiness

Percent of public school graduates who scored at or above the college-ready criterion score on both the ELA and math portions of the TAKS, SAT, or ACT

	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	56.4	56.2	62.3	65.4	69.8	69.4	74.5	NA
COOKE	39.1	36.5	43.8	44.3	52.2	52.4	56.3	NA
DENTON	47.0	49.5	56.3	59.2	66.2	65.3	68.2	NA
FANNIN	35.8	47.3	48.3	44.0	57.6	54.1	57.2	NA
GRAYSON	40.8	42.3	51.4	52.5	59.6	55.7	64.8	NA

Data Source: Texas Education Agency; Academic Excellence Indicator System (2006-2011) Texas Academic Performance Reports (2012), College Ready Graduates.

The high school completion rates may have improved by over 90 percent, but the college readiness rates reflect a different story. In order to be considered “college ready,” a student must have met or exceeded the college-ready criteria on the TAKS exit level test, the SAT test, or the ACT test. If a student meets any one of these three criteria, they will be considered college-ready.¹ Additionally, STAAR assessments in the 2012-2013 school year and beyond include a measure of college and career readiness standards for Algebra II and English III, higher content and performance standards than TAKS, and new measures for student progress.

Over the last seven years of available data, the percentages of college-ready students across the North Texas corridor have improved. However, the percentages are substantially lower than

the percentage of students graduating. Although 95.8 percent of Collin County students graduate, only 74.5 are college-ready. A similar gap exists in Denton County. The three smaller counties show even larger disparities, with differences between 30 and 40 percent. Cooke County has the largest gap, with 94.5 percent of students graduated and only 56.3 percent college-ready. Granted, not every student will be seeking higher education, but even those entering into the workforce will need the basic math, language, and reading skills required for college.

A major gap exists between high school completion rates and college readiness rates.

According to the latest Texas Education Agency Academic Performance Report, 52 percent of the Class of 2011 was deemed to

be college-ready with just over 58 percent enrolling in a Texas institution of higher education. Of those enrolled in a higher education institution, approximately 66 percent were able to complete one year without remediation.² The importance of college-readiness must be stressed because many students who are not prepared going into college may become discouraged and drop out.

Texas has set forth an educational goal to rank in the top ten states nationally for graduating college-ready students by the 2019-2020 school year.³

¹ Texas Education Agency. (2013). *Glossary for the Texas Academic Performance Report*. Retrieved from Performance Reports: ritter.tea.state.tx.us/perfreport/tapri/2013/glossary.pdf

² Texas Education Agency (2013). *Texas Academic Performance Report 2012-2013 State Performance*. Retrieved from 2012-13 Texas Academic Performance Reports: <http://ritter.tea.state.tx.us/perfreport/tapri/2013/state.pdf>

³ Texas Education Agency. (2010). *House Bill 3 Transition Plan*. Retrieved from House Bill 3 Transition Plan: <http://www.tea.state.tx.us/student.assessment/hb3plan/>

safety



New reporting standards for deaths in Texas make the trends difficult to pin down in the smaller counties. In Collin, Denton, and Grayson counties, the numbers have fluctuated over the years reported. In 2013, deaths of children decreased in both Collin and Grayson counties, while increasing in Denton County. In most counties, fewer than 10 deaths were attributed to unintentional causes.

The number of deaths from child abuse and neglect has remained fairly consistent across counties, but the number of victims, overall, has increased in every county except Denton. Moreover, the number of children receiving services related to family and domestic violence have generally increased in those counties with agencies providing related services. Whether children are direct victims of, or simply witness to, domestic violence, abuse, and neglect, the experience can have a profound impact on their lives. A recent study suggests that merely witnessing or living in an environment of physical or verbal abuse can negatively impact the social, emotional, and psychological development of a child.¹

For most of the counties included both the number and rate of children in the conservatorship of the state increased in 2013. Placing children under the responsibility of the state is one of the primary ways to protect children from violence, abuse, and neglect, and in nearly half of all cases, the ultimate goal for these children is permanent adoption.² The average caseload of a CPS worker managing these situation decreased slightly in 2013 and may continue to decrease as the department hires additional staff following an increase in CPS funding authorized during the 83rd legislative session.³

¹ Kitzmann, K., N. Gaylord, A. Holt, and E. Kenny. (2013). *Child witnesses to domestic violence: A meta-analytic review*. *Journal of Counseling and Clinical Psychology* 71(2): 339-352.

² Texas Department of Family and Protective Services. (2013). *2013 annual Report and Data Book*. Retrieved from Texas Department of Family and Protective Services : https://www.dfps.state.tx.us/About_DFPS/Data_Books_and_Annual_Reports/2013/default.asp

³ Texas House of Representatives: House Research Organization. (2014, May 2). *State Finance Report Fiscal 2014-2015*. Retrieved from House Research Organization website: <http://www.hro.house.state.tx.us/pdf/focus/highlights83.pdf>

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Child Mortality

Number of children aged 0-19 who died due to any cause

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	96	102	86	84	91	100	81	89	105	71	NA
COOKE	10	9	12	5	9	15	6	5	6	<10	NA
DENTON	89	80	78	87	80	75	84	82	64	76	NA
FANNIN	7	9	5	6	3	7	8	3	5	<10	NA
GRAYSON	16	19	21	16	29	20	14	23	23	16	NA

Data Source: Texas Department of State Health Statistics, Center for Health Statistics.

Over the past 10 years, an overall decreasing trend in the number of children dying from any cause occurred throughout the North Texas corridor, state, and nation. Due to the state’s most recent nondisclosure updates, it cannot be said with certainty that this trend is occurring in Fannin County, but based on the prior two years of data, it is highly probable. Although Grayson County reported the same number of child deaths in 2012 as in 2003, a decreasing trend began in 2007.

Motor vehicle accidents are the leading cause of accidental deaths.

The Texas Department of State Health Services adopted a new policy in 2012 regarding the release of death data. For this year, some of the counties simply reported the number of deaths as fewer than 10. The new reporting is a result

of new recommendations issued by the National Center for Health Statistics at the Centers for Disease Control and Prevention.^{1,2}

The most recent report by the Texas Child Fatality Review Team (TCFRT) found that in 2011, there were 3,625 child deaths, a rate of 52.7 per 100,000 children; this is a decrease in both the number and rate of child deaths from 2010. Natural causes account for the largest portion of child deaths, but in 2011, the natural death rate for children fell to a seven year low at 36.1 deaths per 100,000 children. Of those deaths where causes can be determined, the next largest group is accidental deaths. For 2011, the accidental death rate for children was 8.4

deaths per 100,000 children, and the leading cause was motor vehicle collisions. According to the report, 3 of every 4 child deaths resulting from a motor vehicle collisions could have been prevented. The next largest causes of death among children are homicide and suicide with rates of 2.2 and 1.6 deaths per 100,000 children, respectively.³

¹ National Center for Health Statistics. (2014, May 30). *Data Use Restrictions*. Retrieved from CDC Wonder: <http://wonder.cdc.gov/DataUse.html#http://wonder.cdc.gov/DataUse.htm>

² The adoption of the regulations cited in the previous footnote by the state of Texas were communicated via email by a staff member at the Center for Health Statistics at the Texas Department of State Health Services.

³ Texas Department of State Health Services. (2014, April). *Texas Child Fatality Review Team Annual Report 2013*. Retrieved from Maternal and Child Health: <https://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&emlID=8589987385>



Child Abuse

Confirmed Victims of Child Abuse and Neglect

Number of cases confirmed by CPS and rate per 1,000 children

		2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	Number	989	1,032	925	1,090	1,203	1,246	1,220	1,260	1,097	1,082	1,168
	Rate	6.4	5.8	4.9	5.8	6.2	6.2	5.9	6.3	5.4	4.6	4.8
COOKE	Number	96	142	163	157	179	122	105	58	100	122	208
	Rate	10.0	14.4	16.5	16.0	18.2	12.4	10.6	5.9	10.2	12.5	21.2
DENTON	Number	576	700	963	952	1,040	1,000	858	976	909	929	898
	Rate	4.5	5.0	6.6	6.1	6.4	5.9	4.9	6.2	5.6	4.8	4.5
FANNIN	Number	104	79	101	99	119	116	47	53	56	52	91
	Rate	14.2	10.4	13.2	12.5	14.7	14.2	5.7	7.0	7.4	6.9	12.0
GRAYSON	Number	274	309	371	340	413	340	285	305	289	453	559
	Rate	9.9	11.0	13.2	12.0	14.6	12.0	10.0	10.9	10.2	15.5	19.0

Data Source: Texas Department of Family and Protective Services; Annual Report and Data Book, Statistics by Counties.

Deaths from Child Abuse and Neglect

Number of deaths confirmed by the Department of Family and Protective Services

		2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN		3	4	2	10	2	2	6	3	2	4	2
COOKE		1	0	0	0	0	0	0	1	0	1	1
DENTON		0	2	4	3	6	2	4	2	1	2	2
FANNIN		0	0	1	2	1	2	0	0	0	0	1
GRAYSON		0	2	1	0	2	0	0	0	3	0	3

Data Source: Texas Department of Family and Protective Services; Annual Report and Data Book, Statistics by Counties.

In 2012 and 2013, victims of child abuse and neglect increased in all counties but Denton. Most notably, the rate of cases per 1,000 children jumped from 12.5 to 21.2 in Cooke County, and 6.9 to 12 in Fannin County — much higher than the rate of cases for the state as a whole at 9.3. Confirmed cases held steady in Collin County. Each county had at least one child die as a result of abuse and neglect. More than 100,000 Texas children were involved in Child Protective Services (CPS) investigations in 2013. Parents were the most common perpetrator in these cases, with neglectful supervision as the confirmed allegation in approximately 66 percent of cases. Hispanic children make up roughly half of Texas' child population, and account for about 46 percent of CPS confirmed abuse victims, as well as 43 percent of children removed from their homes.¹

The Children's Advocacy Centers of Texas (CACT) points to 10 signs of child abuse, which include changes in eating, sleep patterns, school performance or attendance, and fear of going home. The network of 68 advocacy centers that serve 162 Texas counties reported that 95 percent of the children served last year knew their perpetrator, and 26

percent were younger than kindergarten age.² For Texas as a whole, the percentage of confirmed victims younger than 3-years-old is almost 40 percent.¹

The rates in Cooke and Fannin counties jumped much higher than the state rate.

Texas law requires all individuals who suspect that a child might be the victim of abuse or neglect to make an official report. This requirement extends, not only to professionals, but all persons, including those who might otherwise have privileged communications — like an attorney or clergy member. Moreover, the law prohibits one from delegating the responsibility of reporting to a subordinate.³

Perhaps unsurprisingly, medical personnel, school officials, and law enforcement were the top three

sources for reports of child abuse and neglect. In about 8 percent of cases in 2013, one of the child's parents reported abuse to authorities, while the victim themselves reported their abuse in just 0.3 percent of cases.¹

While neglectful supervision was the main determination in CPS cases in Texas, the majority of CACT's cases found sexual abuse in 68 percent of cases and physical abuse in 12 percent of cases.⁴ Statewide, 156 children died from abuse and neglect in 2013 at a rate of 2.2 per 1,000 children.

¹ Texas Department of Family and Protective Services. (2013). *2013 Data Book*. Retrieved from the Texas Department of Family and Protective Services website: http://www.dfps.state.tx.us/About_DFPS/Data_Books_and_Annual_Reports/2013/

² Children's Advocacy Centers of Texas. (2014). *Our Impact*. Retrieved from the Children's Advocacy Centers of Texas website: <http://www.cactx.org/child-abuse-in-texas>

³ Texas Family Code: § 261.101

⁴ Children's Advocacy Centers of Texas. (2014). *2013 Annual Report*, 3.



Child Homicide

Number of deaths from intentional injury of children under 20

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	3	4	5	2	2	3	2	1	2	<10	NA
COOKE	0	0	0	1	0	0	0	1	1	<10	NA
DENTON	1	3	4	5	5	3	4	1	0	<10	NA
FANNIN	0	0	0	1	0	0	0	0	0	0	NA
GRAYSON	0	2	2	1	0	0	0	2	1	<10	NA

Data Source: Texas Department of State Health Services; Center for Health Statistics, Deaths due to homicide under age 20.

The child homicide rate in the U.S. is substantially higher than other developed countries, with each state and county reporting vastly different rates. Homicides of children under the age of 5 tend to be committed by family members, most frequently resulting from beating or suffocation and are likely vastly undercounted. Homicides which occur in middle childhood are seldom and have causes ranging from maltreatment and firearms to sexual abuse and multiple-victim homicides within the family. Homicides of teenagers are most often committed by acquaintances and typically involve male victims, male offenders, and firearms.¹

The child homicide rate in the U.S. is substantially higher than other developed countries.

Unfortunately, policy changes beginning in 2012 limit the certainty to which we can describe the child homicide trends within the North

Texas corridor, as numbers less than 10 were not released in order to prevent inadvertent disclosure. Additionally, because the numbers are so small, less than or equal to five for all years listed, it is difficult to identify trends. According to the Texas Child Fatality Review Team (TCFRT), there were 138 child homicides in Texas in 2011; indicating that those occurring in the North Texas corridor represented less than 3 percent of all child homicides in Texas. TCFRT reported that of the deaths reviewed, 31 percent were caused by child abuse or neglect and 26 percent were caused by assault. All victims of child abuse were less than 15 years old, with 88 percent under the age of 5.²

Of the homicides reviewed, TCFRT found that approximately 70 percent involved a weapon; of these, 52 percent involved a firearm, 33 percent involved another person’s body part, and 11 percent a sharp instrument. In cases involving a firearm with an identifiable owner, 20 percent were owned by a child’s friend or

acquaintance and 17 percent were owned by a family member.²

As a frame of reference for the North Texas corridor and state child homicide numbers, the U.S. Department of Justice’s Bureau of Justice Statistics reported 1,405 child homicides across the nation for 2011. This represents a decrease of 13 percent over the number reported in 2002. Less encouraging is the difference in the distribution of the decrease across age groups. While the number of homicides in the 12-17 age group decreased almost 20 percent over the 10-year period, the number of homicides for those ages 11 or younger decreased just 6 percent.³

¹ Crimes Against Children Research Center. Finkelhor, D. and Ormrod (2001). *Homicides of Children and Youth*. Retrieved from Homicide: <http://www.unh.edu/ccrc/homicide/>

² Texas Department of State Health Services. (2014, April). *Texas Child Fatality Review Team Annual Report 2013*. Retrieved from Maternal and Child Health: <https://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589987385>

³ Cooper, A., & Smith, E. (2013, December). *Homicide in the U.S. Known to Law Enforcement, 2011*. Retrieved from Bureau of Justice Statistics: <http://www.bjs.gov/content/pub/pdf/hus11.pdf>

Suicide

Number of intentional deaths by suicide and other self-inflicted injury among children 19 years old and younger

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	4	4	3	2	5	9	2	5	7	12	NA
COOKE	0	0	0	0	0	0	1	2	0	0	NA
DENTON	3	1	4	6	0	2	3	2	5	<10	NA
FANNIN	0	0	0	0	0	0	1	1	0	<10	NA
GRAYSON	0	2	3	0	1	2	1	1	3	<10	NA

Data Source: Texas Department of State Health Services, Center for Health Statistics (NOTE: 2011 data are provisional).

As with other death-related indicators, it is difficult to identify with certainty a trend from the numbers of adolescent suicides for the five-county region presented in the table, due to the numbers for all counties being small in nature and suppressed in the cases of Denton, Fannin, and Grayson counties.¹ Collin County has seen increases in the number of adolescent suicides beginning in 2010 and persisting through to the most recent data, while Cooke has returned to their previous pattern of not reporting any suicides, but no other assumptions can be made about the counties for which exact data was undisclosed.

A report release by the Office of the U.S. Surgeon General suggests that mental disorders are significant contributor to suicide in the United States, and another study suggests that as many as 90 percent of

children who commit suicide suffer from a mental disorder of some kind.²³ According to the Centers for Disease Control and Prevention, in 2011, males under the age of 19 were three times more likely than their female counterparts to commit suicide. For both genders, the highest rates of suicide were found among the white, non-Hispanic population, while the lowest were seen among African-Americans, reporting rates at least half those of white, non-Hispanics.⁴

In 2011, males under the age of 19 were three times more likely than females to commit suicide.

While males are more likely to successfully commit suicide, recent data from the Youth Risk Behavior Surveillance System suggests that females were more likely than males to be bullied (both electronically

and on school property), and more likely to seriously consider suicide, make plans for a suicide attempt, or actually commit suicide. Both males and females were equally likely to require medical treatment as a result of a suicide attempt.⁵

¹ Beginning in 2012, the State of Texas has adopted new recommendations issued by the Nation Center for Health Statistics at the Centers for Disease Control and Prevention, which suggests that birth and death data published for geographies with fewer than ten instances should be suppressed. An explanation of this policy can be found at <http://wonder.cdc.gov/DataUse.html#http://wonder.cdc.gov/DataUse.htm>

² Office of the U.S. Surgeon General. (1999). Children and mental health. In *Mental health: A report of the Surgeon General*. Chapter 3. Washington, D.C.: U.S.GPO <http://www.surgeongeneral.gov/library/mentalhealth/#sthash.PQQA5YV.dpuf>

³ Shaffer, D., & Craft, L., (1999). Methods of adolescent suicide prevention. *Journal of Clinical Psychiatry*, 70-74.

⁴ Centers for Disease Control and Prevention. *Web-based Injury Statistics Query and Reporting System (WISQARS)* [Online]. (2014). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer). Available at www.cdc.gov/injury/wisqars/fatal.html

⁵ Centers for Disease Control and Prevention. (2014). *Texas 2013 Results*. Retrieved from Youth Risk Behavior Surveillance System: <http://nccd.cdc.gov/youthonline/App/Results.aspx?LID=TX>

CPS Caseload

Average number of cases assigned to each Child Protective Services caseworker per month

	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	28.9	28.3	26.4	22.0	25.3	26.1	30.1	27.2
COOKE	26.3	29.3	17.5	17.3	20.8	21.0	23.2	20.9
DENTON	28.1	27.2	23.3	18.2	23.7	26.3	26.0	25.2
FANNIN	25.1	24.1	24.0	25.1	23.1	22.1	19.4	17.7
GRAYSON	30.4	36.4	33.6	21.1	23.4	24.8	29.7	26.9

Data Source: Texas Department of Family and Protective Services (DFPS).

The average number of cases assigned to Child Protective Services (CPS) caseworkers per month decreased in each of the five counties in 2013, though all are still above the 12 recommended by the Child Welfare League of America for most situations.¹ Fannin County caseloads decreased for the fourth year in a row to 17.7 per caseworker, the lowest in the five-county region. Collin, Denton, and Grayson counties each averaged more than double the recommended number.

Statewide, the average daily caseload in 2013 was 19.9 investigation cases. Caseworkers also handled an average of 20.5 adoptive and home development cases, 31.8 substitute care services cases, and 48.6 kinship cases.²

The statewide turnover rate in 2013 was 25.5 percent for caseworkers; for supervisors, the turnover was much lower at 6.6 percent. Furthermore, 24 percent of caseworkers in 2013 had been employed with CPS for less than a year.³

CPS caseworkers in all five counties continue to be assigned more than the recommended caseload.

An independent review of CPS revealed that caseworkers only spend about 26 percent of their time with children and families, with the rest of their time spent on a computer, attending meetings, and traveling. Recommendations for improvement included increased training and mentoring, as well as allowing caseworkers to make decisions without consulting supervisors.⁴

¹ Administration for Children and Families. (2014). *CWLA Standards*. Retrieved from U.S. Department of Health and Human Services: Administration for Children and Families: <https://www.childwelfare.gov/management/workforce/compendium/cwla.cfm>

² Texas Department of Family and Protective Services. (2014). *2013 Data Book*, 35.

³ Texas Department of Family and Protective Services. (2014). *2013 Data Book*, 27.

⁴ Rosenthal, Brian M. (2014, June 18). Review: CPS hobbled by bureaucracy, high turnover. *The Houston Chronicle*.



Children Receiving Services for Domestic Violence

Number of children less than 18 years old receiving services from family violence shelters or crisis centers

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
COOKE	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
DENTON	201*	NA	258	258	292	251	303	294	284	347	331
FANNIN	NA	NA	NA	NA	NA	NA	NA	NA	NA	175	NA
GRAYSON	NA	NA	NA	NA	NA	294	113	139	145	NA	NA

Data Source: Grayson County Crisis Center; Fannin County Family Crisis Center; Denton County Friends of the Family. *Incomplete Data.

Last year, 331 children in Denton County received services from family violence or crisis centers. This number is a slight decrease from the previous year, but the trend since 2005 has not shown steady movement in one direction or the other. The number of children receiving services from 2008 to 2009 in Grayson County decreased more than 60 percent, but in the following two years, the number increased. The numbers above reflect both residential and non-residential services.

However, the data does not reflect the number of children who need but do not receive services because of lack of resources. In the 2013 National Census of Domestic Violence Services, 88 percent of Texas domestic violence programs reported their information about services provided during the

24-hour survey period. More than 1,300 requests on that day could not be met. Many of those requests were for shelter, but among the non-residential services most often requested, but not met, were financial assistance, legal representation, and housing advocacy.¹

The data does not reflect the number of children who still need help.

The number of Texas children who have been sheltered from domestic violence remained steady from 2010 to 2012, at over 14,000. In 2010, more than 16,700 children received non-residential services, which include services other than shelter. This number dropped to about 15,600 in both 2011 and 2012. In 2012, 114 women were killed in family violence incidents. The

number of hotline calls, however, decreased from more than 200,000 in 2011 to about 191,000 calls.²

The Texas Attorney General’s website maintains a personal safety plan with steps victims can take if they plan to leave their abuser. These include packing a bag to leave with a trusted friend or family member, opening a separate bank account, and sharing a code word with children, family, and friends to discreetly alert them when police are needed.³

¹ National Network to End Domestic Violence. (2014). '13 Domestic Violence Counts: Texas Summary. Retrieved from the National Network to End Domestic Violence website: http://nnedv.org/downloads/Census/DVCounts2013/State_Summaries/DVCounts13_StateSummary_TX.pdf

² Texas Council on Family Violence. (2013). *Facts and Statistics*. Retrieved from the Texas Council on Family Violence website: <http://www.tcfv.org/resources/facts-and-statistics>

³ The Attorney General of Texas. (2014). Domestic Violence: A Personal Safety Plan. Retrieved from the Attorney General of Texas website: <https://www.texasattorneygeneral.gov/victims/domestic.shtml>

Child-Related Sex Crimes

Number of cases filed by indictment or information for the offenses of indecency with a child or sexual assault of a child

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	101	180	122	151	106	99	115	107	122	139	124
COOKE	0	6	11	3	7	5	18	7	11	13	8
DENTON	83	84	97	96	98	108	98	82	67	95	103
FANNIN	28	23	25	37	22	22	26	12	19	28	23
GRAYSON	62	66	59	60	49	34	18	26	30	44	25

Data Source: Texas Office of Court Administration (OCA); Court Activity Reporting and Directory System, Ad Hoc Search.

Sexual abuse is defined in section 261 of the Texas Family Code as any sexual conduct harmful to a child’s mental, emotional, or physical welfare, as well as failure to make a reasonable effort to prevent sexual conduct with a child. Boys and girls of any age and race can be victims of sexual abuse, and the perpetrator can be anyone, but is most often someone known to the child.¹

When looking at the number of child-related sex crime cases filed in the North Texas corridor over the 10 years listed, Collin and Grayson counties saw decreases of 31 percent and 62 percent, respectively; whereas Cooke and Denton saw increases of 33 percent and 23 percent, respectively. Fannin’s number fluctuated throughout the 10 year period, but reported the same number in 2013 as in 2004. One possible explanation for the drastic decrease in cases filed in Grayson County is the lack of Sexual Assault

Nurse Examiner program for the last seven years; as a result, victims must travel to Collin or Cooke County to be examined.²

A perpetrator is most often someone known to the child.

In 2012, 5,928 children in the state were confirmed victims of sexual abuse (approximately 9.5 percent of children who suffered some form of maltreatment); those children abused in the five-county region account for just over 5 percent of sexually-abused children in Texas. Nationally, for the same year, 9.3 percent of children who suffered some form of maltreatment were victims of sexual abuse, and of those who were sexually abused, about 52 percent were under the age of 11.³

There are many emotional, social, psychological, and physical effects experienced by victims of sexual

abuse, particularly as children. Victims may experience emotional responses such as low self-esteem, lack of trust, depression, and guilt or shame, as well as physical responses like sleep disorders, alcohol or drug abuse, eating disorders, or even self-injury. Aside from the traumatic experience itself and all the trials that come with disclosing the ordeal to family, friends, and law enforcement, the long-lasting effects of sexual assault can be significant.⁴

¹ The Attorney General. (2010, May 6). *What Can We Do About Child Abuse?* Retrieved from Publications: https://www.texasattorneygeneral.gov/ag_publications/txts/childabuse1.shtml

² Strauch, N. (2014, June 28). Local groups try to offer a little bit of relief for sexual assault victims. Retrieved from The Herald Democrat: <http://heralddemocrat.com/news/local/local-groups-try-offer-little-bit-relief-sexual-assault-victims>

³ U.S. Department of Health and Human Services. (2012). *Child Maltreatment*. Retrieved from Administration on Children, Youth, and Families, Children’s Bureau: <http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf>

⁴ Rape, Abuse, & Incest National Network. (2006). *Adult Survivors of Childhood Sexual Abuse*. Retrieved from Effects of Sexual Assault: <https://rainn.org/get-info/effects-of-sexual-assault/adult-survivors-of-childhood-sexual-abuse>

Unintentional Deaths of Children

Number of unintentional deaths of children ages 0-19

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	13	21	30	13	21	21	20	17	13	14	<10
COOKE	2	4	4	4	1	3	3	1	1	0	<10
DENTON	19	26	12	16	16	21	14	18	17	11	11
FANNIN	1	3	3	4	2	2	4	5	0	3	<10
GRAYSON	6	5	5	11	9	13	6	4	11	6	<10

Data Source: Texas Department of State Health Services; Center for Health Statistics, Deaths due to Unintentional Injuries under the age of 20.

The table above counts the number of deaths attributed to motor vehicle accidents, drowning, and other causes not related to illness, homicide, or suicide. According to the Centers for Disease Control and Prevention, suffocation was the leading cause of unintentional deaths in the U.S. for children under the age of 1, most often occurring during sleep. The leading cause for those ages 1-4 was drowning, and for those ages 5-19, the leading cause was motor vehicle accidents.¹

For the same year, the national reported rate of unintentional deaths of children 18 and under was 10.4 per 100,000, a decrease of 28 percent from the 2005 rate of 14.4 children per 100,000.¹ The state of Texas rates only decreased by about 8 percent, however, they had comparatively lower rates of 9.5 in 2005 and 8.7 in 2010.

Teenagers between the ages of 15 and 17 had the highest accidental death rates, with a rate of 13.9 per 100,000 children in 2011. Children between the ages of 10 to 14 years old had the lowest accidental death rate in Texas for 2011, with a rate of 3.8 deaths per 100,000; however, 5 to 9 years trailed close with 4 deaths per 100,000 children.

77 percent of all motor vehicle fatalities could have been prevented in 2011.

For those aged 15 to 17, motor vehicle collisions were the leading cause, with a death rate of 9.7 per 100,000 children. The Texas Child Fatality Review Team (TCFRT) estimated that 77 percent of all motor vehicle fatalities could have been prevented in 2011. The three most cited factors involved in motor vehi-

cle accidents were drugs or alcohol, speed, and reckless driving.²

The second leading cause of accidental fatalities across the Texas child population was drowning. The TCFRT found that the rate of drowning deaths is consistently highest in the 1-4 year old demographic, at 3.5 in 2005 and increasing to 4.0 in 2011. The TCFRT also found that 78 percent of these deaths could have been prevented, more than half of them having occurred in pools or hot tubs and a fourth of them taking place in open water.²

¹ Centers for Disease Control and Prevention. *Web-based Injury Statistics Query and Reporting System (WISQARS)* [Online]. (2014). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer). Available at www.cdc.gov/injury/wisqars/fatal.html

² Texas Department of State Health Services. (2014, April). *Texas Child Fatality Review Team Annual Report 2013*. Retrieved from Maternal and Child Health: <https://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&itemID=8589987385>

ER Visits Related to Alcohol and Substance Abuse

Number of child alcohol or drug-related ER visits

		2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	Alcohol	56	58	36	27	43	71	51	59
	Drugs	33	29	30	15	23	39	33	37
COOKE	Alcohol	3	0	2	1	2	3	0	1
	Drugs	0	0	0	0	0	0	0	0
DENTON	Alcohol	61	59	52	48	35	44	51	44
	Drugs	19	10	10	9	14	25	23	17
FANNIN	Alcohol	1	0	0	0	0	1	0	0
	Drugs	0	0	0	1	0	1	0	2
GRAYSON	Alcohol	3	0	0	0	3	3	7	4
	Drugs	0	2	1	0	1	1	3	0

Data Source: Dallas-Fort Worth Hospital Council Foundation; Business Intelligence.

In Collin County, 59 youths went to the emergency room last year for alcohol-related incidents, and 37 youths visited for drug abuse. Denton County saw a slight decrease in both alcohol and drug-related ER visits from 2012. According to the National Institute on Drug Abuse, patients younger than 21 accounted for just under 20 percent of all drug and alcohol related ER visits nationwide in 2009, which translates to more than 800,000 visits.¹ Although the number of ER visits for drug and alcohol abuse may be relatively low in the five-county region, it is important to note that they only represent a fraction of overall drug and alcohol use.

In a 2012 report from the Interagency Coordinating Committee on the Prevention of Underage Drinking, about 25 percent of Texans ages 12 to 20 were estimated to have consumed alcohol in the previous month. The percentage jumps to nearly 50 percent among minors ages 18 to 20. Approximately 17 percent of those in the 12 to 20 age group

The number of Texans who use drugs or engage in underage drinking significantly contribute to another public safety concern — traffic fatalities.

were estimated to have engaged in binge-drinking in the previous month. The number of Texans who use drugs or engage in underage drinking significantly contribute to another public safety concern — traffic fatalities. Of all traffic fatalities in Texas in 2012, 32 percent involved 15- to 20-year-old drivers who had a blood alcohol content of greater than 0.01.²

According to the White House Office of National Drug Control Policy (ONDCP) report on drug use in Texas, marijuana accounted for the greatest proportion of drug treatment admission in 2011 followed by cocaine and heroin. The North Texas region, including Collin and Denton counties, has been identified as a High Intensity Drug Trafficking Area, meaning those counties participate in a program that coordinates local, state, and federal law enforcement

agencies as a specific response to drug trafficking. According to ONDCP, the most significant drug trafficking problem in the region involves methamphetamine, but cocaine, marijuana, and heroin also contribute to the high density designation.³

It is important to note that no hospitals in Cooke, Fannin, or Grayson counties are members of the DFW Hospital Council Foundation, which only reports data from its member hospitals.⁴ Therefore, numbers in those counties might be underreported, as they only reflect those individuals who reside in those counties but visited a member hospital in another county.

¹ National Institute on Drug Abuse. (2011, May). *Drug Facts: Drug-Related Hospital Emergency Room Visits*. Retrieved from DrugAbuse.gov: <http://www.drugabuse.gov/publications/drugfacts/drug-related-hospital-emergency-room-visits>

² Interagency Coordinating Committee on the Prevention of Underage Drinking. (2012). *Texas: State Profile and Underage Drinking Facts*. Retrieved from: http://store.samhsa.gov/shin/content/PEP12-RTCUAD-STATES/texas_profile.pdf

³ Office of National Drug Control Policy. (2010). *Texas Drug Control Update, 2*. Retrieved from: http://www.whitehouse.gov/sites/default/files/docs/state_profile_-_texas_o.pdf

⁴ DFW Hospital Council. (2014). *Hospital Membership*. Retrieved from DFW Hospital Council: <http://www.dfwhc.org/hospital-membership>

Children in Conservatorship

Number of children in DFPS legal responsibility, and the rate per 1,000 children

		2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	Number	539	532	574	656	737	663	465	416	465	429	468
	Rate	3.5	3.0	3.1	3.5	3.8	3.3	2.3	2.1	2.3	1.8	1.9
COOKE	Number	75	87	90	107	104	90	76	72	89	87	130
	Rate	7.9	8.8	9.1	10.9	10.6	9.2	7.7	7.4	9.0	8.9	13.2
DENTON	Number	243	297	438	564	650	588	451	540	596	684	636
	Rate	1.9	2.1	3.0	3.6	4.0	3.5	2.6	3.4	3.7	3.5	3.2
FANNIN	Number	49	50	67	76	69	80	71	49	41	30	25
	Rate	6.7	6.6	8.8	9.6	8.6	9.8	8.7	6.5	5.4	4.0	3.3
GRAYSON	Number	173	150	152	185	253	279	204	190	163	146	200
	Rate	6.3	5.4	5.4	6.6	9.0	9.9	7.2	6.8	5.8	5.0	6.8

Data Source: Texas Department of Family and Protective Services; Annual Report and Data Book, Statistics by Counties.

Children are placed in the Texas Department of Family and Protective Services (DFPS) programs when there is immediate danger to their physical health or safety. Children in this situation can reside in their own home and be in DFPS legal responsibility, or they can be in an out-of-home placement, which typically means foster care or relative care. In 2013, 29,523 children in Texas were in DFPS responsibility, which translated to a rate of 3.8 per 1,000 children. Of these children, approximately 54 percent lived in foster care, 34 percent lived with their relatives, and 8 percent remained in their own home. Children may transition out of conservatorship of the state through permanent family reunification, permanent placement with a relative, adoption, or by aging out of the system at age 18.¹

Within the first 90 days of entering conservatorship of the state, a permanency goal must be set for each child; for nearly half of these children, the ultimate goal is adoption, and about one-third have an ultimate goal of permanent family reunification. More than half of all children placed in adoptive homes are between ages 1 and 5, and nearly one-third have some disabling condition. Among those children with a disabling condition, approximately 13 percent have a learning disability and roughly 8 percent have been diagnosed with an emotional disturbance.¹

While the raw numbers of children in DFPS responsibility are greater in the larger counties of Collin and Denton than in the smaller, due to the size of their child populations, the rates of children in DFPS respon-

Approximately one-third of children in adoptive homes have some disabling condition.

sibility are considerably larger in the smaller counties. For example, in 2013, about 13 of 1,000 children in Cooke County were in the conservatorship of the state, compared to roughly 2 in 1,000 children in Collin County. All counties increased steadily until 2007, at which point Collin and Fannin generally decreased through the most recent year listed. Cooke County in particular reported the drastic increase in their rate of children in DFPS responsibility by 50 percent from 2012 to 2013 alone.

¹ Texas Department of Family and Protective Services. (2013). 2013 annual Report and Data Book. Retrieved from Texas Department of Family and Protective Services : https://www.dfps.state.tx.us/About_DFPS/Data_Books_and_Annual_Reports/2013/default.asp

ER Visits Related to Gunfire

Number of child ER visits related to gunfire

	2006	2007	2008	2009	2010	2011	2012	2013	2014*
COLLIN	3	4	6	4	5	11	6	7	3
COOKE	0	0	1	0	1	0	0	0	0
DENTON	4	4	8	3	4	7	2	4	1
FANNIN	2	2	1	0	1	0	1	0	0
GRAYSON	2	1	2	0	1	0	1	3	0

Data Source: Dallas-Fort Worth Hospital Council Foundation; Business Intelligence. *2014 data is for the first quarter only.

The state of Texas does not provide official data for emergency room visits; as a result, the data above comes from the DFW Hospital Council Foundation, which only reports data from its member hospitals. This is an important consideration because no hospitals in Cooke, Fannin, or Grayson counties are currently members of the council.¹ Therefore, numbers in those counties might be underreported, as they only reflect those individuals who reside in those counties but visited a member hospital in another county. Moreover, numbers for all counties are likely underreported, to some extent, because the data does not include residents of any of the five-county area who accessed non-member hospitals for their emergency care.

The most recent numbers available from the Centers for Disease Control and Prevention (CDC), for

2011, indicate an overall decreasing trend of child firearm deaths in the state of Texas. In 2003, there were 184 deaths of children under 18, involving firearms, which equates to a rate of 2.8 per 100,000 Texas children; in 2011 there were 158 involving firearms, a rate of 2.2. This represents a decrease of approximately 14 percent over nine years. For the same time, the number of firearm deaths for the same population decreased nationally by just 4 percent, from a rate of 2.6 to 2.5.²

Gunshot injuries among children ages 5 to 9 increased by 172 percent from 2003 to 2012.

Despite these decreases in firearm-related deaths in both the state and the nation, national estimates of nonfatal firearm injuries tracked

by the CDC reflect a different story, of increasing incidents involving children ages 0-19. Overall, incidence of nonfatal gunshot injuries increased by 6 percent for children under 18 from 2003 to 2012, but the greatest increase in incidence occurred for children ages 5 to 9, for whom the number of gunshot injuries increased by 172 percent during the same time period. While children ages 15 to 19 only experienced a 4 percent increase during that time, they accounted for about 90 percent of the 12,737 nonfatal gunshot injuries in 2012.³

¹ DFW Hospital Council. (2014). *Hospital Membership*. Retrieved from DFW Hospital Council: <http://www.dfwhc.org/hospital-membership>

² Centers for Disease Control and Prevention. *Web-based Injury Statistics Query and Reporting System (WISQARS)* [Online]. (2014). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer). Available at www.cdc.gov/injury/wisqars/fatal.html

³ Centers for Disease Control and Prevention. *Web-based Injury Statistics Query and Reporting System (WISQARS)* [Online]. (2014). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer). Available at www.cdc.gov/injury/wisqars/nonfatal.html

Approved Foster Care Homes Number of Foster Homes Approved by Child-Placing Agencies (CPA)

	2009	2010	2011	2012	2013
COLLIN	183	199	239	203	192
COOKE	0	2	4	1	2
DENTON	159	169	198	166	176
FANNIN	8	9	10	7	9
GRAYSON	26	30	30	25	19

Data Source: Texas Department of Family and Protective Services; Annual Report and Data Book, Statistics by Counties.

Data from the National Survey of Child and Adolescent Well-Being (NSCAW) indicates the majority of children who enter the foster care system – about 60 percent – do so as a result of neglect. About 10 percent enter as a result of physical abuse, and 8 percent due to sexual abuse.¹ The goal of placing a child in a foster home is that they will receive the safe, stable, and nurturing support that had been lacking in their prior living arrangement.

The basic requirements for becoming a foster and/or adoptive parent in Texas include being at least 21 years of age and financially stable, agreeing to a home study, and submitting to background and reference checks. Prospective foster parents must also attend free training courses to learn about the issues abused and neglected children face. The training allows the Texas Department of Family and Protective Services (DFPS) and the families to determine whether or not the family is a good fit for foster or adoptive care.²

Other requirements for foster or adoptive care include having reasonable lodging space, a maximum of six (including biological) children in the home, agreeing to a nonphysical discipline policy, obtaining CPR certification, and completing at least 20 hours of relevant training each year.²

All five counties in the North Texas corridor increased their number of approved foster care homes year-by-year until 2011. Since 2012, Collin and Grayson counties have decreased the number of approved homes. Cooke, Denton, and Fannin had minimal increases in 2013.

Roughly 60 percent of children enter the foster care system as a result of neglect.

If there are no foster homes available in the child’s home county, the search is expanded to surrounding counties, usually one within the same region (as defined by DFPS).

¹ U.S. Department of Health and Human Services, Administration for Children, Youth, and Families (November 2001). National Survey of Child and Adolescent Well-Being: One Year in Foster Care Report. Washington, D.C. http://www.acf.hhs.gov/sites/default/files/opre/oyfc_report.pdf

² Texas Adoption Resource Exchange. (2014). Requirements for Foster/Adopt Families. Retrieved from Adoption, Why Not You?: https://www.dfps.state.tx.us/Adoption_and_Foster_Care/Get_Started/requirements.asp



Students Disciplined for Possession of a Controlled Substance on School Grounds

Number of public school students disciplined for possessing alcohol, tobacco, or controlled substances on school grounds

		2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
COLLIN	Alcohol	78	72	60	75	97	95	83	117	92	67
	Tobacco	107	123	92	115	104	74	134	101	81	59
	Controlled Substances	210	232	232	263	284	310	318	380	349	444
COOKE	Alcohol	5	6	9	20	<5	<5	<5	<5	<5	<5
	Tobacco	9	15	16	5	13	15	<5	5	13	<5
	Controlled Substances	<5	11	12	5	<5	7	6	9	5	13
DENTON	Alcohol	58	65	40	80	108	51	49	79	76	70
	Tobacco	98	71	72	55	45	93	93	91	85	89
	Controlled Substances	204	192	177	259	205	213	214	339	267	329
FANNIN	Alcohol	<5	5	7	13	<5	9	8	5	<5	<5
	Tobacco	13	9	5	<5	<5	19	11	23	17	10
	Controlled Substances	8	<5	21	18	5	6	13	9	13	22
GRAYSON	Alcohol	19	16	18	11	<5	13	10	13	6	13
	Tobacco	42	62	45	31	33	34	33	49	27	42
	Controlled Substances	56	64	69	36	68	57	51	62	71	73

Data Source: Texas Education Agency: Disciplinary Report.

Among the students disciplined for possession of alcohol, tobacco, or controlled substances, controlled substances was generally the most reported offense, with alcohol violations being reported least overall. Tables with “< 5” listed indicate the state’s decision not to disclose those amounts smaller than five for risk of accidental identification of those parties.

When disciplinary actions occurred for possession of controlled substances, both Cooke and Fannin increased their numbers by over 150 percent (in part due to the minimal number reported in 2003), with the other counties increasing overall, although less drastically. As for tobacco-related disciplinary cases, all counties experienced decreases in number with the exception of

Grayson County, which reported the same number in 2012 as in 2003. In regards to the number of alcohol-related cases, all counties ultimately saw decreases except Denton.

According to a recent national study released by the National Center on Addiction and Substance Abuse, drug and alcohol use is prevalent on school campuses, with 86 percent of teen respondents reporting witnessing drug, tobacco, and alcohol use among peers during the school day.¹ “More than a third of students say it is very easy or fairly easy for students to drink, use drugs or smoke during the school day without getting caught.”² According to the Centers for Disease Control and Prevention’s 2013 Youth Risk Behavior Surveillance System survey of Texas high school students,

Drug and alcohol use is prevalent on school campuses in the U.S.

20 percent of survey respondents stated they currently used tobacco and 36 percent said they currently drink alcohol. Additionally, 1 in 5 students were currently using marijuana, 1 in 5 had taken prescription drugs without a doctor’s diagnosis, and 1 in 4 students said they had been offered, sold, or given an illegal drug on school property.³

¹ National Center on Addiction and Substance Abuse at Columbia University (2000, August). *National survey of American attitudes on substance abuse XVII: Teens*. Retrieved from www.casacolumbia.org/addiction-research/reports/national-survey-american-attitudes-substance-abuse-teens-2012, page 2.

² Ibid.

³ Centers for Disease Control and Prevention. (2013). High School Youth Risk Behavior Survey Data. Retrieved from Youth Risk Behavior Surveillance System (YRBSS): <http://nccd.cdc.gov/youthonline/App/Default.aspx>

Commitments to the Texas Juvenile Justice Department (formerly TYC)

Number of adjudicated youth subsequently committed to the Texas Juvenile Justice Department

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
COLLIN	15	17	17	18	17	14	13	14	11	8	15
COOKE	1	2	3	2	5	4	4	3	2	1	1
DENTON	31	26	38	29	28	30	17	13	16	18	12
FANNIN	4	1	3	0	3	1	0	2	1	2	2
GRAYSON	22	17	10	11	5	12	3	6	5	9	2

Data Source: Texas Youth Commission; Texas Juvenile Justice Department.

The Texas Juvenile Justice Department (TJJD) was established in December 2011, thereby replacing the existing Texas Juvenile Probation Commission and the Texas Youth Commission and assuming all of their operations. The mission of TJJD is to provide safety for the citizens of Texas through partnership with communities and by delivering “a continuum of services and programs to help youth enrich and value their lives and the community by focusing on accountability of their actions and planning for a successful future.” A juvenile, or “youth” as defined in the table, is a person who is at least 10 years old, but not yet 17 when they commit an act defined as “delinquent” or “conduct in need of supervision.” Adjudication of a youth is similar to a conviction in adult court.¹

All counties across the North Texas corridor had a decrease in the number of commitments to TJJD, except Fannin, which reported an overall increase of just one commitment for

the 10 years reported. The largest decreases in the number of commitments were seen in Grayson and Denton counties, by about 88 percent and 54 percent, respectively.

Over a 10-year period, there was a decrease in the number of commitments.

According to a recent report published by TJJD, male offenders accounted for 73 percent of all juvenile offenders in Texas in 2010 and 2011. Of the juvenile offender population in 2011, 25 percent were white, 49 percent were Hispanic, and 25 percent were black. The average age of juvenile offenders in 2011 was 15 years old, but the 16-year-old population was the most represented age group for that year. Additionally, more than half of those referred had previously been referred to juvenile probation, with 34 percent having one prior referral, 19 percent with two prior referrals, and 46 percent having had three or more prior referrals.²

Those who were referred, adjudicated, and subsequently committed to TJJD in the North Texas corridor in 2011 represented less than 4 percent of those committed in the state for that year.² Offenses for which juveniles are committed to TJJD vary, but include aggravated assault, aggravated robbery, burglary, and drug offenses.³ The length of time that a youth can be sentenced is influenced by the offense severity, the initial sentencing of the judge, and the progress that youth makes during treatment. Ultimately, the longest time a juvenile may be sentenced for a felony is 40 years.⁴

¹ Texas Juvenile Justice Department. (2013). *Overview of the Juvenile Justice System in Texas*. Retrieved from About TJJD: http://www.tjjd.texas.gov/aboutus/agency_mission.aspx

² Texas Juvenile Justice Department. (2013, November). *The State of Juvenile Probation Activity in Texas: Calendar Year 2011*. Retrieved from TJJD Research Publications: http://www.tjjd.texas.gov/statistics/Statistical_Report_2011.docx

³ Texas Juvenile Justice Department (2013). *Commitment Profile*. Retrieved from TJJD Research and Data: <http://www.tjjd.texas.gov/research/profile.aspx>

⁴ Texas Juvenile Justice Department. (2013). *Determining How Long Youth Stay in TJJD*. Retrieved from TJJD Role in Juvenile Justice: http://www.tjjd.texas.gov/about/how_class.aspx

Research Methodology

***Beyond ABC: Assessing Children’s Health in the North Texas Corridor* represents the latest information available about the issues affecting children in the region. What follows is a brief description of the methodology employed, data sources selected, and issues faced.**

METHODOLOGY

As with years past, the compilation of this year’s report was completed thanks to the input of a dedicated Advisory Board. After reviewing the indicators used in previous years, the Advisory Board established the final list of indicators to be included with this year’s document. Research associates with the University of Texas at Dallas Institute for Urban Policy Research then worked to identify the most consistent, recent and historical data available for each of the five counties. For most indicators, this data is as recent as 2013.

In revisiting some sources to collect current and historical data for the five-county region, the research team found that source data had been updated since production of the 2012 report. Not uncommon with official data sources, the team found instances where preliminary data used in previous reports had since been updated by the original author. In an effort to ensure continuity in the computation of numbers across years, the research team asked for all indicator data to be reported by the source agencies for 2014 and all prior years. What this means for the reader is that, on occasion, data presented in the 2014 report may differ from data presented in the 2012 report even if the source remained the same. The reader can rest assured that the source of those discrepancies was typically a shift in the source agency’s calculation or reporting practices, and that data presented in the 2014 report is calculated consistently across all years.

Each year, this report is designed to present the newest data of the highest integrity, and the development of new sources and methodologies sometimes presents an opportunity for significant improvement. For this reason, some indicators underwent significant methodological changes in the 2013 report on Dallas County, and when applicable, those changes have been implemented in the 2014 report for the North Texas corridor. In most cases, these changes allowed for more comprehensive, consistent, and accurate information across all years. Some indicators which underwent methodological improvement include Children with All Parents Working and Children with Developmental Disabilities.

DATA SOURCES

For the vast majority of indicators, data were retrieved directly from the official government agencies charged with maintaining accurate records of events. Sources include the Texas Education Agency, Texas Department of Family and Protective Services, Texas Department of State Health Services Center for Health Statistics, and others. Because this report focuses on the North Texas corridor, the team also utilized data from local sources when that data was more recent or more directly germane to the intent of the indicator than state level data. In limited cases where county-level data was not provided by the official agency, the need to summarize data to the county level necessitated some additional manipulation of data, often from the original sources (e.g., school districts). Finally, for a very small number of indicators, the nature of the data forced the research team to engage in original data collection. In those cases, additional safeguards were in place to ensure adequate and accurate transcription of the data.

As new data sources become available each year, the research staff sometimes makes determinations that a change in data source can greatly improve the quality of the information provided. For the 2014 report, several indicators have changed sources (generally consistent with changes made in the 2013 report). In all cases, the change improves the overall quality and consistency of the data. Some indicators which have changed data sources include food-based allergies and children diabetes prevalence.

RESEARCH TEAM

Dr. Timothy M. Bray, Director
Anthony M. Galvan, Senior Research Associate
Sara A. Mokuria, Senior Research Associate
Lauren A. Villa, Research Assistant
Alexis J. Harper, Graduate Research Associate
Sheila N. Dang, Research Intern

real kids

Behind the statistics, real children's lives are at stake every day. We hope you will keep these three North Texas children in mind as you consider policies and practices that impact their future.



Emmy Kaighan, Plano, Texas

Emma's journey started when she woke up at the age of 3 without the ability to walk or talk. After she arrived at Children's HealthSM Children's Medical Center Dallas, Emmy was diagnosed with Acute Disseminated Encephalomyelitis (ADEM), a rare disease that aggressively attacks the healthy tissue in the brain, and was placed in a medically-induced coma in Children's Medical Center's intensive care unit for over a month.



Benefiting from the unique expertise of her physicians and innovative technology available at Children's Medical Center, she survived. Or as Emmy explained, "They fixed all the problems that were going on in my brain." However, she continues with multiple therapies to support her physical and cognitive abilities.

Emmy, now age 7, loves to play with her first-grade friends, swim, play soccer and rollerblade. She also spent her summer advocating for other children suffering with complex medical conditions. In June, Emmy, along with her parents and two siblings, traveled to Washington, D.C., to lobby members of Congress. In addition to witnessing the unveiling of the Advancing Care for Exceptional (ACE) Kids Act, authored by U.S. Congressman Joe Barton (Texas), Emmy met with several members of the Texas Congressional delegation to request their support for this important legislation.

Emmy's father, Mike Kaighan, said, "We want to ensure that other families can get the same kind of care that we did."

Joshua Biyoyouwei, Allen, Texas

Joshua Biyoyouwei has been a patient of Children's HealthSM Children's Medical Center since being diagnosed with sickle cell anemia at 3-months-old. Ever since, he has faced numerous medical challenges, including having a stroke when he was 18 months old after a three-day bout with an extremely high fever.

"That was the worst day of my life," says Joshua's mom, Vera Johnson.

The result of the stroke created more challenges for Joshua.

Now 6, Joshua is wheelchair bound and will require physical therapy for the rest of his life. Through all the challenges, Joshua is one of the most upbeat, happy kids you will meet. His smile lights up a room, and he's eager to meet new faces and give high-fives. He enjoys throwing the football around and playing with his two sisters.

In order to ensure he does not have another stroke (50 to 70 percent of patients with sickle cell anemia who have a stroke will have another if left untreated), Joshua must receive blood transfusions for the rest of his life. The one thing that could change Joshua's life would be a stem cell transplant.

Unfortunately for Joshua, the wait could be even longer because of his race. According to Be the Match, "Patients are most likely to match someone of their own race or ethnicity. Today, there simply aren't enough registry members of diverse racial and ethnic heritage." Each year, Children's Medical Center hosts a "Be the Match Donor Registry Drive" encouraging individuals to donate to help children like Joshua.



Maddie Smith, Trophy Club, Texas

Maddie was only three days old when she came to Children's HealthSM Children's Medical Center. "She was breathing a little heavy and the doctor was smart enough to check her blood gases that showed it was way out of whack," her dad said.

Diagnosed with Methylmalonic Acidemia, a rare genetic disorder, Maddie is unable to properly process certain proteins and fats. As a result of her early diagnosis and treatment, Maddie escaped a possible death sentence, but she continues to receive three-hour dialysis treatments three times a week.



However, Maddie and her family are hopeful she will receive a kidney and liver transplant in the near future.

Maddie's doctor says that one donor can save several lives. "We can get the heart, two lungs, two kidneys, one liver, one pancreas and one small bowel so there are eight individuals who can benefit from every donor," said Dr. Mouin Seikaly, Children's Medical Center Dallas.

The Smith family remains hopeful. Her mom, Jessica, explains, "Something like this can either break you or make you, and I think a lot of it is a choice. It's really easy to allow negative thoughts to destroy you. We agreed early on that we weren't going to do that. We were going to stick together and allow each other to have bad days. It's a big deal, forgiveness and just being positive and allowing ourselves to think anything but positive."

National Recognition for Children's HealthSM Children's Medical Center



Cancer

The largest program of its kind in North Texas and across most of the middle United States, the Pauline Allen Gill Center for Cancer and Blood Disorders at Children's Medical Center is part of a National Cancer Institute-designated facility. The center carries out numerous clinical, translational and laboratory research studies and missions related to education and advocacy.



Nephrology

The Nephrology program at Children's Medical Center provides a spectrum of services for children and adolescents with congenital and acquired kidney-related conditions and disorders. It is one of the largest pediatric nephrology divisions in the nation and the primary health care provider for children with end stage renal disease (ESRD) in North Texas, as well as one of the largest pediatric dialysis programs in the United States.



Cardiology & Heart Surgery

The Heart Center at Children's Medical Center ranked in the top 20 nationally, does more than diagnose and treat the full spectrum of pediatric cardiovascular disease, defects and conditions; they are pioneering better ways to understand and care for the heart.



Neurology & Neurosurgery

The Neurology service at Children's Medical Center is one of the leading pediatric neurology divisions in the nation. The program provides care for children with conditions across the neurological and developmental spectrum, with particular emphasis on muscular, physiologic and behavioral disorders.



Gastroenterology

The Gastroenterology (GI) program at Children's Medical Center treats a variety of common and complex gastrointestinal and hepatobiliary disorders. The program works to provide advanced treatment and research using state-of-the-art diagnostic and therapeutic gastrointestinal procedures to the more than 1,100 patients per month.



Orthopedics

The Orthopedics program at Children's Medical Center, ranked in the top 5 nationally, is widely recognized as one of the best pediatric programs in the United States. The experts at Children's treat all pediatric orthopedic conditions from bone fractures to highly complex cases.



Neonatology

The 52-bed, Level IV Neonatal Intensive Care Unit at Children's Medical Center combines advanced technology with highly trained health care professionals to provide comprehensive care for over 550 critically-ill newborns annually.



Urology

The urology program at Children's Medical Center, ranked in the top 10 nationally, is comprised of highly trained pediatric specialists and offers the North Texas area's most medically innovative program for children with urological needs.

Planting the Seeds

For 18 years, *Beyond ABC* has highlighted the most pressing issues facing children in North Texas. The report has been a valuable tool, providing detailed information for lawmakers, nonprofits, grant writers, and local leaders as they determine the needs of the community. As the North Texas region grows, the divide between Dallas County and the five North Texas counties decreases. In order to meet the region's growing needs, Children's HealthSM is making several updates to ensure *Beyond ABC* continues to provide comprehensive, timely information.

In 2015, Children's Health will shift from producing a Dallas County report and North Texas report every other year and simply provide one annual report on all six counties. As we prepared the 2014 book, the *Beyond ABC* Board and editors took this update into account by choosing indicators that would accurately assess issues in all six counties.

In addition, the *Beyond ABC* Board's mission grew beyond simply educating the community on the needs of our children toward implementing the community recommendations. We started at the beginning of 2014 by inviting the Dallas Advisory Board to implement their 2013 recommendations. Nearly half of the board members accepted this charge and hit the ground running. By combining the advisory board's vast array of

resources, contacts, and expertise, we partnered together with the community to positively impact the well-being of children in Dallas County. As you will see, the board's diligent work paid major dividends.

At Children's Health, we are committed to empowering decision makers with information, collaborating with the community, and planting seeds to a better future. We expect these updates will accomplish these goals.



for a Better Future

RECOMMENDATION RESULTS

Supporting Pre-K

- **Urging lawmakers to support universal pre-K topped the 2013 recommendation list.** During the 2013 *Beyond ABC* symposium, one panelist explained that Dallas County has an abundance of open slots. Children’s HealthSM, along with several board members, partnered together with Dallas ISD to fill these open spots by encouraging families to register their children for pre-K during the district-wide “Round-up.” The efforts were impactful. As a result of the coordinated push, DISD experienced a 110 percent increase in 4-year old pre-K registration from May 2013 to May 2014.

Increasing the Immunization Rates

- **By incorporating immunizations as key quality improvement initiative,** Children’s Health Pediatric Group increased the immunization rate of its patients from 70 percent in 2012 to 80 percent in 2014.
- **With the Immunization Partnership, Children’s Health hosted a forum** to discuss the barriers to higher vaccination participation rates and brainstorm opportunities to break through existing obstacles.
- **The Family Place hired full-time nurses to assist children** living at the Safe Campus location with immunizations, routine health assessments and identification of children with special needs.

Widespread Assessment of Children with Special Needs

- **As part of Mental Health Month in May,** the Children’s Medical Center Krissi Holman Library Family Resource used a donation from Rio Grande Latin Market to purchase educational books and brochures for parents and children coping with mental health issues.
- **Head Start of Greater Dallas provided developmental screenings within 45 days of a child’s entry into a program**—if a test revealed “concerns,” the child was referred for further evaluations and referrals.

Promote the Need for More Foster Homes

- **Community Partners of Dallas encouraged more families to become foster parents** through educational meetings with foster and adoptive parents, volunteer groups, and donors.

Promote the Establishment of More Medical Homes

- **United Way allocated \$220,000 each year for three years to PediPlace’s Illness to Wellness program,** which provides a medical home for uninsured and underinsured children who lack access to primary pediatric care.
- **Children’s Health expanded its first-class pediatric primary care network in North Texas** with the opening of two new offices in Mill City and Celina, bringing the total count of Children’s Health Pediatric Group locations to 18.



HEALTH & WELLNESS ALLIANCE FOR CHILDREN

Determined to Make a Measurable Difference

With more than 40 outstanding community organizations actively engaged and guiding our work, the Health and Wellness Alliance for Children was established by Children's Health System of Texas to measurably improve the overall health and well-being of all children in our Dallas community, and in time, throughout the region.

Why Begin in Dallas County?

Despite cutting-edge medical facilities and a community dedicated to its children, the current state of children's well-being in Dallas County is not good—and it's getting worse.

- 29 percent of our kids live in poverty
- 18 percent don't have health insurance
- 28 percent have inadequate food and nutrition
- 35 percent live in a single-parent home

The Alliance was formed because for any one organization, this set of challenges is too great; and for the entire community, the status quo is not acceptable.

Our goal is to create common community intent to achieve large scale population-level improvement.

Guided by the voices of our at-risk children and their families, our first priority is asthma.

Why Asthma?

Guided by the voices of our at-risk children and their families, our first priority is asthma.

Approximately 60,000 kids in Dallas County alone have asthma. That's enough to fill the American Airlines center three times.

What Does it Mean to Our Community?

The financial impact of unmanaged asthma in Dallas to families and medical facilities is estimated at \$60M per year. The emotional impact on our children and their potential as adults is immeasurable.

What Can We Do About It?

Working groups of volunteer members across multiple organizations are planning and implementing four key strategies.

1. Developing asthma-healthy physical environments
2. Improving access to health care
3. Offering standardized asthma plans for care providers
4. Providing family support and education

We Need Your Voice

As a dynamic learning organization, the Alliance is interested in your expert insights and perspective.

Please join us online via our blog at www.healthandwellnessalliance.com and contribute to the ongoing discussion around the pressing issues impacting our community's children.

School-Based Health Care

Telehealth Brings Health Care To Schools Through Children's HealthSM Pediatric Group

When a child becomes sick at school, it is often difficult for a parent to leave work to take their child to a pediatrician's office during normal business hours. Fortunately, exciting technological advances are providing new tools for families, educators and health care providers. Through a secure link, nurses can now access health care professionals at Children's HealthSM Pediatric Group and provide children the care they need without ever leaving school. School-Based Telehealth is a coordinated strategy that increases the availability of health care and improves access to health care resources in schools.

One of the most important goals of Telehealth is to help children stay healthy so they can do their best in school. If children are ill, they tend to perform poorly. Healthy students are better equipped for academic success.

The 2014-2015 school year includes 26 School-Based Telehealth sites in Dallas, Grayson and Tarrant counties. School-based Telehealth allows Children's HealthSM to work by the side of educators and parents to make life better for children.

Telehealth benefits everyone:

FOR FAMILIES

- Health care can be provided in a familiar environment and kids do not miss school.
- Parents can remain at work versus having to physically respond to a "sick child" call from school.

FOR SCHOOLS

- Telehealth reduces absentees, which ultimately increases revenue for the school.
- The instructional time for children is increased when they can remain in school.

FOR SCHOOL NURSES

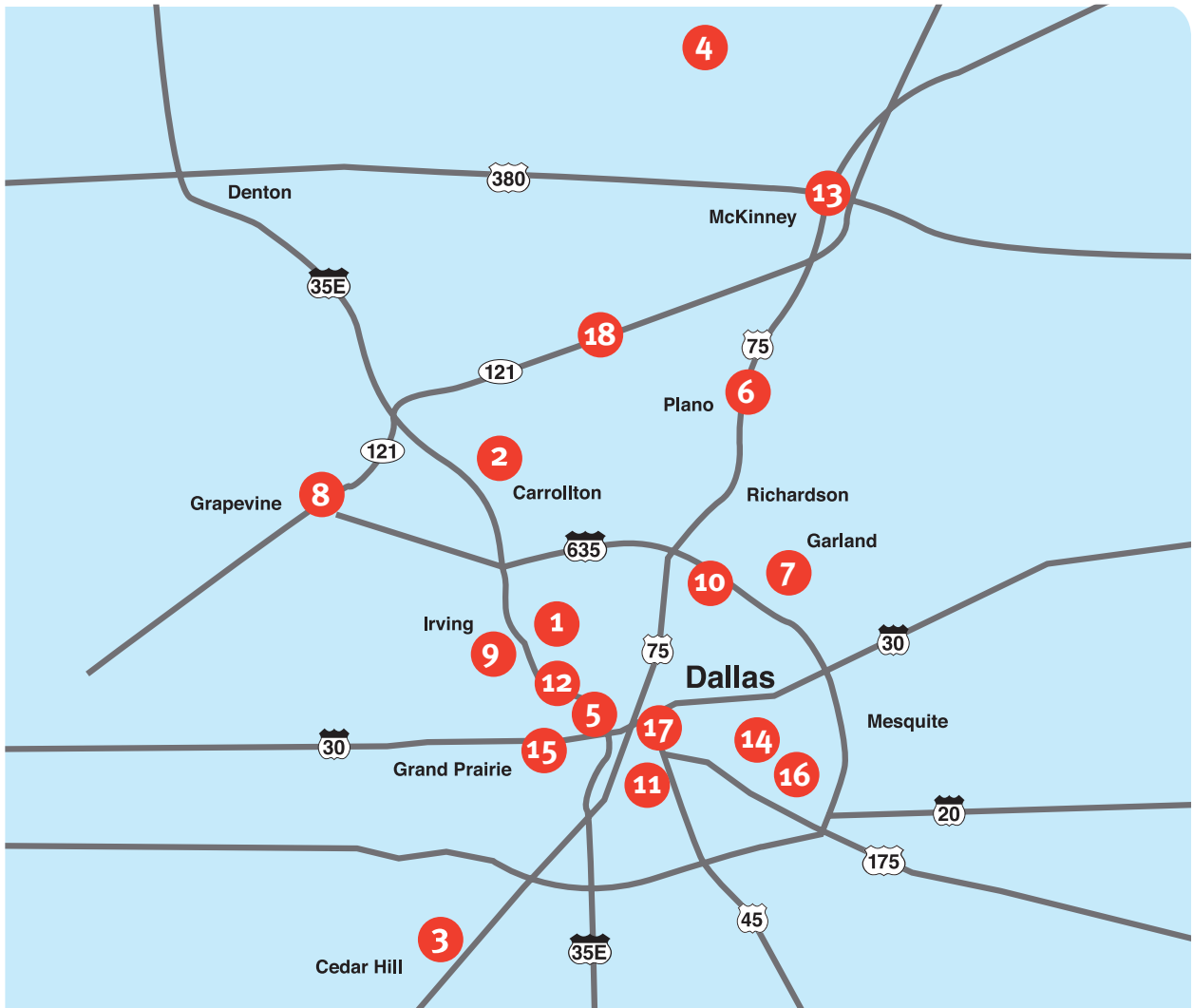
- School nurses have an expanded reach of clinical resources.
- Leveraging technology, school nurses access advanced educational opportunities.



children'shealthSM
Pediatric Group

Children's HealthSM Pediatric Group offers primary pediatric care, enabling your family to select a pediatrician who will be by your side for everything from routine and ongoing well-child visits to sick appointments when your little one becomes ill. All backed by a century of expertise from a name you can trust: Children's Health System of Texas. We cover all of your child's primary care needs and accept most private insurance.





Children's HealthSM Pediatric Group Locations

- | | | |
|---|--|--|
| <p>1 Bachman Lake
2750 W. Northwest Hwy., Suite 170
Dallas 75220</p> <p>2 Carrollton
3044 Old Denton Road. Suite 138
Carrollton 75007</p> <p>3 Cedar Hill
294 Uptown Blvd., Suite 120
Cedar Hill 75104</p> <p>4 Celina
1060 S. Preston Road, Suite 106
Celina 75009</p> <p>5 Cockrell Hill
4351 DFW Turnpike, Suite 150
Dallas 75211</p> <p>6 East Plano
900 E. Park Blvd., Suite 100
Plano 75074</p> | <p>7 Garland
455 N. Garland Ave.
Garland 75040</p> <p>8 Grapevine
2805 E. Grapevine Mills Cir.
Suite 120
Grapevine 76051</p> <p>9 Irving
1111 W. Airport Fwy., Suite 143
Irving 75062</p> <p>10 Lake Highlands
8330 Abrams Road, Suite 112
Dallas 75243</p> <p>11 Lancaster Kiest
3200 S. Lancaster Road, Suite 181
Dallas 75216</p> <p>12 Medical District
Children's Health Specialty Center
2350 Stemmons #F2400
Dallas 75207</p> | <p>13 McKinney
1720 N. Central Expy., Suite 150
McKinney 75070</p> <p>14 Mill City
4922 Spring Ave.
Dallas 75210</p> <p>15 Oak Cliff
3434 W. Illinois Ave., Suite 306-3
Dallas 75211</p> <p>16 Pleasant Grove
1401 S. Buckner Blvd., Suite 139
Dallas 75217</p> <p>17 St. Philip's
1600 Pennsylvania Ave.
Dallas 75215</p> <p>18 West Plano
7800 Preston Road, Suite 300
Plano 75024</p> |
|---|--|--|

Recent Studies Regarding Children's Issues

2013 State of States' Early Childhood Data Systems; The Early Childhood Data Collaborative, February 2014. www.ecedata.org

2014 KIDS COUNT Data Book: State Trends in Child Well-being; The Annie E. Casey Foundation. www.aecf.org/2014db

A Measure of Change: Texans Champion the Value of Immunizations; The Immunization Partnership, 2014. www.immunizeusa.org

America's Children: Key National Indicators of Well-Being 2014; Federal Interagency Forum on Child and Family Statistics. www.childstats.gov

Are the Children Well? A Model and Recommendations for Promoting the Mental Wellness of the Nation's Young People; Child Trends, July 2014. www.childtrends.org

Bullying Surveillance Among Youths: Uniform Definitions for Public Health and Recommended Data Elements; Centers for Disease Control and Prevention, 2014. www.cdc.gov

Child Care in America: 2014 State Fact Sheets; ChildCare Aware of America, March 2014. www.usa.childcareaware.org

Exploring Instability and Children's Well-Being; Urban Institute, July 2014. www.urban.org

For Kids' Sake: State-Level Trends in Children's Health Insurance Coverage; State Health Access Data Assistance Center, 2014. www.shadac.org/kids2014

Game Changers: Stats, Stories and What Communities Are Doing to Protect Young Athletes; Safe Kids Worldwide, August 2013. www.safekids.org

Health Coverage and Care in the South in 2014 and Beyond; The Henry J. Kaiser Family Foundation, June 2014. www.kff.org

Health Information Technology in the United States: Progress and Challenges Ahead; Robert Wood Johnson Foundation, 2014. www.rwjf.org

Helping Parents, Helping Children: Two-Generation Mechanisms; The Future of Children, Spring 2014. www.futureofchildren.org

Hunger in America 2014 National Report; Feeding America, August 2014. feedingamerica.org

Indicators of School Crime and Safety: 2013; National Center for Education Statistics and Bureau of Justice Statistics, June 2014. www.nces.ed.gov

Investing in America's Health: A State-by-State Look at Public Health Funding and Key Health Facts; Trust for America's Health, May 2014. www.healthyamericans.org

Keeping Families Safe Around Medicine; Safe Kids Worldwide, March 2014. www.safekids.org

Kids' Share 2013: Federal Expenditures on Children in 2012 and Future Projections; Urban Institute, September 2013. www.urban.org

Lessons from CHIP for Implementation of the Affordable Care Act; First Focus, May 2014. www.firstfocus.net

Literacy Promotion: An Essential Component of Primary Care Pediatric Practice; Pediatrics, June 23, 2014. www.pediatrics.org

Mother's Education and Children's Outcomes: How Dual-Generation Programs Offer Increased Opportunities for America's Families; Foundation for Child Development, July 2014. www.fcd-us.org

Out of Reach 2014; National Low Income Housing Coalition, 2014. www.nlihc.org

Race for Results: Building a Path to Opportunity for All Children; The Annie E. Casey Foundation, March 29, 2014. www.aecf.org

Safeguarding Children in Texas Foster Care; Texans Care for Children, April 2014. www.txchildren.org

Student Reactions During the First Year of Updated School Lunch Nutrition Standards; BTG Research Brief, July 2014. www.bridgingthegapresearch.org

Texoma Regional Economic Dashboard; Texoma Council of Governments. www.texoma.cog.tx.us

The Condition of Education 2014; National Center for Education Statistics, May 2014. www.nces.ed.gov

The State of America's Children 2014 Report; Children's Defense Fund, January 23, 2014. www.childrensdefense.org

The State of Pre-K: Realities and Opportunities in Texas; CHILDREN AT RISK, September 2014. www.childrenatrisk.org

Youth Physical Fitness: Ten Key Concepts; Journal of Physical Education, Recreation & Dance, February 2014. www.humankinetics.com

Key Websites

REGIONAL

Air North Texas
www.airnorthtexas.org

Allen Community Outreach
www.acocares.org

Assistance Center of Collin County
www.assistancecenter.org

Child & Family Guidance Center of
Texoma
www.cfgcenter.org

Children's Advocacy Center Denton
County
www.cacdc.org

Children's HealthSM
www.childrens.com

City House
www.cityhouse.org

Collin County Children's Advocacy
Center
www.cacplano.org

Collin County Government
www.co.collin.tx.us

Communities in Schools of North
Texas
www.cisnt.org

Cooke County Government
www.co.cooke.tx.us

Cooke County United Way
www.cookeuw.org

Court Appointed Special Advocates
(CASA) of Collin County
www.casaofcollincounty.org

Court Appointed Special Advocates
(CASA) of Denton County
www.casadenton.org

Court Appointed Special Advocates
(CASA) of North Texas (Cooke
County)
www.casant.org

Dallas-Fort Worth Hospital Council
www.dfwhc.org

Denton County Government
www.co.denton.tx.us/

Eleos
www.eleoscc.com

Fannin County Children's Center
www.fanninccc.org

Fannin County Government
www.co.fannin.tx.us

Frisco Family Services
www.friscocenter.org

Grayson County Government
www.co.grayson.tx.us

Hope's Door
www.hopesdoorinc.org

LifePath Systems
www.lifepathsystems.org

Minnie's Food Pantry
www.minniesfoodpantry.org

North Texas Food Bank
www.ntfb.org

SMU Center for Family Counseling
www.smu.edu/familycounseling

Texoma Community Center
www.mhmrst.org

United Way of Denton County
www.unitedwaydenton.org

United Way of Metropolitan Dallas
www.unitedwaydallas.org

STATE

211 Texas
www.211texas.org

CHILDREN AT RISK
www.childrenatrisk.org

CHIP | Children's Medicaid
www.chipmedicaid.org

Healthy Texas Babies
www.somedaystartsnow.com

Texans Care for Children
www.texanscareforchildren.org

Texas CHIP Coalition
www.texaschip.org

Texas Council on Family Violence
www.tcfv.org

Texas Department of Family &
Protective Services
www.dfps.state.tx.us

Texas Education Agency
www.tea.state.tx.us

NATIONAL

American Academy of Pediatrics
www.aap.org

American Diabetes Association
www.diabetes.org

American Heart Association
www.heart.org

Asthma & Allergy Foundation of
America
www.aafa.org

Centers for Disease Control and
Prevention
www.cdc.gov

ChooseMyPlate
www.choosemyplate.gov

HealthyChildren
www.healthychildren.org

Let's Move!
www.letsmove.gov

March of Dimes
www.marchofdimes.com

National Association for the
Education of Young Children
www.naeyc.org

National Campaign to Prevent Teen
and Unplanned Pregnancy
www.thenationalcampaign.org

Prevent Child Abuse America
www.preventchildabuse.org

The Kid's Doctor
www.kidsdr.com

KidsEatRight
www.eatright.org

The President's Challenge
www.presidentschallenge.org

Safe Kids Worldwide
www.safekids.org

StopBullying.gov
www.stopbullying.gov

Text4baby
www.text4baby.org

philanthropy

GIVING TO CHILDREN'S HEALTHSM CHILDREN'S MEDICAL CENTER

In 1913, a small group of nurses started the Dallas Baby Camp to meet the specific medical needs of children. The vision that began there could not have become the Children's HealthSM Children's Medical Center we know today without the support of the community. As a not-for-profit health care system, Children's Health has invested in the children and families of our community for over 100 years – thanks to generous gifts that have allowed us to build state-of-the-art facilities and programs, and recruit nationally acclaimed researchers and pediatric specialists. As we work in this next century of service, we want to continue to partner with you.

Widespread philanthropic support is necessary for Children's to:

- Give every child the care that is second to none.
- Pursue bold scientific research initiatives that will change the way disease is treated in both children and adults.
- Provide the right care in the right place at the right time to children who traditionally have not had access to primary care.
- Serve the deepest needs of families in crisis.

Giving to Children's has never been easier. Choose from one of the options below.

- Go to give.childrens.com
- Send a contribution to Children's Health Children's Medical Center Foundation, 2777 Stemmons Freeway, Dallas, Texas 75207
- Contact the Children's Health Children's Medical Center Foundation at 214-456-8360 to talk with one of our Development Officers about how you can make a difference in the lives of the 200,000 children who depend on Children's every year



Join us in making
life better for
children

give.childrens.com

Children's Medical Center Plano

Children's HealthSM Children's Medical Center Plano — which has 72 beds, four state-of-the-art operating rooms and 24-7 emergency services — opened on September 25, 2008, in Plano, Texas. The 155-acre campus preserves wide-open green spaces for an environment of healing and tranquility. Children's Medical Center Plano was designed with patients and families in mind, down to the sparkle in the floor and the large kinetic sculpture hanging in our main atrium. With breezes stirring a 90-year-old oak tree, horses grazing in an adjacent field and a stream bubbling through an outdoor patio, the spirit of nature is everywhere at Children's Medical Center Plano. For more information, see <http://www.childrens.com/locations/plano-campus/>





children'shealthSM

