HOUSE COMMITTEE ON PUBLIC HEALTH
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2002

A REPORT TO THE
HOUSE OF REPRESENTATIVES
78TH TEXAS LEGISLATURE

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CHAIR

COMMITTEE CLERK
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Committee On
Public Health

January 10, 2003

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The Honorable James E. "Pete" Laney
Speaker, Texas House of Representatives
Members of the Texas House of Representatives
Texas State Capitol, Rm. 2W.13
Austin, Texas 78701

Dear Mr. Speaker and Fellow Members:

The House Committee on Public Health of the Seventy-Seven Legislature submits this report on our interim charges to the Seventy-Eighth Legislature. The policy options outlined in this report were developed by the leaders of each charge. The options presented are not all inclusive, but do reflect testimony taken from stakeholders at our committee hearings. The committee respectfully declines to adopt specific recommendations, but offers this report as a reference for discussion of these complex issues by the Seventy-Eighth Legislature.

We thank you for providing us the opportunity to study these important public health issues.

Respectfully submitted,

Patricia Gray, Chair

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ACKNOWLEDGMENTS

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HOUSE COMMITTEE ON PUBLIC HEALTH

INTERIM STUDY CHARGES AND SUBCOMMITTEE ASSIGNMENTS

CHARGE #1 Assess the state of the healthcare infrastructure in Texas in light of hospital closures, rising costs, constrained reimbursement rates, workforce issues and any other pertinent factors. Consider differences in regions or localities that might adversely affect healthcare delivery to specific groups of Texans.

CHARGE #2 Conduct an extensive review of access to programs and treatment options for mental illness and substance abuse. Identify barriers to access and any gaps in existing programs.

CHARGE #3 Examine the costs and benefits of allowing state and local governments to provide health and preventive care without regard to the immigration status of the patient.

CHARGE #4 Gather information about the production, distribution, use and disposal of biological agents that could be used in terrorist actions as well as vaccines that would be used to respond to biological attacks. Review hospital plans for responding to large-scale emergencies. Review government regulations and business practices to determine whether legislation is needed to protect life and property and to detect, interdict, and respond to acts of terrorism.

CHARGE #5 Study the use of complementary and alternative medicines in Texas. Is there a need for the state to develop a regulatory framework for their use?

CHARGE #6 Assess the procedures of health-related licensing agencies regarding the intake of complaints, investigation procedures and timetables, and enforcement of laws and rules. Comment on any factors involving the use or abuse of patient information by healthcare agencies or institutions.

CHARGE #7 Actively monitor agencies and programs under the committee's oversight jurisdiction. Pay particular attention to implementation of recommendations concerning the Department of Health's childhood immunization program.

CHARGE #1

Assess the state of the healthcare infrastructure in Texas in light of hospital closures, rising costs, constrained reimbursement rates, workforce issues and any other pertinent factors. Consider differences in regions or localities that might adversely affect healthcare delivery to specific groups of Texans.

LEAD MEMBER

Rep. Dianne White Delisi

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INTRODUCTION

The Committee conducted two hearings on the charge, addressing Health Care Infrastructure on February 26, 2002, and the Health Care Workforce on April 30, 2002. Witnesses from a variety of health care providers and assessment groups were invited to bring testimony on the issues hindering health care providers and the system.

The initial hearing included testimony on the condition of the state's health care infrastructure from administrators and staff of rural, for profit (investor-owned), non-profit, public and specialty hospitals. Most witnesses agreed workforce shortages existed and must be addressed. In addition, agency staff provided demographics for the state, indicating a need for hospital administrations to be aware of the growth around them and to understand the diversity of the surrounding population.

The second hearing in April included an overview of workforce concerns by a National Conference of State Legislatures researcher, state groups concerned with strategic planning for workforce preparation, and medical school administrators. Recruitment and retention were often mentioned, with ideas varying on how to achieve the goals.

POLICY OPTIONS

Policy Option # 1 — Designate funding through the appropriations process specifically to trauma systems.

Policy Option # 2 — Reduce the number of uninsured Texans by making sure the state's economic environment is open for insurers, and assisting citizens in obtaining coverage through current employers, or through federal or state programs.

Policy Option # 3 — Pass resolution urging the U.S. Congress to address federal Medicare, Medicaid, and CHIP reimbursement issues.

Policy Option # 4 — Increase the number of physicians and nurses in rural and urban facilities, recruiting through training in rural and urban areas.

Policy Option # 5 — Workforce:

a. Expand medical schools and enlarge faculty size to allow class size increases.
b. Expand and/or initiate loan repayment programs.
c. Foster discussion of name change for nursing profession to open the field to more consideration by males.

Policy Option # 6 — Tort reform: adopt a cap on non-economic damages awarded to plaintiffs.

Policy Option # 7 — Ensure medical profession recognizes and teaches health differences between ethnic groups, in addition to focusing on communication problems that can arise between groups and individuals.

Policy Option # 8 — Study the financial responsibility of hospitals toward a patient transferred or released.

BACKGROUND

Workforce Shortages

While a few witnesses indicated an apparent lack of health care workers may be attributed to a mal-distribution of personnel rather than true deficiency, most witnesses agreed the state is facing a shortage of qualified workers. Testimony provided by Dr. Alfred Knight, President and CEO of Scott and White Hospital, Clinic and Health Plan in Temple, and echoed by others, indicated economists and health educators had promoted a concept of excess hospital beds and doctors, in particular specialists. This prognosis drove recent years' development of bed capacity and significantly impacted the number and type of physicians educated.

Shortages also were attributed to difficult working conditions and increasing amounts of paperwork that crowd out patient care, according to Don Richey at Guadalupe Valley Hospital. He said medical staff paperwork responsibilities were matching patient care hour for hour. The aging of the US labor workforce is another reason for the shortages, according to Claire Jordan from the Texas Nurses Association. In addition, she cited working conditions and changes in societal values as reasons fewer people were attracted to the profession.

The workforce problem is not unique to Texas, Tim Henderson from the National Conference on State Legislatures told the Committee. He cited the medical professions inability to adapt to reflect the changes prompted by tighter resources, lack of direction, greater demands and job cutbacks and their accompanying uncertainty. Ideas being discussed or applied in other states include tax credits for nursing education, limiting mandatory overtime, strategic plans expanding medical school enrollments, small grants to community colleges, and programs to address attrition. Liability concerns have been addressed by other states with mutual insurance plans to avoid private market increases, limitation on plaintiffs seeking damages on bills paid by insurers, shortening the statute of limitations and new state authorities for addressing medical errors with written notification of patients.

Data supplied by the Health Professions Resource Center showed the number of registered nurses in the United States at 749 per 100,000 population, while Texas had only 540 nurses per 100,000 in 1996. The number has slowly risen in Texas to 659 per 100,000 population in 2001. Primary care physicians were between 60 and 80 per 100,000 people across the United States in 2002, with Texas at 64 and the border at 57 per 100,000 population. Numbers for certified nurse aides dropped

from 503 per 10,000 elderly in 1998 to 421 in 2001, according to the Health Professionals Resource Center numbers reported in April 2002. Of the state's 254 counties, 24 have no physicians and 20 have only one, while 180 counties are identified as shortage areas.

Citing shortages or mal-distribution of physicians, licensed vocational nursing, certified nursing aides, pharmacists, dentists, respiratory care technicians, and others, Statewide Health Coordinating Council chairman Ben Raimer told the committee that the council would be addressing three critical areas in its biennial update: the need to coordinate and improve efforts to recruit and retain primary care and allied health workers based on solid data indicating need; the need to place priority on a quality workforce for care of the elderly; and the need to ensure a quality public health workforce.

The largest medical occupation is registered nursing, which has more members working outside of the hospital setting than any other profession, according to Tim Henderson from NCSL. In addition, the historically female-dominated profession is losing potential workers to fields opening up in business, law, pharmacy and medicine. Dr. Dolores Sands, University of Texas at Austin's Dean of Nursing, indicated the solution lies in recruitment and retention, with concentration needed on the field's largest minority: men. She suggested a need to change the nursing profession's title to health care managers, technicians, associates, or another title that would avoid the female connotation of a "nurse." However, she said this would be an emotional change for the honored profession. Henderson indicated a national problem with lack of capacity in schools. Nationally, nurse enrollments have declined for five consecutive years (1996-2001), however UT Austin experienced an 18 percent increase in baccalaureate enrollment in 1999-2002, according to Dr. Sands. Some schools in Texas reported substantial enrollment increases in 2001, but indicated they followed the declines of previous years. The forecasted shortage of educators could soon cause more enrollment declines as Texas schools are forced to cut classes. UT has already turned away 30 qualified students a year due to a lack of faculty. If funds were available, the Legislature could appropriate money for additional faculty.

Dr. Nancy Dickey, President of The Texas A&M University System Health Science Center and Vice Chancellor for Health Affairs, said health care use rises with a growing population and a good economy. The medical schools had worked under the assumption of an oversupply projection as managed care was expected to spread, however the idea of managed care becomes less popular, there appears to be more need for health workers. Texas A&M University Health Science Center was looking at addressing state workforce shortages through enlarging class sizes, and training in

non-urban areas with hopes of enticing physicians to remain in rural areas when they complete medical school training. In addition, Texas A&M is offering primary care program admission at the same time as undergraduate admission. Expanding the medical school class sizes and allowing more Texans into medical school might address the number of students leaving the state for education, Dr. James C. Guckian, University of Texas Acting Executive Vice Chancellor for Health Affairs, told the committee. He said nursing classes had 25-30 percent more qualified applicants than the UT schools could accommodate, while allied health classes could have been expanded by 25-45 percent if the financial resources had been available. In addition to the class expansions, he advocated for increased state funding for primary care residencies and some specialty areas such as pediatric sub-specialties, anesthesiology, and radiology since graduate medical education funds from the federal government had been frozen.

The Texas Higher Education Coordinating Board (THECB) adopted methodology in April and October of determining need for new professional schools, including medical school, based on population increases. Dr. Marshall Hill, Assistant Commissioner for Universities and Health Related Institutions, said THECB was increasing traditional and non-traditional medical programs to meet student needs after realizing the state was facing a nursing workforce shortage. A statewide committee on field of study also was implemented to streamline the transfer of course credits as students move among nursing programs in the state. The coordinating board also fosters use of articulation agreements between community colleges and nursing schools. Senate Bill 572 from the 77th Legislative Session addresses the nursing shortage by establishing a program through which the Coordinating Board will award funds appropriated by the legislature (redirected from tobacco settlement funds) to give nursing programs the resources needed to enroll additional students, assure the retention of an adequate number of qualified faculty, including providing faculty salaries, and encourage innovation in the recruitment and retention of students. This bill also amends the nursing financial aid program currently administered by the Coordinating Board to give the board more flexibility in using the appropriated funds in the best way to produce the nurses the state needs. S.B. 572 also increases the pool of qualified nursing faculty by providing incentives for postgraduate nursing students to go into teaching, and it establishes a nurse workforce data center to provide the information policy-makers need to make informed decisions on nursing workforce issues. THECB awarded $2.4 million in grants to entities addressing the shortage through “grow your own” nursing programs, summer preparation for disadvantaged students or development of retention models, as well as another $740,000 toward nurse faculty overloads. In six nursing scholarship programs, THECB distributed $405,000 for professional scholarships and $77,000 for vocational scholarships, as well as administering a loan repayment program.

On another front, educational institutions are joining with local business to expand nursing program enrollment. For example, UT at Arlington obtained funding from members of the Dallas-Fort Worth Hospital Council for 20 additional nursing students over a four-year time period. In California, an industry and education partnership will funnel $1.3 million toward doubling enrollments at San Diego State University, with six hospitals or health systems contributing $70,000 each over three years to support the addition of six instructors and an enrollment of 40 additional students per year.

Some areas have turned to foreign recruitment of physicians and nurses to supplement their workforce. Ben Durr, a Uvalde hospital administrator, indicated they have used a J-1 physician waiver to bring in doctors and their last six nurses have come from the Philippines. Medical students from other countries may practice in the US under a J-1 Visa Waiver from the US Department of State, if they qualify for the medical residency programs. However the US Department of Agriculture quit acting as the federal receiver and reviewer of the waivers in the spring of 2002, although they did agree later to complete processing of received applications. The Texas Department of Health's Primary Care Office had to look to the Conrad/State 20 program as a means of placing doctors in the rural areas formerly served through the J-1 Visa Waiver program. HB 1018 from the 77th Legislature (codified in the Occupations Code, Section 155.1025) allows the state to recommend up to 20 waivers per year for physicians requesting an expedited license through the Conrad/State 20 program, but is limited to faculty in Harlingen. The federal government did expand the Conrad/State program to 30 waivers, and Connie Berry in TDH's Primary Care Office said the department should be able to adopt rules to use unused waivers in other rural shortage areas. Sam Tessen, executive director at the Office of Rural Community Affairs, suggested the application of the available waivers be addressed with state legislation.

The importance of cultural competence should not be neglected in training and hiring all doctors and other health personnel, Dr. Dickey told the committee. Texas A&M was conscious of matching medical resident skill sets with the area they were serving since rural areas have less access to immediate assistance than an urban hospital with multiple doctors if the residents encountered complications with patients. The ability to know and understand people is compounded by doctors coming from different areas of a state, as well as different countries.

Foreign recruitment should be only a short term solution, said Beth Mancini from Parkland Hospital Nurse Administration. She said money was being funneled to schools of nursing from communities and hospitals. Communities need to recognize the economic value of health care and direct their own resources into its provision, according to Sam Tessen (Office of Rural Community Affairs). He suggested communities use the half-cent economic sales tax for job creation in recruiting needed

medical personnel. He also suggested school loan repayments in exchange for provided service from health workers and the exploration of telemedicine for training.

Diversity

Minority populations are increasing across the state, but minority students are under-represented in health career fields. Diversity of the medical profession should mirror that of the population, as there is evidence that treatment quality differs for minorities. Reasons for treatment disparities have been attributed to miscommunication between doctors and patients, lack of access to medical care, or barriers of culture or economics, but no one seems to have a definitive answer. The Legislature appointed a Health Disparities Task Force that began meeting in April 2002 and will provide a report to the Legislature in Spring 2003.

Different population groups have distinct health issues, with propensities for diabetes, asthma or other chronic ailments. The differences should be recognized and taught, with medical personnel taught to understand the differences in communication that also occur between groups and individuals.

Earlier recruitment of students, in elementary and junior high, will open up possibilities to students before their minds are set on certain careers. The recruitment should be by faces of ethnicity to which students can relate, according to Laurie Mitchell, part-time medical/surgical faculty at Prairie View A&M University and nurse-manager of cardiovascular-transplant surgical services at St. Luke's Episcopal Hospital in Houston. She tries to encourage students, in general, and minority students, in particular, to consider the shortage area of the operating room by teaching a summer perioperative class at Prairie View A&M.

Early and minority recruitment are parts of the Baylor College of Medicine's efforts, which were noted by witnesses, and include various programs and partnerships with schools from elementary to college level. They provide curriculum materials for elementary schools, offer week-long or summer enrichment programs, partner with four-year institutions to provide targeted high schools for students interested in the health professions, and have joint programs offering high school to medical school pathways.

In addition, various medical schools within the UT System have automatic admissions agreements with undergraduate schools as a means of recruiting.

In addition, the 77th Legislature passed SB 940 and created the Joint Admission Medical Program, which will provide services to support and encourage highly qualified, economically disadvantaged students pursuing a medical education. Selected students will receive undergraduate and graduate scholarships and summer stipends, and guarantees of admission for qualified students to at least one participating medical school. Students also will receive mentoring from participating medical schools and personal assistance to prepare for medical school admission. The first eligible students will be Spring 2002 high school graduates.

Trauma Care

The February 26th hearing on workforce issues included testimony from representatives of rural, specialty, private, for-profit, not-for-profit, and public hospitals. Information presented to the committee reflects that hospitals state-wide are facing difficulties related to the increasing number of uninsured, Medicaid and Medicare patients, reduced reimbursement rates, over-crowding in emergency rooms, high cost of salaries to recruit and maintain staff, decreased capacity in emergency rooms and intensive care units, increasing liability insurance premiums and overall increased health care costs, which includes the high cost of emergency and trauma care. Hospital representatives reported that the combined effects of all these issues puts stress on trauma care systems. Smaller hospitals and lower level trauma centers identified delays in transferring critical patients to Level I and Level II trauma centers due to lack of bed space and workforce shortages. Many hospital representatives identified lack of access to primary care for patients with Medicare, Medicaid, CHIP and those who are uninsured as a major problem causing patients to seek care in emergency departments which clogs the trauma system.

At the April 30th hearing, Dr. Guy Clifton, chief neurosurgeon from UT-Health Science Center in Houston identified specific problems that traumas systems are facing. He described trauma as a modern epidemic that is in need of immediate attention, and defined trauma patients as those primarily injured in some variety of accident, generally automobile accidents, motorcycle accidents, and falls. He stated trauma is the leading cause of death in persons under 34 years of age. Dr. Clifton described the "Golden Hour" as the first hour after a traumatic injury occurs, during which, if medical attention is received, patients are more likely to have good outcomes than when care is delayed. Dr. Clifton pointed to the increase in diversion days that many hospitals are experiencing. When hospitals are on diversion they are unable to accept transfers of critical patients from other hospitals, or they must close their emergency rooms to ambulance traffic due to high capacity. He stated that one-third to two-thirds of trauma deaths are preventable by the use of organized trauma systems; however it is becoming increasingly evident that some people are not getting the care they

require in a timely manner.

As previously mentioned, strains on trauma systems can be attributed, in part, to an increase in the number of patients using the emergency room for non-urgent care. Dr. Clifton pointed out that both uninsured, and insured patients are visiting emergency rooms more frequently due to lack of primary care access, and fewer clinic hours. In addition, he pointed out that with an uninsured rate of approximately 24% in Texas, trauma centers cannot afford to increase hospital capacity in their emergency rooms or their intensive care units (ICU), and some hospitals are decreasing the number of beds in their ICUs due to nursing and physician shortages.

Another stressor to the stability of trauma systems' infrastructure is the cost of uncompensated care. In a 2000 study of the 15 Level 1 trauma facilities, 10 reported over $8 million in uncompensated trauma care. These costs are estimated to exceed $200 million per year for all Level I and Level II trauma centers combined. Dr. Clifton attributes these costs to the growing number of uninsured patients in the state, decreased federal subsidies (i.e. DSH funds) due to the Balanced Budget Act of 1997, and less ability on the part of the hospitals to cost shift to insured patients due to decreasing profit margins. In addition, recent and upcoming decreases in Medicare reimbursement will further hamper a hospital's ability to cover the cost of care in and out of the emergency room, thereby further crippling hospital infrastructure.

Many of the consequences of these stresses on trauma systems are already being felt. Dr. Clifton pointed out that access to high-level trauma and emergency room care may be limited or unavailable to patients in the most dire need, and preventable trauma deaths will occur more often. There may be an increase in medical errors, and delays in routine emergency room care will get longer.

Jorie Klein, RN and director of trauma services at Parkland Hospital in Dallas testified about trauma care in the Dallas area. She reported that, as of April 2001, Dallas hospitals had not experienced the level of diversion days that other areas in the state had faced. She concurred with Dr. Clifton that uncompensated care is a major stressor on the stability of trauma system infrastructure. In addition, she pointed out the strain that the nursing shortage has on her hospital to maintain the ability to care for trauma patients. Ms. Klein stated that, now more than ever before, trauma facilities must be in constant "stand-ready" operation. She pointed to September 11, 2001 as the driving force behind the need for this ultimate preparedness.

Two solutions were brought out in this discussion: Specify funding for trauma centers and reduce the number of uninsured Texans. During the 77th Legislature, HB 893 was passed in the House and would have earmarked $5 dollars from every license plate sold for direct trauma funding, but was defeated in the Senate. The issue of the un-insured, a very complex problem, is being addressed on several fronts, and is believed to be one solution to this complex problem. Making health care insurance more affordable is clearly an important piece of this problem to help reimbursement to hospitals for services. Other possible solutions may include improving access to primary care for Medicaid and uninsured patients by establishing federally and state funded clinics to help subsidize those doctors who see a high volume of Medicare, Medicaid and self-pay patients, building more Level I trauma facilities in under-served counties, and improving regional coordination of trauma services.

Rising Health Care Costs

The rising cost of health care can be attributed to several things, according to many hospital representatives. Many rural and smaller hospitals find themselves spending more each year to insure their physicians and keep and attract registered nurses to their facilities. Hospitals find that they are caring for more indigent/self-pay patients, more Medicaid, CHIP and Medicare patients, and find that reimbursement is decreasing among publicly funded programs. These hospitals are also seeing more care being delivered in their emergency departments where the cost is much higher. The combination of these two factors creates a dire situation for hospitals. Hospitals must also bear the cost of new technology, pharmaceutical drugs, and uncompensated care.

An article brought to the hearing supports many of these reasons for rising health care costs. "Tracking Health Care Costs" from Health Affairs, September 2001, provides analysis of a variety of data sources that show trends in health costs. The report shows that there was a 2.8% increase in hospital spending on inpatients in 2000, which is a 1.2% increase over the previous year. Payroll costs also grew in 2000 by 4.7%, and data suggest that the rate would accelerate at a rapid rate. The study reports that the trend for the increased payroll costs is accounted for in an increased number of work hours rather than increased hourly wages. Hospital representatives from Texas reported they are seeing increases in both. This report suggests that the movement away from managed care may also contribute to the rise in health care costs, as there are less stringent cost savers, more providers for patients to choose from, and an increase in the bargaining power of providers.

More recent data suggests that health care costs have continued to rise well into 2002. One article,

"Health Care Costs: The Painful Truth", from the October 23, 2002, issue of Business Week reports that HMO premiums for employers increased 16% to 22% in 2002. These increases are in line with increases seen in the past three years. This is due in part to increases in out- patient and physician services and the use of expensive treatments and diagnostic tools. In a September 25, 2002 article in Business Week titled, " Health-Care Costs' Sickening Surge", trends in rising health care costs are said to include higher drug costs, increased hospitalization expenses, and an aging population requiring and demanding more expensive treatments.

Of significant importance to each person testifying before the committee was the issue of reimbursement rates. In every part of the state hospital representatives reported that they were receiving less money for those patients who were on Medicare, Medicaid, and CHIP, and that actual costs for caring for patients is not being covered. Hospitals must then find a way to continue to care for all their patients and operate within their budgets, which many are finding it more and more difficult to do. A growing concern for many hospitals is the financial responsibility they must bear for uninsured patients who are transferred from their facility or who seek follow-up care upon discharge. As the population grows older and continues to seek more health care Medicare reimbursement is more important to the stability of our hospital system.

Texas hospitals are tied to programs that are funded by the federal government. One solution for the state to address reimbursement is to urge Congress to take up the problem of decreasing reimbursement rates for the federally funded health care programs of Medicare, Medicaid, CHIP. Finally, the cost of caring for non-emergent cases in the emergency rooms is very high, and therefore, improving access for patients to get them out of the emergency rooms in non-emergent situations and into primary care clinics is another key to addressing rising health care costs.

DEFINITIONS

CHIP: Children's Health Insurance Program, National program designed for families who earn too much money to qualify for Medicaid, yet cannot afford commercial insurance.

Conrad/State 20 A federal waiver states may use to recommend up to 20 waivers per year to physicians requesting expedited waiver. Legislation at the federal level may increase the number of waivers per state to 30.

Disproportionate Share Hospitals: A hospital with a disproportionately large share of low income patients. Under Medicaid states augment payment to these hospitals. Medicare in-patient hospital payments are also adjusted for this added burden.

Diversion: Procedure put into effect by a trauma facility to insure appropriate patient care when that facility is unable to provide the level of care demanded by a patient's injuries or when the facility has temporarily exhausted its resources. The trauma facility will divert ambulance traffic away from their facility and refuse transfers of patients from other facilities, usually due to workforce shortages or high capacity in emergency rooms and intensive care units.

J-1 Visa Waiver: A J-1 Visa is issued for an exchange visitor who is participating in an established exchange program pre-approved by the U.S. Department of State. Exchange visitors under J-1 visas include secondary school and college students, business trainees, primary and secondary school teachers, college professors, research scholars, medical residents or interns receiving medical training in the U.S., specialists, international visitors, and government visitors. The two-year Foreign Residency Requirement for J-1 visa holders rule requires some J-1 visa holders to reside in their home country for at least two years before they may obtain an immigrant visa to enter the U.S. or adjust their status within the U.S. The J-1 program's duration depends on the program category and the J-1 program sponsor.

Level I Trauma Center: Comprehensive trauma facility and tertiary care facility that has the resources and capability to provide total care for every aspect of injury continuum from research and prevention through rehabilitation.

Level II Trauma Center: Major trauma facility that has the resources and capabilities to provide definitive trauma care to injury patients, but may not be able to provide same spectrum of care as Level I trauma center.

Level III Trauma Center: General trauma facility that has the resources and capabilities to provide resuscitation, stabilization and assessment of trauma patients and can either provide treatment or arrange for appropriate transfer to a higher level trauma facility.

Level IV Trauma Center: Basic trauma facility that has the resources and capability to provide resuscitation, stabilization and arrangement for appropriate transfer of all trauma patients with major and severe injuries to a higher level trauma facility.

Medicaid: A program which provides medical assistance for certain individuals and families with low incomes and resources. This program became law in 1965 as a jointly funded cooperative venture between the Federal and State governments to assist states in the provision of adequate medical care to eligible needy persons.

Medicare: The federal health insurance program for people 65 years of age and older, certain younger people with disabilities, and people with end-stage renal disease (permanent kidney failure with dialysis or a transplant).

Transfer: Movement of a patient from one hospital to another based upon the patient's need (inter-hospital transport) and according to applicable state and federal transfer laws.

Trauma Patient: Any individual who experiences blunt or penetrating single or multiple organ system injury resulting in potential morbidity or mortality.

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CHARGE #2

Conduct an extensive review of access to programs and treatment options for mental illness and substance abuse. Identify barriers to access and any gaps in existing programs.

LEAD MEMBER

Rep. Garnet Coleman and Rep. Arlene Wohlgemuth

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INTRODUCTION

The committee held a public hearing to address this charge on June 25, 2002. At this hearing, the committee heard from state agencies that provided a general overview of mental illness and substance abuse treatment options in Texas. Barriers to better health treatment were highlighted, as were issues relating to how criminal justice and incarceration systems affect mentally ill populations throughout the state.

The committee worked with state personnel and others to identify and assess how changes in mental illness and substance abuse treatment and criminal justice responses might better serve these populations. A range of appropriate treatment options; the court system and its affects on the mentally ill and substance abusers; and the implications of the state's insanity defense on the mentally ill were considered and evaluated by the committee.

POLICY OPTIONS

Policy Option # 1	Require TDMHMR and TCADA to better serve dual mental illness and substance abuse populations by expanding patient access to Co-Occurring Mental Health and Substance Abuse Disorders programs.
Policy Option # 2	Allow patients increased access to appropriate treatment medications.
Policy Option # 3	Create pre-trial opportunities to adjudicate the existence of mental illness or defect.
Policy Option # 4	Establish specialized courts, such as mental health and/or drug courts, to evaluate appropriate treatment and/or incarceration options.
Policy Option # 5	Modernize and clarify Texas' definition of insanity as it relates to criminal proceedings.
Policy Option # 6	Remove statutory bars to informing jurors of the effects of a verdict of "not guilty by reason of insanity."
Policy Option # 7	Establish appropriate in-jail treatment programs for incarcerated mentally ill and substance abusing individuals.

BACKGROUND

Mentally ill and substance abusing populations in Texas need appropriate care to regain and maintain their health. When treatment options are limited, or nonexistent, these under- and untreated people are sometimes inappropriately funneled into the criminal justice and incarceration systems. Unfortunately, these systems are ill-equipped to adequately serve these populations. This report seeks to identify how mentally ill and substance abusing populations in Texas can be better served with appropriate venues of health care and jurisprudence.

According to the 1999 Surgeon General's mental health report, more than five million Texans live with a mental illness, substance abuse disorder, or mental retardation.[1] The Texas Commission on Alcohol and Drug Abuse (TCADA) estimates there are currently 2.8 million Texans dealing with some form of chemical dependency or substance abuse disorder, with about one million of those people considered indigent.[2] While Texas ranks second in population and second in population growth to the rest of the United States, the state ranks 43rd in funding per capita for mental illness.[3] State mental health facilities in Texas admit approximately 16,000 patients a year, yet only have roughly 2,569 beds to serve inpatient needs.[4]

From 1990-2000, many hospitals around the nation providing psychiatric care closed because of financial strain. Texas felt the bite of this trend as its number of hospitals, both acute care and psychiatric, fell from 166 to 106. As a result of these losses, inpatient treatment options for mentally ill and substance abusing populations in Texas decreased. This decrease in inpatient psychiatric treatment services, however, does not translate into a decrease in the demand for those services. In fact, the opposite is true. The Texas Department of Mental Health and Mental Retardation (TDMHMR) reports an increase in admissions of 34% from FY 1996 to FY 2001 for its public psychiatric hospitals. While the number of these hospitals has fallen from thirteen to nine, inpatient admissions have increased from 12,567 to 16,895.[5]

These numbers point to a shift in the utilization and function of public psychiatric care: facilities are admitting more patients for shorter periods of time than was previously the case. For the six year period between FY 1996 and 2001, changes in the length of stay for inpatient facilities are evident:

- Patients staying 90 days to one year decreased 19%;
- Patient stays of one to five years decreased 41%; and

- Patient stays over five years decreased 56%.[6]

However, for the same six year time period:

- Patients staying in inpatient facilities just seven days increased 27%;
- Patient stays between eight and fifteen days increased 79%; and
- Patient stays between 16- 30 days increased 75%.[7]

It is common for mentally ill patients to bounce in and out of treatment centers. The fact that mentally ill patients are spending less and less time in appropriate facilities is indeed cause for concern. It is likely that these individuals barely receive enough attention to have their condition stabilized before they are released. When released with unstable conditions, it is possible that mentally ill individuals may become involved with the criminal justice system and/or emergency room care, both of which can be said to be more expensive and less effective than appropriately administered mental health services.[8]

Increasing Access to Services

Because shorter stays mean higher operating costs for inpatient facilities, these changes prompted TDMHMR to change its methodology of state general revenue dollar allocation from focusing on "bed days" to a new "trust fund" system. The trust fund system allows for equitable distribution of general revenue resources within the state mental health system.[9]

In effect, the trust fund system allows TDMHMR authorities to purchase mental health services from community providers within the state system, thus shifting treatment options away from inpatient facilities towards community-based, or outpatient, clinics. Community and state authorities collaborate to establish operating procedures.[10] Community-based clinics provide a wide array of services to the mentally ill and substance abusers in an attempt to fill gaps that exist in treatment options. To be treated at a community-based clinic, a person must be assessed as having schizophrenia, bi-polar disorder, or major depression.

Clinics offer treatment with high success rates in reducing the symptoms for those receiving timely treatment. The symptoms reduction rate espoused for schizophrenia is 60%, for bi-polar disorder 40%, and for major depression 80%.[11] Forty-two community-based TDMHMR clinics are funded with performance contracts that let the clinics control their own finances;[12]

TDMHMR does not assume any fiduciary risk. However, community-based clinics also grapple with limited resources. Community health centers serving as the first line of defense are often forced to turn patients away because of limited funds.

On the other hand, outpatient treatment programs for substance abuse have generally received a higher level of funding than their psychiatric treatment counterparts. In recent years, Texas has provided services for substance abuse to a substantial population, with 30,366 individuals receiving treatment in FY '01. The operating budget of TCADA has, along with its scope and responsibility, increased dramatically from FY 1985 to FY 1995: its operating budget went from 65 to 180 million dollars, and is currently set at 365.7 million dollars.[13]

One outpatient program that has proved particularly effective for both TDMHMR and TCADA populations is the Co-Occurring Mental Health and Substance Abuse Disorder (COPSD) program. As many mentally ill and substance abusers are victims of both conditions, these types of programs are particularly beneficial. The TCADA/TDMHMR dual diagnosis project was developed following a resolution passed by the 74th legislature, charging these agencies to develop a pilot program to examine the effectiveness of integrated treatment for those suffering from simultaneous mental illness and substance abuse disorders. The project, which has expanded to include 15 co-occurring programs, was selected as an exemplary program by the National Center for Mental Health Services in May of 2001.[14] The program seeks to effectively address the needs of those with active psychiatric and substance abuse disorders, providing stabilization and proven treatment strategies.[15]

Increasing Access to Medications

The increasing gap between mental health needs, access to effective care, and provider availability demonstrates many weaknesses in the current mental health care system. The apparent shortage of qualified mental health providers has prompted a great push for expanded and appropriate mental illness and substance abuse services. In many instances, appropriate services include the provision of psychotropic medications. Unfortunately, there currently exist fewer mental health professionals qualified to prescribe these medications than are demanded by medically needy populations. This means that the mentally ill and substance abusers may not have access to the medications they need to regain and maintain their health.

An increase in the number of health professionals qualified to prescribe necessary psychotropic medications would alleviate this disparity. Because of the current shortage of psychiatrists qualified to prescribe such medications, some general practitioners currently prescribe

psychotropic drugs. However, it might be argued that such practitioners lack the training to make an appropriate mental diagnosis and may therefore put their patients at additional psychological risk. Some physicians argue that simply understanding the pharmacology of psychotropic medications is not sufficient. Further, they argue that a complete and thorough physical evaluation of patients, as well as consideration of other physical maladies, is critical when considering any medication.

During the 1989 congressional deliberations on the Department of Defense (DOD) appropriations bill, the DoD was directed to institute a pilot training program to ready military psychologists to prescribe psychotropic medications. The program graduated ten psychologists who practiced at various military facilities.[16] Using this program as an example, it is possible to discern that qualified mental health professionals can be trained to prescribe safely and efficaciously. Furthermore, such a model demonstrates that a greater availability of qualified mental health providers with prescriptive authority can be used to improve access, increase opportunity for continuity of care, and reduce inefficiency in the current system.

Developing Additional Care Alternatives

While medical remedies to mental health and substance abuse are considered by many to be ideal, they are not the only means of addressing issues related to these illnesses. Many mentally ill and substance abusing individuals become involved with the criminal justice system, but this system is ill-equipped to address and treat mental illnesses.

Between 15-20% of inmates in Texas prisons have a diagnosis of serious mental illness and/or substance abuse disorder. This proportion of the prison population is five times higher than the number of patients receiving treatment in mental health facilities.[17] The University of Texas Hogg Foundation for Mental Health reports that persons who do not receive needed mental health care create an enormous cost burden to communities. A two-year study of 21 persons conducted by the Foundation indicated that these individuals spent one in four weeks in jail. Three-quarters of a million dollars ($750,000) was spent by public and private providers over a two-year period on these individuals, the cost of which was attributable to criminal justice proceedings, state hospitals expenditures, and emergency room care.[18]

For many mentally ill and substance abusing individuals, most involvement with the criminal justice system is a result of the commitment of a non-violent crime, like disturbing the peace or vagrancy. If a judge is aware that a defendant is mentally ill, s/he can order treatment if s/he thinks it would be fair and beneficial to both the individual and the community when resources

are available.[19] As part of sentencing, a court may order that a person undergo a certain amount of treatment in an outpatient setting through one of the state's community-based TDMHMR clinics. Depending upon the seriousness of the crime, a person can be involuntarily committed to an inpatient setting in one of the state's hospitals. State hospitals, however, are typically reserved for those who commit violent crimes and suffer serious mental illness.[20] Under current Texas law, only patients who have been involuntarily committed by court order and meet the criteria of a "danger to self or others" can be forcibly medicated.[21]

Evaluating Current Judicial Oversight

Although eligible defendants can choose to be prosecuted in a typical court, they generally choose to participate in a treatment program in exchange for deferred adjudication of the underlying offense, during which their treatment compliance is scrutinized by the court.[22] The key to specialized courts' success is connecting individuals with services in the community.[23] Programs which offer a realistic treatment alternative to incarceration have been credited with saving substantial governmental resources.[24]

However, the failure of the criminal justice system to identify individuals in need of mental health treatment results in loss of scarce jail and prison capacity and an associated increase in direct cost. Texas could improve its ability to identify those individuals for whom treatment is appropriate by increasing the power of the justice system to successfully identify mental illness. Such an opportunity includes the refinement of Texas' insanity defense.

Texas' insanity definition derives from England's 1843 reaction to M'Naghten's Case.[25] By 1851, a majority of states and federal courts had adopted England's 1843 definition.[26] Since that time, dissatisfaction with the 1843 rule led states and the federal government to range widely in definitions of insanity and the burden of proof when insanity was at issue. Most states expanded their insanity definitions to include acts taken under an "irresistible impulse." Mentally ill persons unable to control their conduct were thought as non-culpable as those unaware what conduct to avoid. The insanity defense articulated by the American Law Institute in 1962 in the Model Penal Code, which included an irresistible impulse test, became the operative insanity definition in most state and federal jurisdictions.[27]

Reacting to the John Hinckley case in 1982, many legislatures dropped the "irresistible impulse" test and required that defendants bear the burden of proof in establishing an insanity defense.[28] Texas also amended its definition of insanity.[29] Texas' current rule is similar to, but more restrictive than, the M'Naghten Rule which for over a century has been criticized for its

narrowness and lack of relation to the developing understanding of mental illness.[30]

Yet, the operative language in Texas' current law is unclear. Texas does not define what it means to "know" the difference between right and wrong. Texas statutes also provide no guidance on how a jury in the context of a plea of insanity should determine whether a mentally ill defendant knew "right" and "wrong." Inconsistent jury verdicts result.[31] Clarity in Texas law would offer improved consistency and clearer instructions for jurors. Modernizing Texas' definition of insanity would improve its application to appropriate cases.

It is the opinion of some that Texas presently thwarts, rather than supports, providing juries with the information they need to do justice in insanity cases.[32] By contrast, jurors in death penalty cases are required to be informed about the effect of a sentence of life imprisonment, including the rules regarding the eventual possibility of parole.[33] Information about the specific effect of the verdict of "not guilty by reason of insanity," including the ongoing supervision by the district court, should be likewise available to jurors.

It could be argued that prosecutors entitled to a jury selected on the basis of its willingness to give the death penalty enjoy an unintended tactical advantage in the determination of whether a defendant is guilty or not guilty by reason of insanity. Studies demonstrate that so-called "death-qualified" juries hold the state to a lower standard of proof than juries do generally.[34] The existing statute on competency to stand trial, revision of which is under consideration by the SB 553 Task Force, may also offer a model for improving determination of sanity.[35] Alternatively, the state's interest in ensuring the full range of punishment can be considered, and the defendant's right to the standard of proof normally required protected, by offering defendants in capital cases a separate jury panel for the guilt-innocence determination than for punishment.

Mentally ill individuals found "not guilty by reason of insanity" in Texas continue under the jurisdiction and supervision of the district court for a period equal to the maximum sentence which could have been imposed had the defendant been found guilty.[36] However, it might be argued that the district court's supervisory powers remain unclear. If the district court should find that an individual can safely be released from confinement in a state facility, the court's flexibility to oversee and enforce conditions of the supervision are currently limited by the cumbersome requirements of contempt proceedings. Improved clarity of district courts' supervisory powers, creation of streamlined oversight procedures, and realistic opportunities for local treatment could improve pre-verdict and post-verdict conditions for courts and those before them.

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22. Mike Kataoka, "Mental health courts impress," Press-Enterprise, February 4, 2002 a A1, *available in* 2002 WL 4963784 (describing high motivation of a specialized court's voluntary participants, who show an astounding 95% show-rate on court dates).

23. Interview with Judge Jan Cochran, Oct. 21, 2002.

24. Specialized courts have been credited with saving state government much more than their cost. "Studies show the $1.1 million a year the state spends on drug treatment courts has saved the state $10 million a year in criminal justice system costs. The state spends $2,000 to $2,500 a year on each person in the drug treatment courts. It costs more than $20,000 annually to keep an inmate in state prison." Editorial, "Wise Investment", Charlotte Observer, June 1 2002, *available in* 2002 WL 21612099 (describing economic benefit of North Carolina drug courts). *See also* Sandy Theis, "New tactic pushed in war on drugs", (Cleveland) Plain Dealer, August 8, 2002 *available in* 2002 WL 6374992 (reporting National Conference of State Legislators' Health Policy Tracking Service' estimate that California's drug courts would save the state $40M annually, and comparing Ohio's ongoing offender costs of $3500 for treatment to $22,000 for incarceration); Encarnacion Pyle, "Drug courts put family at center of healing", Columbus Dispatch June 2, 2002 at 1B *available in* 2002 WL 21190480 (reporting estimated $10 saved per $1 spent on drug courts, and comparing cost of treating offender to ongoing per-child cost of foster care); Jack Tierney, "Drug court tough on offenders and getting results", Fulton Daily News Feb. 2, 2002, *available in* <http://www.fultondailynews.com/content/2002/021802/022102_ideas_tierney_drug_court_toughonoffendrs.shtml> ("Oswego County Drug Treatment Court saves taxpayers' money, because it costs less to treat a person for substance abuse than it costs to keep someone in jail. This also leaves more jail space available for violent criminals."); Cindy West, "US AL: Some Addicts Find Treatment Through Court", Gadsden Times, Jul 12, 2002, *available in* <http://www.mapinc.org/drugnews/v02/n1299/a04.html> (quoting Marshall County District Attorney Steve Marshall: "I am pro-drug court absolutely ... I think it saves us money and makes us safer."). The Thresholds program in Chicago has been able to treat individuals for $26 per day who otherwise would cost $70 per day to incarcerate, has reduced jail days and hospitalizations, and has saved Illinois state mental institutions as much as $916,000 per year. <http://www.bazelon.org/issues/criminalization/factsheets/criminal7.htm>

25. Following dissatisfaction with the result of the M'Naghten case, in which a delusional man killed a civil servant believing he was the Prime Minister, the House of Lords posed a series of questions to a panel of judges in order to clarify and to restrict the law of insanity as a defense to prosecution. *See* Davis v. U.S., 160 U.S. 469, 479-482 (1895) (describing judges' reactions to questions posed in the aftermath of M'Naghten's Case). The judges answers to the post-M'Naghten questions included the following rules:

(a) To establish a defense on the ground of insanity it must be clearly proved that, at the time of committing the act, the accused was labouring under such a defect of reason, from disease of the mind, as [1] not to know the nature and quality of the act he was doing or,

[2] if he did know it, that he did not know he was doing what was wrong.

and

(b) A person under a partial delusion is to be considered as if the facts with respect to which the delusion exists were real.

10 C. & F. 200 (1843) (numbering and lettering not as in original, but to illustrate the separate elements of the definition). The language in (a) is known as the "M'Naghten Rule" and the language in (b) became the general rule applicable when a defendant acts under a mistake of fact.

26. Univ. Missouri -- Kansas City School of Law, "Evolution of the Insanity Defense", *available at* <http://www.law.umkc.edu/faculty/projects/ftrials/hinckley/EVOL. HTM>.

27. Sanford H. Kadish, "Fifty Years of Criminal Law: An Opinionated Review", 87 Cal. L. Rev. 943, 959 (1999); Anne Damante Brusca, "Postpartum Psychosis: A Way Out For Murderous Moms?", 18 Hofstra L. Rev. 1133 (1990) (listing states which had adopted the ALI test by statute). Federal jurisdictions, and some states, adopted the ALI test by judicial decision. *See*, *e.g.*, U. S. v. Brawner, 471 F.2d 969 (C.A.D.C. 1972) (dropping the "Durham" test in favor of the ALI rule accepted in other federal jurisdictions, and recognizing that "The American Law Institute's Model Penal Code expressed a rule which has become the dominant force in the law pertaining to the defense of insanity" at 979).

28. Federal law on insanity, for example, changed dramatically. Formerly, federal courts required the prosecution to bear the burden of proof of every element of an offense, including an offense's mental element, Davis v. U.S., 160 U.S. 469, 479- 482 (1895) (overturning federal murder conviction because jury was told defendant bore the burden of demonstrating lack of capacity to form the mental state which was an element of the offense which the prosecution was required to prove); and the operative definition of insanity was the ALI test. The post-Hinckley federal statute reads:

(a) Affirmative Defense. -

It is an affirmative defense to a prosecution under any Federal statute that, at the time of the commission of the acts constituting the offense, the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his acts. Mental disease or defect does not otherwise constitute a defense.

(b) Burden of Proof. -

The defendant has the burden of proving the defense of insanity by clear and convincing evidence.

18 U.S.C. §17. On establishment of this affirmative defense, a defendant can be confined indefinitely in the custody of the Attorney General following a hearing at which clear and convincing evidence shows the defendant is "presently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of persuades a state to overtake confinement or until a court finds by preponderance of the evidence the person has recovered to such an extent that "his release would no longer create a substantial risk of bodily injury to another person or serious damage to property of another." As a result of this process, Hinckley remains confined.

29. Texas' definition of insanity as a defense to criminal prosecution is located at V.T.C.A. Penal Code §8.01(a), and at the time of Hinkley's attempt on Regan's life read as it originally appeared when enacted by Acts 1973, 63rd Leg., p. 883, ch. 399, § 1, eff. Jan. 1, 1974:

It is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of mental disease or defect, either did not know that his conduct was wrong or was incapable of conforming his conduct to the requirements of the law he allegedly violated.

The statute was amended by Acts 1983, 68th Leg., p. 2640, ch. 454, § 1 (eff. Aug. 29, 1983) and by Acts 1993, 73rd Leg., ch. 900, § 1.01 (eff. Sept. 1, 1994), and now reads:

> It is an affirmative defense to prosecution that, at the time of the conduct charged the actor, as a result of severe mental disease or defect, did not know that his conduct was wrong.

V.T.C.A. Penal Code, § 8.01(a) (2001) ("Insanity").

30. *See* Michael L. Perlin, "Half-Wracked Prejudice Leaped Forth: Sanism, Pretextuality, and Why and How Mental Disability Law Developed as it Did", 10 J. Contemp. Legal Issues 3, 12 Journal of Contemporary Legal Issues 1999 Symposium (describing the M'Naghten Rule as "a formulation that had been seen as outmoded from the time of its first articulation in 1843").

31. Even within the same county, similar situations beget dissimilar verdicts. In Harris county, two delusional mothers who knowingly killed their own children under the influence of delusions with supernatural and religious content received different verdicts. Associated Press, "Woman accused of drownings might use insanity plea," June 25, 2001 (describing the 1998 verdict of not guilty by reason insanity in the beating and strangling capital murder trial of Evonne Rodriguez); "Jury Finds Yates Guilty of Capital Murder" Fox News March 13, 2002 (describing guilty verdict in drowning case, when prosecutors and defense agreed defendant was seriously mentally ill, and actively psychotic at time of killings, but disagreed whether she "knew right from wrong" at the time).

32. "The court, the attorney for the state, or the attorney for the defendant may not inform a juror or a prospective juror of the consequences to the defendant if a verdict of not guilty by reason of insanity is returned." Tex. Code Crim. Proc. Art.46.03 §1(e) (2002).

33. Tex. Code Crim. Proc. Art. 37.07 §4 (mandating jury instruction informing them the effect of parole and good time on sentencing). Note that this legislatively-mandated jury instruction is specifically authorized by Texas' Constitution, Tex. Const. Art. 4 §11 (granting the legislature the power to require juries to be informed about good time and parole), and that the predecessor statute was held an unconstitutional invasion by the legislature of the other two branches of government, Rose v. State, 752 S.W.2d 529 (Tex.Cr.App. 1987). Tex. Code Crim. Proc. Art.46.03 §1(e) (2002) is not authorized by the Constitution, it is arguably as unconstitutional as the statute in *Rose*; however, in the face of the harmless error rule, there is no impediment to its being applied. Because the unconstitutionally mandated jury instruction, which incorrectly stated the law, was held not to warrant remand, *see Rose*, *supra*, one wonders what enforcement mechanism would be needed to ensure district courts actually obeyed a legislative mandate to inform jurors.

34. Samuel R. Gross, "Determining the Neutrality of Death-Qualified Juries: Judicial Appraisal of Empirical Data" 8 Law & Human Behavior 7 (1984).

35. *See* Tex. Code Crim. Proc. Art. 46.02 §4 (2001) (requiring court to empanel a special jury when issue of incompetency is warranted for trial).

36. Tex. Code Crim. Proc. Art. 46.03 §4 (2001) ("Disposition following acquittal by reason of insanity").

CHARGE #3

Examine the costs and benefits of allowing state and local governments to provide health and preventive care without regard to the immigration status of a patient.

LEAD MEMBERS

Rep. Carlos Uresti and Rep. Garnet Coleman

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INTRODUCTION

The committee held a public hearing to address this charge on August 27, 2002. At the hearing, members heard from Dr. Gary McWilliams of the Carelink Program in Bexar county, Paula Gomez of the Brownsville Community Health Center and Dr. Thomas Craven of Brackenridge Hospital in Austin. The witnesses testified on their experiences serving the indigent population, mostly pertaining to the cost difference between providing acute care versus preventive care.

POLICY OPTIONS

Policy Option # 1 The State should grant the authority to local county health departments to determine if they wish to provide preventive care to all county residents.

Policy Option # 2 The State should ensure that health services for children, pregnant women, and the elderly are available.

Policy Option # 3 The State should encourage the U.S. Congress to consider a policy which would access federal matching funds for states to provide health benefits to legal immigrants without a five year waiting period.

BACKGROUND

In August of 1996, Congress changed welfare forever, making drastic reforms in public assistance programs. Sparked by the growing perception that immigrants were increasingly utilizing public benefits, Congress set out to define and limit eligibility.

The Welfare-Reform Act, officially known as the Personal Responsibility and Work Opportunity Reconciliation Act, (PRWORA), placed limitations on the eligibility of immigrants to obtain government benefits. However, since the enactment of PRWORA, very few local governments across the nation have stopped providing non emergency medical care to undocumented residents. In the state of Texas only Tarrant County has decided not to provide certain health services to the undocumented.

Last year Texas Attorney General John Cornyn issued an opinion on this very matter. Asked by the Harris County Hospital district to respond on their proposed hospital policy, the attorney general determined that the policy would violate federal law. Under the welfare reform act, undocumented residents are not eligible for any local or state benefits, with the exception of a few services.

Federal Law

The Personal Responsibility and Work Opportunity Reconciliation Act determines eligibility by whether a non citizen is a "qualified" alien. This group primarily includes registered permanent residents. Others that could qualify include refugees and those who have been granted asylum- such as political and religious asylees. Those fitting into any of these categories become eligible to apply for the following federal benefits: food stamps, SSI and other possible means- tested federal benefits.

However, those non citizens who do not meet the definition of a "qualified" alien are considered a "non qualified" alien. The "undocumented" or illegal immigrant would fall under this category. A non qualified alien is not eligible for any federal public benefits, with exceptions for emergency medical care, immunizations and treatment for symptoms of communicable diseases. The Welfare Reform Act seems to promote the idea that non citizens would be ill fated in relying on public assistance to meet their needs.

Although the act clearly outlines the capacity in which states may or may not administer federal funds, under the act any state may choose to provide state and local benefits to undocumented

immigrants by enacting a law making this a choice. However, there is no language within the act specifying consequences for states who fail to comply with this provision.

The Attorney General's Opinion

On July 10, 2001, Texas Attorney General John Cornyn issued an opinion on Harris County Hospital Districts's potential policy changes. The hospital's new policy manual outlined that county residents would be eligible to receive health care from the district as long as they could pay. Applicants would only be asked to prove residency. The issue of citizenship was never addressed, therefore all county residents who qualified could obtain acute and non-acute health care.

The opinion requested by Harris County Attorney Michael Stafford asked the attorney general to weigh in on the legality of state and federal law and whether violating the law would jeopardize the receipt of state or federal funds. The attorney general concluded that providing non emergency care to the undocumented would violate federal law and possibly hinder the allocation of federal and state funds. However, the opinion emphasized language in the Welfare Reform Act which allows for the expansion of benefits to the undocumented pending the enactment of a state law. As of today most hospital districts continue to provide care to the undocumented, despite the lack of any such law. While state legislators study the issue more closely, public health providers throughout the state must continue to provide care to those in need.

Understandably, much of the debate about access to care centers around cost. Opponents say there is a misconception that emergency room costs are higher than the cost of providing ongoing care. Yet, supporters argue that providing preventive care would keep patients from appearing in emergency rooms with advanced symptoms or progressed stages of disease. Still the indigent population, regardless of their immigration status remain residents of their community and face the challenge of how to meet their healthcare needs.

Most public health workers stress the value of preventive care. Emphasizing that treating all residents would help stop the spread of communicable disease, making the issue about protecting the health of the public. Some even support the idea that the state pay for more than just communicable diseases in order to ensure sufficient safety for all residents. Moreover, others aggressively argue for better availability of non-acute care. Patients suffering from diabetes, high blood pressure or hypertension would be better off receiving ongoing treatment, preventing a patient from ending up in the emergency room with advanced symptoms that could require

expensive care.

Caring for the Undocumented

Testimony provided at the August 27th hearing centered around this very issue. Dr. Gary McWilliams', medical director for the CareLink Program in Bexar county, testified on his experience serving the indigent population. To illustrate a cost comparative between preventive and acute care, Dr. McWilliams' used the example of a hypertension patient. Hypertension which affects one in four adults can cause very difficult problems if left unattended. For CareLink to serve a hypertension patient for one year the cost would fall under $500 dollars. This amount would include an office visit, medicine, an EKG and lab tests. However, if symptoms go untreated illnesses such as stroke, heart attack, kidney failure or blindness could develop.

The cost to treat the average stroke patient is about $6,434. The rehabilitation cost would be around $15, 500. If a patient suffered a heart attack the cost is estimated at $6,766. Treatment of renal failure is estimated at $5,422.

In addition to these costs, individuals who have no other resources would have to stay in the hospital while receiving treatment, straining limited funds with more expenses.

Dr. McWilliams explained that funding for the program comes from property taxes payed by residents of Bexar county, therefore, only residents of the county can qualify for CareLink. While applicants are not asked to answer questions of citizenship, they must be at or below two hundred percent of poverty level and not receiving any other medical assistance in order to be considered.

Once eligible patients are only required to pay for the services they use. The program is set to pay for all but $500 of the total cost. A patient has 48 months to pay their bill, however if they require additional services during that period, Carelink will reassess their file without increasing the $500 maximum payment. Last year the program collected $8 million in funding and continues to strive to serve the needy population.

Federal Legislation

On June 26, the United States Senate Finance Committee approved the Temporary Assistance for Needy Families reauthorization bill (HR 4737). This would allow states to implement new options to provide health care and TANF benefits to legal immigrants using federal matching

funds.

Included in the legislation is an important provision that would allow state and local governments the option to use their own funds to provide subsidized health care to undocumented immigrants without having to pass new legislation.

Also worth noting is the provision permitting states to federally fund Medicaid and CHIP to new legal immigrant pregnant women and children without waiting for the 5-year freeze out.

Although the full Senate was scheduled to vote on this legislation in September, pressing international issues have delayed action until the second session of the 107th Congress.

CONCLUSION

The Welfare Reform Act of 1996 embraced the idea that non citizens should not depend on public resources to meet their health care needs. The act placed limitations on how states could utilize federal funds. While public health care providers want to treat those in need, they must struggle with the lack of funds.

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CHARGE #4

Gather information about the production, distribution, use and disposal of biological agents that could be used in terrorist actions, as well as vaccines that would be used to respond to biological attacks. Review hospital plans for responding to large-scale emergencies. Review government regulations and business practices to determine whether legislation is needed to protect life and property and to detect, interdict and respond to acts of terrorism.

LEAD MEMBER

Rep. Patricia Gray

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INTRODUCTION

The House Committee on Public Health held its first hearing of the interim on this charge in Austin on January 28, 2002. At this hearing the committee took invited testimony from Dr. C.J. Peters of the University of Texas Medical Branch at Galveston, Mary Anne Bobinski of the University of Houston Health Law and Policy Institute, Julia Rathgerber from the Governor's Task Force on Homeland Security, Dr. Dennis Perrotta of the Texas Department of Health, and Jon Hilsabeck from the Texas Hospital Association. These witnesses testified about the various diseases and pathogens that could be used in a bioterrorism event, state and local plans for responding to a bioterrorism event and the differences between a proposed model law on public health emergencies and existing Texas statutes.

POLICY OPTIONS

Policy Option # 1	Review the statutes related to executive powers during a natural disaster or public health emergency and make provisions for extended emergencies and order of succession in the event the Governor is incapacitated.
Policy Option # 2	Provide for the temporary licensing and credentialing of health care providers during a bioterrorism event.
Policy Option # 3	Reexamine the quarantine and isolation procedures set out in statute in light of recent concerns and debate regarding personal freedom and civil liberties.
Policy Option # 4	Consider creating an alternative administrative procedure to the judicial system for notice and due process concerns during a bioterrorism event to avoid any backlog in the courts.
Policy Option # 5	Review funding of the Department of Health's regional epidemiological teams and evaluate their capability to promptly assess and respond o disease outbreaks in human and annual populations.

BACKGROUND

Bioterrorism came to the forefront of the public consciousness following the terrorist attacks on Sept. 11th and the cases of anthrax bacteria being sent through the mail. Most Americans had never imagined that the country was subject to attack of any kind, much less to one from highly contagious, manufactured and purposely dispensed disease pathogens.

Bioterrorism is defined as the overt or covert dispensing of disease pathogens by individuals, groups, or governments for the expressed purpose of causing harm for either ideological, political, or financial gain.[1] And although the cases of anthrax being sent through the mail have received the most media attention, there have been other bioterrorism events in recent years ranging from large-scale events such as the release of Sarin nerve gas in the subways in Tokyo, Japan in 1995 which injured over 5500 people to a case in Texas in 1996 where a lab worker infected 12 co-workers with Shigella dysentariae by tainting breakroom food with samples of the organism taken from lab stock in the freezer.

With bioterrorism as a distinct possibility, federal, state and local governments need to prepare for the possibility of attack. Because of a propensity for natural disaster and a history of responding to disease outbreak in the agricultural arena, Texas has certain plans and procedures for responding to outbreaks in place, but these need to be updated to reflect the modern possibility of responding to manmade disease outbreaks.

Biological Agents That Could Be Used in Terrorist Attacks

Biological weapons are any infectious agent such as a bacteria or virus when used intentionally to inflict harm upon others.[2] This definition is often expanded to include biologically-derived toxins and poisons. Biological warfare agents include both living microorganisms (bacteria, protozoa, rickettsia, viruses, and fungi), and toxins (chemicals) produced by microorganisms, plants, or animals. Some of these agents are highly lethal; others would serve mainly in an incapacitating role. There has also been speculation about the possible terrorist use of new, genetically-engineered agents designed to defeat conventional methods of treatment or to attack specific ethnic groups.

The CDC categorizes biological diseases and agents into different level priorities based on certain criteria and risk factors.

High-priority or Category A agents include: anthrax, botulism, plague, smallpox, tularemia and

viral hemorraghic fevers. These agents are classified as high-priority because they can be easily disseminated or transmitted from person to person; result in high mortality rates and have the potential for major public health impact; might cause public panic and social disruption; and require special action for public health preparedness.

Second highest priority agents, or Category B agents include those that are moderately easy to disseminate; result in moderate morbidity rates and low mortality rates; and require specific enhancements of CDC's diagnostic capacity and enhanced disease surveillance. This category includes diseases and agents such as brucellosis, typhus fever, viral encephalitis, food safety threats and water safety threats.

Finally, third highest priority agents, or Category C agents include emerging infectious disease threats such as Nipah virus and hantavirus and are classified as such because they are emerging pathogens that could be manufactured for mass dissemination because of availability, ease of production and dissemination, and high potential for mass morbidity and mortality rates and a major health impact.

More information about these agents and classification is available at : www.bt.cdc.gov.

State and Local Government Preparedness

The State Emergency Management Plan designates the Texas Department of Health (TDH) as the lead agency in a bioterrorist emergency. As the lead agency, TDH is responsible for detecting and investigating disease outbreaks, communicating with partner agencies, and implementing the emergency management plan.[3] TDH already has procedures in place to respond to disease outbreaks and has responded in the past to natural biological threats such as rabies, salmonella and meningitis. In the past year, however, TDH has been working specifically to improve its preparedness for a bioterrorism event.

In the fall of 2002, TDH requested emergency funding in the amount of $12.1 million for fiscal years 2002-2003. The funding request was granted in the amount of $6.1 million, $2.2 million of which was transferred from another health and human services agency and was spent to fund internal projects such as hiring the regional epidemiology teams and creating the state office of epidemiology. In May of 2002, however, TDH received a federal grant to fund bioterrorism preparedness in the amount of $51.4 million for a project period which ends in August 2003. The federal dollars are now being spent in lieu of state funds to fund all bioterrorism projects at TDH. In the end, only about $850,000 of the original transfer of $2.2 million of state funds was

spent.

To prepare the state for a bioterrorist attack, TDH's main focus is on communication and analysis. Early detection of a disease outbreak depends upon communication between health providers who interact with the public, such as physicians, nurses and lab technicians and the local, regional and state health departments. While early detection about potential outbreaks is largely the responsibility of front-line health providers, TDH must work to educate the provider community about the signs and symptoms of potential biological agents so that providers can be alert for them and provide an accurate diagnosis.

As the state agency designated to respond in the event of a bioterrorism event, TDH has been at the forefront of developing and implementing state response plans. In addition to continuing to bolster communication between providers, local and regional health departments and the state in the event of an attack, TDH has also developed or made improvements in three important areas: regional epidemiology teams, labs, and the Health Alert Network.

There are now regional epidemiological teams in each of the Health Department's eight regions. These teams are composed of three members: an epidemiologist, a public health nurse and a public health technician. These teams are charged with improving disease surveillance, conducting outbreak investigations, and improving the state's capacity to do epidemiology in the field and training.

The state lab network is also improving. New equipment has been purchased for most of the labs. There are nine city health department labs and the central state health office lab that compose the state lab network. TDH is continuing to work to improve and strengthen this network.

The state Health Alert Network (HAN) was established in 1999 to facilitate communication among health organizations. The network uses various methods of communication (faxes, e-mail, etc.) to send out alerts of health threats to local authorities and providers and receive reports back from them. The initial deployment of the HAN began this summer and connected sixty-six local health departments and regional offices. TDH plans to also connect all regional sub-offices as well (usually satellite offices in rural areas) and to add twenty more cities to the network this year.

Hospital Preparedness

Hospitals across the nation will receive a total of $520 million through the Health Resources and Services Administration to improve the capacity to respond to bioterrorist attacks and large-scale epidemics. Texas' share of the $520 million is $8.328 million.

The HRSA funding covers two phases. During Phase 1, the Texas Department of Health conducted an assessment of Texas hospitals to determine their level of preparedness for a bioterrorism event. A comprehensive assessment was performed on 110 hospitals for a sample size of 20 percent of the hospitals in Texas. A more general assessment was performed on the remaining 80 percent of hospitals, with a response from 331 hospitals. Through the assessment, it was determined that hospitals have disaster plans addressing bioterrorism; however, the hospital plans are not well integrated into community/regional plans. Therefore, the primary Texas initiative will be regional planning with the following five priorities: general emergency preparedness; participation in community-wide emergency management preparedness; pharmacy; bioterrorism incident detection; and infection control and decontamination.

Phase 2, currently underway, consists of implementation of regional planning, resulting in improvement in the ability of hospitals to respond to biological events.

The Texas Department of Health has joined forces with hospital associations – including the Texas Hospital Association, Children's Hospital Association of Texas, Dallas-Fort Worth Hospital Council, Greater San Antonio Hospital Council, Texas Association of Public/Nonprofit Hospitals, Texas Association of Voluntary Hospitals, and Texas Organization of Rural and Community Hospitals - to develop a process that will achieve participation of all Texas hospitals in regional planning.

Hospital Regional Planning Process

Texas will be divided into planning regions using the existing 22 Trauma Service Areas (TSAs). During November 2002, the Regional Advisory Councils (RACs) will convene an initial meeting of all hospitals within their TSA to form a Hospital Planning Committee. At the initial meeting, hospitals will organize the planning committee and select an entity to assume the administrative responsibilities involved in regional meetings. In addition, the planning committee will decide the most effective use of the funds currently available for each region. The funds must be used for one of the five priorities identified in the hospital needs assessment. The requests for funds will go to TDH for approval, which will ensure that plans for all regions are consistent and can be rolled up into an integrated Texas plan.

To ensure that all regional plans meet at least minimum standards, TDH has contracted with the Texas Institute for Health Policy Research to develop minimum and "aspirational" standards for regional response plans.

All Texas hospitals had the opportunity to complete either a comprehensive or general needs assessment. A total of 441 hospitals responded, for an overall response rate of approximately 80 percent. This information allows Texas to make data-based decisions for expenditure of federal funds and in developing regional plans. Many other states are just beginning the needs assessment process; some are using the Texas model.

Governor's Task Force on Homeland Security

Governor Rick Perry created the Governor's Task Force on Homeland Security (task force or GTFHS) through executive order last fall. The 18-member task force was charged with assessing the state's readiness for attack and recommending improvements. The task force met a total of three times and issued a report in January. The report and recommendations of the task force are available at www.texashomelandsecurity.org

Government regulations

The heightened awareness of bioterrorism attacks has prompted state legislatures to review existing state statutes related to disaster management and preparedness for public health emergencies. The Center for Law and the Public's Health, a CDC collaborating center sponsored by Georgetown and Johns Hopkins University, developed a Model State Emergency Health Powers Act (MSEHPA or model act) for states to use in examining and developing state powers used to respond to emergencies. Based on an examination of existing Texas state statutes and a comparison to the MSEHPA done by the University of Houston Health Law Institute, there may be some areas that Texas legislators will want to consider next session. Many other states have examined their emergency powers and considered adoption of the MSEHPA. (see Appendices XX (NCSL and Center report).

Definitions

Most of the relevant Texas law which would apply to a bioterrorist event is found in the Texas Disaster Act (Tex. Gov't Code Ann. §§ 418.001- 418.175) and the Communicable Disease Prevention and Control Act (Tex. Health and Safety Code Ann. §§ 81.001-92.009). General provisions which are in effect at all times and relate to emergency planning and disease surveillance are found in both acts. Special provisions relating to extraordinary powers such as

evacuation and quarantine are also found in each act. The triggering event for these special powers and how this event is defined is an important analysis and consideration for lawmakers. The model act defines a "public health emergency", the declaration of which gives rise to special powers in the governor and the public health authority.[4]

A public health emergency is:
"An occurrence of imminent threat of an illness or health condition that: [I]s believed to be caused by any of the following :bioterrorism; a novel or previously controlled or eradicated infectious agent or biological toxin; [a natural disaster]; a [chemical attack or accidental release]; or [a nuclear attack or accident; and [p]oses a high probability of any of the following harms: a large number of deaths in the affected population; a large number of serious or long-term disabilities in the affected population; or widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of people in the affected population."[5]

The Texas Disaster Act defines "disaster" as:
"[T]he occurrence or imminent threat of widespread or sever damage, injury, or loss of life or property resulting from any natural or man-made cause, including fire, flood, earthquake, wind, storm, wave action, oil spill or other water contamination, volcanic activity, epidemic, air contamination, blight, drought, infestation, explosion, riot, hostile military or paramilitary action, other public calamity requiring emergency action, or energy emergency.[6]

Although the Texas language is broad, lawmakers may want to consider making it more specific to cover bioterrorism or specifically define the term "epidemic". The definition of "public health emergency" in the model act may be instructive.

Executive Powers

One major issue that the legislature will have to debate will be the amount of power they choose to vest in the governor during a public health emergency. Existing Texas statutes already vest a significant amount of power in this office. However, Texas legislators may want to review these statutes given the very real possibility of such an event and a traditional reluctance to divest itself of authority in favor of the executive branch. The Texas Constitution, like many other constitutions of southern states, sets forth only limited powers for the governor and the executive branch, entrusting more of the power in the legislature. The Texas legislature and Texas voters have been reluctant to change this allocation of power. In a state of disaster or public health emergency, however, the governor will be able to assume tremendous authority without

oversight from the legislature. The next legislature may want to ensure appropriate checks and balances are in place, even in extraordinary situations.

For the process of declaring and terminating a public health emergency, Texas statutes already contain remarkably similar provisions to the model act under the Emergency Management chapter of the Government Code (Chapter 418). Both the model act and current Texas law contemplate that the governor declares a state of public health emergency ("state of disaster" in Texas law). Texas law allows the governor to declare a "state of disaster" by executive order "if the governor finds a disaster has occurred or that the occurrence or threat of disaster is imminent."[7] Texas law also allows the governor to suspend any regulatory statute or agency rule if compliance with such statute or rule would hinder disaster response.[8] The governor also becomes the commander-in-chief of all state agencies, boards and commissions having emergency responsibilities. [9]

A question remains, however, as to who Texas wants to have this power in the event of incapacitation of the current governor. Texas law does have an "Emergency Interim Executive Succession Act"[10] which provides for an order of succession in the event the governor is unavailable to perform the duties of office. The statute follows the order of succession set out in the Texas constitution which provides that next in succession are the lieutenant governor and the president pro tempore of the senate,[11] and adds to the order the speaker of the house, the attorney general, and then the chief justices of the courts of appeals by numerical order of their judicial districts.[12]

Termination of the state of public health emergency or disaster is also similar in both the model act and Texas statutes. Termination is at the discretion of the governor - the state of disaster may only continue for 30 days, but the governor may renew it. While the legislature may terminate the state of disaster in both the model act and Texas law, this provision would be more difficult in Texas because the legislature only meets for one hundred and forty days every two years. The Texas legislature could meet in special session to terminate the state of disaster, but only the governor could call the legislature to a special session.[13] Texas has never faced a prolonged disaster or public health emergency, so the legislature has never been faced with the issue of termination and renewal before.

Special Powers: Protection of Persons and Property

Another area that Texas legislators will need to address next session is the protection of persons and property. Both the model act and Texas law allow the control of ingress and egress to and

from a disaster area and within the afflicted area.[14] While Texas law gives the governor the power to prescribe routes and modes of transportation, it does not give him the power to order an evacuation, only to recommend one.

In the event of a public health emergency, Texas law allows for mandatory treatment if there is reasonable cause to believe an individual has been exposed to or is carrier of a communicable disease, whereas the model act only allows for quarantine or isolation of any individuals who refuse medical treatment.[15] There is an exemption from medical treatment for religious reasons under Texas law, but this exemption is not recognized in a state of emergency.[16] The public health entities will have to seek a court order to vaccinate or treat individuals who do not comply, so individuals are provided some procedural protections. However, the courts could be easily overwhelmed by these measures during a disease outbreak. The model act allows for this possibility by calling for training of personnel to serve as emergency judges.[17] The questions of mandatory vaccination and/or treatment or isolation and quarantine and how to provide procedural protections without overwhelming the court system will have to be addressed next session. Additionally, another challenging issue that neither existing Texas law nor the model act address is the issue of whether or not people have the right to refuse experimental medical treatment.

Both the model act and Texas statutes have provisions pertaining to the control and use of property during a public health emergency. While the model act authorizes a public health authority to take over private property such as a health facility or to impose rations on medical supplies.[18] Texas law does not give this power to a public health authority, but reserves it for the governor, allowing that office to seize property, if necessary, subject to compensation requirements and to reallocate resources.[19] As to control of property, both the model act and Texas law grant the public health authority powers for the closure, quarantine or decontamination of private property. Texas law, however, requires the authority to give notice of the action and then seek judicial order if the owner of the property refuses.[20] While this provides private property owners a measure of protection, it may also result in a disruption of the court system.

CONCLUSION

The heightened awareness around our state and country of the potential for a bioterrorist event has made our constituents much more focused on the very real possibility of such an event affecting their lives. When past Texas legislatures considered the measures for mandatory

treatment and quarantine, probably few of their constituents gave these measures much thought since the possibility of these laws being triggered was so remote. Next session, however, their focus and expectations will be much more intense and the need for appropriate response and disaster readiness will be real.

ENDNOTES

1. www.tdh.state.tx.us/bioterrorism/default.htm
2. www.tdh.state.tx.us/bioterrorism/default.htm
3. Tex. Gov't Code Ann. Chapter 418.
4. MSEHPA § 104.
5. MSEHPA § 104.
6. Tex. Gov't Code Ann. 418.004(1).
7. Tex. Gov't Code Ann. §418.014(a)
8. Tex. Gov't Code Ann. §418.016
9. Tex. Gov't Code Ann. §418.015
10. see Tex. Gov't Code Ann. Ch. 401.20 et seq.
11. Tex Const. Art. IV, Sec. 3a and Sec. 16
12. Tex. Gov't Code Ann. §401.023
13. Tex Const. Art. IV, Sec. 8
14. Tex. Gov't Code Ann. §418.018 and MSEHPA § 502(d)
15. Tex. Health & Safety Code Ann. §81.083; MSEHPA § 602
16. Tex. Health & Safety Code Ann. § 81.009
17. MSEHPA § 202 (a)(5)
18. MSEHPA § 502
19. Tex. Gov't Code Ann. §418.017
20. Tex. Health & Safety Code Ann. § 81.084

CHARGE #5

Study the use of complementary and alternative medicines in Texas. Assess the need for the state to develop regulatory framework for their use.

LEAD MEMBER

Rep. Bob Glaze

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INTRODUCTION

The committee held a public hearing on May 28, 2002 in Austin to discuss this charge. At the hearing the committee took invited testimony form Dr. Joe D. Goldstich of the Osteopathic Medical Center in Des Moines, Iowa, Dr. Don Warren from the White House Commission on Complementary and Alternative Medicine Policy, Dr. Stephen Tomasovic of the University of Texas M.D. Anderson Cancer Center in Houston and D. Patrick Six from Cadenhead and Shreffler Insurance in Dallas. The witnesses testified to the growing use of alternative medicine and how the state might deal with regulatory issues.

POLICY OPTION

Policy Option # 1	The Governor should create a task force to continue the study of complimentary and alternative medicines. Specifically, if and how these specialties can be incorporated into existing licensing and regulatory statutes. The task force should be made up of Senate and House members, practitioners from complimentary and alternative medicine fields, and interested parties.

BACKGROUND

Before 1991, complementary and alternative medicine (CAM) had never been addressed within Federal programs. Today, researchers estimate over fifty percent of Americans use some form of alternative medicine. The growing use of treatments such as acupuncture, hypnosis and herbs has caused state legislatures to study this issue more closely.

The ability to determine the safe remedies from the unsafe and the effective from the ineffective has become essential in this debate. Mainstream proponents of alternative medicine want validation for their specialities, thereby embracing the idea of regulation, while other advocates of CAM would prefer that the government stay out of the way. Yet, federal and state lawmakers contest they have a responsibility to protect the rights of patients and ensure their safety.

Research conducted in Texas show that a majority of cancer patients will include alternative medicine in their treatment. Some individuals explain their dissatisfaction with traditional medicine, while researchers say most turn to CAM therapies because of their personal philosophical views.

Many physicians have voiced their concerns about the rise in patients using non-conventional methods of treatment and then not sharing this with their doctor. Arguing this could cause more harm than good. This raises the question of whether, Should alternative therapies be subject to licensing and regulatory issues?

CAM Comes Into the National Spotlight

In the summer of 1991, Congress requested that the National Institute of Health (NIH) establish the Office of Alternative Medicine within their director's office. Congress wanted NIH to devise a method that could "fully test the most promising unconventional medical practices". The creation of this office would lay the ground work for future funding of CAM research.

At the time, a study coming out of Harvard University found that over thirty percent of Americans said they were using alternative medicine. By the late 1990's the same researchers reported that number had grown to over forty percent. This information sparked more interest by Congress to learn all they could.

To show a sign of commitment, the report from the 1992 Senate Subcommittee on Appropriations read,

> "To further assist the new effort , the Committee has included language giving the

NIH Director authority to authorize the use of non-FDA approved medications and procedures for the purpose of research provided the has provided informed consent."

By 1997, the Office of Alternative Medicine had become a Center for Complementary and Alternative Medicine. The Center would serve as a place for study of appropriate integration of CAM medicine with traditional practices. Methods would be based on evidence supported by strict scientific review. Moreover, the Center would establish and uphold a comprehensive bibliographic system of complementary and alternative medicine.

More impressive was Congress's commitment to CAM through funding of both offices.

Office of Alternative Medicine

- FY 1992: $2.0 million
- FY 1993: $2.0
- FY 1994: $3.4
- FY 1995: $5.4
- FY 1996: $7.7
- FY 1997: $12.0
- FY 1998: $19.5

National Center for Complementary and Alternative Medicine

- FY 1999: $50.0 million
- FY 2000: $68.7
- FY 2001: $89.2
- FY 2002: $104.6

Estimates of the President's Budget for 2003 expect funding to increase to $113.2 million. Congress also appropriated funds to establish a White House Commission on Complementary and Alternative Medicine Policy.

The White House Commission

In March of 2000 the White House Commission on Complementary and Alternative Medicine Policy (the Commission) was formed. Pursuant to an executive order, a twenty member panel was appointed by President Clinton to provide legislative and administrative recommendations on the potential benefits of complementary and alternative medicine to all citizens.

The Commission members held town hall meetings, invited expert testimony and visited a number of sites in order to gain first hand knowledge of how some medical institutions are incorporating CAM into their conventional practice. In March of 2002, the Commission released their findings to Health and Human Services Secretary Tommy Thompson. A complete version of the report can be found on the internet at http://www.whccamp.hhs.gove/es.html.

One important point made in the Commission's recommendations notes "the lack of an appropriate definition of complementary and alternative medicine". The diversified education, training and qualifications of alternative practitioners proved difficult when trying to clearly define recommendations.

The National Center for Complementary and Alternative Medicine explains that these two terms are different. They define complementary medicine as a method used in connection with conventional medicine. An example of this is aroma therapy.

Recommendations by the Commission include:

- Education and Training of Health Care Practitioners
- Support fo CAM Programs, Faculty and Students
- Additional Education and Training of CAM
- Promoting Accurate, Easily Accessible Information
- Ensuring the Safety of CAM Products

However, other recommendations are controversial. For instance, the idea to increase health care coverage for alternative services has caused some dissent with Commission members. One option suggested that Medicare as well as other medical assistance programs pay for safe and effective alternative treatments. The Commission advised that the Department of Health and Human Services create work groups and conferences to determine the most suitable methods to fund.

Another recommendation called for DHHS to start a nation wide campaign to teach school children the benefits of nutrition, exercise and ways to manage their stress, allowing the use of safe and effective alternative medicine practices.

These controversies caused two members of the panel to submit a minority report to Secretary Thompson. They reported claims that many of the recommendations were not backed by science, but based on encouragement for CAM therapies.

Yet, the Commission also recommends that the president create a federal office to be in charge of coordinating CAM activities and practices. The office should include members from both the private and public sectors as well as alternative and conventional practitioners. The Commission stressed that states should follow this lead and establish their own offices.

An Alternative Curriculum

According to the Journal of the American Medicine Association, 75 of the 125 medical schools in the country provide some type of instruction in alternative medicine. Since most programs are limited only to a few courses, many believe a change must be made in order to keep up with student and patient interest. However, some schools face great resistance by faculty to incorporate new material, arguing they already have too much to teach.

In Texas a new curriculum was introduced at the University of Texas Medical Branch at Galveston. Two faculty members have played key roles in the integration of this curriculum. Dr. George Bernier, former vice president for education, who also served on the White House Commission has helped to shape the core curriculum. Vic Sierpina, associate professor of the university's Department of Family Medicine, co-created the university's alternative medicine website and has now become the leader for implementing these new courses.

In the October 2001 edition of UTMB Monthly, Dr. Bernier stated that," To truly understand how alternative medicine can help or hinder traditional medicine doctors need to incorporate learning about it throughout their training." In that same month the National Institute of Health's National Center for Complementary and Alternative Medicine awarded a $1.5 million grant for the university's medical school curriculum. NIH hopes that the school will serve as a model for medical schools across the nation.

The program is expected to take up to five years to implement. In addition to nurses, doctors, students and patients the university has also enlisted many alternative care practitioners to lend their knowledge. Professor Sierpina states, "This will help our students to think critically and scientifically about alternative therapies so they can better advise their patients."

This curriculum seems to have come at an appropriate time. In April of 2002, the Federation of State Medical Boards approved a "Model Guideline for the use of Complementary and Alternative Therapies in Medical Practice". The Model outlined seven recommendations. One guideline reads, "patients have the right to choose any kind of health care for their problems." The guideline goes on to read that a "physician may offer the patient a conventional and/or CAM treatment" as long as the therapy being recommended is provided by a licensed or state-regulated health care practitioner. Even though the Federation made it clear that state boards could adopt, modify or ignore these guidelines, the evidence clearly shows that the use of CAM therapies is on the rise, suggesting that doctors must learn about these new treatments or risk the lose of patients.

Alternative Medicine and Cancer

Much of the discussion about CAM has focused on the use of these remedies by cancer patients. In 1998, Congressman Dan Burton lead the Committee on Government Reform in an inquiry into the role of complementary and alternative medicine in the U.S. health care system. The committee found that many Americans with cancer were indeed turning to CAM.

The committee heard from a number of families who shared their feelings of dissatisfaction with conventional treatment. Families who had children with brain tumors testified to a clear difference in how researchers define "success" versus what many parents think is success. They learned that researchers many times defined the "success" of a therapy by as little as a thirty percent reduction of tumor size. Several research papers claimed success of a treatment even though many patients had in fact died from the illness or suffered irreversible effects.

At the committee's May hearing, members heard testimony from Dr. Stephen Tomasovic, Vice President for Educational Programs, at the University of Texas MD Anderson Cancer Center. Dr. Tomasovic explained how the cancer center has integrated complementary and alternative medicine into their treatment regimens. In 1998 the center opened a complementary therapy facility on their campus. The facility offers 75 complementary therapy programs to patients, families and care givers free of charge. Referred to as the Place of Wellness, patients can partake in yoga sessions, hear lectures on CAM therapies and receive daily counseling.

The Center also seeks to teach their physicians by offering different professional education programs aimed at major complementary or alternative medicine approaches. They hope this information will enable doctors to understand which approaches may be harmful if used alone or combined with other therapies.

CONCLUSION

Much research was done during the two year study by the White House Commission. Their findings and recommendations are helpful resources for states to utilize. As complementary and alternative medicines become increasing prevalent, legislators, practitioners and patients will benefit from coming together and finding a common ground.

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CHARGE #6

Assess the procedures of health related licensing agencies regarding the intake of complaints, investigation procedures and timetable, and enforcement of laws and rules. Comment on any factors involving the use or abuse of patient information by healthcare agencies or institutions.

LEAD MEMBERS

Rep. Jaime Capelo and Rep. Glen Maxey

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INTRODUCTION

On September 24, 2002 the committee held a public hearing to address the complaint procedures of health care licensing board. The committee invited representatives from selected health licensing agencies to give testimony about complaint procedures. The committee developed a survey consisting of six questions about complaint procedures and sent out a copy to each individual agency. These questions focused the witnesses' testimony on the issues the committee deemed most pertinent.

The questioning and testimony focused on the number of complaints received, the nature of those complaints, intake procedure, timetable for processing complaints and consumer access to information. In addition, the committee members inquired as to whether each agency's complaint process is based on state regulation or agency policy or interpretation.

Various health related licensing agencies gave testimony. The individuals giving testimony on behalf of the agencies were Patrick Waldron with the Texas Department of Health; Katherine Thomas with the Health Professions Council and Board of Nursing Examiners; Ron Philo with the Anatomical Board of The State of Texas; Lisa McGiffert with Consumers Union; Donald Patrick with the Texas State Board of Medical Examiners; Gay Dodson with the Texas State Board of Pharmacy; Dr. James Bolton with the State Board of Dental Examiners; Sherry Lee with the State Board of Examiners of Psychologist; Allen Hymans with the State Board of Podiatric Medical Examiners; Chris Kloeris with the Texas Optometry Board; Bobby Schmidt with the State Committee of Examiners in the Fitting and Dispensing of Hearing Instruments; Terrie Hairston with the Texas Board of Vocational Nurses and John Maline with the Texas Board of Occupational and Physical Therapy.

Based of the testimony and survey responses the committee was able to identify areas in each agency's complaint process in need of improvement.

SURVEY QUESTIONS AND RESPONSES

Question 1. How Many complaints were received this year? How many complaints have been received in the last five years?

Table 1.A Number of Complaints Received

Number of Complaints Received	1997	1998	1999	2000	2001	2002	Totals
Texas Department of Health	1957	2052	2262	1713	1704	1561	11249
Board of Nurse Examiners	2334	1685	2229	2424	2062	1658	12392
Anatomical Board	-	-	-	-	-	2	2
Board of Medical Examiners	-	1264	1158	1458	1365	1725	6970
Texas Board of Pharmacy	1736	1314	1533	1577	1683	1800	9643
State Board of Dental Examiners	512	477	468	617	659	793	3526
State Board of Examiners of Psychologists	-	205	194	171	154	191	915
State Board of Podiatric Medical Examiners	-	112	77	105	138	110	542
Texas Optometry Board	-	151	119	116	84	162	632
Fitting and Dispensing	-	25	29	63	77	86	280
Board of Vocational Nurses	-	1546	1400	1194	1153	1328	6621
Board of Occupational and Physical Therapy	OT -	68	35	68	69	64	304
	PT -	172	246	177	169	184	948

- = No Data

OT = Occupational Therapy

PT = Physical Therapy

Please Provide a breakdown of how each complaint was resolved?

Table 1.B 1997 Complaints Resolved

TEXAS HEALTH LICENSING AGENCIES	TDH	BNE	AB	BME	TBP	SBDE	SBEP	SBPME	TO	FD	BVN	BOPT
License Revocation	-	38	-	-	-	-	-	-	-	-	-	-
License Suspension		1	-	-	-	1	-	-	-	-	-	-
License Restriction	-	0	-	-	-	-	-	-	-	-	-	-
Informal Conference	-	260	-	-	-	-	-	-	-	-	-	-
Reprimand	-	4	-	-	-	4	-	-	-	-	-	-
Administrative Penalty	4	-	-	-	-	-	-	-	-	-	-	-
Rehabilitation Order	-	-	-	-	-	-	-	-	-	-	-	-
Dismissal	-	-	-	-	-	-	-	-	-	-	-	-
Withdrawn by Complainant	-	-	-	-	-	-	-	-	-	-	-	-
Substantiated	355	-	-	-	-	-	-	-	-	-	-	-
Unsubstantiated	724	-	-	-	-	-	-	-	-	-	-	-
Warning	-	11	-	-	-	-	-	-	-	-	-	-
Voluntary Surrender	-	-	-	-	-	-	-	-	-	-	-	-
Fine	-	139	-	-	-	-	-	--	-	-	-	-
Letters	-	-	-	-	-	-	-	-	-	-	-	-
Investigations	-	-	-	-	-	-	-	-	-	-	-	-
No Action	-	-	-	-	--	-	-	-	-	-	-	-
Probation	-	1	-	-	-	16	-	-	-	-	-	-
Texas Peer Assistance Program for Nurses	-	n/a	-	-	-	-	-	-	-	-	-	-

Table 1.B 1998 Complaints Resolved

TEXAS HEALTH LICENSING AGENCIES	TDH	BNE	AB	BME	TBP	SBDE	SBEP	SBPME	TO	FD	BVN	BOPT	
License Revocation	-	66	-	18	-	2	1	-	-	-	-	o-	p1
License Suspension	-	1	-	8	-	-	-	-	-	-	-	4	12
License Restriction	-	-	-	99	-	-	-	-	-	-	-	-	-
Informal Conference	-	278	-	-	-	-	-	-	-	-	-	-	
Reprimand	-	2	-	27	-	6	3	-	-	-	-	-	
Administrative Penalty	5	-	-	22	-	-	5	-	-	-	-	-	
Rehabilitation Order	-	-	-	21	-	-	-	-	-	-	-	-	
Dismissal	-	-	-	1313	-	-	154	-	-	-	-	-	
Withdrawn by Complainant	-	-	-	-	-	-	-	-	-	-	-	-	
Substantiated	272	-	-	-	-	-	-	-	-	-	-	-	
Unsubstantiated	614	-	-	-	-	-	-	-	-	5	-	-	
Warning	-	1	-	-	-	-	-	-	-	-	-	-	
Voluntary Surrender	-	-	-	-	-	-	11	-	-	-	-	-	
Fine	-	42	-	-	-	-	-	-	-	-	-	-	
Letters	-	-	-	-	-	-	-	-	-	5	-	-	
Investigations	-	-	-	-	-	-	-	-	-	-	-	-	
No Action	-	-	-	-	-	-	-	-	151	-	-	-	
Probation	-	0	-	-	-	21	1	-	-	-	-	-	
Texas Peer Assistance Program for Nurses	-	N/A	-	-	-	-	-	-	-	-	-	-	

Table 1.B 1999 Complaints Resolved

TEXAS HEALTH LICENSING AGENCIES	TDH	BNE	AB	BME	TBP	SBDE	SBEP	SBPME	TO	FD	BVN	BOPT	
License Revocation	-	49	-	6	-	1	3	-	-	-	-	o-	p-
License Suspension	-	1	-	17	-	1	-	-	-	-	-	3	12
License Restriction	-	-	-	71	-	-	-	-	-	-	-	-	
Informal Conference	-	273	-	-	-	-	-	-	-	-	-	-	
Reprimand	-	3	-	13	-	3	1	-	-	-	-	-	
Administrative Penalty	9	-	-	15	-	6	16	-	-	-	-	-	
Rehabilitation Order	-	-	-	26	-	-	-	-	-	-	-	-	
Dismissal	-	-	-	1038	-	-	141	-	-	-	-	-	
Withdrawn by Complainant	-	-	-	-	-	-	-	-	-	4	-	--	
Substantiated	325	-	-	-	-	-	-	-	-	-	-	--	
Unsubstantiated	786	-	-	-	-	-	-	-	-	5	-	--	
Warning	-	3	-	-	-	-	-	-	-	-	-	--	
Voluntary Surrender	-	-	-	-	-	2	11	-	-	-	-	--	
Fine	-	11	-	-	-	-	-	-	-	-	-	o-	p1
Letters		-	-	-	-	-	-	-	-	3	-	--	
Investigations	-	-	-	-	-	-	-	-	-	-	-	--	
No Action	-	-	-	-	-	-	-	-	118	-	-	--	
Probation	-	0	-	-	-	11	-	-	-	-	-	--	
Texas Peer Assistance Program for Nurses	-	59	-	-	-	-	-	-	-	-	-	--	

Table 1.B 2000 Complaints Resolved

TEXAS HEALTH LICENSING AGENCIES	TDH	BNE	AB	BME	TBP	SBDE	SBEP	SBPME	TO	FD	BVN	BOPT	
License Revocation	1	70	-	20	-	2	4	-	-	3	-	o 1	p -
License Suspension	-	2	-	24	-	2	2	-	-	1	-	8	28
License Restriction	-	-	-	45	-	-	-	-	-	-	-	--	
Informal Conference	-	247	-	-	-	-	-	-	-	-	-	--	
Reprimand	-	0	-	16	-	5	3	-	-	-	-	--	
Administrative Penalty	7	-	-	10	-	4	10	-	-	2	-	--	
Rehabilitation Order	-	-	-	32	-	-	-	--	-	-	-	--	
Dismissal	-	-	-	1095	-	-	172	-	-	-	-	--	
Withdrawn by Complainant	-	-	-	-	-	-	-	-	-	5	-	---	
Substantiated	360	-	-	-	-	-	-	-	-	-	-	--	
Unsubstantiated	683	-	-	-	-	-	-	-	-	9	-	--	
Warning	-	6	-	-	-	-	-	-	-	-	-	--	
Voluntary Surrender	-	-	-	-	-	2	9	-	-	-	-	--	
Fine	-	55	-	-	-	-	-	-	-	-	-	1	2
Letters	-	-	-	-	-	-	-	-	-	2	-	--	
Investigations	-	-	-	-	-	-	-	-	-	-	-	--	
No Action	-	-	-	-	-	-	-	-	115	-	-	--	
Probation	-	0	-	-	14	-	-	-	-	1	-	--	
Texas Peer Assistance Program for Nurses	-	47	--	-	-	-	-	-	-	-	-	--	

Table 1.B 2001 Complaints Resolved

TEXAS HEALTH LICENSING AGENCIES	TDH	BNE	AB	BME	TBP	SBDE	SBEP	SBPME	TO	FD	BVN	BOPT	
License Revocation	1	85	-	13	9	3	1	-	-	-	-	o 1	p -
License Suspension	-	13	-	13	42	-	-	-	-	-	-	12	28
License Restriction	-	-	-	49	3	-	-	-	-	-	-	--	
Informal Conference	-	267	-	-	-	-	-	-	-	-	-	--	
Reprimand	-	0	-	17	-	3	7	-	-	-	-	2	-
Administrative Penalty	4	-	-	19	-	-	30	-	-	-	-	--	
Rehabilitation Order	-	-	-	23	-	-	-	-	-	-	-	--	
Dismissal	-	-	-	973	-	-	118	-	-	-	-	--	
Withdrawn by Complainant	-	-	-	-	-	-	-	-	-	4	-	--	
Substantiated	374	-	-	-	-	-	-	-	-	-	-	--	
Unsubstantiated	823	-	-	-	-	-	-	-	-	12	-	--	
Warning	-	3	-	-	-	2	-	-	-	-	-	--	
Voluntary Surrender	-	-	-	-	-	3	6	-	-	-	-	--	
Fine	-	33	-	-	-	-	-	-	-	-	-	1	-
Letters	-	-	-	-	57	-	-	-	-	2	-	--	
Investigations	-	-	-	-	59	-	-	-	-	-	-	--	
No Action	-	-	-	-	115	-	-	-	83	-	-	--	
Probation	-	0	-	-	-	-	-	-	-	-	-	--	
Texas Peer Assistance Program for Nurses	-	89	-	-	-	-	-	-	-	-	-	--	

Table 1.B 2002 Complaints Resolved

TEXAS HEALTH LICENSING AGENCIES	TDH	BNE	AB	BME	TBP	SBDE	SBEP	SBPME	TO	FD	BVN	BOPT	
License Revocation	-	52	-	28	23	0	-	-	-	2	278	o -	p 1
License Suspension	-	1	-	23	50	6	-	-	-	-	24	3	20
License Restriction	-	-	-	66	14	-	-	-	-	-	-	--	
Informal Conference	-	203	-	-	-	-	-	-	-	-	-	--	
Reprimand	-	8	-	19	-	36	3	-	-	-	12	--	
Administrative Penalty	1	-	-	43	-	-	1	-	-	3	-	--	
Rehabilitation Order	-	-	-	23	-	-	-	-	-	-	-	--	
Dismissal	-	-	-	1567	-	-	172	-	-	-	-	-	
Withdrawn by Complainant	-	-	-	-	-	-	-	-	-	15	-	--	
Substantiated	247	-	-	-	-	-	-	-	-	-	-	--	
Unsubstantiated	722	-	-	-	-	-	-	-	-	10	-	--	
Warning	-	25	-	-	-	19	-	-	-	-	210	--	
Voluntary Surrender	-	-	-	-	-	2	10	-	-	-	-	--	
Fine	-	84	-	-	-	-	-	-	-	-	35	--	
Letters	-	-	-	-	-	-	-	-	-	3	-	--	
Investigations	-	-	-	-	-	-	-	-	-	-	-	--	
No Action	-	-	-	-	-	-	-	-	131	-	171	--	
Probation	-	0	-	-	-	26	-	-	-	-	39	--	
Texas Peer Assistance Program for Nurses	-	52	-	-	-	-	-	-	-	-	-	--	

Table 2.A Nature of Complaints Received

AGENCY	NATURE OF COMPLAINTS RECEIVED
Texas Department of Health	Complaints are generally related to the care and services a patient receives at a facility, such as a hospital or psychiatric hospital, or allegations regarding the abrogation of a patient's rights.
Board of Nurse Examiners	Unprofessional conduct/failure to meet minimum standards make up about 50 percent. Drug use, intemperate use, mental illness or lack of fitness make up 40 percent. Criminal convictions, continuing education noncompliance, or action in other states. [1]
Anatomical Board	Both complaints were regarding lack of, or late, receipt of cremains of donated relatives. Each complaint is addressed as it is received.
Board of Medical Examiners	The majority of the complaints received involve quality of care. The other complaints involve intemperate use, unprofessional conduct, and other general actions.
Texas Board of Pharmacy	Complaints received fell into the following categories: Diversion 2%, Convictions 6%, Dispensing Error 19%, Patient Counseling 1%, Theft/Loss 25%, Action by other board 3%, substitution 2%, non-compliance with disciplinary order 3%, Impairment 2%, Falsified application 1%, Changed Prescription 2%, Non - Therapeutic Dispensing 1%, recording Keeping Error 2%, advertising 1%, Billing Dispute 3%, Customer Service 4%, CE Audit 1%, Other Allegations 8%.
State Board of Dental Examiners	The complaints included many allegations of administration, business promotion, dental laboratories, sanitation, and patient morbidity. The majority the complaints were violations of professional conduct and quality of care.
State Board of Examiners of Psychologists	The nature of the Boards complaints are as follows: 35% Continuing Education violations, 35% General practice violations, 20% Child custody evaluation violations, 5% Sex misconduct and 5% School psychology.

[1]The BNE indicates these are rough estimates and are not specifically tracked as performance measures in the agency's data base.

State Board of Podiatric Medical Examiners	Complaints included high fees, refusal to provide patient records, perceived issues of the doctor being rude or not timely in keeping office appointments, Medicaid/Medicare/insurance fraud, physician impairment or misdirection of drugs, neglect, violation of health/safety rules and laws, inappropriate behavior, sexual misconduct, wrongful injury and ultimately patient death.
Texas Optometry Board	The nature of the complaints involved violations of optometry act, control of optometry, advertising, practice without a license and criminal convictions.
Fitting and Dispensing of Hearing Instruments	Complaints included purchasers not receiving a refund for purchased hearing instruments within 30 days of request; purchasers not receiving a 30-day trial period ; not printing required information in an advertisement; and practicing without a license.
Board of Vocational Nurses	The nature of complaints involved criminal convictions of licensees, continuing education violations, negligence/abuse, probation violations, and drug-related or alcohol-related violations.
Board of Occupational and Physical Therapy	*Occupational Therapist* - the nature of complaints included unregistered facility, practicing with an expired license, fraudulent billing, improper supervision, practicing without a license, patient injury/abandonment, felony conviction, detrimental practice, practicing beyond scope, improper documentation, fraudulent advertising, and non-response to continuing education audit letter.
	Physical Therapist - the nature of complaints included continuing education audit failures, unregistered facility, patient injury/abandonment, practicing with expired license, fraudulent billing, improper supervision, practicing without a license, patient injury/abandonment, felony/drug conviction, detrimental practice, practicing beyond scope/order, improper documentation/evaluation, fraudulent advertising non-licensee, failure to register facility, forgery of license and discovering actions in another state.

Table 2.B Ranking of Complaints

AGENCY	HOW COMPLAINTS ARE RANKED AND TREATED
Texas Department of Health	Some complaints are ranked as more severe that others, and there are some complaints that the department asks the facility to self investigate, especially billing issues. Claims are investigated according to the following guidelines: 2 days-negligent deaths, natural disasters; 5 days- transfer violations; 10 days-serious physical injury; negligent harm in a facility; 14 days-current inpatient a victim of abuse/neglect/exploitation in the facility; 45 days-substandard patient care; 60 days-discharge patient a victim of abuse/neglect/exploitation while in facility; 180 days - general complaints, billing, minor regulatory infractions, self-investigates.
Board of Nurse Examiners	Complaints are assigned a priority status: Priority 1 - those indicating credible evidence exists showing a violation involving actual deception fraud or injury to clients or to the public or a high probability of immediate deception, fraud or injury to clients or the public.
Anatomical Board	Each complaint is addressed as it is received.
Board of Medical Examiners	All investigations must be completed within 125 days. If information indicates that the continued practice of the subject may constitute an imminent threat to the public health the case will be handled as a Priority 1 and will be completed within 6 weeks.
Texas Board of Pharmacy	The more serious complaints result is disciplinary action, if sufficient evidence is obtained to prove that the licensees violated the laws and rules governing the practice of pharmacy. The less serious complaints may closed with a dismissal letter or verbal admonition, if sufficient evidence is obtained.
State Board of Dental Examiners	The complaints are ranked as follows: • Priority 1 - Represents more serious allegations of violations, including patient death, patient injury, practicing without a license, and unsanitary conditions. • Priority 2 - Represents less serious threats to the public welfare, including records-keeping and advertising violations.

State Board of Examiners of Psychologists	By Board rule, complaints are ranked as follows: • Priority 1 - Complaints involving imminent personal harm to the public. • Priority 2 - Complaints involving sexual misconduct on the part of the licensee. • Priority 3 - Complaints involving current applicants for licensure. • Priority 4 - Complaints involving other administrative violations of Board rules or act. Complaints with Priority 1 and 2 are investigated immediately and upon determination of probable cause, they are set for the next informal settlement conferences.
State Board of Podiatric Medical Examiners	Cases are reviewed at intake and those determined to be serious, as determined by the facts provided and the nature of the allegation may be assigned a high priority status.
Texas Optometry Board	Complaints constituting an immediate threat to public health are given priority.
Fitting and Dispensing of Hearing Instruments	The board does consider some complaints to be of a more serious nature. Proposed new rules were published in the Texas Register for a 30-day comment period on September 20, 2002. These rules will define the relevant factors the complaints committee considers when deliberating complaints and establish severity levels and a sanction guide based on the relevant factors.
Board of Vocational Nurses	The Board is in the process of developing a ranking system.
Board of Occupational and Physical Therapy	All complaints are assigned a priority status in the following categories. • Violation of the Practice Act involving actual deception, fraud or injury to clients or the public, or high probability. • Violation of the Practice Act involving a high probability of potential deception, fraud or injury to clients or the public. • Violation of the Practice Act involving a potential for deception, fraud, or injury to clients or the public.

Table 3.A Intake Procedure for a Complaint

AGENCY	INTAKE PROCEDURE FOR A COMPLAINT
Texas Department of Health	A compliant hotline is open to receive patient complaints 24 hours a day/7 days a week. Staff are also available to take telephone complaints from people with limited English proficiency or who submit written complaints in a language other than English**.**
Board of Nurse Examiners	The Board or any person may initiate a proceeding before the agency by filing a complaint in writing and signed by the complainant. The complaints are then reviewed and processed by agency support staff to determine whether the agency has jurisdiction. The complaints are then reviewed, assigned a priority under rule 213.13(c) and assigned to an investigator by the Director of Enforcement. Each complaint against a registered nurse which requires a determination of competency is reviewed by an employee with a professional nursing background, normally a registered nurse investigator or consultant.
Anatomical Board	A complaint will be taken in any form, but it is requested that it be made in writing or e-mail, so that the nature of the complaint is clear and a record can be kept.
Board of Medical Examiners	All allegations are initially reviewed by supervisory staff to determine whether they involve a licensee of TSBME and whether the allegations, if true, would be a violation of the Medical Practice Act. When allegations are determined to be within the Board's jurisdiction, an investigation is initiated and assigned to an investigator to determine the validity of the allegations.
Texas Board of Pharmacy	A complaint may be filed in writing either on agency form, letter or e-mail.

State Board of Dental Examiners	Anyone can file a complaint with the State Board of Dental Examiners using any of the following methods: (1) Call the Board office at 512 463-6400 and request that a complaint form be mailed. (2) Call the Health Professions Council hotline at 1-800-821-3205 and leave a voice message. (3) Download a complaint form from the agency's website at www.tsbde.state.tx.us. (4) Visit the Board's office and request a complaint form and assistance if necessary. (5) By letter, write down all information and explain the circumstances of the complaint.
State Board of Examiners of Psychologists	Once the complaint is received at the office, it is date stamped and routed to investigations. An investigation assistant enters the complaint into the system, enters complaint into the complaint intake log, and sets up a paper file. The complaint is then reviewed by the Enforcement Division Manager and assigned to an investigator. Waivers are secured if not already provided. The complaint is reviewed by General Counsel. Notification is then sent to the respondent requesting a response to a complaint. Upon determination of probable cause, the allegation set for an informal settlement conference. Then an agreed order is negotiated or set for SOAH hearing. If no probable cause is determined, then complaint is set for staff dismissal review. The complaint is then closed out in the system after notification to the respondent and complainant.
State Board of Podiatric Medical Examiners	An investigator reviews the complaint, and a written complaint file is created and assigned an exclusive identifying case number. The complaint information is entered into the computer on our agency's investigations Database. A letter acknowledging receipt of the complaint, information regarding investigative process, and case number assigned to the complaint is mailed to the complainant.

Texas Optometry	The investigator determines whether a complaint is within the jurisdiction of the Board. A copy of the complaint is sent to the licensee and the Board Member on the Investigative-Enforcement Committee for the area of the complaint. Te Licensee has 14 days to respond to the complaint.
Fitting and Dispensing of Hearing Instruments	The agency will mail a complaint packet to anyone requesting one. The complaint form and instructions may also be found on the agency's website at: http://www.tdh.state.tx.us/hcqs/plc/fdhi.htm.
Board of Vocational Nurses	All complaints received are logged into our system by Enforcement division staff. Complaints can filed in written format using the agency form.
Board of Occupational and Physical Therapy	A complaint can be made to the Board, an investigator, board coordinator, or executive director. The complaint must contain sufficient information to allow the case to be investigated. the agency will also accept anonymous complaints in all situations.

Table 3.B Form in Which Complaint Can Be Filed

AGENCY	FORM IN WHICH COMPLAINT CAN BE FILED
Texas Department of Health	In person, by telephone, through written correspondence, or via electronic submission (e-mail). On some occasions, complaints are submitted by telephone. There is no form to submit complaints for hospitals, however, the complainant may submit a narrative.
Board of Nurse Examiners	A complaint can be received in either a Board form, letter or submitted via internet.
Anatomical Board	A complaint will be taken in any form, but it is requested that it be made in writing or e-mail**.**
Board of Medical Examiners	The Board will accept complaints by complaint form, letter or e-mail. Complaints are taken by telephone only when the complainant has physical limitations and no way to submit a written complaint.
Texas Board of Pharmacy	The complaint may be filed on the agency form, letter or email.
State Board of Dental Examiners	The complaint may be: faxed to the Board's office 512-463-7452, mailed to the Board's address, E-mailed or hand delivered to the agency. The agency does not accept complaints over the telephone. The agency accepts anonymous complaints. The Director of Enforcement usually speaks with individuals wishing to file an anonymous complaint.
State Board of Examiners of Psychologists	The Board has a complaint form which is available by mail upon request and also downloadable on the agency website.
State Board of Podiatric Medical Examiners	A complaint may be filed using the agency's written complaint form. The Board also accepts typed, or hand written letters, e-mails or facsimiles.
Texas Optometry Board	Complaints should be submitted on the Board's form in writing. Complaints submitted by e-mail are also accepted.
Fitting and Dispensing of Hearing Instruments	Complaints should be in writing, in order to receive a written release form, but will be accepted by telephone or email. Anonymous complaints are also accepted.

Board of Vocational Nurses	Complaints may be filed in written form using the agency form, letter or e-mail.
Board of Occupational and Physical Therapy	Complaints may be filed on an agency complaint form, a written letter, fax, e-mail through the agency web site , or by a phone call.

Table 4 Timetable for Processing a Complaint

AGENCY	TIMETABLE FOR PROCESSING A COMPLAINT
Texas Department of Health	Complaints are processed immediately and assigned a time frame for completion based on the type of complaint. Claims are investigated according to the following guidelines. • 2 days-negligent deaths, natural disasters. • 5 days- transfer violations. • 10 days-serious physical injury, negligent harm in a facility. • 14 days-current inpatient a victim of abuse/neglect/exploitation in the facility. • 45 days-substandard patient care. • 60 days-discharge patient a victim of abuse/neglect/exploitation while in facility. • 180 days - general complaints, billing, minor regulatory infractions, self-investigates
Board of Nurse Examiners	All parties must be notified in writing within 30 days upon receipt of the complaint of a projected schedule for resolving the complaint. Within 30 days after the complaint is received, the staff places a timetable for completion, not to exceed a year.
Anatomical Board	A complaint is addressed the same day it is received and usually resolved within two weeks.
Board of Medical Examiners	The board set a target to close complaints within 250 days. Evaluation of a complaint is completed within two weeks of receipt, usually less, and the complainant is then notified. The investigator must notify the complainant within 14 days after the case has been assigned.
Texas Board of Pharmacy	The agency must notify the complainant the agency has received a complaint no later than the 30th day after the agency receives the complaint; and the agency must notify complaints of the status of their complaints at least every four months until the complaint is closed. section 555.006 of the Texas Pharmacy Act.

State Board of Dental Examiners	**Daily -** Complaints are forwarded to the Director of Enforcement for review. **1 to 4 days -** Cases are reviewed to determine jurisdiction, type of allegation, and priority, then assigned to an investigator. **1 to 3 days after receipt from DOE** – The cases are returned to the Enforcement/staff person who makes the needed copies, enters the new information into the system, assembles the file, generates the opening letters to the complainant, respondent, and any second opinion doctors listed, and delivers the case to the assigned investigator. The opening letter to the complainant advises them that the complaint has been received, who the investigator is, and the investigator's phone number. The letters to the respondent includes a copy of the complaint, and requires that records be submitted. The letter to a second opinion doctor requires that records be sent. This process takes **one to three days** usually, with the outgoing letters being sent out daily. The respondent and second opinion doctors are required to submit records within **fifteen days of receipt of the opening letter.** However, the letters are sent regular mail. If a response is not received, the investigator will either send a second letter certified mail, or have the Enforcement/staff person do so.Once the letter is signed for, another **fifteen-day period is started in which a response must be received**. At the expiration of fifteen days, the investigator prepares a subpoena, which is then signed by the Executive Director, and returned to the investigator. This usually takes three to four days. The investigator serves the doctor with the subpoena and is then provided the records. If the records are not provided, the case then must be referred to the Attorney General. While a case is still open, letters are sent to the complainant and respondent every **90 days that advises them that the case is still open.**
State Board of Examiners of Psychologists	Upon receipt of a complaint, both the respondent and complainant are informed that resolution of complaints takes between six months and one year. Quarterly status reports stating that the complaint is still active are provided to both parties until the complaint is resolved. Complaints that require longer than one year to resolve are provided an updated schedule for resolution. Respondents are required to respond to a complaint within 30 days of receipt of the complaint from the Board.

State Board of Podiatric Medical Examiners	The target for completing an investigation is 120 days.
Texas Optometry Board	• The licensee is required to reply to the agency's correspondence within 14 days. • The complaint is acknowledged usually within a week. • The agency keeps parties apprised every 90 days.

Fitting and Dispensing	• complaints received by phone a complaint packet.- 3 days • complaint packet will be date stamped.-- 1 day • complaint number assigned, begin a complaint file Prepare a letter of response to complainant that complaint has been Received, enter initial tracking information, check for cross licensure and forward file to program administrator for review. - 5 days of program date stamp • Program administrator will make determination of type of complaint, jurisdictional or non-jurisdictional, note alleged violations of specific law/rules, if appropriate to notify licensee at this point, and whether to forward to investigation section. Tracking information will be entered.-- 15 days of program date stamp • Complainant notified in writing at least quarterly.--Every 90 days from initial letter • Program administrator will review the returned file from investigations section and note recommendation to board committee or make program proposed decision.--5 working days of decision • If board committee or program proposes disciplinary action, cease/desist, or other letter of concern, the parties will be notified in writing and tracking information will be entered. --15 working days of decision • licensee requests a formal hearing, a complete hearing packet will be forwarded to OGC--10 working days of request • After completion of the hearing process, orders or correspondence will be completed as directed by OGC. • Within 5 working days of decision
Board of Vocational Nurses	The average time for complaint resolution is 135 days. Parties are notified quarterly until the final disposition, on all written complaints filed with the Board.

Board of Occupational and Physical Therapy	• Complainants are sent an letter by the agency acknowledging the complaint-- 10 days after receipt. • Complainant is informed of the 120 day initial time frame to complete investigations. • Status letters are sent to the parties of the complaint--90 days.

Table 5 Privileged Details and Safeguards

AGENCY	PRIVILEGED DETAILS AND SAFEGUARDS
Texas Department of Health	The disclosure of confidential information obtained in complaint investigations is prohibited by various laws and regulations. Safeguards used to protect the confidentiality include the following: disclosure personnel receive ongoing training, Release documents ae edited to de-identify complainants, other patients, facility staff, committee minutes and medical records, the office of General Counsel of the Texas Department of Health review all Redacted documents. The state of Texas Attorney General's Office has the final review of documents and issues decisions. surveyors are instructed to limit copies of confidential material/patient records to only those records that are pertinent for evidence.
Board of Nurse Examiners	The identity of a non-testifying complainant is confidential and not subject to disclosure to the respondent under the public information act. A respondent is entitled to investigatory information such as all known exculpatory information in the Board's possession and information in the Board's possession that the Board intends to offer into evidence in a contested hearing. A complaint and investigation concerning a Registered Nurse and all information compiled in connection with as investigation are confidential and not subject to disclosure under Chapter 552, Government Code; and not subject to disclosure, discovery or subpoena to anyone other than the Board, Board employee, or agent. Information about the initiation of formal charges is available to the public.
Anatomical Board	The complaint is confidential except from those individuals needed to resolve the situation.
Board of Medical Examiners	Complainant identity and all investigative information are confidential and privileged by statute. Patient names are not used in public board documents.
Texas Board of Pharmacy	Any documents that could disclose the identity of a person who reports to or assists the Board under Section 555.010 of the Texas Pharmacy Act, Tex. Occ. Code Ann.

State Board of Dental Examiners	Under the Texas Occupations Code (Dental Practice Act) at Section 254.006, investigation files and other records are confidential and may only be released to the person(s) investigated at the completion of the investigation. Complaints are the foundation of investigatory action and therefore complaint information is only released to the person investigated after the investigation has been concluded. Patient information and details received by the agency as a result of investigations are also a part of the investigation file and are held in strict confidence. Additionally, patients are only referred to by their initials in pleadings and other filings when cases are litigated. Typically, only the patient/complainant and the dentist/respondent will have access to complaint details during the prosecution of a case.
State Board of Examiners of Psychologists	All details of a complaint are privileged and confidential in accordance with Section 501.205 of the Psychologists' Licensing Act. Only Agreed Orders and other Board orders are open to the public. However, once a complaint is referred to SOAH, the fact that a complaint is referred to SOAH is a matter of public record. Confidentiality is maintained by such factors as a separate office for enforcement staff, who maintains the paper files, security on the enforcement computer system, and trained open records staff overseen by the General Counsel. Additionally, a complaint cannot proceed unless the patient signs a waiver for release of patient records for the Board. The patient records obtained from the licensee become part of the confidential investigation record.
State Board of Podiatric Medical Examiners	The entire investigative file is statutorily confidential . The files are maintained in a locked metal file cabinet located in a locker room.
Texas Optometry Board	The entire complaint process is public. The Optometry Act does not contain confidentiality provisions. Optometric records are not confidential.

Fitting and Dispensing of Hearing Instruments	The complaint files are deemed to be confidential (closed to the general public) pursuant to HB 2824 (76th Legislature) if they were filed after September 1, 1999. The statutory language was added in the Occupations Code, Section 402.154 (h). The following information is disclosed: that a complaint has been filed; the case is pending review and investigation; the licensee is entitled to due process; and provide the current licensure status of the licensee. Further detail and contents of the complaint and the pending investigation are not available to the general public (litigation exception to the Open Records Act). The Texas Department of Health, Professional Licensing and Certification Division has an individual responsible for handling any Open Records requests.
Board of Vocational Nurses	Board records are subject to disclosure in accordance with the Texas Government Code, Chapter 552 - Open Records. All complaints, adverse reports, investigation files, and other investigative information in the possession or, received or gathered by the Board or its employees or agents relating to a licensee, an application for license, or criminal investigation or proceedings are privileged and confidential and are not subject to discovery, subpoena, or other means or legal compulsion for their release to anyone other than the Board or its employees or agents involved in licensee discipline unless and until ordered by a court of competent jurisdiction after a court hearing on a motion for a protective order and/or motion to quash the subpoena any interlocutory appeal of the same.
Board of Occupational and Physical Therapy	All files of open investigations, and the fact that an investigation may be ongoing are confidential by board rule. Investigation files are secured by storage in a locked investigator's office or are kept under his direct control during working hours. No other employee has access to the files of on-going cases.

Table 6 Consumers Access to Non-Privileged Details

AGENCY	CONSUMERS ACCESS TO NON-PRIVILEGED DETAILS
Texas Department of Health	Consumers can get information about licensing of a facility via telephone or through the internet by accessing the Texas Department of Health's website, Licensing/Certification heading, Health Facility licensing and Compliance Division subheading, Hospital Directories. Consumers are provided with general information about a hospital, name and license/medicare number. In addition consumers can get information about enforcement actions taken against health care facilities via the same web site; enter the Enforcement Program subheading. The select General/Special Hospitals and view enforcement action against facilities within the last two years amount of penalty assessed, the infractions resulting in the penalty and other information available to the general public.
Board of Nurse Examiners	The public has access through standard public information requests pursuant to Chapter 552,Government Code, and can get copies of any permanent licensee's file, including formal charges, the nature of those charges, disciplinary proceedings of the Board, final disciplinary actions, warning and reprimands. Privileged information such as social security numbers and e-mail addresses are not subject to disclosure. If the consumer is the complainant, that complainant has ongoing notification of the status of the complaint as referenced earlier. Public information concerning disciplinary history such as formal charges or final orders can by accessed by phone or online. The online information indicates whether disciplinary history has occurred, but not the detail of that history.
Anatomical Board	The complaints received this year were privileged , but the board will release any non-privileged complaint details.

Board of Medical Examiners	Complaint information is not available to consumers. Unless the complaint results in action by the Board. Consumers may access a licensee's disciplinary history by calling the agency's 800 number or by checking the licensee's physician profile or license verification report which are both available on the agency's website. Currently, consumers may obtain a copy of the full board disciplinary order by submitting a written request. The full text of board orders will soon be available on the agency website.
Texas Board of Pharmacy	Consumers have access to information as to whether a licensee has been the subject of a disciplinary order by either calling the agency or visiting the website. In addition a consumer may obtain a copy of any public disciplinary order upon receipt of a written request. The Board also will provided summaries of complaints filed against licensees if the complaint resulted in a public action.
State Board of Dental Examiners	The details of a complaint are confidential and are not released to the public. Final administrative action taken by the agency as a result of a complaint is public information and is reported as a disciplinary action (Board Order). Details of a disciplinary action (Board Order) include findings of fact, conclusions of law, sanctions and penalties.
State Board of Examiners of Psychologists	In accordance with Section 501.205 of the Psychologists' Licensing Act, consumers do not have access to any complaint information. This means that information about pending complaints or complaints which are dismissed is not available. However, if a complaint is resolved with an agreed order for disciplinary action, the agreed order is available to the public. Also, if a complaint is heard at SOAH and the result is a Board Order, the order is available to the public. Agreed orders and Board orders must be requested in writing, by e-mail, or by FAX.

State Board of Podiatric Medical Examiners	Consumer are provided with complaint information on request, whenever there has been Board action or the licensee has been disciplined. They may obtain copies of agreed board orders, which detail the complaint, the board's findings and the licensee's punishment by making a request for same in writing. Basic information on discipline and Board action is also provided by phone. A complete list of all licensees that have had disciplinary action taken against them is listed on the agency's website.
Texas Optometry	A member of the public can telephone the agency for disciplinary information on any licensee. Licensee information is not available on-line at this time.
Fitting and Dispensing	Further detail and contents of the complaint and the pending investigation are not available to the general public (litigation exception to the Open Records Act). Consumers can go to the website at: http://www.tdh.state.tx.us/hcqs/plc/fdhi.htm for information regarding a licensee's license status and disciplinary action.
Board of Vocational Nurses	Board records are subject to disclosure in accordance with the Texas Government Code, Chapter 552 - Open Records. In addition, disciplinary actions taken by Board are published in the LVN LONESTAR the agency newsletter.
Board of Occupational and Physical Therapy	Information in closed investigation files, like almost all other information kept in the agency, is subject to the Public Information Act, and is therefore considered available to the public when requested.

REFERENCES

Texas Department of Health, Hospital Licensing Division, *Responses to survey questions of the House Committee on Public Health,* September 24, 2002

Board of Nursing Examiners for the State of Texas, *Responses to survey questions of the House Committee on Public Health,* September 24, 2002

The Anatomical Board of the State of Texas, *Responses to survey questions of the House Committee on Public Health,* September 24, 2002

Texas State Board of Medical Examiners, *Responses to survey questions of the House Committee on Public Health,* September 24, 2002

Texas State Board of Pharmacy, *Responses to survey questions of the House Committee on Public Health,* September 24, 2002

State Board of Dental Examiners, *Responses to survey questions of the House Committee on Public Health,* September 24, 2002

Texas State Board of Examiners of Psychologists, *Responses to survey questions of the House Committee on Public Health,* September 24, 2002

Texas State Board of Podiatric Medical Examiners, *Responses to survey questions of the House Committee on Public Health,* September 24, 2002

Texas Optometry Board, *Responses to survey questions of the House Committee on Public Health,* September 24, 2002

State Committee of Examiners in the Fitting and Dispensing of Hearing Instruments, *Responses to survey questions of the House Committee on Public Health,* September 24, 2002

Texas Board of Vocational Nurses, *Responses to survey questions of the House Committee on Public Health,* September 24, 2002

Texas Board of Occupational and Physical Therapy, *House Responses to survey questions of the Committee on Public Health,* September 24, 2002

CHARGE #7

Actively monitor agencies and programs under the committee's oversight jurisdiction. Pay particular attention to implementation of recommendations concerning the Department of Health's childhood immunization program.

LEAD MEMBER

Rep. Jaime Capelo

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INTRODUCTION

The House Committee on Public Health heard testimony on the status of childhood immunization on August 27, 2002. Testimony was provided by: Fernando Gomez, M.D., M.P.H. - Director of Health, San Antonio Metropolitan Health District; Dr. Eduardo Sanchez - Commissioner, Texas Department of Health; Jaime Fergie, M.D. - Driscoll Children's Hospital and Texas Medical Association; and Julia Henion - Chief Nursing Officer, Driscoll Children's Hospital.

POLICY OPTIONS

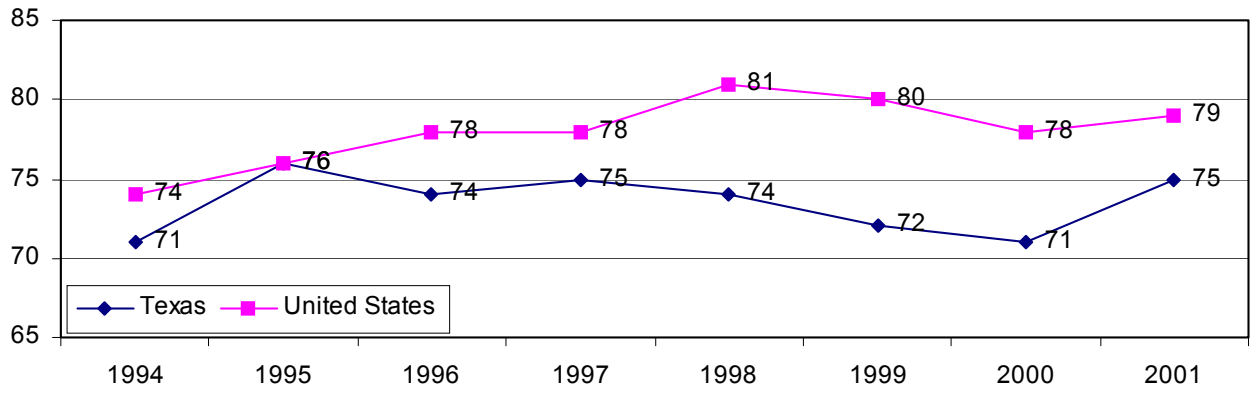
Policy Option # 1	The committee recommends that vaccine education programs for both parents and providers be improved.
Policy Option # 2	Improve the Immunization Registry, ImmTrac, by changing from an opt-in to an opt-out registry.
Policy Option # 3	Increase the Medicaid administration fee for vaccines provided through TVFC to cover the physicians actual costs of providing the vaccines.
Policy Option # 4	Support the reinstatement of TDH's "Shots Across Texas" program.

BACKGROUND

Controlling infectious diseases through the use of vaccinations was heralded as one of the "Ten Great Public Health Achievements" of the past century in a 1999 report by the Centers for Disease Control and Prevention [1]. Without vaccines, millions of children and adults would contract serious diseases that are now preventable and many would have long-lasting effects and even die as a result. Since the introduction of vaccines, many diseases such as polio and small pox have been eradicated from the United States and other diseases such as Haemophilus Influenzae Type B have nearly disappeared [2]. Over the years immunizations have proven to be the safest way to prevent diseases that place children at risk. The Texas Department of Health (TDH) has estimated that for every dollar spent on the DTaP vaccine (diphtheria, tetanus, and pertussis), $23.40 is saved in indirect and direct costs [3]. Many professionals in the field believe that vaccinations should be treated as a public health issue. The reasoning for this stems from the fact that non-immunized children not only put themselves at risk but also puts many other people at risk who come in contact with the children. The groups most at risk include 1) all children under two months who have not yet begun their immunization series, 2) immune deficit children and adults, and 3) the 5-10% of the population that does not respond to immunizations.

Texas has traditionally ranked lower than the national average for vaccine coverage levels for two-year old children [4, 5]. From 1995-2000, the gap between the national average and the Texas vaccine coverage areas widened. In 2000, Texas ranked 50th among the states for coverage of 19-35 month-old children [6]. That year Texas' immunization rates (70%) were eight percentage points lower than the national average (78%). The National Immunization Survey Data for 2001, showed that Texas had improved to 42nd in the nation with a statewide immunization rate of 74.9% in comparison to the national average of 78.6% [7].

National Immunization Survey Results
1994-2001, Texas and U.S. Rates Compared



The national survey also looks at the immunization rates for Bexar County, Dallas County, and El Paso County, and the city of Houston. In 2001, three of these metropolitan areas were below the state average of 74.9%. Dallas County had the lowest with 68.9%; El Paso County was 69.2%; and the city of Houston was 70.5%. Bexar County, however, had a slightly higher rate than Texas as a whole with an immunization rate of 75.1% [8].

When we take a closer look at the data, we discover that over 80% of infants 3 months to 6 months were fully immunized. However, the children older than 15 months had much lower immunization rates, dropping below 60%. The fact that immunization rates decrease with age indicate that many children begin, yet fail to complete their vaccine series. This is further illustrated by the high percentage (above 90%) of children receiving the third dose of DTP vaccine. The fourth dose of DTP is recommended at 15 months to 18 months. As many as one-quarter of Texas children fail to receive the fourth dose [9].

Low immunization rates are a cause for concern. When immunization levels drop, the potential for disease outbreaks increases. For example in 1989-1990, Dallas County had a severe outbreak of measles with 2,175 reported cases, 238 hospitalizations, and 9 deaths. The following year Dallas County made a concerted effort to increase immunization rates and made changes in their measles vaccine recommendations. As a result of this attention, only 29 cases of measles (and no deaths) were reported [10, 11].

A more recent example occurred just last year when Texas experienced a significant increase in the incidence of pertussis (more commonly known as whooping cough) with 738 reported cases.

In 2000, only 327 cases were reported and in 1999, only 152. Health officials are even more concerned with the number of pertussis cases in the current year. The number of cases that have been reported through September of 2002, already exceeds the 2001 levels. It is projected that if the current trend continues that the number of cases could double the amount in 2001 [12, 13].

No one factor alone is contributing to the low immunization rates in Texas. A portion of Texas families choose not to immunize their children based upon religious, medical, or safety reasons. Another contributing factor is the lack of health insurance. The Texas Immunization Survey (2000), found that only 54.8% of Texas children without insurance were immunized, compared to 72.1% of children with Medicaid and 73.6% of children with private insurance [14]. Vaccine shortages are another contributing factor to the low immunization rates. This is a problem occurring both at the state and national level [15]. The shortages stem from several reasons, one of which is production delays due to compliance with Food and Drug Administration manufacturing practice guidelines. Perhaps the biggest reason is that many pharmaceutical companies are no longer manufacturing vaccines because it is no longer a profitable business [16].

PLANS TO IMPROVE THE IMMUNIZATION RATES IN TEXAS

As a result of the immunization problem that Texas is dealing with, the Board of Health asked the Texas Department of Health (TDH) to place a higher priority on improving immunization rates in 1999. In response to this request, TDH developed and issued (May 2000) The Comprehensive State Plan to Improve Immunization Levels in Texas (commonly referred to as the TDH Immunization Action Plan) [17]. The Immunization Action Plan focuses on five areas:

- Enhancing community involvement
- Improving provider awareness and participation
- Increasing parent awareness and participation
- Improving TDH data systems, including the immunization registry
- Coordinating diverse TDH operations that impact immunizations

In order to achieve the goals of the Immunization Action Plan, TDH implemented or participated in two processes during FY 2002 to improve the immunization rates in Texas. The agency participated in a partnership of external immunization stakeholders that came together from across the state to address the immunization issue. Their plan was recently released and will be discussed shortly. TDH also established an internal process during the summer of 2002 to bring together the public health programs that reach children with the goal of working more closely in the future to improve immunization rates. Their report on this internal process is due out in late

November.

Immunizing Texas – A Statewide Plan to Increase Immunization Rates in Texas
Immunization partners first met in February of 2002 to discuss the issue of low immunization rates and to develop strategies that would lead to an organized plan to increase rates throughout the state. During this meeting the partners recognized that regional and cultural differences in Texas can impact the effective delivery of vaccines and in turn the immunization rates in communities. The partners then went on to endorse a plan to organize a series of local meetings throughout the state to gather information, garner support and enthusiasm for the immunization initiative, and to have stakeholders' buy-in on local efforts to increase immunization rates in their own communities. The local immunization meetings were held between April and July of 2002. In April of 2002, the first statewide immunization stakeholder meeting was held. As a result of the local and statewide meetings the Texas Immunization Partnership came up with several recommendations to increase immunization rates in Texas [18].

- Reinstate "Shots Across Texas"
- Develop an Education Program Targeted for Parents
- Develop an Education Program Targeted for Providers
- Improve the Immunization Registry, ImmTrac
- Simplify Immunization Data Collection and Reporting
- Address Barriers Caused by Vaccine Funding Issues
- Increase Medicaid Administration Fee for Vaccines Provided Through TVFC
- Maintain Strong Immunization Partnerships.

<u>Reinstate "Shots Across Texas"</u>
The Texas Department of Health initiated the "Shots Across Texas" media and educational campaign to increase awareness for immunizations among health care providers, parents, and guardians in 1993. This campaign was a public-private partnership that included leaders from hundreds of businesses, associations, agencies, and non-profit organizations. During 1994, Shots Across Texas earned a great deal of support from TDH, the Texas Legislature, and the Governor. Through 1996 Texas saw an increase in the immunization rates across the state. However, since that time financial support for the media campaign has waned. During the '02-'03 biennium, no money was specifically allocated for Shots Across Texas. The Immunization Partnership believes that by increasing state funding for immunization initiatives and reinvigorating Shots Across Texas, the successes of the mid-1990s can be repeated [19].

Develop an Education Program Targeted for Parents

During the first year of a child's life, vaccine coverage rates correspond somewhat well with babies' regular exam schedules. However by the time the child reaches 19 months the immunization rates drop. The Immunization Partnership suggests that a public campaign should be established to encourage parents of children to visit their health care providers to have their children's immunization status assessed. The Immunization Partnership believes that this campaign can help with the problem of incomplete vaccine series among older children [20].

Studies have shown that uninsured children have lower vaccine coverage rates than insured children. Children 150% to 185% poverty lose their Medicaid eligibility at their first birthday. Because of this, the Immunization Partnership considers it imperative to have a coordinated effort to transition children from Medicaid to the Children's Health Insurance Program (CHIP) to assure completion of the vaccine series [21].

Develop an Education Program Targeted for Providers

Although parents play a large role in the vaccination of their children it is also important to assure that all medical and health care providers are also educated as to the current recommendations and guidelines for children's vaccine needs. One suggestion of the Immunization Partnership is to include education concerning childhood vaccines and immunizations in all health care provider education curriculum and training. This education would stress the importance of vaccines, the importance of immunization registries, establish routines for reminder/recall systems, etc [22].

Another suggestion from the Immunization Partnership is to promote the Texas Vaccine for Children Program (TVFC) and encourage providers to enroll. TVFC provides free vaccines to physicians, physician assistants, nurses, and pharmacists to vaccinate children through 18 years of age who are on Medicaid, uninsured, underinsured, Alaskan Native, or American Indian. Currently only 54.8% of licensed specialty physicians (family practice, general practice, and pediatricians) are enrolled in the TVFC program. Physicians who are enrolled in TVFC are encouraged to participate in AFIX (Assessment of coverage, Feedback of information, Incentives for outcomes, and eXchange of information) which is used to assess the immunization provider practices. The program has proven to be effective in improving the immunization rates within a provider's practice. The Immunization Partnership suggests expanding AFIX to providers that are not enrolled in TVFC as well [23].

Improve the Immunization Registry, ImmTrac

ImmTrac is a statewide immunization registry jointly developed by the Texas Department of Health (TDH) and Electronic Data Systems (EDS), a private information database. The ImmTrac database receives vaccination information for a child, with the consent of the parent. The information includes input from the Bureau of Vital Statistics, Women, Infant and Children (WIC) clinics, Medicaid, the Integrated Client Encounter System (ICES), private health care providers and private health plans. State statutes currently require health plans to report all vaccines that are provided through private insurance. Vaccines provided through public funds and cash payment are to be reported by the health care provider. This immunization information is then available to schools, childcare centers, health departments and public/private health care providers [24].

The purposes of the immunization registry are to:

- consolidate records from multiple providers to help with vaccination decisions;
- generate reminder and recall notices for vaccine appointments;
- provide official immunization records for enrollment in schools, child-care facilities, and camps;
- prevent unnecessary administration of vaccines;
- streamline vaccine management; and
- help to prevent disease breakout.

Currently every state either has or is in the process of creating an immunization registry. Texas is one of 12 states that requires written consent from the parent to participate in the registry. One state requires verbal consent. The remainder of the states have implied consent to participate until the parent chooses to opt-out of the registry [25].

The Immunization Partnership suggests to change the current "opt-in" ImmTrac to an "opt-out" version. Nearly 99% of Texas parents choose to "opt-in" or participate in the program [26]. They believe that many benefits would come from this change, including a reduction in paperwork for providers, ready access to a reminder/recall system, more efficient local registries, ability to target areas in the state with low rates and a centralized record keeping that will protect from over-vaccination [27].

Another suggestion of the Immunization Partnership is to expand access to the registry. Currently there are immunization providers who are unable to access ImmTrac. The partnership would like all vaccine providers to have the ability to enter their data into the registry and

allowed to access the registry to view the immunization histories of their patients [28].

Simplify Immunization Data Collection and Reporting

One of the biggest complaints from providers is the large amount of paperwork that goes along with various health programs. For example, individual child health programs (TVFC, Medicaid, CHIP) and health plans (HMOs, PPOs, other insurers) all have their own enrollment forms, eligibility requirements, reporting requirements and rules. The Immunization Partnership believes that many of these requirements could be combined and forms consolidated to reduce the paperwork burden on the providers' practices and staff [29].

Address Barriers Caused by Vaccine Funding Issues

The Immunization Partnership recommends that the Texas Legislature mandate that all state-regulated health plans provide coverage for all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). By requiring health plans to provide coverage for ACIP vaccines there will no longer be a delay in payments for newly licensed vaccines when they are first introduced on the market. Immediate coverage will be available for all children insured by state regulated health plans [30].

This mandate, however, will not cover health plans that are federally controlled under ERISA (Employee Retirement Income Security Act). In order to remedy this, the Immunization Partnership recommends that the Texas Legislature pass a resolution to the U.S. Congress to encourage all ERISA health plans to cover vaccines recommended by the ACIP [31].

Increase Medicaid Administration Fee for Vaccines Provided Through TVFC

The Centers for Medicare and Medicaid (CMS) permit a state to reimburse providers for the administration cost of vaccines a maximum of $12.24 to $17.85. Currently, Texas reimburses physicians $5.00 for each vaccine administered [32]. This payment does not cover the providers' costs for administration, which is estimated to be around $5.83 [33]. The Immunization Partnership suggests that the reimbursement fee should be increased to at least cover the physician's cost of administering the vaccine [34].

Maintain Strong Immunization Partnerships

The last recommendation of the Immunization Partnership is to maintain a strong state-wide partnership network. They suggest that the network include primary stakeholders, as well as local communities, schools, childcare providers, businesses, the media and other individuals and entities that have an interest in furthering immunization initiatives in Texas [35].

Texas Department of Health Internal Plan

The Texas Department of Health realized that in order to be effective in increasing immunization rates they would have to improve internal operations in order to strengthen their relationships with external partners and stakeholders. Their present plan builds on recommendations and activities that were identified in the *Comprehensive State Plan To Improve Immunization Levels In Texas,* that was created May of 2000.[36]

The creation of the Internal Immunization Improvement Workgroup grew out of activities designed to address low immunization rates for Texas children 19 months through 35 months of age. The workgroup focused on enhancing internal TDH operations and efficiencies to improve the ability of the agency to improve childhood and adult immunizations rates in order to enhance the health of Texans. In this regard, the group identified four goals around which TDH should focus its efforts. [37]

These goals are:

- Improve internal functions of the Immunization Division.
- Coordinate resources between TDH programs to maximize internal collaboration.
- Define and support roles, responsibilities and relationships of TDH programs, Public Health Regions, TDH-operated healthcare delivery facilities and Local Health Departments in maximizing immunization activities.
- Standardize, consolidate and improve in the areas of: data, infrastructure, access, marketing and education and program/contract management.

To achieve these goals, the group further identified the following four objectives:

- The Immunization Division will develop and implement operating procedures considering industry best practices.
- TDH will establish an intra-agency standard for communicating immunization related information.
- TDH will clarify roles, responsibilities and relationships between TDH - Austin and Public Health Regions.
- TDH will maintain an immunization database that serves as the public health tool used by all TDH programs and reporting entities regarding immunization data.

Each objective is accompanied by specific strategies that the group feels are achievable with the full support of TDH senior leadership and staff. However, to expedite the department's work

towards achieving these goals and objectives, the group additionally makes the following specific recommendations:

Conduct a business improvement team review of the Immunizations Division

The conduct of a business review is considered a priority at this time as the Division is in a state of potential organizational transition, creating a prime opportunity to review the practices of the Division and incorporate recommended process improvements. Since the Department is committed to conducting such reviews across the organization, and the work of the Immunzations Division is vital to achieve one of the five stated priorities of the Department, this review should be initiated urgently.[38]

Form an internal implementation team to carry out the work of this plan

The Internal Immunizations Improvement Workgroup recognizes that they have only begun the work of focusing the Department and it's resources on issues around Immunizations. In fact, due to time considerations, they were unable to complete the scope of activities listed in their charge. These include:

- Delineating Roles and responsibilities
- Utilization of Resources and
- Evaluation.

In order to complete this important work, the group strongly recommends the formation of an ongoing internal implementation team that has the necessary time, staff cooperation and administrative support to proceed. Current utilization of resources needs to be examined with consideration of how intra-agency collaboration can best occur in order to maximize available resources within the constraints placed on the Department by Federal guidelines, other grants and legislative rider requirements.

Implementing recommended strategies may have unintended or unanticipated consequences in other areas of the Department which need to be considered as well by performing impact analyses. Implementation should not begin without a plan for evaluation. Which strategies will be evaluated, how and by whom, are questions that must be resolved in order to proceed. Successful evaluation also requires resources. This Workgroup was limited by not having access to specific line items and budget expenditures relating to immunizations.[39]

Develop a timeline for implementation

Developing a timeline is critical to successful project management, especially projects with

multiple stakeholders, strategies, and responsible parties. The timeline will assist Implementation Team members in thinking through all of the steps and milestones of the project. It assists with keeping the process moving in a sequential and structured manner. The timeline provides a map that helps all parties see which direction the project is heading. This keeps people informed and facilitates both internal and external stakeholder support.[40]

Establish an Immunization Coordinating Council

One of the assumptions that the Workgroup operated under was that internal TDH work outlined in this document would be carried out in coordination with activities involving external stakeholders as outlined in "Immunizing Texas: A Statewide Plan to Increase Immunization Rates in Texas." Not surprisingly, the discussions of the internal Workgroup covered many of the same issues that were raised by external stakeholders. Specifically, these included: media and educational campaigns, provider education, improving the statewide immunization registry, simplified data collection and reporting and maintaining strong immunization partnerships. The Immunization Coordinating Council would provide the formally recognized forum for ongoing input from external stakeholders and bring visibility and continuing external buy-in to this important activity that is key to protecting the health of Texans.

The implementation of these recommendations is not without challenge, nor is it something that can be set into motion without the impact being felt agency-wide. However, the Workgroup believes that these recommendations are made based on sound public health principles using multi-disciplinary professional expertise.[41]

CONCLUSION

The Texas Department of Health must develop and use unified messages concerning public health priorities such as immunizations, and first must share these messages internally. This will enable the department as a whole to provide consistent information to their external partners and stakeholders, thereby enhancing the department's credibility and its leadership role in improving public health in Texas. As these plans are being carried out, it is important to keep in mind that the effects of these programs will not be able to be seen immediately. Because of the time it takes to collect data, conduct analysis, and report results it will be several years for improvements in immunization rates to be reflected in the national survey results.

ENDNOTES

1. House Committee on Public Health Testimony of Julia Henion, Vice President and Chief Nursing Officer of the Driscoll Children's Hospital. Presented August 27, 2002.

2. Texas Pediatrics Society, "Immunization Policy Paper." August 19, 2002.

3. Ibid.

4. There are two primary methodologies used in Texas to assess vaccine coverage levels among children – the National Immunization Survey (NIS) and the Texas Immunization Survey (TIS). The NIS is a large, on-going, random-digital-dial survey conducted by the Centers for Disease Control and Prevention to measure vaccine coverage levels of children 19 months to 35 months of age. Annual results are released during the summer each year – the most recent results are for 2001. The TIS is a population-based survey of children 3 months to 24 months of age that occurs every two years (1994, 1996, 1998, 2000). The TIS began in 1994 as an in person survey, but has since changed to a random-digital-dial survey. The survey was not conducted in 2002, therefore the 2000 data is the current data.

5. Vaccine coverage levels are most commonly reported as a 4:3:1 rate. The 4:3:1 statistic refers to four doses of diphtheria-tetanus-pertussis vaccine (DTP/DTaP), three doses of poliovirus vaccine, and one dose of measles, mumps, rubella (MMR) vaccine. Rates for the 3:3:1, other vaccine combinations, and individual vaccines are also sometimes reported. The terms "vaccine coverage level" and "immunization rate" are often used interchangeably.

6. Texas Department of Health Immunization Division, "Rider 45: Report to the Legislative Budget Board and the Governor on Plans to Increase Immunization Rates in Texas." General Appropriations Act, Article II, Rider 45, submitted September 30, 2002.

7. Ibid.

8. Texas Pediatrics Society, "Immunization Policy Paper." August 19, 2002.

9. Texas Department of Health Immunization Division, "Rider 45: Report to the Legislative Budget Board and the Governor on Plans to Increase Immunization Rates in Texas." General Appropriations Act, Article II, Rider 45, submitted September 30, 2002.

10. Texas Pediatrics Society, "Immunization Policy Paper." August 19, 2002.

11. House Committee on Public Health Testimony of Jaime Fergie, Texas Medical Association and Driscoll Children's Hospital. Presented August 27, 2002.

12. Ibid.

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