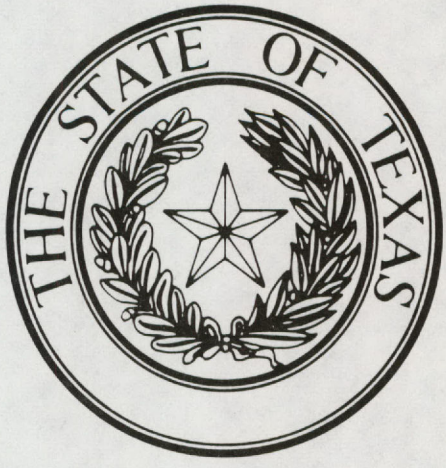
INTERIM REPORT ON HEALTH PROMOTION

Senate Subcommittee on Health Services

Report to the 70th Legislature

January 1987



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The Senate of Texas

Subcommittee on Health Services

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January 12, 1987

The Honorable William P. Hobby, Jr., Lieutenant Governor
The Honorable Chet Brooks, Chairman, Senate Committee on
Health and Human Resources

As directed by Governor Hobby, the Senate Subcommittee on Health Services herewith transmits its interim report on health promotion to the 70th Texas Legislature.

The report offers fourteen recommendations for your consideration.

The Subcommittee acknowledges the serious fiscal constraints the State of Texas currently is experiencing. It should be noted that many recommendations offered in the report could be enacted without a state appropriation, and others, if implemented, could potentially result in long-term cost savings to the state.

Respectfully submitted,

Carlos F. Truan
Chairman

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TABLE OF CONTENTS

INTRODUCTION

> We are killing ourselves by our own careless habits. We are killing ourselves by carelessly polluting the environment. We are killing ourselves by permitting harmful social conditions to persist -- conditions like poverty, hunger and ignorance -- which destroy health, especially for infants and children. (1)
>
> Joseph A. Califano, Jr.
> Former Secretary
> U.S. Department of Health, Education and Welfare

During the twentieth century, major advances in medical care have occurred. Effective vaccines have controlled the spread of communicable diseases which once reached epidemic proportions, such as smallpox, polio and typhoid. The development of penicillin and other antibiotics has greatly increased our ability to fight infections. And, new treatment approaches and medical research discoveries have greatly enhanced our fight against cancers and other chronic diseases.

Concurrent with the advances in medical science have been advances in public health practices which have equally combatted the spread of diseases and disabling conditions. Water quality has improved to the point that people now take the safety of drinking water for granted. Additionally, the regulation of wastewater and sewage have had a major impact on reducing the spread of diseases, as has the regulation of food preparation and storage.

The struggle with infectious diseases has diminished to such an extent that today the diseases which place Americans at greatest risk of illness and premature death are chronic in nature and largely preventable. Whereas the primary causes of death in 1900 were influenza and pneumonia (11.8%), tuberculosis (11.2%), and heart disease (9.4%), as we enter the last decade of this century, the major causes of death are heart diseases (34.4%), cancers (23.9%), strokes (6.5%), and accidents (6.6%). (2) It should be noted that the current four major causes of death account for more than seventy percent of all deaths in the United States. Further, among persons one to forty years of age, accidents are the principal cause of premature death. (3) As shown in Appendix 1, the leading causes of death in Texas closely parallel those for the nation.

Significant future reductions in mortality rates from the leading causes of death will principally come from their prevention, primarily through health promotion efforts. Appendix 2 contains a list of major controllable factors which place people at risk for the major causes of death. Persons' abilities to minimize their chances of acquiring chronic diseases or disabling conditions will depend largely upon their knowledge of health-related behaviors which place them at risk of disease or disability and their skills in adopting healthful behaviors into their lifestyles. Health promotion, including health education, skills training, regulatory interventions, and an array of other

activities, is the most effective vehicle for providing such knowledge and skills.

Much of the impetus for health promotion activities in recent years emanated from a report entitled Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention issued by the Public Health Service in 1979. The report specified major national goals for reducing preventable causes of morbidity and mortality and identified risk factors which can be addressed through health promotion activities. Subsequently, the Public Health Service published Promoting Health/Preventing Disease: Objectives for the Nation in 1980 which set forth specific and measurable objectives for priority areas, such as smoking, misuse of alcohol and drugs, and accident prevention and injury control. Under the leadership of the Texas Department of Health, The University of Texas School of Public Health, and the Texas Medical Association, Texas was one of the first states to hold a conference of public and private sector representatives to develop specific objectives for the population and health-related needs of our state. A summary of the highest priority objectives for health promotion efforts is included in Appendix 3.

Health promotion programs in Texas have not always received sufficient fiscal support to encourage their development and expansion. Lack of support for health promotion programs emanates partially from the difficulty in linking direct monetary savings with health promotion and other prevention activities.

It also results from a desire to have immediate positive gains in health status and concurrent decreases in health care expenditures, which is not always possible. Such expectations tend to overlook the fact that most health-related habits are deep-rooted, reinforced by societal norms, and sometimes even addictive in nature. Additionally, when fiscal resources are scarce, as they currently are for the State of Texas, it is difficult to invest limited state dollars in programs whose cost savings benefits may not be immediately evident.

However, the potential cost savings from health promotion programs can be estimated. Studies in major national corporations have indicated health promotion programs can result in significant costs savings through reduced employee absenteeism and medical care costs. Tenneco found, for employees participating in fitness programs, medical care costs decreased by about fifty percent and absenteeism declined thirty-two percent for women and seventeen percent for men. (4) A study by Prudential cited an average savings of $353.38 per employee participating in fitness programs. (5)

Potential cost savings in direct health care services for the State of Texas can also be estimated. For example, the Texas Department of Health reports the total cost, including staff time, of providing services to clinic clients with syphilis or gonorrhea is about $96 per client. In 1985, the twelve public health regions saw more than 77,000 clients with such venereal diseases, totaling expenditures of more than $7 million in one

year alone. Since venereal diseases are preventable, most, if not all, of the expenditures could have been avoided.

Acquired Immune Deficiency Syndrome (AIDS) is another example of how prevention efforts can reduce health care expenditures. AIDS is a relatively new disease with associated high medical costs. The current estimate for the average cost of AIDS cases is about $60,000. There presently is no cure for or vaccine against the AIDS virus, and the only effective preventive measure is education. Texas ranks fourth nationally in the number of AIDS cases. Unless immediate efforts are made to reduce the prevalence of AIDS in Texas, the associated medical and social costs of this deadly disease will continue to increase for many years to come.

Cancer prevention activities could also result in long-term cost savings to the Texas economy. The 1986 Texas Cancer Plan reports that in 1980 the estimated loss to Texas' economy from lost earnings of persons with cancer exceeded $1.5 billion. (6) Cancer is the second leading cause of death in Texas. One of the primary contributing factors to a person developing cancer is smoking, a voluntary behavior which can be prevented.

Another example of possible long-term cost savings from health promotion efforts is the prevention of teenage pregnancy. The Texas Department of Human Services reports that in 1985 more than 7000 births to teenagers were paid by Medicaid. Prevention of teenage pregnancy, thus, could reduce the state's expenditures for Medicaid and other social programs.

Interim charge to the Subcommittee

Recognizing the importance of health promotion programs in reducing the incidence of disabling conditions and diseases and expenditures on health care, the Senate Subcommittee on Health Services was directed by Lieutenant Governor Bill Hobby to examine health promotion efforts in Texas and to offer recommendations on how such efforts could be improved. Among the activities undertaken in addressing this charge were:

1. A review of death and disease statistics associated with the major causes of premature death in Texas;

2. A survey of health promotion programs currently conducted by selected state agencies;

3. A review of relevant recommendations and legislative initiatives proposed by previous task forces and legislative committees; and

4. Establishment of an advisory committee to suggest possible future health promotion initiatives in Texas.

This report summarizes the findings of such efforts and offers for consideration recommendations for addressing preventable causes of morbidity and mortality in Texas.

WHAT IS HEALTH PROMOTION?

For purposes of this report, health promotion is defined as: "any combination of health education and related organizational, economic and environmental supports for behavior conducive to health in individuals, groups or communities." (7)

Health promotion programs acknowledge that individuals do not have total personal control over all factors which may affect their health and well-being. In addition to personal lifestyle behaviors, health may be influenced by hereditary factors, access to and appropriate utilization of health care services, and environmental conditions. Some persons may have a hereditary predisposition to cancer or heart disease; for these people, health promotion programs can assist in maximizing their health status. Persons who are diabetic and indigent may not fully understand the benefits of proper diet and may have difficulty obtaining insulin or maintaining regular medical checkups. Non-smokers can be negatively affected by passive cigarette smoke or other pollutants in their work environments. Health promotion programs attempt to address these and the multiplicity of other factors which may have detrimental repercussions on persons' health status.

Factors associated with the major causes of disease and injury leading to premature death and disability are referred to as risk factors. Risk factors are the environmental, hereditary and behavioral influences which increase a person's risk of

disease or disability. Individual risk factors alone, such as cigarette smoking, can have a significant adverse effect on a person's health. Additionally, a combined effect of risk factors greatly multiplies a person's risk of disease. For example, because of their exposure to toxic materials, asbestos workers are at an increased risk for lung cancer. Asbestos workers who smoke have 30 times more risk for lung cancer than their co-workers. However, asbestos workers who smoke are 90 times more at risk for lung cancer than persons who neither work with asbestos nor smoke. (8)

Calculations by the Center for Health Promotion Research and Development at The University of Texas Health Science Center at Houston indicate there are six risk factors which collectively contribute to almost half of all deaths in Texas of persons 64 years of age or younger: alcohol and drug abuse; cigarette smoking; poor nutrition and lack of exercise; poor availability and use of health services; non-use of seatbelts; and environmental and work-related threats. (A detailed explanation of the calculations used to determine the incidence of these risk factors is included in Appendix 4.) The potential and dramatic impact of reducing the incidence of such risk factors can be noted, for example, in the fact that out of the estimated 45,000 Texans who die each year from heart disease, lung cancer, emphysema and bronchitis, at least 17,000 deaths are attributable to a single risk factor, smoking tobacco. (9)

Caution must be taken in believing that behavioral risk factors are easily controllable or changeable. Lifestyle choices must be viewed within a larger societal context of multiple factors which can influence an individual. Peer pressure, cultural influences, and the mass media all have significant effects on a person's behavior.

There is an increasing awareness among health professionals of the value in pursuing a comprehensive approach to altering high risk behaviors. A comprehensive approach to health promotion requires participation by non-health sectors of society, as well as health professionals. Employers, educators, the media, and government agencies all have an important role in reducing the incidence of disease and disability through effective health promotion initiatives.

There are several health promotion initiatives in Texas which exemplify a comprehensive approach to reducing the incidence of risk factors. Most noteworthy are the following programs which have been found to have a significant positive impact on health-related behaviors. In 1986, these three health promotion programs each received the U. S. Department of Health and Human Services Award for Excellence in Community Health Promotion: (10)

Don't Buck the Odds, Buckle Up

In the Arlington area, a safety and health coalition was instigated by the New Car Dealers Association of Metropolitan Dallas, Parkland Memorial Hospital and the Texas Department of Health for the purpose of encouraging compliance with the new mandatory seatbelt law. Two target populations were identified which needed additional encouragement to use seatbelts. A combined approach of providing educational opportunities to interested employers and community groups and developing a multi-level media campaign was used. A speakers bureau, which included former Dallas Cowboy football players, was also used. The next planned phase includes a poster contest for children which emphasizes the need for all family members to use seatbelts.

HealthAdventure

The Houston Academy of Medicine, Harris County Medical Society, and Shell Companies Foundation, Inc. developed a program for elementary school children designed to assist them in making healthy lifestyle decisions. Children receive health screenings and use workbooks that focus on growth and development, the lungs, the eyes, the heart, safety, and physical fitness. Teachers receive in-service training on how to use the classroom materials. Further, a 46-foot van equipped with interactive educational displays and screening tests is used, with special attention being given to the most disadvantaged schools.

Mesa Physical Fitness Program

In Amarillo, the Mesa Petroleum Company conducts a comprehensive physical fitness and health promotion program for its 750 employees, their spouses, and their dependent children. The program includes such activities as risk assessments and fitness profiles, exercise programs, smoking control programs and policies, and nutrition and weight control classes. Cash awards are made to participants through a wellness incentive plan. Recently, the program was extended to the community at-large.

MAJOR PREVENTABLE RISK FACTORS IN TEXAS

To assess the potential impact certain behaviors have on the development of major diseases and injuries which can result in premature death, the Centers for Disease Control (CDC) utilizes a statistical formula that incorporates mortality rates and prevalence rates of risk factors. In such calculations, premature death is defined as the mortality of persons ages one to sixty four years. By applying CDC's methodology, it is possible to estimate the annual number of deaths in Texas which can be attributable to specific risk factors. Statistics on the prevalence of morbidity and nonfatal injuries are not readily available, except for a few specific communicable diseases, such as sexually transmitted diseases. Thus, the closest estimation of the impact of specific behavioral risk factors can only be calculated from mortality data.

With support from the Centers for Disease Control, the Texas Department of Health conducted the Texas Behavioral Risk Factor Survey and determined the prevalence rate of specific risk factors in Texas. Based on findings from the Texas Behavioral Risk Factor Survey in 1982 and 1984, the Center for Health Promotion Research and Development with The University of Texas Health Science Center at Houston calculated that approximately fifty percent of all premature deaths in Texas can be attributed to a handful of preventable risk factors. According to such calculations, which provide the best available estimate given

current knowledge, premature deaths due to major diseases and injuries are correlated with six risk factors as follows:

11.6% of deaths are attributable to Alcohol Abuse

This includes deaths resulting from liver disease, homicides, suicides, motor vehicle accidents, and other injuries and diseases in which alcohol has been determined to be a factor in the cause of death.

9.8% of deaths are attributable to Cigarette Smoking

This includes deaths due to lung cancer, heart disease, emphysema and other chronic obstructive pulmonary disorders. According to the Texas Department of Health, in 1985 more than 6500 people in Texas died from lung cancer.

8.6% of deaths are attributable to a Lack of Access to or Utilization of Health Services

This statistic includes deaths primarily from breast, genital, and digestive cancers, chronic kidney disease, diabetes, heart disease, and strokes. With proper and timely health screening, early signs of such chronic disease can be detected and treated. Thus, deaths from such diseases possibly could have been prevented with appropriate and timely medical care.

6.7% of deaths are attributable to a Lack of Physical Exercise and Poor Nutrition

This includes deaths resulting from chronic conditions, such as heart disease, chronic kidney disease, diabetes, and some cancers, all of which can result from improper diet and poor physical fitness.

5% of deaths are attributable to Environmental Pollution

This includes deaths caused by emphysema and some cancers which can result from poor air quality and environmental pollutants.

3.6% of deaths are attributable to Non-use of Seatbelts

This includes deaths occurring as a result of motor vehicle accidents. According to the Texas Department of Public Safety, the majority of persons in Texas killed in motor vehicle crashes were not wearing their seatbelts.

A detailed chart illustrating the calculations of prevalence rates for each risk factor and the estimated number of attributable deaths is contained in Appendix 4. It is important to note three aspects of these calculations. First of all, this technique for calculating attributable risk is new and, as previously mentioned, is based on mortality statistics rather than persons' current health status. Second, the calculations are conservative since they are based only on the number of

deaths for persons 1 to 64 years of age; the findings may also apply to persons older than 64 years of age. Third, the multiplicity of risk factors in a given person greatly increases his chances of premature death. For example, an intoxicated person involved in a motor vehicle accident may be fatally injured because he was not wearing a seatbelt.

The six most significant risk factors affecting the health status of Texans are all theoretically preventable. The usage of alcoholic beverages and cigarettes can be curtailed. Accessibility to and utilization of health services can be improved, as has resulted from recent indigent health care initiatives in Texas. People can improve their nutritional intake and their frequency of exercise. Environmental pollution, including passive cigarette smoke, can be better regulated. And, through regulatory interventions and public awareness campaigns, people can be encouraged to use seatbelts.

In setting priorities for health promotion activities, it is important to realize some interventions can have a more immediate impact on reducing individuals' risk of disabling conditions and chronic diseases. For example, recent legislation in Texas mandating usage of seatbelts and raising the age at which alcoholic beverages can be purchased have both had an immediate positive impact on reducing the number of deaths from motor vehicle crashes. Additionally, since cigarette smoking is the single most preventable cause of illness and premature

death (11), significant health gains can be made by helping people to quit or to never begin smoking.

By taking steps to maximize scarce resources for health promotion programs through better coordination of activities and targeting interventions to behaviors or conditions which most directly affect persons' health and lifestyle decisions, the incidence of chronic diseases, disabling conditions, and premature deaths in Texas can be ultimately reduced.

RECOMMENDATIONS

I. State Agency Programs

(1) INTERAGENCY COUNCIL ON HEALTH PROMOTION

ISSUE: Health promotion efforts conducted by state agencies are often fragmented and focused on specific diseases or health-related behaviors rather than being coordinated and comprehensive.

RECOMMENDATION: **THE LEGISLATURE SHOULD ENCOURAGE ESTABLISHMENT OF AN INTERAGENCY COUNCIL ON HEALTH PROMOTION UNDER THE HEALTH AND HUMAN SERVICES COORDINATING COUNCIL FOR THE PURPOSES OF IDENTIFYING, COORDINATING, AND MINIMIZING DUPLICATION OF HEALTH PROMOTION EFFORTS AMONG STATE AGENCIES.**

DISCUSSION: The Subcommittee on Health Services requested key state agencies to report on the extent and type of health promotion activities they conduct and the source and amount of funding for such activities. The survey indicated health promotion activities in Texas are conducted by many state agencies on a variety of topics and using a multitude of approaches. Often there is a duplication of efforts. This is most evident in substance abuse programs, where the Texas Department of Health, Texas Department of Mental Health and Mental Retardation, Texas Education Agency, Texas Commission on Alcohol and Drug Abuse, Texas Department of Public Safety, and

the Texas Department of Highways and Public Transportation all have substance abuse informational activities.

By coordinating their efforts, it is likely state agencies will be able to maximize their limited resources for health promotion efforts.

The Health and Human Services Coordinating Council is statutorily mandated, (Chapter 131, Title 9, Human Resources Code, V.T.C.S.), to "serve as the primary state resource in coordinating and planning for health and human services" and is the most appropriate state entity to coordinate an Interagency Council on Health Promotion.

At a minimum, the following state agencies, which currently have statewide health promotion initiatives, should be represented on the Interagency Council on Health Promotion: the Texas Department of Health, Texas Commission on Alcohol and Drug Abuse, Texas Department of Mental Health and Mental Retardation, Texas Education Agency, Texas Department of Public Safety, the Texas Department of Highways and Public Transportation, and the Texas Department on Aging.

(2) STATE EMPLOYEE ASSISTANCE PROGRAMS

ISSUE: State employees are a valuable resource for the State of Texas, and steps should be taken to assist them in obtaining optimal health status.

RECOMMENDATION: **THE LEGISLATURE SHOULD ENCOURAGE STATE AGENCIES TO MAKE EMPLOYEE ASSISTANCE PROGRAMS AVAILABLE TO STATE EMPLOYEES.**

DISCUSSION: Employee Assistance Programs provide a mechanism for confidentially and professionally addressing emotional, marital, substance abuse, and other problems which adversely affect employees' job performances. There are a variety of approaches which may be taken with Employee Assistance Programs, the most common being a contractual agreement with counselors and health professionals who can provide confidential screening, referral, and counseling services to employees and their families.

The Governor's Task Force on State Employee Health Insurance advocated establishment of Employee Assistance Programs for state employees. The task force reported that, in addition to the health promotion benefits to employees and the job performance benefits to employers, the State of Texas could also benefit from reduced insurance costs. According to the Task Force, "employees who have access to an employee assistance program are more likely to seek professional assistance, thereby reducing the incidence

of serious medical conditions .... This lower insurance utilization rate translates directly into insurance savings for both the employees and the state." (12)

The Texas Commission on Alcohol and Drug Abuse, one of the state agencies which has had an Employee Assistance Program in place for several years, reports significant positive results from its program. A copy of the Commission's Employee Assistance Policy Statement is included in Appendix 5.

(3) STATE EMPLOYEE HEALTH PROMOTION

ISSUE: Employee fitness programs reduce absenteeism, medical care costs, and disability and worker's compensation expenditures, and increase employees' morale and productivity. Additionally, state employees can derive positive benefits from access to health promotion information.

RECOMMENDATION: **THE LEGISLATURE SHOULD ENCOURAGE ALL STATE AGENCIES TO DEVELOP FITNESS PROGRAMS FOR THEIR EMPLOYEES AND TO MAKE AVAILABLE TO EMPLOYEES EDUCATIONAL MATERIALS ON ALCOHOL, DRUG AND TOBACCO USAGE, AND REFERRAL INFORMATION ON LOCAL COMMUNITY HEALTH EDUCATION, SCREENING AND TREATMENT FACILITIES.**

DISCUSSION: In 1983, the Texas Legislature enacted the State Employee Health Fitness and Education Act, (Art. 6252-27, V.T.

C.S.), a landmark measure that was the first of its kind in the nation. The preamble of the Act states:

> The legislature finds that effective state administration is materially enhanced by programs designed to encourage and create a condition of health fitness in state administrators and employees, and that public money spent for these programs serves an important public purpose. Among the purposes that may be served by these programs are an understanding and diminution of the health risk factors associated with modern society's most debilitating diseases, development of greater productivity and work capacity, reduction in absenteeism, reduction of health insurance costs, and an increase in the general level of health fitness. (13)

The legislation enables state agencies to use available public funds and facilities for health fitness education and activities for state employees. Prior to implementation of an employee fitness program, agencies are required to submit a plan to the Governor's Commission on Physical Fitness detailing the purpose, nature, duration, costs, and expected results of the program and to obtain the written approval of the Governor or his representative. In late 1984, the Governor's Commission on Physical Fitness developed guidelines for implementation of the Act and distributed them to all state agencies and institutions of higher learning. To date, twenty-five state agencies have approved program plans, representing a total potential employee pool of over 65,000 persons. The quality and type of programs

vary greatly, primarily due to the extent of resources an agency devotes to the program.

No general appropriations have been made for the State Employees Health Fitness and Education Act; however, the Act authorizes agencies to use legislatively appropriated funds, such as lapsed or unexpended funds for salaries and professional fees and services, to initiate and maintain employee health and fitness programs. The ways in which state funds may be expended include the purchase of relevant equipment, supplies and training activities. State funds may not be used to purchase employee memberships in health clubs, pay registration fees for employees to enter teams in sports leagues, procure uniforms for sports teams, sponsor activities not open to both genders, or pay employee medical costs.

Major studies conducted in Texas offices of Tenneco and Prudential provide strong support for the premise that employee fitness programs significantly reduce absenteeism and medical care costs. For example, Tenneco found that medical care costs of male and female employees participating in a fitness program decreased by 58% and 44% respectively and absenteeism decreased 32% for females and 17% for males. (14) A study by Prudential found a 45.7% reduction in major medical costs, a 20.1% reduction in the average number of disability days, and a 31.7% reduction in direct disability dollar costs for employees participating in the fitness program. Additionally, the Prudential study revealed an average combined savings of $353.38

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and an average operational cost of $120.60 per participating employee.(15) Employee fitness programs for state employees might have similar positive fiscal implications for the State of Texas.

Some state agencies may not have adequate resources to establish a comprehensive Employee Assistance Program or fitness program; however, at a minimum, health promotion information should be made available to state employees. Providing employees access to accurate information about health risk behavior can have a beneficial effect in assisting employees in developing and maintaining positive health practices which can ultimately improve their well-being and job performances.

(4) GOVERNOR'S COMMISSION ON PHYSICAL FITNESS

ISSUE: Funding for the Governor's Commission on Physical Fitness was removed during the 69th Texas Legislature, Third Called Special Session.

RECOMMENDATION: **THE LEGISLATURE SHOULD SUPPORT CONTINUATION OF THE ACTIVITIES OF THE GOVERNOR'S COMMISSION ON PHYSICAL FITNESS.**

DISCUSSION: The Governor's Commission on Physical Fitness was established in 1971, (Art. 4413(44), V.T.C.S.), and charged with: (1) educating the public about the benefits of physical

fitness; (2) developing physical fitness programs for persons of all ages; (3) serving as the coordinating body for fitness programs for schools, state and local government, and private industry; and (4) collecting and disseminating pertinent information. The Commission also is charged under the State Employee Health Fitness and Education Act with reviewing plans for employee fitness programs for state employees.

Major accomplishments of the Commission include: (1) developing guidelines for implementation of the State Employee Health Fitness and Education Act of 1983; (2) conducting in-service training for more than 14,000 Texas teachers on usage of fitness tests for students; (3) training about 8000 persons to provide specialized physical activity for senior citizens; (4) recruiting employee fitness program leaders in private industry to donate their time to assist state agencies in developing low cost employee fitness programs; and (5) conducting quarterly training programs for state agencies wanting to establish or expand employee fitness programs.

During the budget-cutting legislative session in September 1986, the Legislature removed all state appropriations for the Commission, with the provision that the Governor's Office could continue the agency's functions through funding from the Governor's budget.

The Governor's Commission on Physical Fitness has provided useful technical assistance to state agencies in developing low cost employee fitness programs which ultimately can reduce

employee absenteeism and medical care costs, thereby reducing expenditures for the State of Texas. The Legislature should ensure that the major activities of the Commission are continued.

II. School Health Activities

(5) SCHOOL HEALTH PROGRAM

ISSUE: Comprehensive school health initiatives for school-age children need to be expanded and should incorporate the students' families and local community organizations.

RECOMMENDATION: **THE LEGISLATURE SHOULD SUPPORT THE TEXAS CANCER COUNCIL'S EFFORTS TO CONTINUE AND EXPAND THE SCHOOL HEALTH PROGRAM SO THAT EACH REGIONAL EDUCATION SERVICE CENTER HAS A SCHOOL HEALTH SPECIALIST. ADDITIONALLY, THE TEXAS EDUCATION AGENCY AND THE TEXAS DEPARTMENT OF HEALTH SHOULD WORK JOINTLY TO CONTINUE DEVELOPMENT OF REGIONAL NETWORKS UNDER THE SCHOOL HEALTH PROGRAM WHICH: (1) DESIGN AND IMPLEMENT LOCAL HEALTH PROMOTION PROGRAMS THAT REINFORCE SCHOOL HEALTH EDUCATION, HEALTH SERVICES, AND PHYSICAL EDUCATION CURRICULA FOR GRADES KINDERGARTEN - 12; AND (2) SERVE AS RESOURCES FOR NURSES AND TEACHERS PROVIDING HEALTH AND PHYSICAL EDUCATION.**

DISCUSSION: Through funding from the Texas Cancer Council, the Texas Education Agency has initiated the School Health Program and placed health educators in fifteen of the twenty

regional education service centers and a statewide school health coordinator in the Texas Education Agency. Regional education service centers funded for the 1986 - 1987 school year are: Edinburg (I), Corpus Christi (II), Houston (IV), Beaumont (V), Huntsville (VI), Kilgore (VII), Richardson (X), Fort Worth (XI), Waco (XII), Austin (XIII), Amarillo (XVI), Lubbock (XVII), Midland (XVIII), El Paso (XIX), and San Antonio (XX).

Under the School Health Program, regional networks have been established which correspond to regional education service centers' boundaries and coordinate activities with local health departments, voluntary health associations, and school personnel. The regional networks enable the sharing of instructional materials, health data, training programs, and other resources for health teachers and school nurses among school districts.

The School Health Program is an excellent vehicle for coordinating health promotion activities between school districts and community organizations and providing technical assistance on the content and presentation of health promotion activities for school-age children. The School Health Program can ultimately help improve the health status of children as they mature by helping them be cognizant of and acquire health practices which improve and promote good health and by supporting the role of school nurses in protecting the health of students.

(6) SCHOOL-AGE PREGNANCY

ISSUE: The incidence of school-age pregnancy and parenthood in Texas is one of the highest in the nation. It is essential students acquire concepts and skills that will enable them to make informed decisions about sexual behavior.

RECOMMENDATION: **THE TEXAS EDUCATION AGENCY SHOULD CONTINUE TO ASSIST LOCAL INDEPENDENT SCHOOL DISTRICTS IN DEVELOPING COMPREHENSIVE SCHOOL HEALTH PROGRAMS WHICH INCLUDE THE PREVENTION ASPECTS OF SCHOOL-AGE PREGNANCY.**

DISCUSSION: It is essential children and adolescents obtain accurate information about reproduction and human sexuality so they can make informed decisions about future sexual activities.

According to the 1987 State Health Plan, the pregnancy rate for Texas females 15 - 19 years of age is one of the highest in the nation, as is that for girls younger than 15 years of age.(16) The Select Committee on Teenage Pregnancy, in its report to the 68th Legislature, stated:

> These young women are not prepared physically, emotionally, or financially for pregnancy and parenthood. Maternal death is 60 percent higher for young teens than for their 20 - 24 year old counterparts. The risk of congenital malformations, low birth weight, birth injuries and infant death are much more likely among babies born to teenagers. Pregnant teens are seven times more likely to attempt suicide than their non-pregnant peers, and sadly, they are

> more likely to abuse and neglect their children. While over half of teen mothers are unwed, 95 percent of them choose to keep their babies. Eight out of ten teen mothers never finish high school and 60 percent have another child while they themselves are still school-age. (17)

In July 1986, the State Board of Education adopted a plan for addressing school-age pregnancy and directed the Texas Education Agency to:

(1) emphasize prevention of school-age pregnancy through the required curricular elements in social studies, health, physical education, science, and vocational education which focus on personal decision making and responsibility;

(2) develop and disseminate a technical assistance publication for grades Kindergarten - 12 which focuses on the teaching of self-responsibility and decision making;

(3) provide technical assistance to local education agencies, upon their request, on the development and implementation of resources which focus on the roles of decision making and personal responsibility in the prevention of school-age pregnancy;

(4) serve as a clearinghouse for information about relevant community resources;

(5) work with other agencies and organizations in identifying high-risk students; and

(6) conduct a statewide conference in February 1987 which will provide "positive leadership in the implementation of the

school-age pregnancy prevention program, 'Education for Self-Responsibility'".(18)

The Subcommittee on Health Services commends the State Board of Education for taking an affirmative and comprehensive approach in addressing teenage pregnancy.

(7) HEALTH TEXTBOOKS

ISSUE: Health textbooks in Texas' schools have contained minimal information about sexually-related topics.

RECOMMENDATION: **THE LEGISLATURE SHOULD ENCOURAGE THE STATE BOARD OF EDUCATION TO CONTINUE ITS RECENT COMMITMENT TO PROVIDING THOROUGH AND ACCURATE INFORMATION ABOUT SEXUAL BEHAVIOR, SEXUALLY TRANSMITTED DISEASES, AND THEIR CONSEQUENCES IN HEALTH TEXTBOOKS FOR STUDENTS.**

DISCUSSION: To date, health textbooks in Texas' public schools have contained very limited information on reproductive health and responsible sexual behavior. In light of the high incidence of teenage pregnancy in Texas and the increasing numbers of persons with AIDS, it is critical that students examine the responsibilities and ramifications attendant to sexual activity as they approach sexual maturity.

In recognition of this need, the State Board of Education recently refused to adopt a secondary health textbook that had

not adequately addressed responsibility with respect to sexual behavior. The Subcommittee on Health Services encourages the State Board of Education to adopt health textbooks which provide accurate and thorough treatment of concepts and skills needed by students to recognize the scope of the problems associated with school-age pregnancy and other sexually-related conditions.

(8) YOUTH FITNESS

ISSUE: Physical fitness levels of Texas' school-age children have declined during the past decade.

RECOMMENDATION: **PHYSICAL FITNESS INSTRUCTION AND PARTICIPATION SHOULD BE REQUIRED OF ALL STUDENTS, GRADES KINDERGARTEN - 12, FOR A MINIMUM OF THIRTY MINUTES PER DAY, THREE TIMES PER WEEK WITHOUT CLASSROOM EXEMPTIONS. ADDITIONALLY, THE TEXAS EDUCATION AGENCY SHOULD: (1) DEVELOP A MODEL PHYSICAL EDUCATION CURRICULA FOR GRADES KINDERGARTEN - 12, WITH THE PRIMARY OBJECTIVE OF OBTAINING SUFFICIENT PHYSICAL FITNESS LEVELS FOR ALL STUDENTS; (2) ENSURE ANNUAL FITNESS EXAMINATIONS FOR ALL STUDENTS; AND (3) MAKE A CLEAR STATEMENT OF THE IMPORTANCE OF PHYSICAL FITNESS IN RELATIONSHIP TO OTHER ESSENTIAL ELEMENTS FOR PHYSICAL EDUCATION.**

DISCUSSION: Teaching children the importance of physical fitness and the health benefits of physical activity can have

positive lasting effects throughout their lifetimes. Maintaining sufficient levels of physical fitness also can enhance children's abilities to concentrate in the classroom and perform academic activities.

In 1984, the Governor's Commission on Physical Fitness, the Texas Association for Health, Physical Education, Recreation, and Dance, and the American Heart Association conducted the Texas Youth Fitness Study in order to assess physical fitness levels of school-age children. The study revealed an overall deterioration of youth fitness levels in the preceding decade, especially in cardiorespiratory endurance. In 1985, the Texas Education Agency conducted a similar study on physical fitness levels of students in randomly selected school districts and obtained results similar to the Texas Youth Fitness Study. Results of both Texas studies parallel findings in the National Children and Youth Fitness Study (1985) that fitness levels in school-age children have declined in recent years despite the nation's greater attention to physical fitness and wellness.

In the most recent State Board of Education Rules for Curriculum, physical education requirements are as follow: (1) daily physical education in Kindergarten through the third grade; (2) an equivalent of 112 minutes of physical education per week in grades four through six; (3) one unit of physical education in grades seven and eight; and (4) one and one-half units of physical education in grades nine through twelve.

A primary objective of physical education classes should be to foster the development and maintenance of cardiovascular and overall physical fitness levels appropriate to students' individual abilities. By specifying minimum time requirements, recommending the content of physical fitness instruction and participation, and annually evaluating all students' fitness levels, the Texas Education Agency will be helping to ensure that students actively participate in appropriate and sufficient physical fitness activities on a regular basis.

III. Regulatory Initiatives

(9) CLEAN INDOOR AIR LEGISLATION

ISSUE: Exposure to passive cigarette smoke significantly increases a nonsmoker's risk of lung cancer, cardiovascular diseases, and respiratory diseases.

RECOMMENDATION: **THE LEGISLATURE SHOULD ENACT CLEAN INDOOR AIR LEGISLATION WHICH WILL LIMIT SMOKING IN PUBLIC PLACES.**

DISCUSSION: Current state law permits smoking in all places except where it is expressly prohibited. Enactment of clean indoor air legislation would reverse such requirements in that it would enable smoking only in public areas in which it is expressly permitted.

According to the Texas Cancer Plan, two out of three persons in Texas do not smoke. (19) State legislation should be enacted which minimizes nonsmokers' exposure to cigarette smoke by enabling them to work, dine, and conduct their daily activities in smoke-free environments.

During the past two years, thirteen Texas cities, including Austin, San Antonio, and Houston, have enacted clean indoor air laws through passage of local ordinances. A state clean indoor air act is one component of a plan to provide similar health benefits to other nonsmokers throughout the state.

Restricting the areas in which smoking occurs also can ultimately reduce the number of persons smoking by providing social environments which discourage smoking.

(10) MINORS' ACCESS TO TOBACCO PRODUCTS

ISSUE: Usage of tobacco products in all forms significantly contributes to premature death and physical decline.

RECOMMENDATION: **THE AGE AT WHICH PERSONS CAN PURCHASE ANY TOBACCO PRODUCT SHOULD BE RAISED TO EIGHTEEN YEARS.**

DISCUSSION: Tobacco usage is a major risk factor for development of cancer, cardiovascular diseases, and respiratory diseases, and cigarette smoking is the single most preventable cause of chronic illnesses and premature death. Additionally,

usage of chewing tobacco and snuff greatly increases individuals' chances of developing oral cancers.

Increasing the age at which tobacco products can be purchased will reduce teenagers' access to them and, ultimately, has the potential for reducing the number of persons who smoke or chew tobacco.

(11) MOTORCYCLE HELMETS

ISSUE: The number of fatal injuries to motorcyclists has increased since the helmet law was repealed in 1977.

RECOMMENDATION: **THE LEGISLATURE SHOULD REQUIRE HELMETS TO BE WORN BY ALL PERSONS DRIVING OR RIDING ON MOTORCYCLES.**

DISCUSSION: In 1977, the 65th Texas Legislature amended Article 6701c-3, V.T.C.S., to permit persons eighteen years of age or older to drive or ride motorcycles on public streets and highways without protective headgear. The previous law, which required all persons to wear helmets, had been in place since 1967.

Currently, only minors are prohibited from operating or riding a motorcycle without protective headgear approved by the Department of Public Safety. Violators are guilty of a misdemeanor and can be fined between $10 and $50.

The Texas Department of Health reports that during the past nine years motorcyclists accounted for ten percent of all traffic fatalities, even though motorcycles represented only three percent of all registered vehicles in Texas. The Texas Department of Health further reports that prior to repeal of the helmet law, an average of seven motorcyclists per 10,000 motorcycles died each year, compared to a current average of twelve motorcycle fatalities per 10,000 motorcycles.

Additionally, a study conducted by the Department revealed injured cyclists without helmets had more severe head and nervous system injuries and had hospital bills more than twice that of cyclists who wore helmets. The study also revealed forty-one percent of unhelmeted cyclists did not have hospital insurance, compared to only twenty-seven percent of cyclists who were wearing helmets.

IV. Risk Reduction Programs

(12) AIDS EDUCATION

ISSUE: Public education is currently the best defense against spread of the AIDS virus.

RECOMMENDATION: **THE LEGISLATURE SHOULD APPROPRIATE FUNDS TO THE TEXAS DEPARTMENT OF HEALTH FOR THE EXPANSION OF HEALTH EDUCATION AND RISK REDUCTION EFFORTS SPECIFIC TO ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).**

DISCUSSION: Internationally, AIDS is one of the most serious public health threats of the century, and Texas is no exception. In the past five years, more than 1000 persons have died of AIDS in Texas. The number of deaths is expected to escalate dramatically by 1990. Texas currently has the fourth largest incidence of AIDS of any state in the nation.

There is a lot of public fear and misconception about how the AIDS virus is transmitted. Although AIDS is an infectious disease, it cannot be casually transmitted in ways as can measles or the flu. The AIDS virus is transmitted through sexual contact, the sharing of intravenous drug needles and syringes, and contaminated blood products. The virus also can be transmitted from infected mothers to their infants.

Due to specific risk behaviors, the AIDS virus has been found, to date, primarily among bisexual and homosexual men, intravenous drug users, hemophiliacs, the partners of the previous four groups, and infants of women infected with the virus. It is expected there will be an increased proportion of heterosexual persons infected with the virus in the near future.

Although there presently is no cure for AIDS, it is a disease which is largely preventable through changes in personal behavior, such as avoiding the exchange of semen during sexual activities and preventing the exchange of blood products which have not been screened for AIDS virus antibodies.

In October 1986, U.S. Surgeon General C. Everett Koop issued a comprehensive educational report on AIDS and called for early education of children about the behaviors which place persons at risk of developing AIDS. In his report, the Surgeon General stated:

> Adolescents and pre-adolescents are those whose behavior we wish to especially influence because of their vulnerability when they are exploring their own sexuality (heterosexual and homosexual) and perhaps experimenting with drugs. Teenagers often consider themselves immortal, and these young people may be putting themselves at great risk. (...)
>
> Those of us who are parents, educators and community leaders, indeed all adults, cannot disregard this responsibility to educate our young. The need is critical and the price of neglect is high. The lives of our young people depend on our fulfilling our responsibility. (20)

The Texas Department of Health has relied primarily on federal grants to fund public education and risk reduction programs on AIDS. Because the federal funds have been limited, the Department has not been able to develop and implement a comprehensive and aggressive education program which is severely and immediately needed throughout the state.

(13) RISK REDUCTION TOOLS AND PROGRAMS

ISSUE: To be most effective, health promotion programs should be targeted toward individuals' and/or communities' concerns and needs.

RECOMMENDATION: **THE LEGISLATURE SHOULD SUPPORT CONTINUATION OF THE TEXAS BEHAVIORAL RISK FACTOR SURVEY AND RISK REDUCTION PROGRAMS OF THE TEXAS DEPARTMENT OF HEALTH.**

DISCUSSION: Initially begun in 1982 through a federal grant, the Behavioral Risk Factor Survey has been a useful tool in assessing the health habits, risk behavior patterns, and preventive care practices of persons throughout Texas. Prior to development of the Behavioral Risk Factor Survey, the Texas Department of Health primarily had to rely on mortality data to assess risk behavior patterns which contribute to premature deaths and preventable chronic diseases. Mortality data provides very limited risk behavior data in that it does not reveal

thorough information of current behaviors which over time may ultimately lead to premature morbidity and mortality. Information obtained from the Behavioral Risk Factor Survey has helped to maximize the effectiveness of health promotion efforts by enabling programs to be targeted toward behaviors that place persons at greater risk for chronic diseases and premature deaths.

One such program is the Adult Health Program which offers a number of activities specifically designed to reduce a person's risk of premature death and disability. An appraisal tool is used to identify persons at risk as a result of lifestyle habits and/or family or environmental conditions. Individuals receive medical screening tests based on identified risks, such as diabetes, hypertension, and cancer screening, and counseling on relevant lifestyle factors. Counseling may include exercise, nutrition, injury prevention, stress, tobacco use, and testicular and breast self-examination. The Adult Health Program is offered by most public health regions and some local health departments in clinics, schools or worksites. The Texas Department of Health reports preliminary program evaluation results indicate persons participating in the Adult Health Program are making positive changes in their lifestyle habits.

Another example of the Department's risk reduction programming is the Planned Approach to Community Health (PATCH) Program. This program, funded by the Public Health Promotion Division, allows local health departments to develop broad-based

community coalitions for health promotion. Going through a planned series of steps from data collection to program implementation and evaluation, demonstration communities have experienced significant results. Outcomes from such programs have included community and school drug abuse prevention activities, development of senior citizen centers, and nutrition and weight control programs.

V. Access to Health Education

(14) INDIGENT HEALTH CARE PROGRAMS

ISSUE: Effective health education programs for indigent persons need to be available throughout Texas.

RECOMMENDATION: **THE LEGISLATURE SHOULD SUPPORT CONTINUATION AND EXPANSION OF THE MATERNAL AND INFANT HEALTH IMPROVEMENT ACT AND THE HEALTH SERVICES IMPROVEMENT ACT.**

DISCUSSION: Adopted by the 69th Texas Legislature, the Maternal and Infant Health Improvement Act (MIHIA) and the Health Services Improvement Act are two landmark legislative initiatives that resulted from the study conducted by the Task Force on Indigent Health Care. The Task Force on Indigent Health Care recognized health education as a important component of preventive care services and advocated implementation of

comprehensive local health education initiatives throughout the state.

Designed to improve the accessibility and availability of health care services for indigent persons, the two enabling acts have also increased the availability of health education services for indigent persons throughout Texas. Health education is a significant component of the MIHIA program at the local level. The central office of the Texas Department of Health is developing informational and outreach materials for all MIHIA contractors. Additionally, policies relating to the Health Services Improvement Act require all funded programs to contain health information components.

The Maternal and Infant Health Improvement Act and the Health Services Improvement Act are effective vehicles for increasing the availability of quality patient education programs and health services for indigent persons and should receive the Legislature's continued support.

ENDNOTES

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(3) Healthy People, p.3.

(4) "New Fitness Data Verifies: Employees Who Exercise Are Also More Productive", Athletic Business, December 1984, p. 3.

(5) "Reduced Disability and Health Care Costs in An Industrial Fitness Program", Journal of Occupational Medicine, vol. 26, no. 11, November 1984.

(6) Texas Cancer Plan: Actions and Directions for the Future 1986-2000, Legislative Task Force on Cancer in Texas, September 10, 1986.

(7) Lawrence Green and L.W. Anderson, Community Health, Fifth edition, C.V. Mosby, Co., St. Louis, Missouri, 1986.

(8) Healthy People, p. 13.

(9) Texas Department of Health

(10) The Secretary's Community Health Promotion Awards 1986, U. S. Public Health Service, Department of Health and Human Services, pp. 118-120.

(11) "Smoking is killing your constituents", Texas Department of Health, July 1986.

(12) The Governor's Task Force on State Employee Health Insurance: Quality and Cost Containment, 1984, p. 110.

(13) State Employees Health Fitness and Education Act of 1983, Section 2, Art. 6252-27, V.T.C.S.

(14) Athletic Business, December 1984, p. 26

(15) Journal of Occupational Medicine, November 1984.

(16) 1987-1988 Texas State Health Plan, p. 89.

(17) Select Committee on Teenage Pregnancy Final Report, Texas House of Representatives, October 1982.

(18) "Plan for Action", State Board of Education, July 12, 1986.

(19) Texas Cancer Plan, p. 109.

(20) The Surgeon General's Report on Acquired Immune Deficiency Syndrome, U.S. Public Health Service, Department of Health and Human Services, 1986, pp. 4-5.

Appendices

Appendix 1

LEADING CAUSES OF DEATH IN TEXAS
1985

source: Vital Statistics
Texas Department of Health

LEADING CAUSES OF DEATH IN TEXAS, 1985

Rate Per 100,000 Estimated Population

		DEATHS	RATE	PERCENT OF TOTAL DEATHS
	ALL CAUSES	118,183	721.9	100.0
1	Diseases of the Heart	40,079	244.8	33.9
2	Malignant Neoplasms	24,032	146.8	20.3
3	Cerebrovascular Diseases	8,793	53.7	7.4
4	Accidents and Adverse Effects	7,095	43.3	6.0
5	Bronchitis, Emphysema, Asthma, and Allied Conditions	3,730	22.8	3.2
6	Pneumonia & Influenza	3,521	21.5	3.0
7	Suicide	2,236	13.7	1.9
8	Homicide	2,213	13.5	1.9
9	Diabetes Mellitus	1,911	11.7	1.6
10	Certain Conditions Originating In The Perinatal Period	1,412	8.6	1.2
	All Other Causes	23,161	141.5	19.6

source: Texas Vital Statistics 1985
Texas Department of Health

Appendix 2

PROMINENT CONTROLLABLE RISK FACTORS IN TEXAS

source: Public Health Promotion Division
Texas Department of Health

PROMINENT CONTROLLABLE RISK FACTORS

Cause of Death	Risk Factors
Heart Disease	Smoking, high blood pressure, elevated serum cholesterol, diabetes, obesity, lack of exercise, type A behavior
Cancers	Smoking, alcohol, solar radiation, ionizing radiation, worksite hazards, environmental pollution, medications, infectious agents, diet
Stroke	High blood pressure, cardiac function
Accidents, other than motor vehicle	Alcohol, smoking (fires), product design, home hazards, handgun availability
Influenza/penumonia	Vaccination status, smoking
Motor Vehicle Accidents	Alcohol, no safety restraints, speed, vehicle design, roadway design
Diabetes	Obesity (for adult onset)
Cirrhosis of Liver	Alcohol
Suicide	Handgun availability, alcohol or drug misuse (stress)
Homicide	Handgun availability, alcohol (stress)

source: Public Health Promotion Division
Texas Department of Health

Appendix 3

OVERVIEW OF THE IMPLEMENTATION PLAN FOR THE TEXAS 1990 HEALTH PROMOTION OBJECTIVES

* Introduction
* Health Promotion
* Smoking and Health
* Misuse of Alcohol and Drugs
* Nutrition
* Physical Fitness and Exercise

source: Public Health Promotion Division
Texas Department of Health

INTRODUCTION

The Texas Conference on Disease Prevention and Health Promotion developed over 200 health objectives for attainment by the year 1990. These objectives set quantitative and qualitative targets in fifteen areas relating to Preventive Health Services, Health Protection, and Health Promotion.

The development of these objectives was an outgrowth of the Surgeon General's Report on Health Promotion and Disease Prevention in 1979. That report chronicled a century of dramatic gains in the health of the American people, reviewed present preventable threats to health, and identified fifteen priority areas in which, with appropriate actions, further gains can be expected over the decade. The report established broad National goals--expressed as reductions in overall death rates or days of disability --for the improvement of the health of Americans at the five major life stages. Specifically, the goals established were:

* To continue to improve infant health and, by 1990, to reduce infant mortality by at least 35 percent, to fewer than nine deaths per 1,000 live births.
* To improve child health, foster optional childhood development, and, by 1990, reduce deaths among children ages one to 14 years by at least 20 percent, to fewer than 34 per 100,000.
* To improve the health and health habits of adolescents and young adults and, by 1990, to reduce deaths among people ages 15 to 24 by at least 20 percent, to fewer than 93 per 100,000.
* To improve the health of adults and, by 1990, to reduce deaths among people age 25 to 64 by at least 25 percent, to fewer than 400 per 100,000.
* To improve the health and quality of life for older adults and, by 1990, to reduce the average annual number of days of restricted activity due to acute and chronic conditions by 20 percent, to fewer than 30 days per year for people aged 65 or older.

To manage the accomplishment of these goals, objectives were established in the fifteen priority areas. Assistance to accomplish these was then requested for all the states. Texas responded by being the first state to take the national objectives and ask 250 of its medical, public safety, education, and business leaders to tailor them to reflect the needs and priorities of the state population. The Texas 1990 health objectives were developed as health planning tools for focusing public and private resources toward improvements in health status and for monitoring progress bringing about health improvements.

Since establishment of the Texas health objectives, many objectives have been addressed through established program efforts while others have been utilized as the bases for proposing new health initiatives through such avenues as the Texas State Health Plan and appropriation request from state agencies. To utilize

further the direction provided by the 1990 Texas health objectives, a review was undertaken to identify those objectives of highest priority and to develop an implementation plan for each one. Seventy seven objectives are addressed in the 1990 Texas Health Objectives Implementation Plan. The plan is broken down into fifteen sections each of which addresses a known risk factor associated with the ten leading causes of death (See Figure 1). These fifteen areas are grouped in three sections that indicate the primary type of intervention needed to impact the area of risk. The interventions which delineate the section are preventive health services, health protection, and health promotion. Health education and health promotion techniques are essential in accomplishing objectives in any of the three sections. A summary of the implementation plan is provided below.

HEALTH PROMOTION

There are a number of intervention strategies which are general in nature and cut across all (five) categories in the health promotion section. For that reason, the following implementation activities are recommended as part of each health promotion topic area.

Strategy: Technical Assistance

Action(s):

* Assist state and local groups to develop model health promotion campaigns and stage those specific events.

Strategy: Education and Information

Action(s):

* Coordinate a statewide "Health Promotion Week" which would include the following:
  - A statewide conference.
  - An annual Worksite Health Promotion Award given in two categories— (less than 100 employees and more than 100 employees).
  - Statewide and community level health promotion activities for children, adults, elderly, and disabled with emphasis on learning healthy living behaviors.
* Make recommendations for health promotion content and skill areas to include in curriculum for kindergarten and pre-kindergarten age students.
* Establish Parent Teacher Association (PTA) forums to train PTA members to present health promotion activities in the classrooms.
* Develop and support self-concept improvement programs for students who are low-achievers and/or non-participants in school activities.
* Develop and implement health promotion campaigns for youth in non-traditional, non-school based organizations which serve youth outside the classroom.
* Establish and promote a statewide computerized network of information and referral numbers for use by directory assistance operators to facilitate citizen referral to local agencies having health promotion programs addressing situations leading to stress and violent behavior toward self or others.

Strategy: Legislative and Regulatory Action

Action(s):

* Establish by special proclamation a state "Health Promotion Week".
* Establish incentives regulations for life and health insurance companies that encourage the offering of reduced premiums to the insured who participate in the practice of healthy lifestyle behviors such as weight maintenance, blood pressure control, regular exercise, and not smoking.

Strategy: Data, Research, and Surveillance

Action(s):

* Develop a Health Promotion Implementation Task Force which could:
  - plan priority messages to be promoted in each of the (five) health promotion areas; and
  - assist in identifying possible funding sources to implement health promotion programs and surveillance activities.

* Develop and implement a method of identifying and obtaining reliable data to assess the baseline and periodic health status of Texans in the (5) health promotion areas.

SMOKING AND HEALTH

I. STATEMENT OF THE PROBLEM:

Cigarette smoking is currently recognized as the largest single preventable cause of premature death and disability in our society. The death rate for those who smoke two or more packages of cigarettes a day is twice as high as the death rate for people who do not smoke. On the average, smokers have a risk of lung cancer death 10 times greater than non-smokers, and a risk of fatal heart attack two times greater.

The Surgeon General has determined that cigarette smoking is dangerous to health and that:

* Smoking causes lung cancer, heart disease, emphysema, and may complicate pregnancy.
* Quitting smoking now reduces serious risks to health.
* Smoking by pregnant women may result in fetal injury, premature birth, and low birth weight.
* Cigarette smoke contains carbon monoxide (This prevents the body's blood supply from absorbing oxygen.)

Yet, smoking-related disorders in U.S. citizens continue to cause an estimated 350,000 premature deaths each year and account for some $13 billion in medical care and $25 billion in lost productivity and wages according to U.S. Surgeon General. A remarkable aspect of these statistics is that starting smoking is voluntary and, therefore, these losses are almost entirely preventable.

SPECIAL NOTE:

Smokeless tobacco in the form of chewing tobacco and snuff are becoming an increasing concern especially among young people. It has been demonstrated by Jayant, et. al., and Jussawalla and Deshpande that, compared with non-users, persons chewing tobacco were six times more likely to develop cancer of the oral cavity or the hypopharynx and three times more likely to develop cancer of the oropharynx. In addition, Winn, et. al., found that white women who used snuff but did not smoke tobacco, had a risk 4.2 times greater for developing oral or pharyngeal cancer than those who used neither snuff nor cigarettes. For these reasons, objectives should be expanded to cover all tobacco use.

II. OBJECTIVE(S):

1. By 1990 there will be a 50% reduction in the number of 12-18 year old children who smoke or use tobacco in other forms.

2. By 1990 there will be a 50% reduction in the number of pregnant women who smoke.

3. By 1990 the proportion of adults who smoke or use tobacco in other forms will be reduced by 25%.

4. By 1990, increase the extent of state and local governmental action related to smoking and health.

III. IMPLEMENTATION PLAN:

Strategy: Technical Assistance

Action(s):

* Involve medically related professional groups in serving as supporters/advisors on smoking cessation programs for students.
* Encourage health-related professional organizations to provide support and advice on smoking cessation programs to their clients/patients.
* Coordinate activities among the Texas Cancer Council and other statewide advocacy/funding groups concerned with smoking and health.

Strategy: Education and Information

Action(s):

* Produce and promote use of public service announcements targeting youth about health and social effects of smoking.
* Promote participation of youth organizations in conducting educational programs on the health effects of smoking, the social desirability of not smoking and on other health risk reducing behaviors.
* Encourage establishment of non-smoking policies in schools for faculty, staff, and students.
* Establish student peer support activities such as:
  - Peer assistance programs which would include student support groups working with student smokers who wish to stop.
  - Peer education programs which use older students to work with younger students in providing tobacco use education programs.
  - Peer education program activities that promote the social desirability of not smoking.
  - Exemplary role model events recognizing celebrity or student role models.
* Develop and implement a comprehensive health promotion campaign for pregnant women that includes the effects of smoking on the unborn child. When possible, utilize existing materials such as public service announcements.
* Provide special programs for pregnant teenagers concerning risks related to smoking during pregnancy.
* Encourage employers to offer worksite programs which include education on the effects of smoking, cessation techniques, and incentives for reducing or quitting smoking.

* Develop and promote use of mass media materials (including public service announcements) and/or educational programs specifically designed to reduce smoking among minority, blue collar, and low-income persons.
* Support the Office on Smoking and Health at the Texas Department of Health in establishing a clearinghouse of information on existing resources, materials and program models, and informing the public and statewide health organizations of the Office's services.
* Support continuation and strengthening of the statewide networks concerned with smoking/tobacco education.

Strategy: Grants to Local Providers

Action(s):

* Encourage local providers of prenatal care to include patient and staff education in their service delivery by administratively collecting data on educational protocols and services provided as part of the funding requirements for receiving Indigent Health Care funds.

Strategy: Legislative and Regulatory Action

Action(s):

* Establish incentives for life and health insurance companies which offer lower premium rates as outlined in Sections 3.1401 through 3.1405 of the Texas Administrative Code to non-smokers or persons who successfully complete smoking cessation programs.
* Work to establish a statewide smoke-free indoor air act to create no smoking areas in all public places and at worksites.
* Develop and support regulations and activities directed toward eliminating tobacco advertising in all magazines published or distributed in Texas.
* Develop funding and support for community smoking education activities at the regional offices of the Texas Department of Health.
* Support legislation to raise the legal age at which tobacco may be purchased from 16 years to 18 years.
* Enact model smoking policies/programs for state agencies, as recommended by the Governor's Task Force on State Employee Benefits.
* Support a tax increase on cigarettes and smokeless tobacco products to deter smoking among youth and to pay for health promotion and education activities.

Strategy: Data, Research, and Surveillance

Action(s):

* Establish within the Office on Smoking and Health at the Texas Department of Health a system to collect data and monitor progress toward meeting objectives related to reduction of smoking and tobacco use.

* Through Medicaid funding, support development of preventive education program models which assist in reducing disease onset and length of hospital stays caused by diseases related to smoking/tobacco use.

MISUSE OF ALCOHOL AND DRUGS

I. Statement of the Problem:

Alcohol and drug abuse is a complex problem involving physiological, psychological, environmental, cultural, and economic factors. It leads not only to serious health problems for the user, but also has a great impact on family members and society at large. The misuse of alcohol and drugs is a major contributor to suicide, crime, domestic violence, child neglect, motor vehicle injury, falls, fires, and other injuries. Addiction to alcohol and drugs cuts across all segments of society, but adolescents, young adults, pregnant women, the elderly, and children of alcoholics are at highest risk.

In 1984, there were an estimated 811,956 individuals ages 18 and over classified as problem drinkers in Texas. The impact of alcohol abuse on the criminal justice system is significant. In 1984, there were 893,073 arrests made in the state, 45 percent of which involved driving while intoxicated, public drunkenness, and liquor law violations.

The total economic cost of alcohol abuse in Texas in 1984 was $8 billion, or $511 per individual Texan. The largest portion of the cost, $4.8 billion was due to impaired productivity, while alcohol-related motor vehicle crashes cost $874 million. Health care for alcohol abuse cost $863 million, and crime costs totaled $648 million.

The misuse of drugs influences equally the lives of many Texans. Since most drug abuse is an illicit or hidden activity, it is difficult to estimate the direct or indirect impact such activities have on individuals in the state.

Statistics do show that the drug abuse problem in Texas is continuing to grow at a fast rate. In 1974, there were 34,013 drug arrests in Texas; in 1984, there were 56,290. There were over 2100 inmates in the Texas prison system last year who were drug law violators, as compared to 765 in 1975. The percentage of arrests for opium, morphine, heroin, synthetic narcotics, or cocaine rose from 10% in 1974 to 19% in 1984, which means the use of "hard" drugs has become more serious in the last ten years. And this trend is also documented by the number of overdose deaths from heroin, which has grown from 14 deaths in 1980, 23 in 1981, 32 in 1982, 43 in 1983, 67 in 1984, to 90 already reported in incomplete 1985 statistics.

Drug-related crime cost Texans $1.1 billion in 1984, while the cost for treating drug abuse totaled $71 million. Productivity losses were $1.5 billion. **The total cost of drug abuse in Texas in 1984 was $2.8 billion, or $181 per Texan.**

II. OBJECTIVE(S):

1. By 1990, fatalities from motor vehicle accidents involving drivers impaired by alcohol or drugs should be reduced by 10% per year for all ethnic and age groups.

2. By 1990, the proportion of problem drinkers among all age groups should be reduced, with program efforts concentrated on populations determined to be at greatest risk.

3. By 1990, the proportion of adolescents 10 to 17 years old frequently abusing drugs or other substances should be reduced, as should the onset of experimentation and use of chemical substances among the preadolescent age group.

4. By 1990, the proportion of women of child-bearing age aware of risks associated with pregnancy and drinking, in particular with Fetal Alcohol Syndrome, should be greater than 90% with emphasis given to the poorly-educated population.

III. Strategies and Actions Need to Achieve Objectives:

Strategy: Technical Assistance

Action(s):

* Upgrade the evaluation procedure used with persons convicted of driving while intoxicated for their referral into treatment programs.

Strategy: Education and Information

Action(s):

* Public information/media campaigns should be established covering all problem areas and target age groups.
* An educational program should be implemented to encourage pharmacists to provide counseling on drug use specifically with pediatric and geriatric populations.
* Peer assistance programs on alcohol and drug misuse should be available at all worksites.
* Develop public education campaigns for statewide implementation concerning motor vehicle accidents and their relationship to misuse of alcohol and drugs.
* Encourage additional support to expand the Texas Alcoholic Beverage Commission training for bar owners and bartenders on the effects of alcohol and on dealing with intoxicated patrons.
* Encourage model programs such as "Project Graduation" in all senior high schools to support chemical-free events for students.

* Develop a training program for probation officers dealing with identification and referral of problem drinkers.
* Develop public awareness campaigns promoting responsible drinking behaviors.
* Develop awareness, education and intervention programs designed to reduce the number of problem drinkers among Hispanic males.
* All school districts will adopt curriculum materials which have been approved by the Texas Commission on Alcohol and Drug Abuse for alcohol and drug abuse education. Such materials should be developed to comply with the essential elements for health in Chapter 75 of the Texas Education Code, and should complement a comprehensive school health education curriculum plan.
* Promote sponsorship of chemical-free youth activities in school and community settings.
* Promote college and continuing education training of teachers in use of effective teaching strategies that discourage abuse of substances.
* Coordinate educational programs for pregnant women about Fetal Alcohol Syndrome with the Maternal and Infant Health Improvement Program, Primary Care Program, and the Maternal and Child Health Division of the Texas Department of Health.
* Develop and implement a community based education campaign addressing Fetal Alcohol Syndrome that targets women in the child bearing age.
* Develop and distribute English/Spanish public service announcements primarily for radio concerning Fetal Alcohol Syndrome and its prevention.
* Work with school districts to provide information concerning Fetal Alcohol Syndrome to health, family living, and other school classes as relevant.

Strategy: Legislative and Regulatory Action

Action(s):

* Support passage of an alcoholic beverage open container law for Texas.
* Support legislation which requires, in accident situations, tests for alcohol and drug blood levels that impair driving skills.
* Assure that state legislation is maintained which currently identifies the legal drinking age at 21 years, regardless of actions of the federal government.
* Establish an expanded substance abuse recovery program in the Texas Prison System.

NUTRITION

I. Statement of the Problem

Data related to nutritional status of Texans are routinely recorded by many agencies's health and nutrition programs but are not aggregated nor analyzed. Thus, Texas-specific information concerning food and nutrition related problems is essentially non-existent. Without an ongoing nutrition-related data collection, analysis and reporting system, the identification of priority food and nutrition problems and the appropriate targeting of limited resources will continue to be incredibly difficult.

II. Objectives

1. By 1990, state legislators, state agencies and the private sector should coordinate efforts and resources to develop a sound system for nutrition data collection, retrieval, dissemination, and surveillance.

2. By 1990, all children entering day care, preschool, and grades K-12 in both private and public institutions will have their height and weight recorded annually by staff trained to perform such measures.

3. By 1990, the legislature will increase its support of those state programs that reach the population at greatest risk for undernutrition/hunger and it should oppose any further federal cuts in food assistance programs.

4. By 1990, identify the populations in Texas at risk for development of malnutrition and nutrition related diseases.

5. By 1990, the at risk population will be educated as to food availability, self help programs, food banks, community gardening programs, shopper's assistance programs, etc.

6. By 1990, nutritional education should be a required component of the curriculum for grades K-12 to be included at a minimum as a portion of comprehenhsive health education, fitness, sciences and home economics programs.

7. By 1990, nutrition education for health professionals and allied health professionals will be an integral component of their education and continuing education.

8. By 1990, food and nutrition education information materials will be made available that address age, sex, language, cultural and ethnic differences of target populations.

9. By 1990, nutrition education programs will be targeted at high risk groups such as pregnant and lactating women, infants and children, elderly and individuals at risk for the development of nutrition related chronic diseases.

10. By 1990, nutrition education programs for comprehensive weight management will include the multifactorial aspects of exercise, cultural recognition, lifestyle changes, societal support and proper nutrition.

11. By 1990, the proportion of women breastfeeding their babies upon hospital discharge and who continue for a minimum of three months, should increase.

III. Strategies and Actions Needed to Achieve Objectives:

Strategy: Technical Assistance

Action(s):

* Develop training guidelines and resource packages for service providers to use with Texans at risk of nutrition-related problems/diseases as identified through Texas specific data (if possible).
* Develop education modules for normal nutrition as it relates to health promotion, i.e., Dietary Guidelines, Exercise, anti-Quackery, etc., for use by public and private agencies, associations, PTAs, business, schools, and so on.
* Reassign or hire a Texas Department of Health Central Office Nutritionist to develop and implement a detailed plan for nutrition surveillance to include: participation in CDC's Nutrition Surveillance Program, parameters of nutrition surveillance, implementation, monitoring, expansion and refinement.
* Coordinate with other agencies in developing nutrition surveillance to address the State's priority nutrition data needs; i.e., target populations, baseline data, monitoring data, evaluation data, etc., with which to plan and implement food and nutrition programs.
* Develop training guidelines and resource packages on how to implement the nutrition surveillance system and interpret reports.
* Plan, pilot test and refine nutrition surveillance systems in such a manner as to minimize cost, paperwork and any additional workload of field staff.
* Proceed with the statewide implementation plan.

Strategy: Education and Information

Action Steps:

* Work with school districts in program development to assure that nutrition education is a required component of the grades K-12 curriculum.
* Work with Texas universities and colleges in programs for health and allied health professionals to include nutrition education in required courses.
* Utilize school and senior lunch programs as opportunities to promote healthy food choices.
* Develop educational campaign to be utilized with the Legislature, private agencies/associations, and other public agencies to market nutrition surveillance and its benefits.
* Provide inservice for staff actually involved in implementing nutrition surveillance.

Strategy: Legislative or Regulatory

Action(s):

* Continue the financial support of the 1985 Omnibus Hunger Act.
* Pass a Bi-partisan continuing resolution to oppose federal budget cuts in food and nutrition programs.
* Provide resources to implement statewide nutrition surveillance systems.
* Pass a continuing resolution to support the intent of nutrition surveillance and interagency coordination to facilitate its implementation.

Strategy: Data, Research, and Surveillance

Action(s):

* Conduct research, using varied target populations, on impact of nutrition education programs/activities.
* Identify resources for periodic data collection concerning nutritional status.
* Identify resources for developing nutritional status indicator standards for certain population groups; i.e., teens, middle-aged, elderly, etc.

PHYSICAL FITNESS AND EXERCISE

I. Statement of the Problem:

Approximately 32 percent of the adult Texans surveyed in 1984 by the Texas Department of Health reported that they never participate in active physical exercise. The percentage of Texans in 1984 who engaged in regular, vigorous exercise for a minimum of 30 minutes three times a week (which is desired for cardiovascular fitness) approximates the 34 percent participation rates found nationally among adults (Medical Benefits, 1984).

A Texas Youth Fitness Study conducted in 1984 indicates that Texas youth have physical fitness scores lower than those of students elsewhere in the country and that:

* cardiorespiratory endurance has declined significantly over the norms of Texas students 10 years ago;
* abdominal strength measurements reflect poor performance;
* shoulder strength for males is significantly lower than the national norms; and
* upper body strength is poorer at all age levels than the national norms.

II. Objectives:

* By 1990, the proportion of Texans who are vigorously exercising in appropriate health-related fitness activities (The term "health-related fitness activity" includes any activity designed to improve cardiovascular fitness, as well as flexibility and strength) at least 30 minutes three times a week will be greater than:

Age Group	Percent Exercising
10-17	70%
18-35	70%
36-55	60%
56 +	50%

with special considerations to include women, minorities and the elderly.

III. Strategies and Actions Needed to Achieve Objectives:

Strategy: Technical Assistance

Action(s):

* Develop training guidelines and resource packages to teach service providers, including physicians, to make appropriate exercise assessments and prescriptions.

* Work with business, civic groups, and insurance carriers to educate employers about the benefits of employee health and fitness programs at the worksite.
* Encourage public and private sector hospitals to provide information on physical fitness and health promotion for their patients/service area.

Strategy: Education and Information

Action(s):

* Assist school districts to implement quality physical education curriculum which includes regular exercise sessions and accurate physical fitness assessments for all students. Utilization of the Texas Fitness Program in recommended.
* Develop public education campaigns and community based events targeting women and low-income persons to increase awareness and motivation for proper exercise.
* Develop and make available resource packages to assist employers in establishing worksite health and fitness programs.

Strategy: Legislation and Regulatory Action

Action(s):

* Provide resources for more high quality, convenient exercise programs and facilities for high-risk populations, such as low-income persons, through cooperative use of existing community facilities.
* Identify specific projects to be implemented next biennium and supported by legislative action. (Coordinate with business and health coalitions around the state.)

Strategy: Data, Research, and Surveillance

Action(s):

* Identify resources for periodic data collection on physical fitness and for research on the benefits of exercise.
* Identify resources for developing and creating norms for adult fitness assessment.
* Conduct research, using varied target populations, on strategies for increasing motivation to exercise.

APPENDIX 4

PREVALENCE RATES OF RISK FACTORS
AND
ATTRIBUTABLE CAUSES OF DEATH CALCULATIONS

source: Center for Health Promotion
Research and Development

The University of Texas
Health Science Center
at Houston

BEHAVIORAL RISK FACTOR	PREVALENCE OF RISK FACTOR ACCORDING TO TEXAS BEHAVIORAL RISK FACTOR SURVEY (TDH)	CAUSE OF DEATH	RELATIVE RISK ACCORDING TO POPULATION STUDIES	POPULATION ATTRIBUTABLE RISK (PAR)	# OF DEATHS 1983	ATTRIBUTABLE DEATHS	% OF ALL DEATHS 1 - 64 YEARS
ALCOHOL							
Drinks and Drives	0.09	MV Injuries	6	0.31	3520	1092	2.93
Binge Drinker	0.27	Other Injuries	5	0.52	2266	1177	3.15
	0.27	Homicides	5	0.52	2184	1134	3.04
Chronic Drinker	0.07	Liver Disease	20	0.57	880	502	1.35
	0.07	Suicide	5	0.22	1781	390	1.04
	0.07	Liver Cancer	5	0.22	86	19	0.05
TOTAL PERCENTAGE OF ALL DEATHS 1 - 64 YEARS							11.6 %
SMOKING	0.27	Heart Disease	1.7	0.16	5529	879	2.36
	0.27	Lung Cancer	10.8	0.73	2813	2041	5.47
	0.27	Emphysema	6.1	0.58	215	125	0.33
	0.27	Stroke	1.3	0.07	1303	98	0.26
	0.27	Other Cancer	1.3	0.07	6299	472	1.26
	0.27	Flu & Pneumonia	1.4	0.10	470	46	0.12
TOTAL PERCENTAGE OF ALL DEATHS 1 - 64 YEARS							9.8%
NUTRITION AND PHYSICAL ACTIVITY							
Diet	*	Chronic Kidney & Diabetes		0.20	810	162	0.43
	*	All Non-lung Cancer		0.10	6299	630	1.69
Overweight	0.37	Heart Disease	2	0.27	5528	1493	4.00
Physical Inactivity	0.14	Heart Disease	1.3	0.04	5529	223	0.60
TOTAL PERCENTAGE OF ALL DEATHS 1 - 64 YEARS							6.7%
ACCESSIBILITY TO AND UTILIZATION OF HEALTH SERVICES							
Uncontrolled Hypertension	0.04	Heart Disease	2.6	0.06	5529	333	0.89
	0.04	Stroke	10	0.26	1303	345	0.92
Diagnosed Hypertension	0.21	Heart Disease	1.5	0.10	5529	525	1.41
	0.21	Stroke	2	0.17	1303	226	0.61
Other Non-use Health Services	*	Breast, Genital, Digestive Cancer		0.45	3294	1482	3.97
	*	Chronic Kidney & Diabetes		0.35	810	284	0.76
TOTAL PERCENTAGE OF ALL DEATHS 1 - 64 YEARS							8.6%
SEATBELT NON-USE	0.61	MV Injuries	2	0.38	3520	1334	3.6%
ENVIRONMENTAL POLLUTION	*	All Cancer		0.20	9112	1822	4.88
	*	Emphysema		0.20	215	43	0.12
TOTAL PERCENTAGE OF ALL DEATHS 1 - 64 YEARS							5.0%

Note: Prevalence rates are based on 1984 Texas Behavioral Risk Factor Survey, except for Seatbelt Use, Diagnosed Hypertension and Overweight categories which are from the 1982 version.

CALCULATIONS MADE BY THE CENTER FOR HEALTH PROMOTION RESEARCH AND DEVELOPMENT, THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT HOUSTON

APPENDIX 5

TEXAS COMMISSION ON ALCOHOL AND DRUG ABUSE
EMPLOYEE ASSISTANCE PROGRAM
POLICY STATEMENT

source: Texas Commission on Alcohol and Drug Abuse

TCA EAP Policy Statement

TCA believes that it is in the best interest of the individual employee and our agency to provide an Employee Assistance Program which confidentially deals with personal/medical problems which cause unsatisfactory job performance. Therefore it is the policy of TCA to handle such problems within the following guidelines.

1. The purpose of this policy is to assure TCA employees that if personal problems are the cause of unsatisfactory job performance, they may receive help to resolve such problems in an effective and confidential manner.

2. TCA recognizes that many personal or medical problems may result in poor job performance, and as such TCA has a legitimate concern for the appropriate provision of care for those problems and their resolve. Appropriate care most often will aid the individual in resolving the problem instead of allowing the problem to worsen.

3. Therefore, TCA advocates early intervention and referral for help in a confidential manner.

4. Personal problems which impair job performance may include but are not limited to alcohol abuse, drug abuse, alcohol/drug abuse by a family member, marital problems, emotional problems, financial problems, legal problems, sexual problems, and physical problems.

5. Personal problems are not the concern of TCA; job impairment is. Any action, such as a referral to the program will be based on job performance only. No one on the TCA staff will discuss the personal problem with the employee.

6. Self-referral is encouraged as it is noted the earlier a problem is addressed, the easier it is to deal with and the higher the success rate. The referral resource has professional personnel who can assist you in finding the appropriate helping resource for any type of personal/medical problem.

7. Confidential help for personal/medical problems may be obtained by contacting the evaluation and referral resource listed in our EAP brochures and posters.

8. Any aspect of the use this program is deemed confidential and shall be maintained as such by any person who has knowledge of an employee's participation in the program. No entry is made in the personnel file of any employee using the program. The program participant's supervisor(s), or any personnel at any helping resource to which the employee is referred, is forbidden to discuss any information about the employee's participation in the program. Any TCA employee or family member of a TCA employee may seek information about the EAP from the evaluation and referral resource with the assurance that any such conversation will be held in strict confidence.

9. Employees seeking aid through the EAP are assured that their job security, promotion opportunities and reputation will not be affected or jeopardized.

10. Family members of troubled employees are encouraged to use the program. Family of a TCA employee may contact the evaluation and referral center, in order to seek confidential help for the troubled employee. This program is a benefit to the families of our employees as well as the employees themselves.

The immediate supervisor of an employee who manifests prolonged, impaired job performance which is not due to lack of job skills or knowledge, will confidentially refer the employee to the EAP for aid at the earliest indication that job performance has become unacceptable. The supervisor's referral will be based on job performance evaluaton only, and the supervisor will make no attempt to determine if the employee is seeking treatment. Any further action by the supervisor must be based on evaluation of job performance.

After a reasonable opportunity for job performance improvement has been allowed, the appropriate disciplinary action up to and including dismissal will be taken if adequate improvement is not observed.

It is the responsibility of the employee to comply with referrals for diagnosis and treatment and to cooperate with the helping agency. Continued unacceptable job performance not due to a lack of job skills or knowledge will result in disciplinary action appropriate to the employees job performance evaluation.

In instances where referral appointments must be set during work hours, sick or personal leave may be granted to obtain help on the same basis as it is granted for other personal business or health matters. This action will also be handled confidentially.

APPENDIX 6

LIST OF ADVISORY COMMITTEE MEMBERS

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