2001 - 2002 Texas State Health Plan Update

Ensuring a Quality Health Care Workforce for Texas

Statewide Health Coordinating Council

STATE OF TEXAS
OFFICE OF THE GOVER

GEORGE W. BUSH
GOVERNOR

October 30, 2000

Ben G. Raimer, M.D.
Chair
Texas Statewide Health Coordinating Council
1100 West 49th Street
Austin, TX 78756-3199

Dear Dr. Raimer:

I am pleased to receive the *2001-2002 Texas State Health Plan Update* entitled, "Ensuring a Quality Health Care Workforce for Texas." I appreciate the Statewide Health Coordinating Council members' committed work in recommending courses of action that could help Texas move forward to meet the health care challenges of the 21st Century.

Again, thank you for your efforts in developing this plan. You are helping to make Texas a beacon state.

Sincerely,

GEORGE W. BUSH

GWB:lsl/jo

POST OFFICE BOX 12428 AUSTIN, TEXAS 78711 (512) 463-2000 (VOICE)/(512) 475-3165 (TDD)

Statement of the Chairman

The *1999-2004 Texas State Health Plan*, which was developed by the Texas Statewide Health Coordinating Council (SHCC) in 1998, envisions a Texas in which all citizens are able to achieve their maximum health potential. Texas, the second fastest growing state in the United States, is challenged to meet its health care workforce needs for future generations. This plan formed the basis to begin that process. Now the council introduces the first biennium *Update* to that plan, the *2001-2002 Texas State Health Plan Update: Ensuring a Quality Health Care Workforce for Texas.*

In this *Plan Update*, we have brought together a wide variety of experts in the fields of health care and health care education, led by members of the SHCC, to examine broad issues identified in the initial plan and to recommend courses of action that will enable us to prepare a health care workforce that is ready to address the health needs of all Texans in the 21st Century.

The SHCC has reviewed the work of several committees of experts addressing health personnel data, the academic health centers, community competencies for health professionals, aging, recruitment and retention, minority health, models for community health practice, and consumer information. From this list, one can see that responsibility also rests at the feet of the consumer and community!

We also believe that prevention and education are the primary approaches to quality health care. Local communities must be empowered to plan and direct interventions that have the greatest impact on the health of their citizens. We, and future generations, must take steps now to assure that we are healthy, productive, and better able to make informed decisions.

The *Texas State Health Plan* and its first biennial *Update* focus on the integration of planning, education, and regulation of the Texas health care workforce to ensure a quality of health care for all Texans. We are committed to the belief that a healthy Texas can be a productive Texas. We believe that Texas is on the right track in preparing our state for its future. We envision a Texas in which every citizen enjoys optimal health status, is informed, and is productive.

Ben G. Raimer MD

Ben G. Raimer, M.D., Chairman
Texas Statewide Health Coordinating Council

STATEWIDE HEALTH COORDINATING COUNCIL

A VISION

We envision a Texas in which all are able to achieve their maximum health potential - A Texas in which:

* **Prevention and education are the primary approaches for achieving optimal health.**

* **All have equal access to quality health care.**

* **Local communities are empowered to plan and direct interventions that have the greatest impact on the health of all.**

* **We, and future generations, are healthy, productive and able to make informed decisions.**

A Healthy Texas is a Productive Texas

2001-2002 Texas State Health Plan Update
Texas Statewide Health Coordinating Council
November 2000

Name/City	*Representing*
Officers:	
Ben Raimer, M.D. Chair, Galveston	University Representative
James A. Endicott, Jr. 1st Vice Chair, Harker Heights	Public Member
David A. Valdez, M.D. 2nd Vice Chair, San Antonio	HMO Representative
Susan M. Scott-Galindo, M.Ed. CCC/SLP Secretary, Bryan	Health Care Professional
Laura Prendergast Gordon Parliamentarian, El Paso	Public Member
Members:	
Joan Wood Biggerstaff Plano	Public Member
Adena Williams Loston, Ph.D. Houston	Community College Representative
Joe C. Frush Abilene	Hospital Representative
Charles T. Ku, D.D.S. Lewisville	Health Care Professional

Members (Continued):

Name/City	*Representing*
Rebecca Uribe-Garza, M.D. Laredo	Health Care Professional
Judy Petty Wolf San Antonio	University Representative
P. J. (Schneider) Wright Spring Branch/San Antonio	Public Member
Dolores H. Carruth, M.D. Irving	Texas Higher Education Coordinating Board
Vijay Ganju, Ph.D. Austin	Texas Department of Mental Health & Mental Retardation
Jacinto P. Juarez, Ph.D Laredo	Texas Health Care Information Council
Demetria Montgomery, M.D. Austin	Texas Department of Health
Karl Urban, M.P.Aff. Austin	Texas Health & Human Human Services Commission

Staff Supporting the Statewide Health Coordinating Council

Office of Policy and Planning
Texas Department of Health

Director	Ann Henry
Director of Strategic Planning	Rick Danko, Dr.P.H.
Director, Health Professions Resource Center	Bruce Gunn, Ph.D.
Coordinator of Health Workforce Development	Suzanne R. Adair, Ph.D.

Renato Espinoza, Ph.D., M.P.H.
B. Dennis Finuf, M.P.Admin.
Wendy Francik, M.A.
Nick Hoover, M.P.Aff.
Mary Soto, M.A., CHES
Gregg Ukaegbu, M.P.Admin.

The Council would like to express its appreciation to other staff in the Texas Department of Health who contributed to this plan:

Donna C. Nichols, M.S.Ed., CHES
Sheila Marie Austin
Michael G. Messinger
Kristin Rosacker

J.C. Chambers	William R. Archer III, M.D.
Chairman, Texas Board of Health	Commissioner of Health

This publication is issued by the Texas Department of Health for the Statewide Health Coordinating Council under the authority of Chapter 104, Health and Safety Code, and is financed by public funds appropriated by the Texas Legislature.

Table of Contents

List of Tables

List of Figures

Foreword

The Texas State Health Plan is prepared every six years and updated biennially. The plan serves as a guide to help Texas decision makers formulate appropriate health policies and programs.

The Texas Statewide Health Coordinating Council, a 17-member council with 12 members appointed by the governor and five ex-officio members representing specified state agencies, develops the plan. The Texas Health Planning and Development Act, Chapter 104 of the Health and Safety Code, is the enabling legislation for the Statewide Health Coordinating Council. Under the authority of Chapter 104, the governor with the consent of the senate appoints council members to staggered six-year terms.

The broad purpose of the Statewide Health Coordinating Council is to ensure that health care services and facilities are available to all Texans through health planning activities. Based on these planning activities, the council makes recommendations to the governor and the legislature through the Texas State Health Plan. The council provides overall guidance in the development of the Texas State Health Plan, submission of the plan to the governor, and promoting the implementation of the plan. The plan is due to the governor for adoption by November 1 of each even-numbered year. Staff in the Office of Policy and Planning with assistance from other program areas at the Texas Department of Health supports the council's activities.

House Bill 1716 from the 75th Legislature amended Chapter 104 of the Health and Safety Code and focused the council's planning activities on the health professions workforce. The council produced the 1999-2004 Texas State Health Plan, "Ensuring a Quality Health Care Workforce for Texas," which is the foundational plan for this six year planning cycle. This 2001-2002 Texas State Health Plan is the first update to that foundational document. For the purposes of this report, the 1999 – 2004 Texas State Health Plan will be referenced as the *Texas State Health Plan* and the 2001-2002 Texas State Health Plan Update will be referred to as the *Update*.

The *Texas State Health Plan* outlined Texas's interests in health professions workforce issues. The state is a major provider of medical and health education through its system of publicly funded health science centers, universities, and community and technical colleges. Texas is a major purchaser of health care services through the state's Medicaid program and other public health care programs as well as a provider of these services through its system of publicly funded medical schools and hospitals. Finally, with its citizens, Texas shares responsibility for the health, safety, and welfare of its residents. In the *Texas State Health Plan*, the council developed and presented seven goals, with objectives and strategies, to ensure that Texas has the workforce with the skills and abilities to meet the needs of its growing and diverse population.

The *Texas State Health Plan* was presented to Governor Bush on October 31, 1998. Over 400 copies of the plan have been distributed to state legislators, universities, licensing boards, professional associations, and other interested parties. That plan has served as the foundational health professions information and workforce planning document. It has informed the Statewide Health Coordinating Council ad hoc committee reports, legislative studies, and Texas Higher Education Coordinating Board strategic planning. This ongoing effort to ensure a quality health care workforce for Texas is reflected in this *Update.*

Copies of the 1999 – 2004 Texas State Health Plan are available from the Texas Department of Health, Office of Policy and Planning at a cost of $20.00. To order a copy of the plan, call 512-458-7261. The plan can be downloaded from the website at www.tdh.state.tx.us/stateplan/ShPlan.htm.

Introduction

The workforce policy question the Statewide Health Coordinating Council (SHCC) addressed in the *Texas State Health Plan, Ensuring a Quality Health Care Workforce for Texas* is whether or not the current and future supply of health care professionals in Texas will be adequate to meet the current and future needs of the population. The *Texas State Health Plan* is the state's foundational workforce-planning document incorporating policy, research, and a strategic plan with goals, objectives and strategies. This *Update* furthers that strategic plan with new strategies to strengthen the systems that support and ensure a quality health care workforce for Texas.

Demographics

Texas is the second fastest growing state in the nation. Currently, about 20 million people live in Texas. The Texas population is increasing at a rate roughly twice that of the nation as a whole and is second only to California in population growth. Texas has the distinction of having one of the fastest growing youth (18 and under) populations as well as one of the fastest growing aging populations (60 and over). Forecasts predict that Texas's population will reach 34 million by 2030.

Another distinctive characteristic of Texas's population is its diversity. Between 1990 and 2030, the Hispanic population is expected to increase by 250 percent, the Black population by 60 percent, and the category of Other (primarily Asian) by 648 percent. The Anglo population is expected to increase by 20 percent. According to these predictions, by 2030 46 percent of the Texas population will be Hispanic, 10 percent Black, 8 percent Other, and 36 percent Anglo. The projected rates of growth in the youth and elderly populations and in minority populations will result in increases in demand for health services. This increase in demand and the special health care needs of these populations must be taken into consideration in the planning and preparation of the health care workforce.

Review of the 1999 – 2004 Texas State Health Plan Goals and Objectives

The urgency of addressing health care workforce issues continues due to the demographic, economic, and health care challenges that the state faces and will face in the future. These challenges must be addressed in order to meet the future needs

of the Texas population for sufficient numbers, types, and distribution of health providers and to develop the skills and competencies that will be vital to the effective performance of the state's health care system in the future. In the *Texas State Health Plan*, The Statewide Health Coordinating Council defined seven goals with objectives and strategies, related to the planning, education, and regulation of health professionals that would ensure that Texas is prepared to meet the health care needs of the future. The goals and objectives of the *Texas State Health Plan* were presented in 1998 and are repeated below.

GOAL 1: Ensure that the needed number of health care professionals are educated and trained.

Objective 1.1 Conduct workforce supply and requirements planning for Texas 2000-2030.

GOAL 2: Improve health professions regulation to ensure quality health care for Texans.

Objective 2.1 Establish fair and equitable mechanisms and processes that will address health professions regulation.

GOAL 3: Address the maldistribution of health professionals.

Objective 3.1 Increase access to medical care through technology.

Objective 3.2 Increase access to health care through the coordination of recruitment and retention activities.

GOAL 4: Create a health care workforce trained and equipped to use education and prevention as the primary approach to helping Texans achieve optimal health.

Objective 4.1 Increase the implementation of prevention activities in the health care community through the academic curriculum.

Objective 4.2 Build the competencies of the public health workforce in the areas of core public health functions

Objective 4.3 Create incentive systems to encourage prevention activities.

Objective 4.4 Develop a comprehensive approach to education of children in grades K-12 to encourage healthy lifestyle choices.

GOAL 5: Reduce disparity in health status among all population groups and enhance their access to quality health care by developing a diverse and culturally competent workforce.

Objective 5.1 Develop a diverse and culturally competent workforce.

Objective 5.2 Develop a workforce equipped to meet the needs of Texas aging populations and the population of persons with disabilities.

GOAL 6: Create a health workforce that works with communities and in partnership with federal and state governments to have the greatest positive impact on the health of citizens.

Objective 6.1 Design systems in which local communities are empowered to plan and direct interventions that have the greatest positive impact on the health of citizens.

Objective 6.2 Develop the skill level of health professionals in working with communities.

GOAL 7: Develop the health care partnership between consumers and health care professionals through increased access to health care information.

Objective 7.1 Enable consumers to make better health care decisions.

Implementation of the *Texas State Health Plan*

For a number of the goals, strategies were defined which included the appointment of SHCC ad hoc committees to study and make recommendations to the council on actions to be taken. Ad hoc committees were formed to study issues related to Goals 1, 3, 5, 6, and 7. Specifically, those ad hoc committees focused on the following issues

* Ad hoc committee on Health Personnel Data (Goal 1)
* Ad hoc committee on Recruitment and Retention (Goal 3)
* Ad hoc committee on Minority Health (Goal 5)
* Ad hoc committee on Community Competencies for Health Care Professionals (Goal 6)
* Ad hoc committee on Models for Community Health Practice (Goal 6)
* Ad hoc Committee on Consumer Health (Goal 7)

Reports from those ad hoc committees are included in this *Update* (see Appendices A, C, E, F, G, H).

The *Texas State Health Plan* has a goal which focuses on the development of a workforce trained and equipped to use education and prevention as the primary approach to creating health. In response to the strategy proposed for that goal, the Academic Health Centers were surveyed about their inclusion of these concepts in their academic curricula. The responses to those surveys are reproduced in this document (Appendix B).

In addition, the *Texas State Health Plan* called for the Texas Department on Aging to conduct a study and report on the health issues of an aging population and their relationship to health workforce education, planning, and practice. That report is included in this *Update* (Appendix D).

It should be noted that one of the requirements for the preparation of the *Texas State Health Plan* is statewide stakeholder input. Stakeholders were recruited to participate as members of the SHCC ad hoc committees. That participation included: public members; institutional representatives; subject matter experts; representatives from other state agencies; health care professionals; and representatives of health professions associations. Participation in those ad hoc committees was statewide and inclusive (see Appendix I). Over 90 people served on these ad hoc committees. In addition, two ad hoc committees held daylong workshops and invited attendance and participation of others. One of the ad hoc committees held focus groups involving participants from across the state. The Statewide Health Coordinating Council itself hosted a Symposium on March 28, 2000, which was attended by 85 participants. The council has been impressed with the level of participation by the ad hoc committees, symposium attendance, continued dialog about workforce issues, and the work products submitted.

76th Legislative Session and Interim

There were a number of bills passed during the 76th Legislative session directly related to health professions education, planning and regulation. (For a complete listing, see Appendix J.) Three bills (HB 2025, SB 1288, and SB 590) expanded health professions education and training in the El Paso, Laredo and the Coastal Bend areas. House Bill 1945 created permanent funds for health related institutions

of higher education for public health purposes. That bill specified funding for those education centers as well as the regional academic health center in the Rio Grande Valley. In addition funds were appropriated to the Texas Higher Education Coordinating Board for the administration of grants for programs in Nursing, Allied Health, Minority Health Research and Education, and other health related programs. The General Appropriations Act, Article III, section 35, set funding formulas for health professions education.

The 76th Legislature passed several bills pertaining to the regulation of health professionals:

> House Bill 1342 implements a multi-state licensure compact for registered nurses, licensed practical nurses, and licensed vocational nurses. This compact permits nurses licensed in one state in the compact to practice in another state in the compact without obtaining an additional license.
>
> House Bill 1864 established programs to train and certify community health workers (*promotores (as)).*
>
> House Bill 110 requires the Texas Board of Medical Examiners to create a profile of each physician licensed and provide public access to that information.
>
> Senate Bill 982, Senate Bill 1131 and Senate Bill 556 dealt with scope of practice issues relating to diabetes counseling, hospital clinical privileges of advance practice nurses and physician assistants, and occupational therapists.

Two issues raised by the Statewide Health Coordinating Council in the *Texas State Health Plan* were the development of a statewide telemedicine plan and a legislative study of the process for determining changes in scope of practice.

On the issue of telemedicine, House Bill 1398 directed the Health and Human Services Commission to establish a Medicaid Telemedicine Advisory Group. That advisory group is to provide the legislature with recommendations to improve telemedicine

consultation services and on areas for expansion of telemedicine in the Texas Medicaid Program. Also during this interim, the House Research Organization of the Texas House of Representatives released a report in May 2000 entitled "Telemedicine in Texas: Public Policy and Concerns." That report further explicates many of the telemedicine policy issues identified in the *Texas State Health Plan.*

The Statewide Health Coordinating Council's Symposium in March of 2000 featured a panel discussion on processes to determine any changes to a health professions scope of practice. That discussion indicated that this policy issue is still important to health professions workforce policy, planning, and regulation.

Other activity during this interim session affecting workforce policy discussion includes the Senate Committee on Human Services interim charge to study issues related to the health professions workforce and a higher education long range strategic planning process implemented by the Texas Higher Education Coordinating Board (THECB). Members of the Statewide Health Coordinating Council participated in both of these discussions by providing testimony to the Senate Committee and participating on the THECB health professions task forces.

The plan has served as the primary informational and planning document for the health professions workforce in Texas. It has been the source for ongoing dialog about workforce issues. Professional associations have published excerpts in their newsletters. Universities have used the document in program assessment and faculty discussion. It has been used in classrooms for student policy analysis. Chapter 1 on demographics has been widely used for its general description of the state.

The *Texas State Health Plan* has served as the state's policy and planning document and has been used to provide background and support for grant applications. The Texas Department of Health submitted a proposal to the Centers for Disease Control and Prevention and was funded to purchase equipment for local health departments to build a statewide communications system, which would be part of the national Health Alert Network and the Public Health Training Network. The schools of public health (University of Texas Health Science Center at Houston, University of North Texas at Fort Worth, and the Texas A&M University System) collaboratively responded to the national Health Resources and Services Administration's Public Health Training Center Grant. That proposal was approved and funded. In October

1999, the *Texas State Health Plan* was featured in a presentation at a national health professions issues workshop sponsored by the Agency for Healthcare Research and Quality.

In all, the period since the publication of the *Texas State Health Plan* has been a very active one. State agencies have worked collaboratively on health professions workforce issues. Universities have participated on both Statewide Health Coordinating Council and Texas Higher Education Coordinating Board ad hoc committees and task forces. Health professions associations and other health related organizations such as the Texas Hospital Association have sent representatives. The purpose of the *Texas State Health Plan* was to identify workforce issues, propose goals, objectives and strategies to ensure an adequate and competent workforce for the future, and create opportunities for those issues to be addressed. Given the level of participation, the exchange of information, and the extent of the collaboration around these issues, the council feels that they have achieved the intent and purpose of that document.

Overview of the *2001 – 2002 Texas State Health Plan Update*

This *Update* will build on work done since the foundational plan. Chapter 1 will review issues related to workforce planning and forecasting, education and training, recruitment and retention, and the regulatory systems that are essential to ensuring a quality health care workforce. The Statewide Health Coordinating Council's strategies are designed to strengthen elements of each of these systems. **The council's entire set of new strategies to further the goals and objectives proposed in the *Texas State Health Plan* are included as Table 1-1 at the end of Chapter 1 on page 25.** Chapter 2 describes the Texas Workforce Supply for a number of selected professions and discusses trends that will affect workforce demand. Appendices A, C, D, E, F, G, H include the ad hoc committee reports and the Texas Department on Aging report. Appendix B includes the survey responses from the Academic Health Centers on their continuing efforts to increase the implementation of prevention activities in the health care community through the academic curriculum.

Chapter 1
Strengthening Systems for Workforce Planning and Development

Strengthening Systems for Workforce Planning and Development

INTRODUCTION

The purpose of this *Update* is to further the goals, objectives and strategies put forward in the *Texas State Health Plan: Ensuring A Quality Health Care Workforce for Texas.* Many of the recommendations proposed in this *Update* by the Statewide Health Coordinating Council (SHCC) focus on strengthening four interdependent systems. Those systems are: workforce monitoring and forecasting; education and training; recruitment and retention; and regulatory systems that affect the health professions workforce. The SHCC in its vision statement has expressed its values for community development to improve health and the availability of health information to meet the needs of consumers. In this chapter, background on activities in each of these areas is presented and the SHCC recommendations pertaining to them are highlighted. A complete set of SHCC recommendations is presented in table format at the end of this chapter.

WORKFORCE MONITORING AND FORECASTING

Health care workforce monitoring and forecasting is directed toward informing policymakers of current or future imbalances between the supply and the needs for health professionals. Workforce planning allows for the identification of shortages, surpluses and maldistribution of health professionals by geographic region, specialty, and practice setting – conditions that can adversely affect access to care, quality of care, and health care costs.

The foundation for effective workforce monitoring and forecasting is the collection of accurate workforce data. The availability of timely, accurate, and accessible data on the state's health care providers is important for the following purposes:

- Tracking changes in the supply, distribution and composition of the state's health care workforce;
- Managing state dollars effectively to establish and support health professions education and training programs;

- Maximizing federal funds through programs such as the Health Professions Shortage Area designations and loan repayment programs for health professionals;
- Developing targeted recruitment efforts into the health professions based on identified need; and
- Supporting community-based public and private workforce planning and development efforts.

Appendix A of this *Update* reports on the work done by the SHCC's Ad hoc Committee on Health Personnel Data. That committee proposes a minimum set of data to be collected on selected licensed health professionals in Texas in order to shape workforce planning, higher education planning, decisions about distribution of state dollars for health professions education, and other policy decisions. The Ad hoc committee's study cited gaps in the data currently collected by the health professions licensing boards. The need for better workforce data was also highlighted in two other forums: the Texas Higher Education Coordinating Board's (THECB) long-range strategic planning effort and the Statewide Health Coordinating Council's Symposium on "Ensuring A Quality Health Care Workforce for Texas."

In September 1999 the THECB began a major long-range strategic planning effort to identify a small number of goals that the agency should pursue in the next five to ten years. As part of that study, the THECB established four task forces focusing on: Participation and Success, Civil Rights Issues, Technology Workforce, and Health Professions Education. The THECB contracted with the Council for Aid to Education, a subsidiary of the RAND Corporation, to help them accomplish this task. A primary finding of the Health Professions Task Force study is that better data on Texas's health professionals is necessary if Texas is to be assured that its higher education institutions can produce an adequate number of health care professionals. The THECB's board has adopted the following recommendation:

- Provide financial support to automate state data collection, including information about education of physicians, dentists, nurses, and allied health professionals.
- Direct health professional licensing and regulatory agencies to collect data using the *minimum data set* defined by the Statewide Health Coordinating Council's Ad hoc Committee on Health Personnel Data.

- This would allow state agencies and institutions of higher education to more easily share data and information about health professionals, while protecting the integrity and confidentiality of individual records and information.

The SHCC hosted a Symposium on health professions workforce issues on March 28, 2000. The need for better health professions data arose in panel discussions on workforce planning, nursing workforce, and allied health workforce issues. The SHCC and the Health Professions Resource Center have been most concerned with being able to track statewide health professions supply. However, presentations at the symposium made strong cases for the growing need for good data to support local workforce planning and development efforts. Texas' three Area Health Education Centers have a network of community-based centers that support local workforce development and stated they would benefit from enhanced data. Public/ private partnerships formed by the Dallas-Fort Worth Hospital Council and the Dallas-Fort Worth Area Health Education Center to address nursing shortages, and the Greater Houston Partnership Health Services Steering Committee, which was formed to address skill shortages in the health professions in the Houston/Galveston area, serve as models that demonstrate the importance and the effectiveness of community-based health professions workforce planning efforts.

A Case For Workforce Data And Monitoring

The Nursing Shortage

Texas, with the rest of the nation, faces a nursing shortage crisis that could affect the quality and availability of health care to Texas' citizens. The importance of workforce data and ongoing workforce monitoring at the national and state levels is illustrated in this issue.

The early 90's were characterized by the projection of possible nursing surpluses, primarily due to the national and state responses to a nursing shortage in the late 80s.[1] However, by 1996, the Institute of Medicine convened a Committee on Nurse Staffing in Hospitals and Nursing Homes to evaluate the impact of changes in the health care delivery system on nurse utilization and the quality of care. In 1998, the United States Congress charged the Division of Nursing, U.S. Department of Health and Human Services, with implementing strategies to enhance the production of bachelor degree nurses (BSNs). In the same year, the Department of Veterans affairs

announced that by 2005 it would require that its nurses have a BSN degree due to the complex medical needs of veterans.[2]

What began as primarily a sharing of anecdotal stories attributing perceived declines in quality of care to a lack of registered nurses in the workforce led to the discussion of other nursing issues focusing on: the numbers of licensed but non-practicing nurses; the use of contract nurses; hospitals' inability to fill critical care nursing positions; decreasing enrollments in nursing degree programs; and the inability to hire doctoral trained nurses for faculty positions. Limited published research and lack of reliable and valid data made proving or disproving these anecdotal storied difficult. *Health and Nurses in Texas,* a study conducted by the Center for Health Economics and Policy at the University of Texas Health Science Center at San Antonio states:

> ...warnings about surpluses a few years ago have been replaced with concerns about shortages in the nurse workforce. Unfortunately, lack of current data about nurses, their careers and work environment pose serious barriers to effective planning. Given the continuing expansion of the health care sector and the importance of nursing in delivering health services, timely and reliable information on this key human resource is needed with increasing urgency.[3]

Over the past two years there has been increased activity at both the national and state level to collect and maintain data systems for nursing workforce monitoring and planning. Based on empirical data collected on the nursing workforce in Texas and augmented by research at the national level, informed recommendations and policies for nursing education funding, faculty salaries, and strategies for recruitment into the nursing profession are being proposed. This case study illustrates the need for ongoing workforce monitoring for effective and timely health professions policymaking. Given the dynamics of the health care environment, workforce monitoring and planning does not ensure against possible workforce shortages. It does, however, ensure that information is available in order for policymakers and institutions of higher education to respond in as rapid and appropriate a manner as possible to a changing market.

State Initiatives

After a report by the SHCC's Ad hoc Committee on Health Personnel Data in January of 2000, the House Appropriations Regulatory subcommittee asked the SHCC to present testimony on health professions data. The subcommittee and the licensing boards expressed concern about the costs related to implementing the minimum data set proposed by the SHCC. Also, the 76th Legislature had requested that the Department of Information Resources perform a Regulatory System Requirements and Comparative Analysis. That study is to determine regulatory system requirements, improvements to regulatory data systems through technology, recommendations for system solutions, estimated costs to buy or build new systems, and strategies for funding the implementation of new systems. Seven of the fourteen regulatory agencies included in the study are health professions licensing boards. The House Appropriations Regulatory subcommittee asked the SHCC and the Health Professions Resource Center to conduct a pilot study in which certain health professionals, as a part of their license renewal, will be asked to go to a secure website and enter their workforce data. Numbers of health professionals responding and completeness of the data submitted will be analyzed and reported to the House Appropriations Regulatory subcommittee in January 2001.

While there seems to be a consensus among state agencies, institutions of higher education, and legislators on the importance of health professions workforce data, there is a concern about costs and a continued search for the best and most cost effective way to collect needed data. The SHCC hopes that the Ad hoc Committee report, the DIR Regulatory Systems and Comparative Analysis Study, and the pilot project conducted by the Health Professions Resource Center will provide the legislature with the information it needs to determine the most efficient and cost effective way to implement the minimum data set for health professionals.

SHCC Recommendations

The *Texas State Health Plan's* first goal is: "Ensure that the needed number of health care professionals are educated and trained." The accomplishment of that goal for Texas requires cooperation and collaboration among the many state agencies and universities, as well as other private and public partners. The SHCC, the THECB, and the Senate Committee on Health Services have all provided forums for the discussion of workforce issues and the formulation of solutions and recommendations. In this *Update*, the SHCC proposes the following strategies to strengthen the

workforce monitoring and forecasting systems (See Goal One, Strategy 1.1.1 and 1.1.2 for full text).

- The minimum data set, developed by the SHCC Ad hoc Committee on Health Personnel Data to improve information for workforce planning, allocation of educational resources, recruitment and retention of health professionals and evaluation of those programs; should be implemented and data collected on selected health professionals. The reporting of health personnel data is non-mandatory for health professionals, except for those data elements required for board administrative and regulatory purposes.
- The Health Professions Resource Center, the Texas Higher Education Coordinating Board, the Texas Workforce Commission, and the Research Division of the Texas Legislative Council should work cooperatively to conduct workforce projection studies and define and conduct workforce studies and surveys that will inform workforce and education policy development.

EDUCATION AND TRAINING

The *Texas State Health Plan* proposed goals, objectives and strategies for education and training of the health care workforce. The SHCC proposed a goal to "Create a health care workforce trained and equipped to use education and prevention as the primary approach to helping Texans achieve optimal health." The strategy under that goal was to survey the Academic Health Centers on their programs, curricula, and other initiatives in implementing prevention activities. Appendix B of this *Update* includes the responses from the Academic Health Centers to the survey. In general, the reports from the medical schools, nursing schools, schools of allied health, public health, and dental health indicate changes in curricula, numbers and types of training sites, research, and other activities in this area.

The SHCC is convinced that improvement in health status will come about primarily through communities assessing and addressing their local health needs. The health care professionals in those communities have an important role to play in that community development. An Ad hoc committee was formed to address the core competencies of health professionals in working with communities. That Ad hoc committee was a strategy proposed to help attain the goal of "creating a health workforce that works with communities and in partnership with federal and state governments to have the greatest positive impact on the health of citizens." The

report of the Ad hoc committee on Community Competencies for Health Professionals is included as Appendix C in this *Update.* The SHCC proposes the following strategy to develop the skill level of health professionals in working with communities with its citizens (see Goal 6, Strategy 6.2.1 for full text.).

> The core competencies outlined in the Community Competencies for Health Professionals report should be integrated into professional associations' accreditation, certification, continuing professional education and licensure processes. Institutions training health professionals should incorporate them as benchmarks for graduation, entry into professional practice and continuing competence.

In considering demographic factors, which affect health care needs, the SHCC requested that the Texas Department on Aging study aging population health issues and their relationship to health workforce education, planning, and practice. The report referred to in the above strategy is included as Appendix C in this *Update.* Based upon this report, the SHCC recommends further study with a focus on forecasting health specialties that are needed to fulfill the health care needs of this population. Each of the reports produced from strategies proposed in the *Texas State Health Plan,* furthers the SHCC's goal to ensure a quality health care workforce for Texas.

In addition to these reports produced for this *Update,* the Texas Higher Education Coordinating Board embarked upon an ambitious strategic planning process that included a focus on health professions education and training issues. The SHCC's legislative mandate directs it to work collaboratively with the Texas Higher Education Board (THECB) to make recommendations on health professions workforce education and training. The THECB has appointed Dr. Dolores Carruth as its representative to the SHCC. During the THECB's strategic planning process, Dr. Ben G. Raimer, Chair of the SHCC, was a member of the THECB Health Professions Task Force.

The THECB's Health Professions Task Force was charged to:

- Review information on the quality, accessibility, productivity, and cost of the health-related programs offered by Texas higher education institutions;

- Review information on the demand for health profession in Texas and its major regions over the next 10 years; and
- Identify the best strategies by which higher education can produce an adequate number of appropriately trained health care professionals for Texas and its major regions.

The Health Professions Task Force established subcommittees in the fall of 1999 in the areas of medicine and dentistry, nursing, and allied health to study health professions education issues and make recommendations. Some of the issues discussed in these task forces are highlighted in the following sections.

THECB Subcommittee on Medicine and Dentistry

Of major concern to the medical and dental schools are the financial repercussions to medical schools and teaching hospitals due to decreases in federal financing under Medicare and Medicaid and decreases in revenues resulting from cost containment measures. The issue of establishing new medical schools in the state was considered but not supported due to the belief that new schools would weaken existing health-related institutions, jeopardize national accreditation, require extensive new state general revenue funding, and take several years to gain accreditation. The medicine and dentistry subcommittee proposed a set of recommendations based on four themes.

Participation – Providing the broadest array of students access to medical and dental education.

Success – Ensuring that students who enter Texas medical and dental schools graduate, complete their medical training, and enter the profession with the technical and critical thinking skills necessary to deliver quality care. Success also includes retaining graduates to practice in Texas.

Workforce – Preparing and training the required number of physicians and dentists to meet the needs of Texas growing population.

Technology - Ensuring that medical and dental students have access to, understanding of, and the appropriate training to utilize advances in technology that will translate into better health care delivery for Texas.

The subcommittee submitted their recommendations in these areas to the THECB long-range strategic planning committee. The SHCC supports several of the proposed

recommendations. Some of the medicine and dentistry subcommittee's recommendations are included under the SHCC's Goal One, Strategy 1.1.3b, while others are incorporated under goals and strategies related to recruitment and retention and the maldistribution of health professionals.

THECB Subcommittee on Nursing

Of prime importance to the nursing subcommittee was the issue of the nursing shortage and the actions that could be taken by the THECB, the Texas Legislature, and higher education institutions offering degrees in nursing. Past nursing shortages have been regarded as cyclical; however, recent studies indicate that the current nursing shortage is due to fundamental changes in society, the delivery of medical care, and an aging nursing faculty and workforce.[4] Solutions to this nursing shortage will require different responses than those taken in the past.

The nursing subcommittee proposed a number of recommendations to the THECB strategic planning committee. The SHCC supports the following recommendations for nursing (See Goal One, Strategy 1.1.3c for full text.):

- The THECB should support a moratorium on new nursing education programs until data indicate an adequate number of qualified nurse faculty and clinical sites are available.
- The legislature should increase funding for nursing schools for recruitment, retention and graduation of professional nurses, expanding distance-learning programs, and increasing faculty salaries.

THECB Subcommittee on Allied Health

The subcommittee on Allied Health began by producing a document entitled, *Allied Health Professions Education: A Primer,* in response to the need for the Health Professions Task Force to understand the diversity of occupations, roles, education, certifications, licensures, and accreditations that make up the field of allied health.[5] Allied health professionals comprise over 60 percent of the entire health care workforce. They may receive their education and training from high schools, vocational schools, community colleges, universities, and hospitals. This primer defines allied health professionals, identifies issues related to allied health education, and discusses the role the market plays in the demand for allied health workers. The Subcommittee on Allied Health also structured their recommendations along the

themes of participation, success, workforce and technology. The SHCC supports the following recommendations (See Goal One, Strategy 1.1.3d for full text.):

- Create incentives for institutions of higher education to form partnerships in the delivery of allied health programs to improve student participation across the state.
- Improve articulation of courses from the community colleges to the universities and health science centers.
- Review the impact of formula funding policies that hinder the development and implementation of programs.
- Simplify and shorten the THECB and institutions of higher education approval processes for instructional programs in order to provide a more timely response to the changing needs of the health care industry.

Some of the issues explored by the THECB Health Professions Task Force were also discussed in the larger forum of the SHCC Symposium. Also, during the fall and spring of 1999 – 2000, many of the issues were presented to the Senate Committee on Health Services, charged to study health professions workforce issues. These separate studies and forums for discussion have served to bring a focus to health professions education issues and build consensus among state agencies and higher education institutions around health professions workforce issues.

Other Related State Initiatives

The Texas Department of Health and the THECB are currently preparing a report on health professions education needs in the Texas-Mexico Border which was mandated through House Bill 1378, passed in the 76th Texas Legislature. That report will review health care needs, health care facilities, workforce resources, state government health care costs, number and location of state-operated health education facilities, health education costs, trends in health education, and existing and future health professions degree and certificate programs. That report is due to the legislature in January 2001. The lieutenant governor also gave an interim charge to the Senate Finance Committee to study Graduate Medical Education (GME) funding and to make recommendations for the 77th Legislative session. According to the *Annals of Internal Medicine*:

> The Balanced Budget Act of 1997 (BBA) had a profound impact on the financing and organization of many health care services. The Act disproportionately affected U.S. teaching hospitals, leading to

> substantial budget reductions in many institutions and the threat of cuts in major programs and services that teaching hospitals provide to communities.[6]

An Association of American Medical Colleges Fact Sheet published in May 2000 shows that the financial condition of America's teaching hospitals has declined due to reductions in both public and private revenue resulting from the BBA and the growth of managed care.[7] The resulting financial crisis in teaching hospitals dramatically affects GME, specifically funding related to the training of medical residents. The 76th Legislature implemented formula funding ratios for health professions education, but did not address the issue of GME. The Senate Finance Interim Committee on GME is working with the THECB to develop and propose a funding formula for GME to be presented to the 77th Legislature.

RECRUITMENT AND RETENTION

The importance of recruitment and retention activities to ensuring a quality health care workforce is the focus of both the SHCC Ad hoc Committee on Recruitment and Retention and the SHCC Ad hoc Committee on Minority Health Reports (See Appendices E and F). This was also a theme underlying all of the THECB Health Professions Task Force subcommittee reports and recommendations. Recruiting people into the health professions is an essential first step in building and maintaining a quality health care workforce. The second step is supporting those students who have chosen to enter a health profession. The third step is retaining those students to practice in Texas and recruiting them to practice in medically underserved areas. To be effective the state needs to strengthen those three steps through collection of data, coordination of efforts, increasing minority recruitment, and supporting community level recruitment and retention efforts.

The SHCC Symposium panel on Workforce Supply and Demand highlighted the importance of having good data to monitor workforce supply and demand. From that data, local, regional and statewide workforce needs can be assessed. That data can then be used to develop workforce plans and target recruitment efforts to specific health professions needs. The workforce development and planning projects by the Greater Houston Partnership and the Dallas Fort Worth Area Health Education Center presented at the SHCC Symposium demonstrate the power of local public and private efforts to address health professions workforce efforts. Those local planning efforts

explored local needs, derived local solutions and formed public/private partnerships to address those needs through targeted recruitment and student support.

There are a number of systems in place to support local, regional, and statewide recruitment and retention efforts.

Health Professions Resource Center – the role of this center is to maintain comprehensive health professions databases on licensed health professionals in Texas. The HPRC maintains a website displaying information on health professions shortage areas and workforce distribution by county.

Center for Rural Health Initiatives – is expanding the Texas PRAIRIE DOC program, which is a comprehensive recruitment approach, involving communities and other partners and participants.

Texas Higher Education Coordinating Board – administers physician loan repayment programs. The Family Practice Residency Program instituted in 1979 has resulted in the retention of 87 percent of resident physicians remaining and practicing in Texas with 48 percent of those locating practices in cities with 50,000 population or less.

Area Health Education Centers – have statewide community-based centers, which support workforce development and planning, recruitment programs, identification of clinical training sites, and continuing professional education and other professional support services.

Texas Department of Health Programs – the Texas Department of Health's Office of Border Health, Office of Minority Health, and the Primary Care Resources Program also have an emphasis on health professions recruitment and retention.

University Programs – Texas' 137 public community and technical colleges, and general academic and health-related institutions of higher education offer health professions degrees and support recruitment efforts. Key examples of these types of programs are Texas A&M University System's Partnership for Primary Care, and the Medical School Familiarization Program through the University of Texas Medical Branch at Galveston.

Professional Associations – such as the Texas Academy of Family Physicians, the Texas Medical Association, the Texas Osteopathic Medical Association, and the Texas Nurses Association support workforce planning and recruitment initiatives.

In order to better support all of these initiatives the SHCC proposes a number of strategies under Goal Three "Address the maldistribution of health professionals," with the Objective of "increasing access to health care through the coordination of recruitment and retention efforts." (See Goal 3, Objective 3.2 for full text.)

- Strategy 3.2.1. The state should enhance recruitment and retention of health professionals into Health Professional Shortage Areas by expanding state financial incentives, including, but not limited to, loan repayment, loan forgiveness, scholarship, grant programs and accessing federal matching dollars through the National Health Service Corps. Financial incentive programs should be established for all health care professionals.

- Strategy 3.2.2. The Statewide Health Coordinating Council should convene a collaborative partnership of state agencies, Academic Health Centers, Area Health Education Centers, professional associations and others to coordinate statewide recruitment and retention efforts of health professionals.

Recruiting and Retaining Minorities in the Health Professions

The SHCC Ad hoc Committee on Minority Health established a need for more minorities in the health professions through its discussion of under-representation of minorities in the health professions, disparities in health status and treatment of minorities, and the projected demographic changes in Texas's population. The THECB recommends: "Supporting and encouraging regional planning efforts among secondary schools, health professional programs, and health care employers to develop strategies for recruitment and retention of students reflective of the state's diverse population." This was a result of each Health Professions Task Force subcommittee's (Medicine and Dentistry, Nursing, and Allied Health) proposed recommendations to expand and enhance programs directed toward recruiting minorities into the workforce.

Recruitment of minorities into the health professions is an educational pipeline issue that must be addressed with academic preparation in the elementary and secondary schools. The Healthy People 2010 program developed by the Centers for Disease Control and Prevention has a goal to eliminate health disparities and provides some focus and direction to states' efforts to achieve the same goal. The SHCC proposes the following strategies (see Goal 5, Objective 5.1 for full text):

- Educational institutions at all levels, elementary, secondary, community college and university, should plan, implement, and strengthen their health professions programs to meet the Healthy People 2010 goals and strategies for increasing the number of minorities in the health professions.
- The Texas Department of Health's Office of Minority Health should review the Healthy People 2010 goals and strategies related to reducing disparities in health status in minority populations, and promote and coordinate efforts by programs in TDH, other Health and Human Services agencies, and private and public organizations to meet those objectives.
- The Texas Board of Health should establish an advisory committee to the Office of Minority Health.

REGULATION OF HEALTH PROFESSIONALS

The SHCC has identified two areas where regulation affects or may affect health professions and the assurance of access and quality care to all Texans. Those areas include the process in changing health professionals' scopes of practice, telemedicine and public health workforce initiatives.

Scope of Practice

Scopes of practice, as defined in the medical practice acts, delineate what duties a health professional can perform, what prescription authority each one has and under what kinds of supervision duties can be performed. Changes in scopes of practice generally require legislative changes to the medical practice acts. Proposed changes in scopes of practice are of critical importance to the health professionals involved and to the general public. Changes in scopes of practice can provide ways to decrease the costs of medical care and increase the delivery of services to at-risk or rural and underserved populations, providing greater access to care. However, they also generate concerns for consumer protection, professional autonomy and livelihoods, quality of care and cost containment. State legislators are faced with making decisions

of such importance within the compressed time of a legislative session and frequently under a great deal of pressure from those professionals affected. In order for the legislature to make informed decisions on these issues, criteria for changing a profession's scope of practice or for licensing a new profession must be established. That process must include a discussion of these issues in a broader public forum and involve consumers, health professionals, hospitals and other health care employers, public health policymakers and others. Any process established should ensure patient safety and quality of care, demonstrate adequate professional competency, estimate potential cost benefits of the change, and increase in ability to expand access to care for rural and underserved populations.

The following speakers on the SHCC Symposium Panel on Scope Of Practice focused on a number of possible processes to effectively manage scope of practice issues. Dr. Ben Raimer, Chair of the Statewide Health Coordinating Council, cited the 1998 Pew Commissions Report which advocates that scope of practice issues be data based, use alternative dispute resolution processes, and that legislatures establish "sunrise" and "sunset" processes to license new professions or to change existing professions' scopes of practice.[8] Washington, Colorado, and Maine all have sunrise review processes which establish criteria for decision making, include public meetings and hearings, and include reports to the legislature with findings, recommendations and rebuttals.

Representative Patricia Gray, Chair of the House Committee on Public Health, commented on how time consuming issues of scope of practice are during a busy legislative session. Her experiences have led her to believe that a better process is needed to ensure that issues are fully explored and developed through a more inclusive and objective process so that legislators can be better informed to make scope of practice legislative decisions.

Dr. Bruce Levy, former Executive Director of the Board of Medical Examiners, also presented on the scope of practice panel. Dr. Levy believes that the rule making process can be an effective and flexible way to manage some scope of practice issues.

The rulemaking process can be invoked if it involves defining terms or language already in a statute, which describes the scope of practice for a particular profession. The appropriate licensing board(s) would negotiate with their constituencies and draft rules based upon the existing legislation. Rules can be amended and do not require legislative action.

Suzanne Marshall, Deputy Director of the Center for Public Policy Dispute Resolution at the University of Texas School of Law, described the services provided by the Center and how they could be incorporated into a formalized process for determining changes in scopes of practice. The use of alternative dispute resolution processes is a major component in the Pew Commission's recommended strategies for determining changes in scopes of practice (See Exhibit 1-1). Texas meets most of the recommendations relating to alternative dispute resolution through the Texas Governmental Dispute Resolution Act of 1997, which established the use of alternative dispute resolution by state agencies as state policy and provided the statutory framework for the development and use of alternative dispute resolution procedures for state government.

The issue of scope of practice determinations is an issue for the legislature. The SHCC has discussed concerns related to the current system. It has explored possible methods and processes that could be instituted. Given the current health care market, issues related to scope of practice will continue to proliferate. In the interests of assuring sound public policy for regulating health professions and quality of care for all Texans, the SHCC proposes the following action to fulfill the strategy of "creating a fair and equitable process for addressing changes in scopes of practice for health professionals in Texas." (See Goal 2, Objective 2.1 for full text.)

> The lieutenant governor or the speaker of the house should request a legislative interim study to establish a process for determining changes in scopes of practice. The study should review and recommend a process that would include, but not be limited to, sunrise review, alternative dispute resolution, and rulemaking.

Telemedicine

The lack of available qualified health professionals continues to be a major barrier to accessing health care in rural Texas and in some urban areas. Telemedicine technologies hold promise for providing greater access to medical care, ensuring

quality of care, and containing costs through early diagnosis and intervention. The SHCC views telemedicine as a strategy to address the maldistribution of health professionals and increase access to health care through technology.

In the *Texas State Health Plan*, the SHCC proposed that the state address issues related to telemedicine by appointing a task force to develop a statewide telemedicine plan that would increase access to medical care, extend the workforce, and enhance workforce training. Issues to be addressed in that plan included: establishing guidelines for the Telecommunications Infrastructure Fund Board (TIFB) on funding telemedicine projects; identifying and recommending a statewide telecommunications infrastructure for telemedicine; defining the role of medical schools, hospitals, and public health clinics; making policy recommendations to ensure the quality of care; designating a group to coordinate statewide telemedicine initiatives; and, reviewing and making recommendations on interstate licensing issues related to the use of technology.

A Texas House Research Organization Report entitled, *Telemedicine in Texas: Public Policy Concerns,* covers issues identified by the SHCC and addresses policy issues that have come to the forefront since the *Texas State Health Plan*. That report states, "The rapid growth of telemedicine raises issues for Texas lawmakers regarding public health and safety, financing, consumer protection, and regulation of medical practice." [9] Policy issues that are coming to the forefront pertain to: reimbursement, equipment standards, medical regulation, and confidentiality and security.

One of the major issues that has hampered the use of telemedicine technologies is federal and state reimbursement for services performed via telemedicine. The Texas State Insurance Code for private health carriers is very liberal in its reimbursement of telemedicine procedures and in presenting practitioners. However, both Medicaid and Medicare have strict limitations on the types of services that can be reimbursed and who qualifies as an eligible presenter. A May 2000 report by the Office for the Advancement of Telehealth at the Health Resources and Services Administration (HRSA) identifies required fee sharing between referring physician and specialist, and the Health Care Financing Administration's interpretation of eligible presenters as limiting factors to the advancement of telemedicine.[10]

These issues are being addressed in Texas and at the federal level. House Bill 1398, passed during the 76th Legislative session, established a Health and Human Services Commission Medicaid Telemedicine Advisory Committee. That committee is charged to develop legislative recommendations to improve telemedicine services and identify areas for expansion of telemedicine in the Texas Medicaid Program. That committee has been meeting and will make recommendations to the legislature in October of 2000. Additionally, at the federal level, several laws have been proposed in Congress. Senate Bill 2505 seeks to provide increased access to health care for Medicare beneficiaries through telemedicine. That bill eliminates fee sharing, eliminates the requirement for a tele-presenter and allows reimbursement in non-Metropolitan Service Areas, and rural and urban Health Professional Shortage Areas. The expansion of eligible presenters or the elimination of the requirement for a tele-presenter reflects the proposed use of telemedicine in home health care and monitoring patients from their home.

The SHCC proposes in its strategies to address the maldistribution of health professionals and improve access to care that:

> The State Legislature should include telemedicine third-party reimbursements for Medicaid, Children's Health Insurance Program, Texas Healthy Kids Corporation and other state-sponsored programs in the state's mandated coverage. The following practitioners should be considered for third party reimbursement for telemedicine/ telehealth services: physicians, dentists, clinical psychologists, advance practice nurses, physician assistants, certified nurse midwives, clinical social workers, occupational therapists, physical therapists, speech therapists, marriage and family therapists, and other licensed health care providers. The state should consider issues related to scope of practice, fraud and abuse, and quality of care (see Goal 3, Objective 3.1 for full text).

The state provides funding to build the state's telemedicine capacity through grants offered through the Texas Telecommunications Infrastructure Fund Board (TIFB). The Office of the State Auditor's report on the TIFB, released in February 2000, specifically cited the need for TIFB to better assess telecommunications needs (including telemedicine), seek input from professional advisory groups, increase collaboration with other state agencies, and fund more advanced projects (statewide networks) as allowed in their enabling legislation.[11] The SHCC includes telemedicine recommendations that relate specifically to the TIFB and funding (see Goal 3, Objective 3.1 for full text). They are:

The 77th Texas Legislature should address high Inter-LATA rates that limit the development and sustainability of rural telemedicine links by establishing a program through the Public Utility Commission's Universal Access Fund that can be accessed to offset Inter LATA rates.

The 77th Texas Legislature should amend the TIFB's enabling legislation to provide for the following:

a) Definition of telemedicine/telehealth to include store and forward, teleradiology, mandatory disease reporting and health alerts, continuing education for health professionals, prisoners' health programs, behavioral health services, counseling and mental health services.
b) Flexibility in telecommunications protocol/technology so that the most cost-effective connection can be instituted, e.g., DSL instead of T-1.
c) Independent, private practitioners who deliver direct patient care; beneficiaries who live in rural or underserved areas, accept Medicaid or Medicare patients, and connect to an Academic Health Center or regional hospital; should be eligible for TIF funding.

The Telecommunications Infrastructure Fund Board should consider the following telemedicine/telehealth funding priorities:

a) Projects that address the maldistribution of health professionals through the development of telemedicine technology in rural and underserved areas.
b) The development of telehealth institutes and telehealth curriculum development in Academic Health Centers for all health professions students.
c) Funding for evaluation of telehealth demonstration grants by independent researchers.
d) The development of statewide networks to improve health care delivery and administration specifically by working collaboratively with the Department of Mental Health and Mental Retardation, the Department of Health, and the Health and Human Services Commission.

COMMUNITY DEVELOPMENT AND CONSUMER INFORMATION

The SHCC's vision statement has guided its study of health workforce issues. That vision statement expresses values for prevention and education, equal access to health care, the empowerment of local communities to plan and direct health interventions that have the greatest impact on their citizens, and the ability of consumers to make informed health decisions. To that end, two strategies were proposed in the *Texas State Health Plan* and ad hoc committees were formed to: 1) explore models for community health practice, and 2) enable consumers to make better health care decisions. Those ad hoc committee reports are included as Appendices G and H in this *Update.* The SHCC supports the following strategy to further the objective of designing and implementing systems to help local communities address health issues (see Goal 6, Objective 6.1 for full text).

> The Texas Department of Health should provide technical assistance to local health departments and communities in preparing a community health profile (Public Health Essential Function #1) to aid them in directed health planning.

Consumers find themselves in positions where they are either overwhelmed with health information or where they are frustrated in their ability to locate specific information to meet their health care needs. The Ad hoc committee on Consumer Information explored the types of information consumers want, need, and use as well as the types of information available to them. As a result of this study, the SHCC adopts the strategy (see Goal 7, Objective 7.1 for full text):

> The Texas Health Care Information Council should develop a clearinghouse providing health and health insurance related information. THCIC should be authorized to coordinate and organize the information available from state agencies and state entities involved in health information activities (i.e. Texas Health Care Information Council, Office of Public Insurance Counsel, Texas Department of Insurance, health professions licensing boards, and the Texas Department of Health).

Summary

This chapter has highlighted SHCC strategies and recommendations related to strengthening the four interdependent systems – workforce monitoring and forecasting, education and training, recruitment and retention, and regulation of health

professionals - that are critical to ensuring a quality health care workforce for Texas. In addition, strategies are proposed based on work done by other ad hoc committees, which supports the SHCC values for community development and responsibility in improving health and for the availability of health information to meet the needs of consumers. The full set of SHCC strategies is included in Table 1-1. The SHCC believes that the strategies and recommendations in this *Update* further the goals and objectives outlined in the *Texas State Health Plan* and will serve to ensure a quality health care workforce for Texas.

Endnotes

1. Pew Health Professions Commission. *Critical Challenges: Revitalizing the Health Professions for the Twenty-First Century.* San Francisco: University of California, San Francisco, Center for Health Professions; 1995.

2. Bednash, Geraldine, "The Decreasing Supply of Registered Nurses: Inevitable Future of Call to Action," *Journal of the American Medical Association*, 283, 22, June 14, 2000.

3. Miller, Don R., "Health and Nurses in Texas," An Initiative of the Texas Nurses Foundation in Partnership with the Texas Institute for Health Policy Research and the Center for Health Economics and Policy at the University of Texas Health Science Center at San Antonio, 1, 1, Winter 2000.

4. Buerhaus, Peter I., Staiger, Douglas O., Auerbach, David I., "Implications of an Aging Registered Nurse Workforce," *Journal of the American Medical Association*, 283, 22, June 14, 2000.

5. Dickler, Robert, Shaw, Gina, "The Balanced Budget Act of 1997: Its Impact on U.S. Teaching Hospitals," *Annals of Internal Medicine*, 132: 820-824, 16 May 2000.

6. Association of American Medical Colleges, "Fact Sheet," 4, 3, May 2000, www.aamc. org.

7. Harrington, Marilyn S., and Rettig, Richard A., "Allied Health Professions Education: A Primer," Handout, Texas Higher Education Coordinating Board Health Professions Task Force, March 6, 2000.

8. O'Neil, E.H. and the Pew Health Professions Commission, "Recreating Health Professional Practice for a New Century," San Francisco, CA: Pew Health Professions Commission. December 1988.

9. Zamrazil, Kristie, "Telemedicine in Texas: Public Policy Concerns," House Research Organization Focus Report, Number 76-22, May 5, 2000.

10. Office for the Advancement of Telehealth. "Telehealth Update," U.S Health Resources and Services Administration, May 2000. www.telehealth.hrsa.gov/

11. State Auditor's Office. "An Audit Report on The Telecommunications Infrastructure Fund Board," Report No. 00-010, February 2000. www.sao.state.tx.us/

Table 1-1. 2001-2002 State Health Plan Update Goals, Objectives and Strategies

Goal 1: Ensure that the needed number of health care professionals are educated and trained.

Objective 1.1: Conduct workforce supply and requirements planning for Texas 2000 – 2030

State Strategy	Actions	Parties Responsible	Timetable
Strategy: 1.1.1 The minimum data set, developed by the SHCC Health Personnel Data Ad Hoc committee to improve information for workforce planning, allocation of educational resources, recruitment and retention of health professionals and evaluation of those programs, should be implemented and data collected on the following professions: Audiologists Chiropractors Dentists Dental Hygienists Dietitians Licensed Vocational Nurses Medical Radiologic Technicians Occupational Therapists Optometrists Pharmacists Physicians Physician Assistants Physical therapists Psychologists Registered Nurses Respiratory Care Practitioners Speech Language Pathologists Social Workers The reporting of health personnel data is non-mandatory for health professionals, except for those data elements required for board administrative and regulatory purposes.	1) The Department of Information Resources (DIR) Regulatory Systems Requirements and Comparative analysis study should include in its proposal the minimum data set for health professionals. 2) If the House Appropriations Regulatory Sub-Committee approves and recommends allocation of funds for the DIR regulatory system that priority be given to implementing the data collection system for health professions. 3) The licensing boards for those professions named should change their licensing and renewal forms and data systems to include the collection of the minimum data set on an annual or biennial basis. The legislature should appropriate funds to the Texas Department of Health to cover the costs of contracting with licensing boards to implement the minimum data set. The legislature should raise the FTE cap for those licensing boards and the Health Professions Resource Center, which are required to implement and maintain the collection of that data. 4) The Texas Legislature should amend H.B. 692, 76th Texas Legislative Session, to allow for the disclosure of the social security number and other licensing board data including, but not limited to, gender, date of birth, and race/ethnicity to the Health Professions Resource Center, other state agencies and state universities. Release of such licensing data should be subject to any confidentiality requirements and guidelines outlined by the open records laws and privacy laws of Texas.	House Appropriations Regulatory Sub-Committee and the 77th Texas Legislature Health Professions licensing boards which license the professionals listed 77th Texas Legislature	End of the 77th Legislative Session Implementation completed by August 2003 End of 77th Legislative Session

State Strategy	Actions	Parties Responsible	Timetable
Strategy: 1.1.2 The Health Professions Resource Center, the Texas Higher Education Coordinating Board, the Texas Workforce Commission, and the Research Division of the Texas Legislative Council work cooperatively to conduct workforce projection studies and define and conduct workforce studies and surveys that will inform workforce and education policy development.	1) Conduct on-going studies using workforce models on individual professions and the Integrated Requirements Model 2) Identify information needs and conduct surveys on issues affecting the workforce: salary, job satisfaction, retirement projections, workplace descriptors, practice patterns, etc. 3) Identify current and future educational needs and funding for health professions education, minority and rural recruitment and retention. 4) The Texas Department of Health should increase the operating budget and staff for the Health Professions Resource Center in order for them to effectively administer both the Department of Health and Human Services Health Professions Shortage Area functions and the workforce planning functions.	The Health Professions Resource Center and the Texas Higher Education Coordinating Board co-sponsor convene and produce workforce and education reports to be presented to the Texas State Legislature each biennium. These reports should be produced with input and support from: Texas Workforce Commission Texas Legislative Council Area Health Education Centers Health Professions Associations Academic Health Centers Schools of Allied Health Community Colleges Center for Rural Health Initiatives Community Health Provider Resources, TDH Texas Department of Health	November 1, 2002 and ongoing
Strategy: 1.1.3 The Statewide Health Coordinating Council, in consultation with the Texas Higher Education Coordinating Board and its relevant advisory committees, proposes the following recommendations for programs and funding for health professions education.	1) The Texas Higher Education Coordinating Board review its GME funded programs to ensure that the state is maximizing federal matching dollars and make recommendations for changes if necessary. 2) The 77th State Legislature implement proposed formula- funding ratios for health professions programs.	Texas Higher Education Coordinating Board 77th Texas Legislature	77th Legislative Session End of 77th Legislative Session

State Strategy	Actions	Parties Responsible	Timetable
Strategy: 1.1.3a The Statewide Health Coordinating Council supports the following recommendations of the Board of the Texas Higher Education Coordinating Board	1) The state has an adequate and appropriate number of health-related institutions and the establishment of an additional health-related institution would weaken the academic capacity of the existing institutions and present a financial burden to the state.		
	2) The Legislature should provide increased financial state support to existing health-related institutions placed in financial jeopardy due to decreases in federal funding and decreases in revenues from managed care organizations because of cost containment strategies.	77th Texas Legislature	End of 77th Legislative Session
	3) Increase the state's financial support of nursing programs to help allay the projected nursing shortage.	77th Texas Legislature	End of 77th Legislative Session
	4) The Legislature should provide financial support to automate state data collection, including information about the education of physicians, dentists, nurses, and allied health professionals.	77th Texas Legislature	End of 77th Legislative Session
	5) The Texas Higher Education Coordinating Board study and streamline the process of transferring credit between community colleges and universities.	Texas Higher Education Coordinating Board	To be set by the THECB
	6) Health professions institutions develop health professions programs that meet the needs of students, employers, and the changing health care environment of Texas. Expand the use of new technologies to deliver health professions education via distance.	Higher Education institutions offering health professions degree programs	Ongoing
	7) Support regional planning efforts among secondary schools, health professions programs, and health care employers to develop strategies for recruitment and retention of students reflective of the state's diverse population.	Texas Higher Education Coordinating Board Academic Health Centers Center for Rural Health Initiatives	Ongoing
	8) The Legislature should expand state support for teaching graduate medical education to Texas medical school graduates and other qualified medical residents.	77th Texas Legislature	End of 77th Legislative Session

State Strategy	Actions	Parties Responsible	Timetable
Strategy 1.1.3b The Statewide Health Coordinating Council supports the following recommendations of the Texas Higher Education Coordinating Board's Task Force on Health Professions subcommittee on Medicine and Dentistry.	1) The Texas Higher Education Coordinating Board should establish a formal recognition process to identify the most successful medical and dental outreach and undergraduate recruiting programs. The THECB should provide a forum to feature these best practices. 2) The Texas Legislature should consider increasing funding for: a) Additional residency positions in all medical specialties for Texas medical school graduates b) Medical and dental Ph.D. programs to provide an adequate workforce for research expansion c) Fellowships for biotechnology and clinical research training	Texas Higher Education Coordinating Board 77th Texas Legislature	To be set by THECB End of 77th Legislative Session
Strategy 1.1.3c The Statewide Health Coordinating Council supports the following recommendations of the Texas Higher Education Coordinating Board's Task force on Health Professions Education subcommittee on Nursing Education	1) The Higher Education Coordinating Board should assess the availability of qualified faculty and clinical sites available to maintain any proposed new nursing programs. The THECB should support a moratorium on new nursing education programs until data indicate an adequate number of qualified nurse faculty and clinical sites are available. 2) The legislature should increase funding to existing nursing schools for the purposes of: a) Increasing the recruitment, retention, and graduation of professional nurses. b) Improving articulation from the LVN to ADN to BSN to MSN to doctoral degree in nursing c) Increasing accessibility to nursing education programs by use of distance learning. d) Increasing faculty salaries to recruit and retain qualified faculty.	Texas Higher Education Coordinating Board	To be set by THECB

State Strategy	Actions	Parties Responsible	Timetable
Strategy 1.1.3d The Statewide Health Coordinating Council supports the following recommendations of the Texas Higher Education Coordinating Board's Task Force on Health Professions Education subcommittee on Allied Health Professions	1) Create incentives for institutions of higher education to form partnerships in the delivery of allied health programs to improve student participation across the state. Examples of desired partnerships include the following: a) Improved articulation of courses from the community colleges to the universities and health science centers b) Sharing resources such as: faculty, funding, and clinical sites c) Establishing interdisciplinary programs d) Urban – rural collaborative efforts e) Public – private collaborative efforts f) Provision of distance learning programs	Institutions of Higher Education offering health professions degrees	Ongoing
	2) Review the impact of formula funding policies that hinder the development and implementation of programs with respect to the following: a) Biennial funding lag b) Programs with small enrollments but important to the community or industry c) Cost of distance learning programs d) Cost of telemedicine technologies	Texas Higher Education Coordinating Board	Ongoing
	3) The Texas Higher Education Coordinating Board and institutions of higher education simplify and shorten approval processes for instructional programs in order to provide a more timely response to the changing needs of the health care industry.	Texas Higher Education Coordinating Board Institutions of higher education offering health professions degrees	Ongoing

Goal 2: Improve health professions regulation to ensure quality health care for Texas
Objective: 2.1 Establish fair and equitable mechanisms and processes that will address health profession regulation

State Strategy	Actions	Parties Responsible	Time Line
Strategy 2.1.1 Create a fair and equitable process for addressing changes in scopes of practice for health professionals in Texas.	1) The lieutenant governor or the speaker of the house should request a legislative interim study to establish a process for determining changes in scopes of practice. The study should review and recommend a process that would include, but not be limited to, sunrise review, alternative dispute resolution, and rulemaking. a) Criteria for determining changes in scopes of practice in any process should address: i) data on the professional or occupational group ii) overall cost effectiveness and economic impact of the proposed regulation iii) extent to which the regulation or expansion of the profession or occupation would increase or decrease the availability of services iv) documentation of improved or enhanced quality of care v) comparison with existing regulations and findings from other states b) Determine agency regulatory responsibility for this function and appropriate funds and FTE's to staff this function.	Lieutenant Governor or Speaker of the House	Interim study 77th and 78th Legislative Sessions

Goal 3: Address the maldistribution of health professionals.
Objective: 3.1: Increase access to health care through technology

State Strategy	Actions	Parties Responsible	Time Line
Strategy 3.1.1 In order to address the maldistribution of health care professionals and increase access to rural and underserved populations, Texas should pass legislation and fund programs that expand the use of telemedicine	1) The State Legislature should include telemedicine third-party reimbursements for Medicaid, Children's Health Insurance Program, Texas Healthy Kids Corporation and other state-sponsored programs in the state's mandated coverage. The following practitioners should be considered for third party reimbursement for telemedicine / telehealth services: physicians, dentists, clinical psychologists, advance practice nurses, physician assistants, certified nurse midwives, clinical social workers, occupational therapists, physical therapists, speech therapists, marriage and family therapists, and other licensed health care providers. The state should consider issues related to scope of practice, fraud and abuse, and quality of care.	77th Texas Legislature	77th Legislative Session
	2) The State Legislature should address high Inter-LATA rates that limit the development and sustainability of rural telemedicine links by establishing a program through the Public Utility Commission's Universal Access Fund that can be accessed to offset Inter LATA rates.	77th Texas Legislature Public Utility Commission	77th Legislative Session
	3) The 77th Texas Legislature should amend the Telecommunications Infrastructure Fund (TIF) Board enabling legislation to provide for the following: a) Telemedicine/telehealth should be defined to include store and forward, teleradiology, mandatory disease reporting and health alerts, continuing education for health professionals, prisoners' health programs, behavioral health services, counseling and mental health services.	77th Texas Legislature	77th Legislative Session

State Strategy	Actions	Parties Responsible	Time Line
Strategy 3.1.1 con't. In order to address the maldistribution of health care professionals and increase access to rural and underserved populations, Texas should pass legislation and fund programs that expand the use of telemedicine.	b) Flexibility in telecommunications protocol/technology so that the most cost-effective connection can be instituted. (e.g. DSL instead of T-1) c) Independent, private practitioners who deliver direct patient care; beneficiaries who live in rural or underserved areas, accept Medicaid or Medicare patients, and connect to an Academic Health Center or regional hospital; should be eligible for TIF funding d) Adoption of the 42 US Code 254b definition of primary health care 4) The Telecommunications Infrastructure Fund Board should consider the following telemedicine/telehealth funding priorities: a) Projects that address the maldistribution of health professionals through the development of telemedicine technology in rural and underserved areas. b) The development of telehealth institutes and telehealth curriculum development in Academic Health Centers for all health professions students c) Funding for evaluation of telehealth demonstration grants by indopendent researchers d) The development of statewide networks to improve health care delivery and administration specifically by working collaboratively with the Department of Mental Health and Mental Retardation, the Department of Health, and the Health and Human Services Commission.	Telecommunications Infrastructure Fund Board	November 2001

Goal 3 Address the maldistribution of health professionals
Objective 3.2: Increase access to health care through the coordination of recruitment and retention activities.

State Strategy	Actions	Parties Responsible	Time Line
Strategy 3.2.1 Enhance recruitment and retention of health professionals into Health Professional Shortage Areas by expanding state financial incentives, including, but not limited to, loan repayment, loan forgiveness, scholarship, grant programs and accessing federal matching dollars through the National Health Service Corps. Financial incentive programs should be established for all health care professionals.	1) Establish and fund state loan repayment programs for the stated health professionals at the Texas Higher Education Coordinating Board. Location of these funds at the Texas Higher Education Coordinating Board allows them to draw down federal matching dollars. 2) The Texas Higher Education Coordinating Board to contract out the administration of these new programs.	77th Texas Legislature House and Senate Appropriations Committees	May 2001

Goal 3 Address the maldistribution of health professionals
Objective 3.2: Increase access to health care through the coordination of recruitment and retention activities.

State Strategy	Actions	Parties Responsible	Time Line
Strategy 3.2.2 The Statewide Health Coordinating Council should convene a collaborative partnership of state agencies, Academic Health Centers, professional associations, Area Health Education Centers, and others to coordinate statewide recruitment and retention of health professionals.	1) Coordinate recruitment and retention efforts among the partners 2) Develop models and programs for community recruitment and retention of health professionals that emphasizes community and economic development and service to the underserved 3) Plan, implement, and strengthen minority recruitment programs to meet Healthy People 2010 goals and strategies for increasing the numbers of minorities in health professions 4) Develop a health professional recognition program to reward professionals who recruit or mentor local health professions students 5) Expand recruitment programs for all health professionals. 6) Provide technical assistance to communities to support the development of telecommunications networks and telehealth activities through TIF grant funding 7) Develop, implement, and coordinate K-12 health careers programs 8) Develop a plan for a relief service for rural health professionals.	Statewide Health Coordinating Council as Convener. Partners to include but not limited to: Center for Rural Health Initiatives Texas Higher Education Coordinating Board Community Health Provider Resources Program, TDH Office of Minority Health Texas Workforce Commission Academic Health Centers Professional Associations Area Health Education Centers Association of Chambers of Commerce Local economic development councils	Report to the Legislature each biennium

Goal 4: Create a health care workforce trained and equipped to use education and prevention as the primary approach to helping Texans achieve optimal health

Objective 4.1 Increase the implementation of prevention activities in the health care community through the academic curriculum

State Strategy	Actions	Parties Responsible	Time Line
Strategy 4.1.1. Academic health centers and other institutions training health professionals should emphasize prevention in health professions education through curriculum development and use of clinic and community–based training sites.	1) The Academic Health Centers, through TIF funding, should increase telehealth activities for training health professionals and public health professionals in community sites. Target areas for grants should include programs or interventions targeted to: a) Geriatric training or geriatric care b) Rural sites and rural populations c) Border health populations and conditions d) Chronic conditions such as diabetes, asthma, childhood obesity, teen pregnancy, smoking cessation e) Bioterrorism and disaster preparedness	Academic Health Centers through Telecommunications Infrastructure Fund discovery grants.	Ongoing
	2) The Academic Health Centers should apply monies from their tobacco endowments to support: a) The development of web-based education b) Travel and housing costs for students training in rural areas c) Purchase model materials from established prevention programs d) Faculty development in curriculum design which incorporates: community and public health, epidemiology, working in multi-disciplinary teams, and cultural competency	Academic Health Centers	Ongoing
	3) The legislature should provide tax incentives through the HMO Premium Tax for those HMOs offering training sites for health professionals	77th Texas Legislature	77th Legislative Session

Goal 4: Create a health care workforce trained and equipped to use education and prevention as the primary approach to helping Texans achieve optimal health

Objective 4.2: Build the competencies of the public health workforce in the areas of core public h ealth functions

State Strategy	Actions	Parties Responsible	Time Line
Strategy 4.2.1 The Texas Department of Health and the universities offering degrees in public health work collaboratively to enhance the education and training of the public health workforce	1) Develop and deliver academic and continuing professional education programs based on the ten essential public health functions and the National Public Health Performance Standards 2) The universities should apply for TIF funding to expand distance learning technologies to Texas Department of Health Regional offices and to local health departments for the provision of academic degrees via distance learning and the delivery of continuing professional education especially in the area of bioterrorism preparedness	The Texas Department of Health The University of Texas Houston – School of Public Health The Texas A&M School of Rural Public Health The University of North Texas at Fort Work – School of Public Health	Ongoing
Strategy 4.2.2 The Commissioner's Council on Local Public Health appoints a task force to review legislation for the purposes of clarifying the roles and responsibilities of local health authorities and local health department directors. Research the credentialing of local health authorities and make recommendations to the SHCC concerning credentialing and any proposed credentialing process.	1) Review current legislation and make recommendations for amendments that would clarify roles and responsibilities of local health authorities 2) Review other state's legislation or credentialing programs 3) Address how clarification of roles and responsibilities and credentialing might improve local public health infrastructure and assure the performance of the ten essential services 4) Make a recommendation on credentialing 5) Study and recommend methods of certifying competence	Commissioner's Council on Local Public Health Texas Department of Health Texas Association of Local Health Officials Texas Association of Municipal Health Officials University of Texas School of Public Health Texas A&M School of Public Health University of North Texas School of Public Health	Report to SHCC November 2001

Goal 4: Create a health care workforce trained and equipped to use education and prevention as the primary approach to helping Texans achieve optimal health
Objective 4.4: Develop a coordinated approach to education of children in grades K- 12 to encourage healthy lifestyle choices.

State Strategy	Actions	Parties Responsible	Time Line
Strategy 4.4.1 The Texas Education Agency and the Texas Department of Health work collaboratively to design a statewide coordinated system of ongoing education and professional development in physical education and health education for educators at all grade levels	1) The Legislature should fund the establishment of a Center for Educator Development to be located in the Texas Education Agency. This Center should: a) Provide technical assistance and support to School Health Advisory Councils required by Texas Education Code 28.004 for each independent school district b) Provide technical assistance and support to schools for the full implementation of the Coordinated Approach to Child Health Program (CATCH). Support to schools should include grant funding for the: i) purchase of curriculum ii) purchase of physical education equipment iii) purchase of food service equipment c) Fund FTE's and travel for 21 TEA CATCH coordinators to be located at the central office and each of the regional service centers. d) Fund an evaluation of the CATCH program and other coordinated health programs.	77th Texas Legislature	77th Legislative Session

Goal 5: Reduce disparity in health status among all population groups and enhance their access to quality health care by developing a diverse and culturally competent workforce

Objective 5.1: Develop a diverse and culturally competent workforce

State Strategy	Actions	Parties Responsible	Time Line
Strategy 5.1.1 Education institutions at all levels, elementary, secondary, community college and university, should plan, implement, and strengthen their health professions programs to meet the Healthy People 2010 goals and strategies for increasing the number of minorities in the health professions.	1) Texas Education Agency and the Texas Higher Education Coordinating Board should increase funding for faculty and curriculum development, and remedial programs in math and science education at the elementary, secondary, and higher education levels with consideration given to institutions serving historically minority populations in order to increase the applicant pool of minorities in health professions. 2) Funded programs for minority recruitment and retention programs should evaluate their effectiveness by tracking degree completion, licensure, and job placement as measures of success. Continued funding of such programs should be based upon their performance in the above areas. 3) The Academic Health Centers should allocate monies from their Tobacco Endowments to increase funding for loans, grants, scholarships, and fellowships to assist minority and disadvantaged students seeking health professions degrees.	Texas Education Agency Texas Higher Education Coordinating Board	

State Strategy	Actions	Parties Responsible	Time Line
Strategy 5.1.2 The Texas Department of Health's Office of Minority Health should review the Healthy People 2010 goals and strategies related to reducing disparities in health status in minority populations, and promote and coordinate efforts by programs in TDH, other Health and Human Services agencies, and private and public organizations to meet those objectives.	1) The 77th Texas Legislature should appropriate funding for the coordination and implementation of programs to reduce disparity in health status among all population groups in Texas. 2) The Texas Board of Health should establish an advisory committee to the Office of Minority Health	House and Senate Appropriations committees Texas Board of Health	

Goal 5: Reduce disparity in health status among all population groups and enhance their access to quality health care by developing a diverse and culturally competent workforce
Objective 5.2 Develop a workforce equipped to meet the needs of Texas's aging populations and the population of persons with disabilities

State Strategy	Actions	Parties Responsible	Time Line
Strategy 5.2.1 The Texas Department on Aging, the Texas Geriatric Training Centers, and the Area Health Education Centers should study and forecast health professionals/specialties that are needed to fulfill the health care needs of an aging population.	1) Study geriatric training and health care professional specialty needs for Texas aging population. 2) Make recommendations for SHCC and the Texas Legislature to consider for the 78th Legislative session.	Texas Department on Aging Texas Alliance of Geriatric Education Centers Area Health Education Centers Texas Academy of Family Physicians Texas Osteopathic Medical Association Texas Medical Association Texas Nurses Association Others as appropriate	Report to SHCC November 2001
Strategy 5.2.2 The Texas Department of Health and the Texas Department on Aging should research and identify health habits and risk behaviors of Texas baby boom population and establish partnerships to formulate initiatives for preventive health practices and screenings.	1) TDH and TDA conduct research and assessment of health conditions, habits, and risk behaviors. 2) Develop targeted public awareness campaigns for the baby boom population 3) Present findings to medical schools and other institutions training health professionals.	Texas Department on Aging Texas Department of Health	Report to SHCC November 2001
Strategy 5.2.3 The legislature should fund a prescription drug pilot program to determine the feasibility and health benefit of providing prescription drug benefits for those older Texans unable to qualify for Medicaid and unable to afford Medigap insurance with a prescription benefit.	1) The Health and Human Services Commission should formulate a proposal for such a program establishing eligibility criteria and scope of coverage. 2) Model programs in states such as Pennsylvania, Minnesota and Illinois should be reviewed 3) Provide quality review and evaluation of the impact of the pilot on Total Cost of Healthcare as an integral part of the pilot's design. 4) Make a recommendation on feasibility and cost/benefit.	Health and Human Services Commission Texas Department of Human Services Texas Department on Aging Area Aging Councils	Report to the Legislature October 2002

State Strategy	Actions	Parties Responsible	Time Line
Strategy 5.2.4 Increase the number of health professionals with specialties or sub specialties in geriatrics	1) Educational institutions offering health professions degrees should promote and/or create incentives for students to choose geriatric specialties or sub specialties 2) Educational institutions programs training health professionals whose practice would include the elderly should provide academic instruction and continuing professional education in treating mental illness, depression, and substance abuse in the elderly	Academic Institutions offering health professions degrees or certifications Area Health Education Centers	Ongoing

Goal 6: Create a health workforce that works with communities and in partnership with federal and state governments to have the greatest positive impact on the health of citizens
Objective: 6.1: Design systems in which local communities are empowered to plan and direct interventions that have the greatest positive impact on the health of citizens

State Strategy	Action	Parties Responsible	Time Line
Strategy 6.1.1 The Texas Department of Health should provide technical assistance to local health departments and communities in preparing a community health profile (Public Health Essential Function #1) to aid them in directed health planning.	1) The process for preparing the community health profile should include: a) Core principles as defined in the ad hoc committee's report b) A broad concept of health and wellness workforce c) Wide representation from the community d) Investigation of root causes for health conditions identified as problematic for that community e) Assessment and better understanding of the community's diverse cultures with complementary and integrative approaches to health and wellness for a positive impact on the community.	Texas Department of Health	Ongoing

Goal 6: Create a health workforce that works with communities and in partnership with federal and state governments to have the greatest positive impact on the health of citizens
Objective 6.2: Develop the skill level of health professionals in working with communities

State Strategy	Actions	Parties Responsible	Time Line
Strategy 6.2.1 The core competencies outlined in the Community Competencies for Health Professionals Ad Hoc Committee report should be integrated into professional associations' accreditation, certification, continuing professional education and licensure processes. Institutions training health professionals should incorporate them as benchmarks for graduation, entry into professional practice and continuing competence.	The Parties Responsible should take the following actions: 1) Evaluate current courses of study to determine if they are preparing students for community health practice 2) Require work in community service settings as part of health professional programs 3) Academic health centers, Area Health Education Centers, Community Colleges and providers of continuing professional education for health professionals and public health professionals should incorporate elements of the proposed core to prepare health professionals to work effectively in communities 4) Research should be conducted to further define curriculum elements for the core curriculum	Professional Associations Academic Institutions offering health professions degrees or certifications Area Health Education Centers	Ongoing

Goal 7: Develop the health care partnership between consumers and health care professionals through increased access to health care information

Objective 7.1: To enable consumers to make better health care decisions

State Strategy	Actions	Parties Responsible	Time Line
Strategy 7.1.1 The Texas Health Care Information Council should develop a clearinghouse providing health and health insurance related information. THCIC should be authorized to coordinate and organize the information available from state agencies and state entities involved in health information activities (i.e. Texas Health Care Information Council, Office of Public Insurance Counsel, Texas Department of Insurance, health professions licensing boards, and the Texas Department of Health).	1) The Texas Health Care Information Council should develop a state of Texas clearinghouse that provides one-stop access to health and insurance-related information. 2) The Texas Health Care Information Council should coordinate and organize the information available from state agencies and state entities involved in consumer health information activities. Responsibilities include: a. Collecting and analyzing data relevant to consumer information and consumer choice; b. Providing and disseminating data related to consumer choice of health plan, provider and treatment options; and c. Recommending methods for organizing data relevant to consumer information and consumer choice.	Texas Health Care Information Council Office of Public Insurance Counsel, Texas Department of Insurance Health Professions Licensing Boards Texas Department of Health	Report to SHCC Fall 2002

Exhibit 1-1

The Fourth Report of the

Pew Health Professions Commission

Public Policy Recommendation 9

Until national models for scopes of practice can be developed and adopted, states should explore and develop mechanisms for existing professions to clearly define and expand their existing scopes of practice and to allow for new professions (or previously unregulated professions) to emerge. In developing such mechanisms, states should be proactive and systematic about collecting data on health care practice. These mechanisms should include:

- Alternative dispute resolution processes to resolve scope of practice disputes between two or more professions;
- Procedures for demonstration projects to be safely conducted and data collected on the effectiveness, quality of care, and costs associated with a profession expanding its existing scope of practice; and
- Comprehensive "sunrise" and "sunset" processes that ensure consumer protection while addressing the challenges of expanding existing professions' practice authority and regulating currently unregulated healing disciplines.

Alternative Dispute Resolution
Purpose of legislation: To enact guidelines for the development and use of alternative dispute resolution (ADR) processes by legislators as one method of resolving disputes between two or more health professions over practice authority acts.

ISSUE 1: Establishment and Administration of ADR Function
Establish who will perform the ADR function (the following assumes the use of the "fact-finding" ADR model – the use of a neutral third-party to collect relevant facts and produce a final recommendation):

1. Determine whether there is a current ADR entity (public) in existence in the state that can perform this ADR function.
2. If no ADR entity exists, consider whether to establish and fund a public ADR entity or whether to contract with a private entity.

ISSUE 2: Applicability to Scope of Practice Disputes
Establish applicability of ADR to scope of practice disputes:

1. Establish forms and filing procedures for parties to jointly request ADR (ADR process only available if all parties agree to participate).
2. Establish what information must be included on the form so that the ADR entity can determine that the dispute is appropriate for resolution (e.g. inability of parties to resolve their differences voluntarily; anticipated prolonged legislative debate; resolution of dispute is in public's best interest and no harm to public's health foreseen).
3. Determine parties' obligations and duties when disputes are accepted for resolution (e.g. parties must provide requested information; parties agree to follow the ADR entity's recommendation).

ISSUE 3: Procedures Used in the ADR Process
Establish procedures for beginning and conducting the ADR process:

1. Require ADR entity to hold an adequate number of hearings, to take testimony of witnesses, and to provide an opportunity for public input.
2. Establish public notice requirements (e.g. local newspaper, other media).
3. Establish reasonable timeframes for fact finding, reviewing and analyzing facts, and developing and finalizing recommendation.
4. Establish format and process for final reports (and documents) and their submission.

ISSUE 4: Implementation of ADR Recommendation
Provide for the implementation of the ADR recommendation:

1. Identify the entity that will receive the recommendation (options include: executive branch agency, legislative committee, appropriate oversight board or individual boards).
2. If implementing legislation is required, identify the entity responsible for introducing the draft legislation (which may be same entity that received the recommendation).
3. Provide that the draft legislation accurately reflects the ADR recommendation.
4. Determine whether to limit the "new" testimony that would be allowed at hearings on the draft legislation (e.g. allow the introduction of only relevant information not available during ADR process).

ISSUE 5: Allocation of Costs
Provide for the allocation of costs for ADR. The options include:

1. State bears costs through the general fund.
2. Parties share costs.
3. State and parties share costs.
4. Portion of license fees are devoted to reasonable ADR costs.

Demonstration Projects for Scope of Practice Innovation
Purpose of Legislation:
To authorize demonstration projects that provide an empirical basis for rational development of legally defined scope of practice provisions, which reflect evolving clinical competence, and make optimum use of skilled health care practitioners. Scope of practice (practice authority) demonstration projects are intended to facilitate the optimal safe utilization of the clinical competence of health care practitioners.

ISSUE 1: Approval Authority
Establish what entity should review, determine the validity, and approve the proposed demonstration project applications. This entity should not be any one licensing board, given that these issues are inherently interdisciplinary, but should be an oversight board, if established, or a centralized agency function.

ISSUE 2: Duties and Powers of Approval Authority
Establish that the oversight board or centralized agency may:

1. Approve, deny, modify or combine applications for a demonstration project; and
2. Solicit public comment on proposed demonstration projects.

ISSUE 3: Application Contents
Establish that the following should be included in the application for a proposed demonstration project:

1. A description of the benefit to the public that will result from the proposed change in practice authority (e.g. expanded choice of practitioners, affordability, accessibility, improved quality of care).
2. Specification of the proposed change in practice authority, the practitioners to whom it applies (not necessarily all members of a profession or category of practitioners) and, if appropriate, any limitation as to qualifications, practice setting, or population to be served.
3. The duration of the proposed demonstration project.

ISSUE 4: Evidence Provided
Establish that the applicant(s) will provide support for the contention that the health care practitioner is clinically competent to provide the proposed service(s). Evidence should include, but not be limited to, the following:

1. Identify other practice settings, states or nations where proposed practice authority is already in effect.
2. Describe how the applicant group's formal educational curriculum provides the requisite clinical competence.
3. Describe how the applicant group has received additional training or other preparation to provide the proposed service(s).
4. Results from specified health care settings or systems (e.g. acute short stay hospitals, Indian Health Service, Veterans' Affairs Medical Centers, etc.) where the proposed change in practice authority is already in effect.
5. Documentation from peer reviewed clinical or scientific literature or other original clinical outcomes evidence.
6. Identification of state or federal regulations authorizing or recognizing the proposed practice authority (e.g. reimbursement policy).

ISSUE 5: Demonstration Project Design and Evaluation

Describe the method by which the proposed demonstration project will be evaluated, including:

1. Study design (assurances for internal and external validity) and inclusion of a control group, practice setting or region, if appropriate.
2. Appropriate human subjects provisions.
3. Data to be gathered regarding the effect of the changed practice authority on access, quality of care, effectiveness, and costs.
4. Resources available to conduct evaluation.
5. Party (or parties) that will conduct the evaluation.

ISSUE 6: Criteria for Evaluating Application

In reviewing and deciding on whether to approve a proposed demonstration project, the oversight board or centralized agency should evaluate whether and how the proposed demonstration project will:

1. Have adequate funding to complete the demonstration project effectively.
2. Have any conflict of interest among the parties involved that may influence the results of the demonstration project. This includes any funding source (with a possible conflict of interest) that cannot be identified through traditional safeguards such as disclosure or project design elements.

The applications should also be evaluated to establish whether the proposed change in practice authority will:

1. Be a benefit to consumers.
2. Promote effective health outcomes.
3. Increase the public's access to a competent health care practitioner.
4. Assure that the public is protected from unsafe health care practices.

ISSUE 7: Liability Insurance Coverage

State law should provide that a health care professional, practicing within the context of an approved demonstration project, should be deemed to be acting within their scope of practice authority to assure that their acts and omissions are covered by professional liability insurance (if any is provided).

Comprehensive Sunrise and Sunset Processes

Purpose of legislation: 1) To allow for "sunrise" review of proposals to change the practice authority of a profession or to create a newly regulated profession that establishes criteria, provides for public participation, and uses scientifically based decision-making. 2) To allow for "sunset" review of regulatory boards and/or the regulation of a profession that provides a mechanisms for evaluation to assure that regulatory bodies are: operating in an effective and efficient manner; providing adequate consumer protection; and that the content of the regulation continues to protect the public.

ISSUE 1: Structure, Duties, and Powers

Sunrise and sunset reviews, or administration by an oversight board or centralized agency, should:

1. Institute a process that allows the parties enough independence to make appropriate recommendations.
2. Assure under the process that decision-makers are not unduly influenced by politics.
3. Assure that the process considers the viewpoints of all affected parties, including the public.
4. Assure that the process has adequate budget and staffing.
5. Provide for enough time for review and completion of process.
6. Develop a reasonable schedule for review of regulatory programs.
7. Determine the disposition of the recommendations and legislative implementation.
8. Link sunset to sunrise when possible to provide coordination and consistency when reviewing regulatory programs, licensing, and scope of practice authority issues.
9. Coordinate sunset review with other oversight mechanisms such as the executive branch and the budget review process.

ISSUE 2: Evaluation Criteria for Sunrise Review

Unregulated practice can clearly harm or endanger the health, safety or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument. Sunrise reviews should determine whether:

1. The change in the authority to practice provides a benefit to the public (choice, access, quality, or costs) without unreasonable risk.
2. The proposed regulation is flexible enough to accommodate changes in technology.
3. The public can reasonably be expected to benefit from an assurance of initial and continuing professional ability.
4. The public cannot be effectively protected by other means in a more cost-beneficial manner.

ISSUE 3: Evaluation Criteria for Sunset Review

Any sunset review of an existing professional board should determine whether:

1. Continued regulation by the regulatory body is necessary and, if so, whether it should be changed.
2. The education, experience, and testing requirements to ensure minimum competence, or whether they are overly restrictive and unduly limit competition between professionals, or whether they place undue burdens on those who want to enter the profession from within or outside the state.
3. The regulations have any deleterious economic impacts on practitioners, the public and the state's business.
4. The regulatory program provides accurate, timely, and comprehensive information to the public about the qualifications and practice history of the licensed professional.
5. The practice authority of the regulated profession helps of hinders access to care.
6. The regulatory program encourages public participation in its policy development.
7. The regulatory program protects consumers against incompetent, negligent, fraudulent, or other illegal acts by licensed professionals or unlicensed persons posing as professionals.
8. The regulatory body performs its operations, programs and statutory duties efficiently, effectively and expeditiously.

ISSUE 4: Performance Standards for Sunset Review

In addition to the evaluation criteria listed above, any sunset review of an existing regulatory agency should:

1. Define performance standards for regulatory programs including appropriate budgetary expenditures, examinations, continuing competency, enforcement activity, aging of cases, consumer/complaint satisfaction, consumer outreach and education.
2. Establish periodic assessment of performance against established standards between formal sunset reviews.
3. Assure consistency among regulatory programs in the carrying out of their responsibilities.

Chapter 2
Texas Health Care Workforce Update

Texas Health Care Workforce Update

INTRODUCTION

The *1999-2004 Texas State Health Plan (SHP)* described the need for an adequate, accessible, and quality health care workforce. Data tables and supply distribution maps were presented in the SHP to illustrate the status of the health care workforce in Texas during 1998. This chapter in the 2001-2003 *State Health Plan Update* continues the analysis of the workforce with 1999 data and the use of workforce models to forecast the supply and requirements for selected professions.

After a discussion of issues related to workforce monitoring and forecasting, a set of selected health professions will be described. Because the Health Professions Resource Center (HPRC) supports the Health Professions Shortage Area designation function of the U.S. Health Resources and Services Administration (HRSA), it has focused its supply and forecasting efforts on those health professions that are incorporated into those designations. That includes primary care physicians and non-physician primary care providers such as nurses and physician assistants for the HPSA Primary Care designation. Dentists are included for the Dental HPSA designation, and psychiatrists and other mental health workers are included in the Mental Health HPSA designation.

The descriptions of these professionals include demographic information and their geographic distribution. The supply trends and requirements forecasts for each of these selected health professions will be evaluated in a separate section. The requirements forecasts were based on the Integrated Requirements Model, beta-test version 3.1 (IRM3.1), that was developed by the U.S. Department of Health and Human Services (U.S. DHHS), Bureau of Health Professions (USBHP). (Note: the term health care professional is used interchangeably in this chapter with the terms provider and practitioner.) Dentists are not evaluated by the IRM3.1 model.

Data and Workforce Modeling

A large number of interrelated factors influence how many providers Texas will need in the future. Since no one workforce model incorporates all of these factors, the use of models to forecast the supply and requirements of providers must be carefully interpreted, especially since these forecasts may be used to formulate state policies and plans. Thus, it is important to know data limitations and the limitations of workforce analyses. Data used for forecasts are dated the moment they are incorporated into the model and some of the data used in models for forecasting are actually forecasts themselves and are subject to considerable change over time. With these caveats in mind, a variety of data sources and methods were used in this report to analyze the workforce and to forecast what could happen to the workforce between now and 2006, a possibly dynamic period in Texas's health care delivery market.

Data Sources and Deficiencies

State licensing boards provided the current (1999) and historical licensee data used to forecast the supply of selected health care personnel and to construct graphs illustrating supply trends. Some licensee data were part of the historical collections stored at the HPRC as "paper" summary reports. Other data were available from the HPRC in a database format that contained the names and information for all licensees in a given year. These historical databases are important because to our knowledge state licensing boards do not maintain historical databases on their licensees.

The supply statistics reported in this chapter and on the HPRC website differ from the statistics available from the individual boards' published reports and websites. The boards' statistics usually include *all* licensee records, with the possible exception of licensees who are practicing out-of-state. The HPRC's statistics include only the active, permanent, within-state workforce. Thus, the HPRC's data *excludes* federal, government, resident/fellow, retired, and a few other categories of professionals. This is done to comply with federal and national practices concerning the reporting of workforce supply statistics.

Changes in licensee data are usually updated during the license renewal process at the 20+ state health professions regulatory boards, either on an annual or biennial basis. Since most data fields are voluntary fields for completion by the licensee, and each board collects different amounts and types of data on their licensees, the quality and quantity of data collected vary greatly among the boards and require different

amounts of editing by HPRC staff before analyses are possible. For example, some boards do not collect race and ethnicity data while other boards do. In other cases, providers do not give address data in a format that allows for geo-coding, or do not report gender and other data on which descriptive statistics can be determined. The Statewide Health Coordinating Council's Ad hoc committee on Health Personnel Data has proposed a minimum data set for health professionals which would provide for more complete and consistent data on licensed health professionals (see Appendix A).

Workforce Models Used in this Report

Two methods or models were used to predict how many and what type of health care personnel will be needed in tomorrow's complex and integrated health care delivery system. Although there are numerous variables that affect the delivery of health care to Texans, only a few of these are employed by existing workforce models. No one method or model is totally reliable for predicting how many, what type, and in what location providers will be needed in the future. A brief description of the methods used in this report follows.

1. *Forecasting the Supply of Physicians and Other Providers to the Year 2006.* A regression program was used with the HPRC's historical supply data, expressed as the ratio of providers per 100,000 population, to forecast supply numbers to the year 2006. The regression program used supply data for the years 1990 through 1999 where available.

   Ratios are some of the simplest mathematical models used by analysts to study workforce supply because they take into account only two types of data variables: population changes and provider supply. An example of a ratio would be the number of dentists per 100,000 people in a county or a census tract.

   Since annual population changes and provider numbers are integral to the calculation of ratios, ratios can be compared across years whereas simple provider totals cannot. Ratios may also be used to compare areas of the state across years and to compare state estimates to federal or state "benchmarks." A drawback of ratios is that they explain little about the dynamics occurring in the health care system that acutely affect provider supply, such as

compensation rates, aging of the workforce, how and to whom care is given, and in what settings care is delivered.

2. *Forecasting the Requirements for Physicians and Non-Physician Providers to the Year 2006.*

   The USBHP IRM3.1 workforce requirements model used in this report translates the expected utilization or need for specific health care services into requirements for particular health professionals. This particular workforce model comes pre-loaded with U.S.-level data that can be changed or replaced with Texas-level data. The IRM3.1 model has been used by the Wisconsin Network for Health Policy Research (1996) and the Texas Medical Association (1999) to estimate the requirements for physicians in certain medical specialties.

   The IRM3.1 also has a substitution factor for non-physicians. Using various populations, insurance coverage and practice plan scenarios; the model paints a picture of what kind of health care provider mix might be necessary to meet future state health care needs. For the purposes of this report, the HPRC looked at both a status quo scenario and a high managed care scenario to establish a range of potential health care professional requirements.

Physicians

Direct Patient Care Physician Supply

In September 1999 there were about 30,400 direct-patient-care (DPC) physicians practicing in Texas. The term includes both allopathic and osteopathic physicians but excludes physicians with a practice type of medical teaching, administration, research or "not-in-practice." Both allopathic and osteopathic physicians are licensed by the Texas State Board of Medical Examiners (TSBME) to practice in Texas. DPC physicians provide direct patient care in one or more of 70+ "general" or "specialist" specialties recognized by the TSBME. Many DPC physicians have a secondary specialty as well. According to the TSBME licensure data for 1991 through 1999, the total DPC physician supply in Texas increased by an average of 685 physicians per year. If federal, resident and fellow DPC physicians are excluded from the physician supply totals as they are in many workforce studies, the annual increase averaged 654 new DPC physicians from 1991 through 1999.

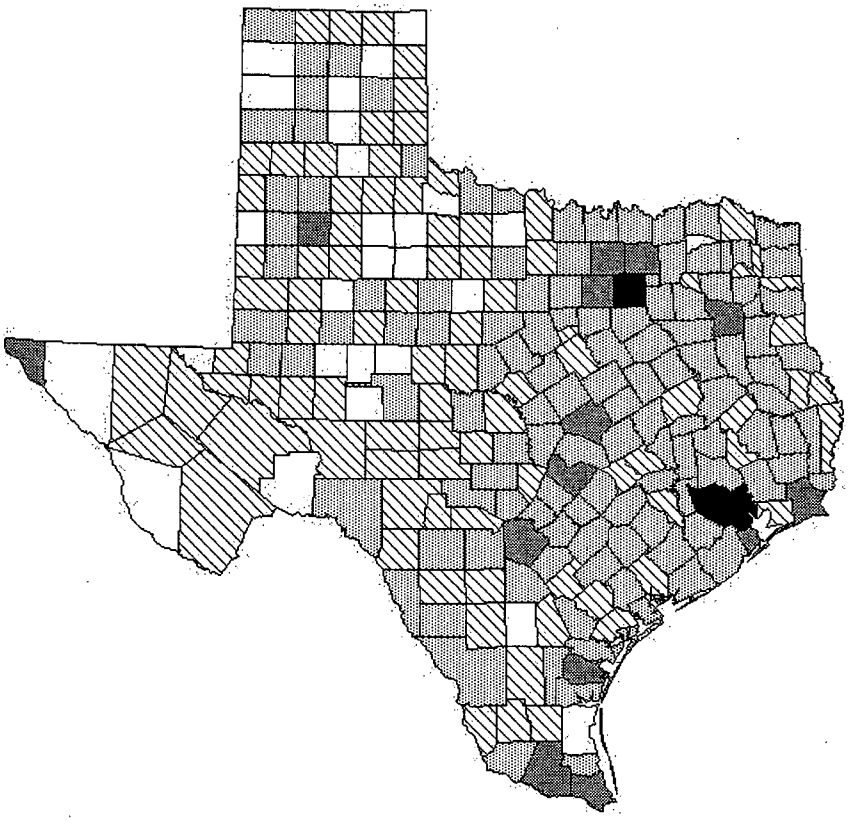
The HPRC uses DPC physician totals that include federal, resident and fellow physicians or DPC physician totals that exclude these providers. This is based upon reporting requirements from the U.S. DHHS Health Professional Shortage Area program that excludes these providers, or, analytical requirements from the U.S. DHHS that includes these types of physicians if using its IRM3.1 workforce model.

Primary Care Physician Supply

The term PC physician includes those physicians practicing in the five DPC specialties of family practice, general practice, general pediatrics, general internal medicine, and obstetrics-gynecology. The primary care specialties are a subset of the 70+ specialties included under the umbrella of DPC.

Of the 30,400 DPC physicians in Texas, 12,800 were PC physicians in 1999, an increase of 17 percent over the number practicing in Texas in 1994. Twenty-six of the state's 254 counties had no PC physicians in 1999 and 20 counties had only one primary care physician. See Figure 2-1.

Figure 2-1. Distribution of Primary Care Physicians by County of Employment Texas 1999



Number of Primary Care Physicians

- 0
- 1 - 5
- 6 - 150
- 151 - 983
- 984 - 2,452

Prepared by:
Health Professions Resource Center
Office of Policy and Planning
Texas Department of Health
Data Source:
Texas State Board of Medical Examiners
September 20, 1999

The active, non-federal, non-resident/fellow PC physician supply increased by an average of 289 physicians per year from 1990 through 1999. Federal, resident and fellow physicians were excluded from the PC physician supply for those years. Although the state's population also increased during this time, the ratio of PC physicians per 100,000 population remained in the range of 57 to 66. Compared to a national benchmark ratio of 60 to 80, Texas remained in the lower range of the national benchmark, sometimes even dropping below the minimum benchmark value. The supply of PC physicians could be even more marginal since some of the physicians listed in the 1999 database practice only part-time. Others limit their practices to paying or insured patients or do not accept Medicaid patients. Thus, in some areas of the state the physician supply is probably less than simple supply ratios would seem to indicate.

The increase in the number of PC physicians, as well as the gains in other health care professionals, derives from several "educational pipelines" that train and deliver these providers to various health care settings such as hospitals, rural health clinics, and research facilities.

The State of Texas assists in the preparation of students for the health care professions by funding state colleges and universities where students receive the basic science education that qualifies them for entry into state-supported or private health professions training schools. Upon graduating from approved training schools, many graduates opt to remain in Texas either to practice or to receive advanced education and training. The exact number of physicians and other health care professionals who leave the state to practice elsewhere is unknown.

In 1999, 47 percent, or about 6,100 of the 12,900 PC physicians practicing in Texas, were trained in Texas schools (Table 2-1). Supplementing this pool of Texas medical graduates were 6,800 PC physicians who received their training from other states or other countries. This in-migrating PC physician supply pool is very significant to the health care delivery system in Texas. Out of those 6,800 non-Texas-trained physicians, 56 percent were trained in other countries and 44 percent were trained in out-of-state U.S. schools.

Losses occur when physicians move to other states or become inactive due to retirement, death, change in profession, or other situations. Although age, gender

Table 2-1. Primary Care Physicians by Location of Training, Texas, 1999.

Medical Schools/School of Osteopathic Medicine	Number of Physicians	Percent of Total
Baylor College of Medicine, Houston	737	5.7 %
Texas Tech University Health Science Center, Lubbock	357	2.8 %
Texas A&M University System, Health Science Center, College Station	136	1.1 %
University of North Texas Health Science Center, Fort Worth	562	4.4 %
University of Texas Medical Branch, Galveston	1,537	11.9 %
University of Texas Medical School, Houston	684	5.3 %
University of Texas Medical School, San Antonio	878	6.8 %
University of Texas Southwestern Medical School, Dallas	1,185	9.2 %
Total in State	6,076	47.2 %
Total Out of State or Out of Country	6,790	52.8 %
Grand Total	12,866	100.0 %

Source: Texas State Board of Medical Examiners, Master Licensing File, September 1999.

and race/ethnicity are important factors in workforce supply studies, little is known about how these variables actually affect the recruitment, retention, and attrition of providers. Most workforce models do not account for the effects of these factors on forecasts. Workforce planning and forecasting should not be based solely on the use of quantitative data since these and other variables may affect attrition rates. Thus, the inclusion of qualitative data concerning the workforce could yield better workforce plans and forecasts.

Race/Ethnicity of Primary Care Physicians

Race/ethnicity data for physician records received by the HPRC in 1999 from the TSBME were missing, so 1998 data were used for this statistic. In 1998, approximately two out of every three of the state's primary care physicians were White, non-Hispanic. See Table 2-2 and Figure 2-2. Of the remainder, 14 percent were Asian-Pacific Islander, 13 percent were Hispanic and four percent were Black.

The percentage of primary care physicians who were White, not Hispanic, fell from 76 percent in 1991 to 67 percent in 1998. The percentage of White, not Hispanic, physicians in the workforce in 1998 (67 percent) was about ten percent more than the percentage of this race/ethnic group in the general population (58 percent). Even though the minority populations in Texas between 1991 and 1998 increased in size, the physician workforce that was Black was about five percent less than the percentage of Blacks in the general population, and, the physician workforce that was Hispanic was about 16 percent less than the percentage of Hispanics in the general

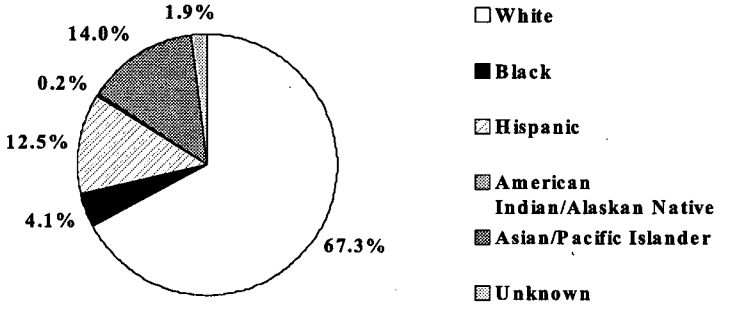
population. The largest proportionate gains in the minority physician workforce occurred with Asian-Pacific Islanders.

Table 2-2. Race and Ethnicity Trends for Primary Care Physicians, Texas, 1991 and 1998.

Race/Ethnicity of Primary Care Physicians	1991		1998	
	Primary Care Physicians	Texas Population	Primary Care Physicians	Texas Population
White	76.4 %	60.3 %	67.4 %	57.6 %
Black	3.3 %	11.7 %	4.1 %	11.6 %
Hispanic	9.8 %	25.8 %	12.5 %	28.3 %
Asian/Pacific Islander	8.8 %	2.2 %	14.0 %	2.5 %
American Indian/Alaskan Native	0.2 %		0.2 %	
Unknown	1.6 %		1.9 %	
Total	100.0 %	100.0 %	100.0 %	100.0 %

Source of Physician Data: Texas State Board of Medical Examiners, 1991 and 1998.

Figure 2-2. Primary Care Physicians– Race/Ethnicity Texas 1998



Source: Texas State Board of Medical Examiners, 1999

In 1999, the projected population for Texas was almost 20 million. Fifteen percent of the population was located in 196 rural counties and 85 percent were located in the 58 urban counties. By comparison, 11 percent of the PC physicians were practicing in the rural areas of the state and 89 percent in the urban areas.

In 1999 there was one non-Federal, non-resident/fellow PC physician for every 1,562 persons statewide. However, this ratio varied considerably for rural and urban areas, physicians in rural areas typically have a larger patient base than physicians in urban areas. The population-to-PC physician ratio in rural areas was 2,125:1, approximately 43 percent higher than the urban ratio of 1,491:1 (Table 2-3). Calculating the provider and population data in terms of providers per 100,000 population, the overall state and urban ratios indicate a marginally adequate number of PC physicians, 64 and 67, respectively, per 100,000 population when compared to the national benchmark of 60 to 80. The rural areas fall below the national benchmark at 47 PC physicians per 100,000 population in 1999.

Table 2-3: Primary Care Physician Ratios for Urban and Rural Areas, Texas, 1999.

Location	Population	Population-per-Primary Care Physician	Primary Care Physicians per 100,000 population
Statewide	19,995,428	1,562 : 1	64
Urban	16,950,419	1,491 : 1	67
Rural	3,045,009	2,125 : 1	47

Source of Physician Data: Texas State Board of Medical Examiners, September 1999.
Source of Population Data: Texas State Data Center, Population Estimates & Projection Program, Texas A&M University.

Some rural counties are more successful than others in attracting physicians to work in their area. The shortage of physicians in rural areas has been partially alleviated through the use of non-physician providers, such as the use of physician assistants in the Big Bend area of Texas.

Gender Differences in Rural and Urban Counties

The composition of the PC physician workforce in Texas varies by gender among urban and rural areas. Three out of every four PC physicians were male in 1999. Gender statistics for 1999 were very similar to those in 1998. A 1998 report of the Council on Graduate Medical Education elaborated on similar findings:

> Historically, rural medical care was almost exclusively provided by male physicians. This was a product of the paucity of women in medicine and the tendency of the few female graduates to locate in urban areas. As the proportion of women in medical schools has increased, there have been concerns that rural physician supplies might dwindle if women continued to settle almost exclusively in

urban areas. Recent work suggests that the problem may be growing less acute with time but that women still are much less likely to settle in rural areas. Although the Council on Graduate Medical Education's (COGME) 5th report concluded that "physician gender has little impact on workforce forecasting" the same cannot be said of geographic mal-distribution. Further research must be done in this area, and programs that support women who have the potential for practicing in underserved rural areas should be encouraged and supported.[1]

The assertion that female physicians do not practice in rural areas as frequently as male physicians was confirmed for Texas. In 1999, 25 percent of the PC physicians practicing in urban areas were female, while only 14 percent of the PC physicians in rural areas were female. However, the proportion of female PC physician workforce has increased from about 16 percent in 1991 to 24 percent in 1999, indicating an increasing pool of potential recruits for rural areas. See Table 2-4.

Table 2-4. Percentage of Primary Care Physicians in Texas by Gender, 1999.

Gender	1991	1995	1999
Male	83.8 %	80.8 %	75.8 %
Female	16.2 %	19.2 %	24.2 %
Total	100.0 %	100.0 %	100.0 %

Source: Texas State Board of Medical Examiners, 1991, 1995,1999.

Age Differences in Rural and Urban Counties

The average age of PC physicians in Texas was 49.7 years in 1999. The ages of PC physicians also differed based on whether the physicians were practicing in a rural or urban county. The average age for PC physicians in urban counties was 49.4 years and the average age in rural counties was 51.4 years. The higher attrition rates of aging rural providers could exacerbate the rural PC physician supply problem.

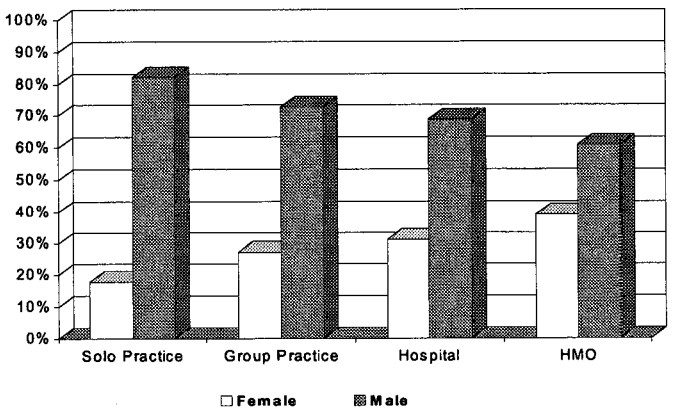
Practice Setting

Practice settings of active, non-federal, non-resident/fellow PC physicians changed only slightly between 1997 and 1999. In September 1999, 38 percent of the PC physician workforce were employed in solo practices, 51 percent were in partnership or group practices, nine percent were hospital based, and two percent were in HMOs. These statistics were in contrast to 1997 PC physician supply data where 40 percent

were employed in solo practice, 47 percent in partnership or group practice, 10 percent in hospitals, and less than one percent were in HMOs. A small percentage of PC physicians in 1999 did not give a practice setting type.

Female PC physicians in general appear to have different preferences for practice settings than their male colleagues (Figure 2-3). Female PC physicians are more likely to practice in HMO settings than their male peers. Since this could affect where physicians choose to practice, gender-related preferences for practice settings are important considerations when developing health care workforce plans. Although many physicians in solo, partnership, group, or hospital practice are also likely contractors with HMOs, this overlap cannot be ascertained from TSBME data since only one setting type may be selected on the renewal licensing form.

Figure 2-3. Primary Care Physicians in Texas By Practice Setting and Gender 1999



Source: Texas State Board of Medical Examiners, September 1999.

Note: Theses were self-reported settings. Many physicians in solo, partnership, group, or hospital practice are also likely contractors withHMs.

Primary Medical Specialty – Gender and Practice Location Differences

Physicians with family practice as their primary specialty comprise almost one-half (48 percent) of the rural physician supply (Table 2-5). This finding corroborates a recent COGME report that indicates that family practitioners are the only specialty group who are as likely to locate in rural areas as urban areas. Factors that may influence these practice decisions include the flexibility of scope of practice and

strong roots for family practice in rural areas. Many of the family practice educational programs reinforce these roots and traditions.[1, 2]

Table 2-5. Primary Care Physicians by Primary Specialty and Practice Location, Texas, 1999.

Physicians by Specialty	1999 Physician Total	% Urban	% Rural
Family Practice	3,772	29 %	48 %
General Practice	972	7 %	15 %
General Internal Medicine	3,981	30 %	22 %
General Pediatrics	2,167	18 %	8 %
Obstetrics & Gynecology	1,913	16 %	7 %
Total	12,805	100 %	100 %

Source of Physician Data: Texas State Board of Medical Examiners, September 1999.

According to the September 1999 TSBME licensure file, PC physicians also vary in their choice of primary medical specialty according to their gender. For example, a greater proportion of female physicians in Texas report pediatrics as their primary specialty than do males (Table 2-6).

Table 2-6. Primary Care Physicians by Primary Specialty and Gender, Texas, 1999.

Physicians by Specialty	1999 Physician Total	% Male	% Female
Family Practice	3,772	33 %	24 %
General Practice	972	10 %	5 %
General Internal Medicine	3,981	30 %	25 %
General Pediatrics	2,167	12 %	30 %
Obstetrics & Gynecology	1,913	15 %	16 %
Total	12,805	100 %	100 %

Source of Physician Data: Texas State Board of Medical Examiners, September 1999

Physician Specialty Mix

The ratio of the number of PC physicians licensed to practice in the five PC specialties to the number of DPC physicians licensed to practice in the remaining specialties is termed the "specialty mix" of generalists to specialists. Nationwide concern over specialty mix has become a major health workforce issue. This concern has resulted in the Council on Graduate Medical Education and the Physician Payment Review Commission to recommend a 50/50 specialty mix (generalist/specialist) goal for the nation by the year 2000. The Association of American Medical colleges, Pew Commission, Robert Wood Johnson Foundation, the American Academy of Family Physicians and others endorsed that goal. The goal was adopted for Texas by the 67th Texas Legislature.

An analysis of specialty mix information indicates that there has been little change in the ratio of PC physicians to DPC specialists in Texas. In 1991, the ratio was 44 percent PC physicians to 56 percent specialist physicians. In 1999, the ratio was 45 percent PC to 55 percent specialists.

Federal "Primary Medical Care"
Health Professional Shortage Areas (HPSAs)

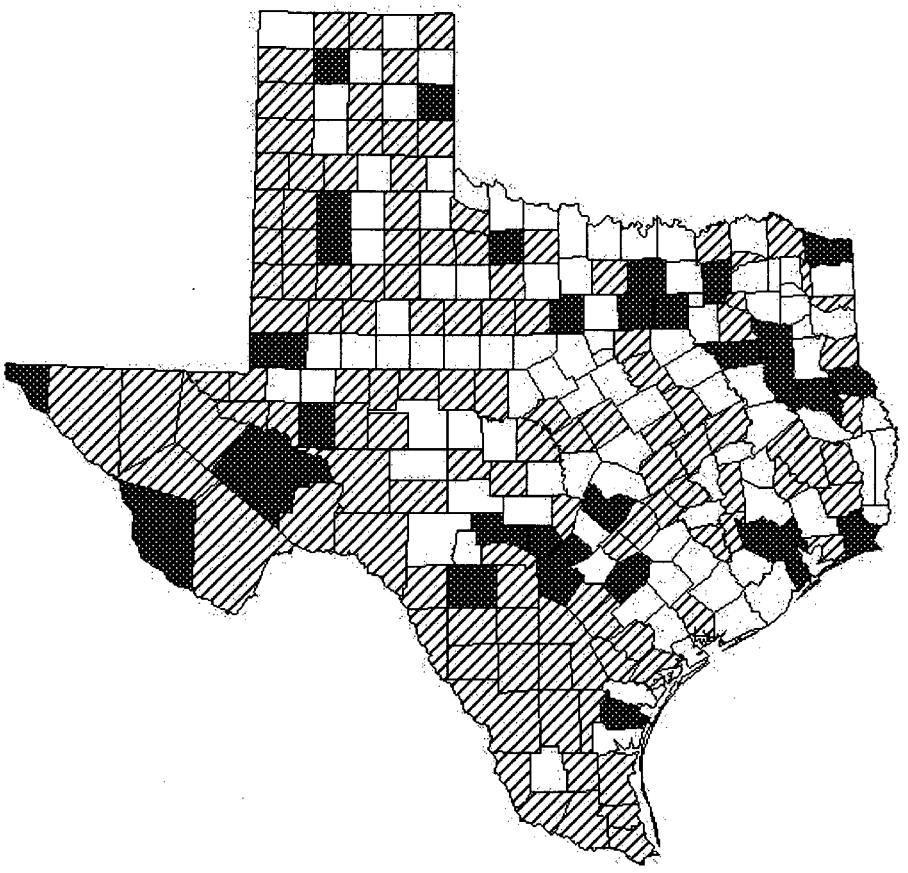
The U.S. Department of Health and Human Services (DHHS) HPSA designation program is administered in conjunction with the HPRC. The designation program uses population-to-PC physician ratios to identify counties having shortages of PC physicians. In June 1999, 58 percent of the counties in Texas (116 whole counties; 32 partial counties) had either whole or partial-county HPSA designations. Ninety-one percent of the 116 "whole county" HPSAs were rural counties. In addition to geographic area designations, the HPSA designation program also provides for the designation of special population groups within geographic areas and for the designation of facilities under certain circumstances.

It should be noted that many of these rural areas also experience shortages of non-physician PC providers including nurses, allied health professionals and mental health providers. Many of these underserved counties have programs that target the recruitment of physicians and non-physician practitioners to increase access to health care for people in their area. The location of these primary medical care HPSA areas is shown in Figure 2-4.

Non-Physician Primary Care Providers

"Non-physician primary care providers" refers to practitioners who deliver medical care directly to patients in a variety of health care settings, but who practice in a more limited scope of practice than physicians. Two non-physician provider types, the physician assistants (PAs) and nurse practitioners, are of major interest because of their increasing importance in health care provider teams employed in HMOs and in other practice settings, such as rural health clinics and school-based clinics. In these settings, they collaborate with physicians in medical practice, providing services in certain practice functions sanctioned by the Texas Medical Practice Act and the Nurse Practice Act. Because they are important to the delivery of health care in Texas, their workforce supply requirements, along with the requirements for physicians, are considerations in workforce planning.

Figure 2-4. Federally Designated Primary Care Health Professional Shortage Areas in Texas 2000



Designation Status

- Undesignated
- Designated - Partial County HPSA
- Designated - Whole County HPSA

Prepared by:
Health Professions Resource Center
Office of Policy and Planning
Texas Department of Health
Data Source:
Division of Shortage Designations
United States Department of Health and Human Services
May 2000

Physician Assistants

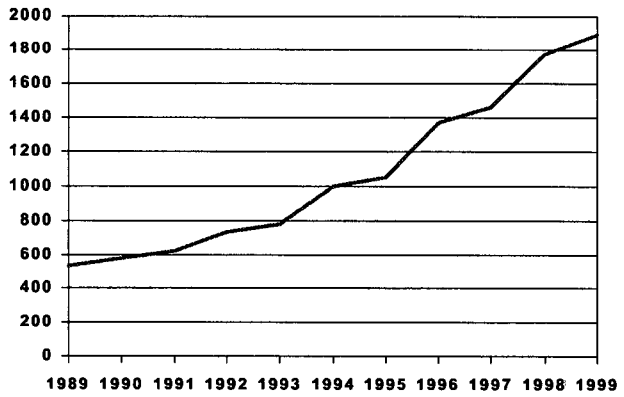
The steadily increasing number of PAs practicing in Texas could be due to their expanding role in the provision of primary care as a result of modifications in the Medical Practice Act. However, other factors could also promote the increase in the use of these non-physician providers, such as the high cost of compensation for physicians and the accepted use of these practitioners in HMO practice environments, rural health clinics and school-based clinics.

Physician Assistant Supply

According to the 1999 TSBME licensure data, there were 1,893 PAs licensed to practice in Texas. Not all PAs were practicing in primary care areas. Examples of non-primary care practice areas include: emergency medicine, general surgery, pediatric sub-specialties, surgical sub-specialties, and internal medicine sub-specialties. Licensure data collected on PAs in Texas do not include specialty data. National survey statistics were used to estimate the distribution of PAs in Texas by specialty for use with the Integrated Requirements Model reported upon later in this chapter.[3]

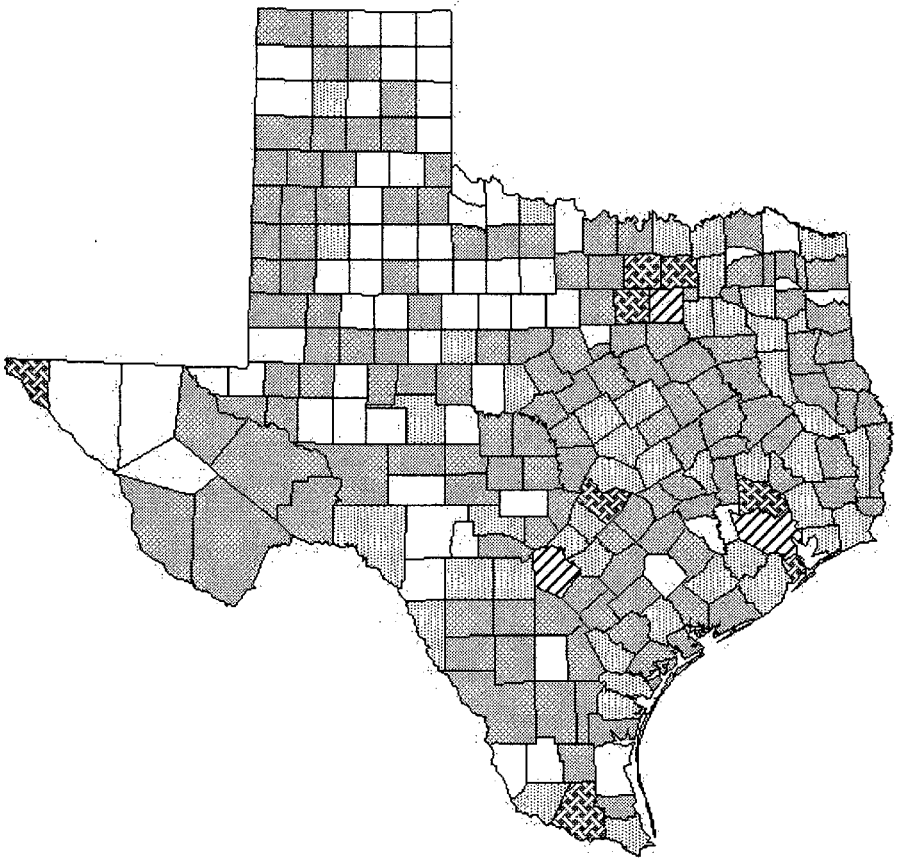
The number of PAs practicing in Texas has greatly increased over the past years. PA totals increased from 571 in January 1989 to 1,893 in September 1999 (Figure 2-5). Out of the total licensed PAs, 20 percent did not indicate a practice address on

Figure 2-5. Physician Assistants
Texas, 1989-1998



Source: Texas State Board of Medical Examiners, September 17, 1999.

Figure 2-6. Distribution of Physician Assistants by County of Employment Texas 1999



Number of Physician Assistants

- 0
- 1 - 5
- 6 - 30
- 31 - 93
- 94 - 291

Prepared by:
Health Professions Resource Center
Office of Policy and Planning
Texas Department of Health
Data Source:
Texas State Board of Medical Examiners
September 17, 1999

their license application or renewal form. Thus, for statistical and mapping purposes, the mailing address was used as a proxy for the missing practice location. Figure 2-6 shows the distribution of PAs in Texas based on their practice addresses.

Race/Ethnicity, age and Gender of Physician Assistants

The race/ethnicity of the majority of the PAs in Texas during 1999 was white. The next most prevalent group were the Hispanic PAs. Male PAs only slightly outnumbered female PAs (Table 2-7).

Table 2-7. Distribution of Physician Assistants by Gender and Race/Ethnicity, Texas, 1999.

Characteristic	Variable	Percent*
Gender	Male	52 %
	Female	47 %
	Gender not provided	< 1 %
	Total	**100 %**
Race / Ethnicity	White, not Hispanic	78 %
	Black	5 %
	Hispanic	10 %
	Asian-Pacific Islander	3 %
	American Indian – Alaska Native	< 1 %
	Ethnicity not provided	4 %
	Total	**100 %**

Source: Texas State Board of Medical Examiners, September 1999.

The average age of PAs in Texas was 41.5 years (see Table 2-8). As with other professional types, rural PAs are generally older than their urban counterparts. The average age of PAs in rural counties was 44.2 years in 1999. And, the average age of PAs in urban areas was 40.9 years.

Table 2-8. Distribution of Physician Assistants by Age, Texas, 1999.

Characteristic	Variable	Percent*
Age	< 40 years	43 %
	40 to 49 years	36 %
	50 to 59 years	19 %
	60 to 69 years	2 %
	> 70 years	< 1 %
	Total	**100 %**

Source: Texas State Board of Medical Examiners, September 1999.

A noteworthy disparity in age and gender exists among PAs based on their practice location - nearly 28 percent of the PAs in urban counties were female but only 12

percent in rural areas were female. Four out of every five PAs (79.6 percent) practiced in urban counties in 1999.

Registered Nurses (RNs)

RN Supply

According to the Texas Board of Nurse Examiners (TBNE) 1999 licensure data, there were 182,594 active RNs practicing in Texas. This total also included federal nurses and nurses employed full-time in nursing (58 percent), part-time in nursing (ten percent), in occupations other than nursing (three percent), and were either unemployed, retired or inactive (29 percent).

With the exclusion of the federal nurses, 118,929 RNs were actively employed in the field of nursing in Texas during 1999, a ratio of 595 RNs per 100,000 population. The state ratio was considerably lower than the ratio at the national level. For example, in 1997 the ratio was 772 RNs per 100,000 population; and, in 1996 the national ratio was 749 per 100,000 population.

Age and Gender of Registered Nurses in Texas – Urban and Rural differences

In 1999 the nursing population in Texas was predominantly female, only eight percent of the nurses being male. The proportion of female to male nurses in rural counties (92.1 percent) was similar to the proportion in urban counties (91.7 percent). Only ten percent of all Texas nurses were located in rural areas.

The average age for RNs in Texas was 45.6 years. Rural nurses were slightly older than urban nurses - the average age for nurses in urban counties was 45 years; and, in rural areas, the average age was 46 years. A recent issue of the Journal of the American Medical Association (JAMA) indicated that the average age of working RNs increased by 4.5 years between 1983 and 1998.[4] They expect to see the aging of the RN workforce to continue:

> Over the next two decades, this trend will lead to a further aging of the RN workforce because the largest cohorts of RNs will be between age 50 and 69 years. Within the next ten years, the average age of RNs is forecast to be 45.4 years, an increase of 3.5 years over the current age, with 40 percent of the RN workforce expected to be older than 50 years. The number of full-time equivalent RNs per capita is forecast to peak around the year 2007 and decline thereafter as the largest cohorts of

RNs retire. By the year 2020, the RN workforce is forecast to be roughly the same size as it is today, declining nearly 20 percent below projected RN workforce requirements.

Another recent report, *Health and Nurses in Texas –The Supply of Registered Nurses: First Look at Available Data*,[5] indicates that the age of the RN workforce in Texas is increasing, wages are stagnating, and RNs are withdrawing in increasingly larger numbers from the active workforce. Without some type of intervention, the RN shortage will increase over the next decade in Texas.

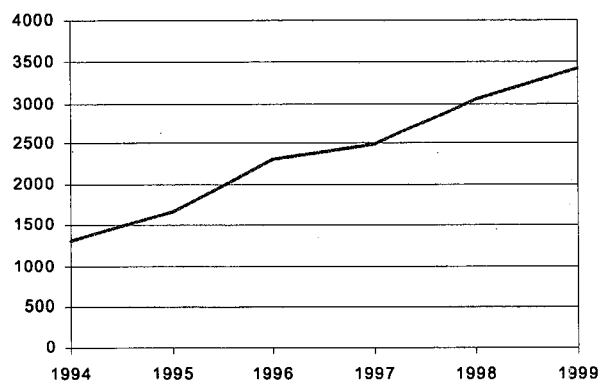
Advanced Practice Nurses (APNs)

The term APN includes all nurses recognized by the TSBNE as nurse practitioners (NP), nurse midwives (NM), nurse anesthetists (NA), and clinical nurse specialists (CNS). The APN specialties are based on the types of practice or target populations of the practice, such as pediatrics, family, school health, women's health, oncology, and psychiatric/mental health.

Nurse Practitioner Supply

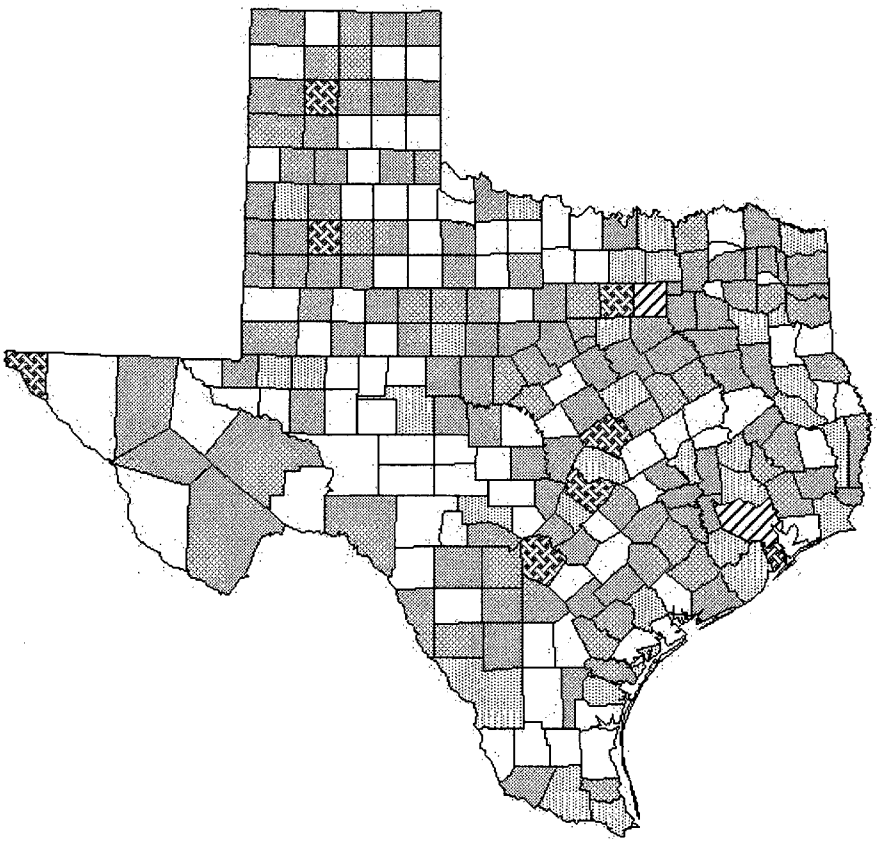
In 1999, there were 3,363 active NPs practicing in Texas (Figure 2-7). The importance of NPs in the delivery of health care is indicated by their steady increase in supply over the past five years, from 1,314 in 1994 to 3,363 in 1999 (Figure 2-8).

Figure 2-8. Historical Supply of Nurse Practitioners Texas, 1994-1999



Source: Texas Board of Nurse Examiners, Sept. 2, 1999 website file. Includes all RNs recognized as Nurse Practitioners in the APN master file, excluding only out-of-state RNs.

Figure 2-7. Distribution of Nurse Practitioners by County of Employment Texas 1999

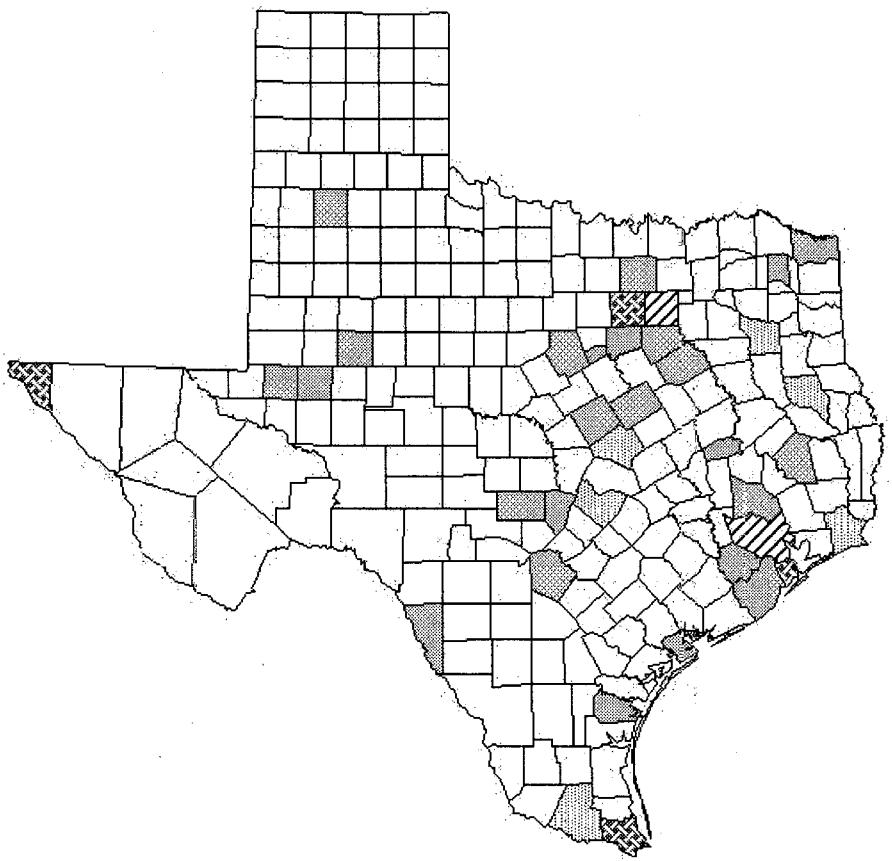


Number of Nurse Practitioners

- 0
- 1 - 5
- 6 - 50
- 51 - 250
- 251 - 512

Prepared by:
Health Professions Resource Center
Office of Policy and Planning
Texas Department of Health
Data Source:
Texas Board of Nurse Examiners
September 17, 1999

Figure 2-9. Distribution of Nurse Midwives by County of Employment Texas 1999



Number of Nurse Midwives

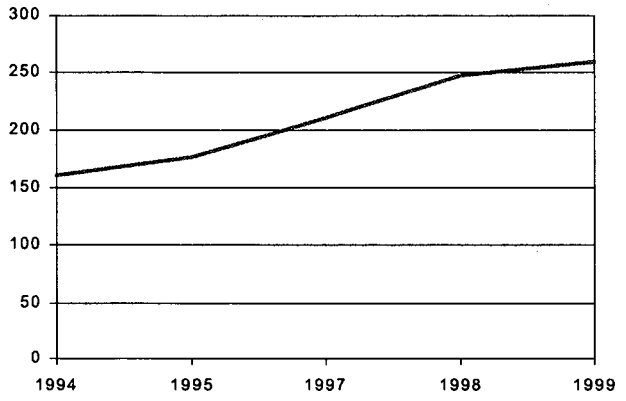
- 0
- 1 - 3
- 4 - 8
- 9 - 16
- 17 - 41

Prepared by:
Health Professions Resource Center
Office of Policy and Planning
Texas Department of Health
Data Source:
Texas State Board of Nurse Examiners

Nurse Midwife Supply

Nurse midwives are primarily located in the urban areas of Texas (Figure 2-9). They have gradually increased in number over the last five years. In 1994 the number of active nurse midwives was 161. By 1999 that number had increased to 259 (see Figure 2-10).

Figure 2-10. Certified Nurse Midwives
Texas, 1994-1999



Source: Texas Board of Nurse Examiners, September 17, 1999.

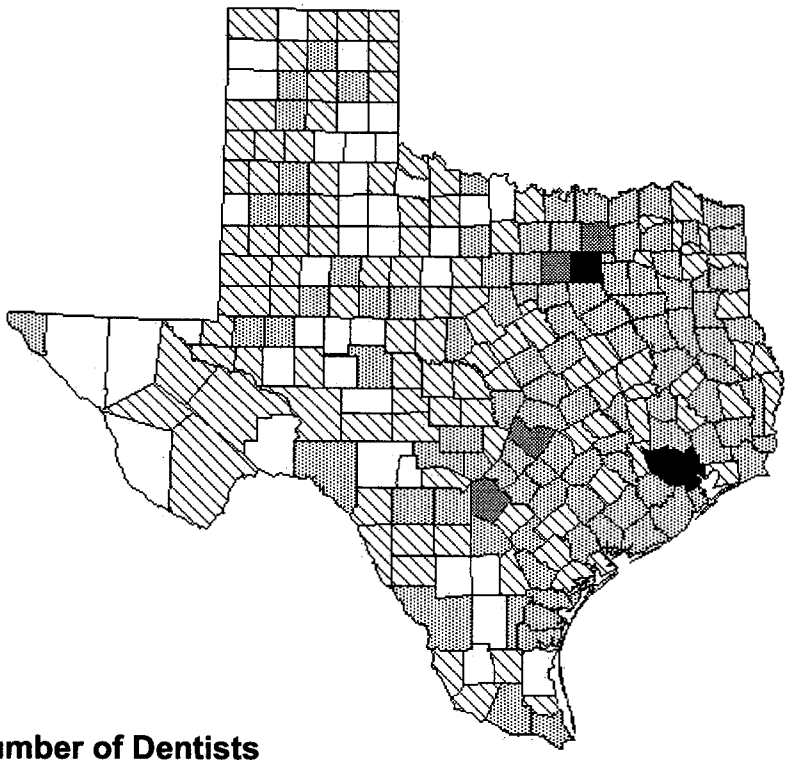
Dentists

The dentists described in this chapter are those considered by the U.S. DHHS as "dental generalists." This term denotes dentists with the following practice types: general dentistry, pediatric dentistry, and dental public health. The term excludes the following "specialist" practice types: endodontics, oral and maxillofacial surgery, oral pathology, orthodontics, periodontics and prosthodontics. Only active Texas dentists were included in the analyses. Dentists with the following practice descriptions were excluded: retired, faculty, military exempt, government, or resident.

Dentist Supply

In 1999, 8,109 out of a total of 15,193 dentists were non-federal general dentists in private practice. These dentists were evaluated for supply and demographic characteristics. See Figure 2-11.

Figure 2-11. Distribution of Dentists by County of Residence



Number of Dentists

- 0
- 1 - 5
- 6 - 150
- 151 - 731
- 732 - 1,681

Prepared by:
Health Professions Resource Center
Office of Policy and Planning
Texas Department of Health
Data Source:
Texas State Board of Dental Examiners

Dentist Practice Location

Most of the 8,109 general dentists (89 percent) were employed in urban areas. The patient base for dentists varied considerably between urban and rural practice locations. In 1999, the population-per-dentist ratio for the state as a whole was 3,832:1; however, in urban areas the ratio was 2,341:1. In rural areas, the ratio was 4,648:1 (Table 2-9).

Table 2-9. Population-per-Dentist Ratios for Urban and Rural Areas in Texas, 1999

Location	Population-to-Dentist Ratio
Statewide	3,832:1
Urban	2,341:1
Rural	4,648:1

Source of Dentist Data: Texas State Board of Dental Examiners, 1999.
Source of Population Data: Texas State Data Center, Population Estimates and Projection Program, Texas A&M University.

Age and Gender of Dentists in Rural vs Urban Counties

The number of male dentists greatly exceeded the number of female dentists in 1999. Only 18 percent of the dentists statewide were female (Table 2-10). An even greater disparity exists in rural areas where female dentists comprise only seven percent of the dental workforce. In urban areas they comprise 20 percent of the dental workforce. Over 60 percent of the dentists statewide were below the age of 50 years (Table 2-10), the average age being 47.6 years.

Table 2-10. Distribution of Dentists by Age and by Gender, Texas, 1999.

Characteristic	Age Range/Gender	Percent
Age	Unknown	< 1.0 %
	25 to 39 years	24.9 %
	40 to 49 years	35.7 %
	50 to 59 years	23.1 %
	60 to 69 years	10.4 %
	70 + years	4.9 %
	Age Total	100.0 %
Gender	Male	81.7 %
	Female	18.3 %
	Gender Total	100.0 %

Source of Dentist Data: Texas State Board of Dental Examiners, 1999.

Federal Dental Health Professional Shortage Areas (HPSAs)

The U.S. DHHS HPSA designation program uses population-to-general dentist ratios to identify counties with a shortage of dentists. In addition to geographic area designations, the HPSA designation program also provides for the designation of special population groups within geographic areas and for the designation of facilities under certain circumstances.

In 1999, 86 counties in Texas were designated by the U.S. Department of Health and Human Services as experiencing a shortage of dentists. Seventy-one of these designations were for whole counties. (Figure 2-12)

Psychiatrists

There were 1,351 psychiatrists licensed by the Texas State Board of Medical Examiners (TSBME) in September 1999 (see Figure 2-13). In addition to physicians practicing in the specialty of psychiatry, physicians in the specialties of child psychiatry and psychoanalysis were also included in this report as "psychiatrists" to comply with the HPSA definition of "general" psychiatry.

Mental Health - Health Professional Shortage Areas

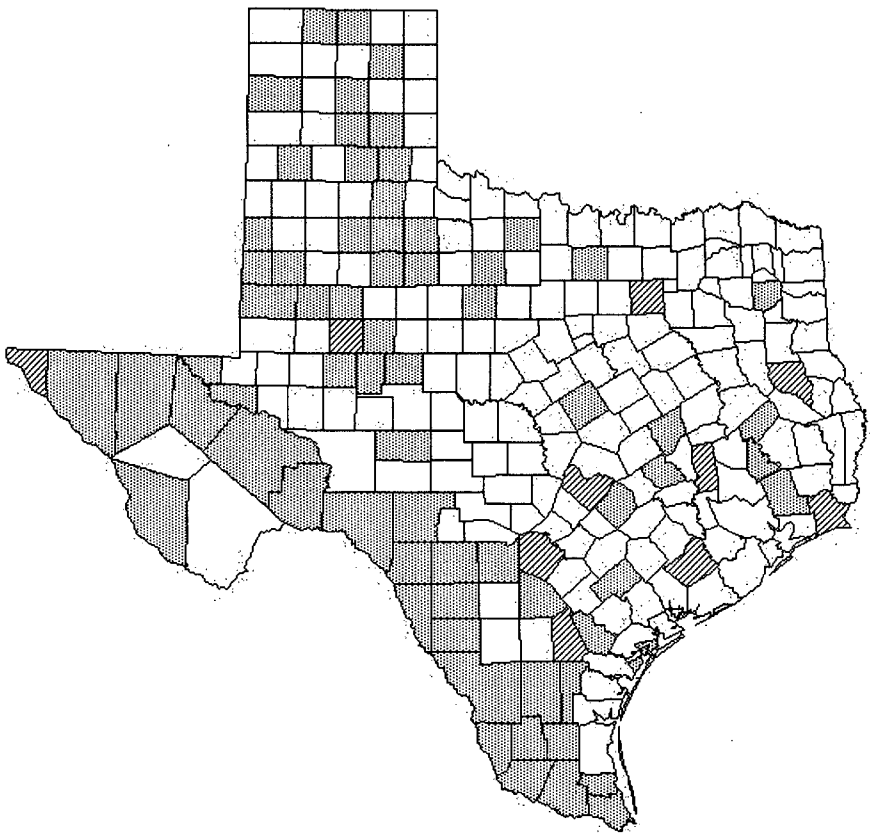
In 1999, 192 counties in Texas were designated by the U.S. DHHS as mental health HPSAs (Figure 2-14). In general, few psychiatrists practiced in rural areas of the state. The population-to-psychiatrist ratio was 13,305:1 in urban areas of Texas. In rural areas, this ratio was 39,546:1, almost three times greater than in the urban areas (Table 2-11).

Table 2-11. Population-to-Psychiatrist Ratios for Urban and Rural Areas, Texas, 1999.

Location	Population-to-Psychiatrist Ratio
Statewide	14,800 : 1
Urban	13,305 : 1
Rural	39,546 : 1

Source: Texas State Board of Medical Examiners, September 1999.
Source of Population Data: Texas State Data Center, Population Estimates & Projection Program, Texas A&M University.

Figure 2-12. Dental Health Professional Shortage Areas Texas 1999

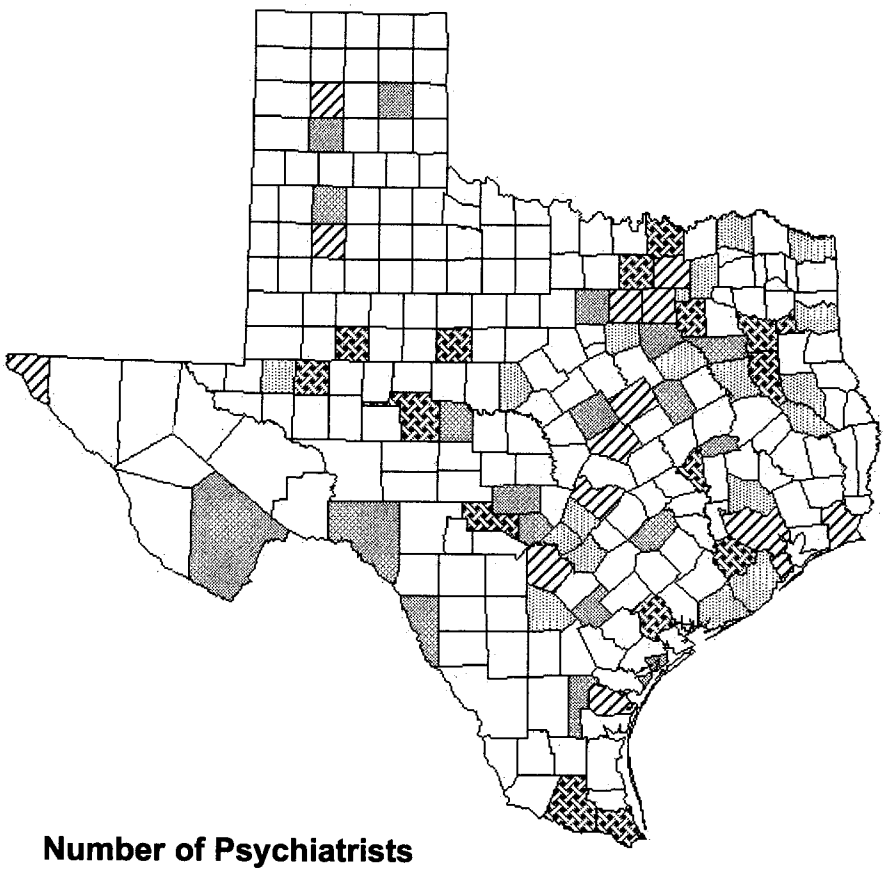


Designation Status

- Undesignated
- Designated - Partial County HPSA
- Designated - Whole County HPSA

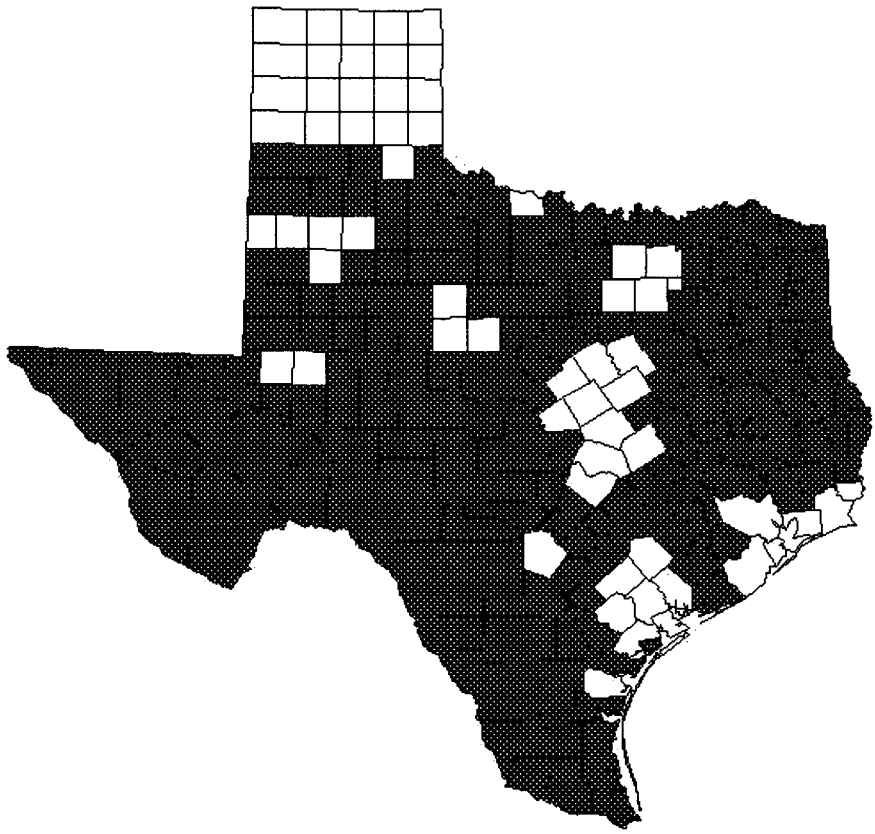
Prepared by:
Health Professions Resource Center
Office of Policy and Planning
Texas Department of Health
Data Source:
Division of Shortage Designation
United States Department of Health
and Human Services
April 20, 1999

Figure 2-13. Distribution of Psychiatrists by County of Employment Texas 1999



Prepared by:
Health Professions Resource Center
Office of Policy and Planning
Texas Department of Health
Data Source:
Texas State Board of Medical Examiners
September 20, 1999

Figure 2-14. Federally Designated Mental Health Health Professional Shortage Areas Texas 2000



Not Designated

Designated

Prepared by:
Health Professions Resource Center
Office of Policy and Planning
Texas Department of Health
Data Source:
Division of Shortage Designation
U.S. Department of Health and Human Services
May 2000

Federal Mental Health, Health Professional Shortage Areas (HPSAs)

The U.S. DHHS HPSA designation program uses population-to-psychiatrist ratios to identify counties with a shortage of psychiatrists. In addition to geographic area designations, the HPSA designation program also provides for the designation of special population groups within geographic areas and for the designation of facilities under certain circumstances.

In 1999, there were 192 mental health HPSAs in Texas that were designated by the U.S. Department of Health and Human Services. (Figure 2-14)

Age and Gender of Psychiatrists

Nearly three out of every four (73 percent) of Texas' psychiatrists were male in 1999; and, slightly more than one-half (51 percent) were over 50 years of age (Table 2-12).

Table 2-12. Distribution of Psychiatrists by Age and Gender, Texas, 1999.

Characteristic	Variable	Percent
Age	< 40 years	13.2 %
	40 to 49 years	31.9 %
	50 to 59 years	28.6 %
	60 to 69 years	17.9 %
	> 70 years	8.4 %
	Age Total	**100.0 %**
Gender	Male	72.8 %
	Female	27.2 %
	Gender Total	**100.0 %**

* Percent of the column total for each characteristic.
Source: Texas State Board of Medical Examiners, September 1999.

Psychologists

The Texas State Board of Examiners of Psychologists (TSBEP) issues four types of licenses to psychologists each of which has different requirements.

- Licensed Psychologist (LP)
- Provisionally Licensed Psychologist (PLP)
- Licensed Psychological Associate (LPA)
- Licensed Specialist in School Psychology (LSSP)

Psychologist Supply - 1999

Since psychologists are included in determining a Mental Health Professional Shortage Area designation, their supply and demographics were also evaluated for this report. However, only their numbers and location (urban, rural) were available for analysis in 1999 because the TSBEP is one of only a few boards that does not collect age, gender and race/ethnicity on its licensees. Licensed psychologists were in greatest supply in 1999 (see Table 2-13).

Table 2-13. Supply and Population-to-Psychologist Ratio in Texas, 1999.

Psychologist Type	Number	Population-to-Psychologist Ratio
LP	3,011	6,641:1
PLP	152	131,549:1
LPA	1,418	14,101:1
LSSP	1,639	12,200:1

Source: Texas State Board of Examiners of Psychologists, September 1999.

Licensed Social Workers

The Texas State Board of Social Worker Examiners (TSBSWE) issues licenses to social workers in Texas. In 1999, there were 14,782 social workers practicing in Texas, a population to social worker ratio of 1,353:1. This supply total is a large increase over the number of social workers since the early 1990s. For example, in 1993 there were 6,783 social workers, a ratio of 2,658:1. Age, gender and race/ethnicity were not available from the TSBSWE.

Workforce Requirements Analysis

The Statewide Health Coordinating Council and the Health Professions Resource Center (HPRC) are charged to monitor and determine if Texas has enough physicians and non-physician providers to adequately staff its health care delivery system, now and in the future. This section of the State Health Plan Update describes efforts to better understand Texas' future requirements.

Matching future supply with future requirements is a major emphasis of health care workforce modeling. Supply is defined as the number and type of health care personnel needed to staff, or available to staff, the current or future health care delivery system. Requirements is the number and type of personnel needed to provide a specified quantity and quality of care to a population. A balance between the two is necessary before other problems such as distribution and access can be adequately addressed. The supply and requirements for health care providers depends in part

on population growth and composition, insurance coverage, geographic location (urban, rural), and provider staffing and utilization patterns under various insurance coverage systems.[6]

Integrated Requirements Model (IRM3.1)

The IRM3.1 model focuses on how different provider types provide medical care to populations covered by private and public insurance payment systems, such as managed care and Medicaid programs. Since the routes along which the future health care delivery system will develop are unknown, a range of potential delivery systems was investigated. This was accomplished by using two insurance coverage scenarios that are included in the IRM and a Texas specific scenario that was developed at the HPRC. The two IRM scenarios are the Status Quo (SQ) and High Managed Care (HMC) scenarios. The requirements estimated under these scenarios are based on U.S.-level insurance and staffing pattern data. The results obtained with them indicate the number of providers required in Texas if Texas had insurance and staffing patterns similar to the national standard for 1995. A Texas (TX) scenario was developed that was based on Texas population projections from the Texas State Data Center and Texas insurance coverage data obtained from several state or federal sources (see Exhibit 2-1). The IRM bases its projections of requirements for health professionals by assigning substitution rates to certain non-physician providers. The assumption is that the services these professionals provide can "substitute" for a certain amount of physician time. Substitution rates used in this analysis were obtained from the Texas Medical Association.

The SQ scenario operates under the assumption that health insurance coverage and staffing ratios of providers (per 100,000 population) will be the same in 2006 as what they were at the national level in 1995. The only variables to change in this scenario are the growth and aging of the Texas population (using the U.S. Bureau of the Census population data for Texas).

The HMC scenario evaluates the effect of increasing the level of HMO penetration among populations for the year 2006. This scenario assumes that Medicare will promote HMO enrollment among its beneficiaries, states will shift their Medicaid populations into HMO settings, and HMOs will enroll more private sector patients. Under the HMC scenario the percentage of the population covered by HMOs increases by almost 13 percent over the percentage of the population covered by HMOs under

the SQ scenario. The population affected the most by this increase in coverage by HMOs is the fee-for-service population.

The TX Scenario is a "modified Status Quo scenario" in that it assumes that the current (mostly 1999 data) insurance coverage rates for people in Texas and the non-physician provider substitution rates for 1999 will remain in effect through 2006. The growth and aging of the Texas population are expected to follow the Texas State Data Center's scenario 1.0 projection.

Workforce Modeling Results

Primary Care - Year 2006 Requirements

All professional types that were analyzed by the IRM3.1 were categorized by their roles in providing patient care in one of the 18 physician specialties included in the model.

The physician specialties evaluated in this report were primary care physicians which includes general practice, family practice, general pediatrics, general internal medicine, and obstetrics and gynecology. The other physician specialty analyzed was psychiatry.

Although the non-physician professions analyzed in this study do not have specialties as such, many do provide patient care in practice settings that often correlate with one of the 18 physician specialty types. A list of the physician specialty areas analyzed in this report, and the types of non-physician providers who may partially substitute for physicians in each specialty are shown in Table 2-14.

Overall, the number of PC physicians required to provide medical care for the Texas population and to function effectively in the health care delivery system varied slightly among the three scenarios. The requirement for PC physicians in 2006 exceeds the projected supply by only several hundred physicians. See Table 2-15.

The total number of PC physicians should be adequate to manage the primary care needs of the state as a whole. However, distribution across the state will continue to be a problem. For example, it appears that Texas could have a small oversupply of family and general practice physicians but a shortage of general internal medicine physicians. The other primary care specialties will be just about right for Texas.

Table 2-14. Sorting of Patient Care Providers According to Physician Specialty.

Physician Specialty	Non-Physician Provider Types	
General Internal Medicine	Acupuncturist Chiropractor Naturopath	Nurse Practitioner Physician Physician Assistant
General Pediatrics	Nurse Practitioner Physician	Physician Assistant
General/Family Medicine	Acupuncturist Chiropractor Naturopath	Nurse Practitioner Physician Physician Assistant
Obstetrics and Gynecology	Acupuncturist Nurse Midwife Nurse Practitioner	Physician Physician Assistant
Psychiatry	Clinical Nurse Specialist Physician - Psychiatrist	Psychologist Social Worker

Source: Health Professions Resource Center, 1999.

Table 2-15. Comparison of Year 2006 Physician IRM3.1 Requirements and Supply Projections for Selected Physician Specialties using Historical Licensing Board Data.

Provider Type	IRM3.1 Scenarios 2006			TX Projected Supply from Trend Data
	SQ*	HMC	TX	
Primary Care				
Primary Care Total	24,383	24,314	25,115	24,629
Family & General Practice	7,436	7,419	7,307	8,580
Obstetrics & Gynecology	3,313	3,302	3,246	3,341
General Internal Medicine	9,257	9,239	10,256	8,277
General Pediatrics	4,377	4,354	4,306	4,431
Mental Health				
Psychiatry	3,225	2,980	5,242	2,604

Source: Health Professions Resource Center, 1999.

*SQ = Status Quo scenario; HMC = High Managed Care scenario; TX = Texas scenario

Psychiatry - Year 2006 Requirements

The results for physicians with a psychiatry specialty were not as clear as the PC physicians. According to the TX Scenario, there will be an unmet demand for physicians in this specialty in 2006. Whether this unmet demand can be resolved through the use of non-physician providers is unclear. When the SQ and the HMC scenarios are compared to supply projections for 2006, it appears that Texas will have an appropriate number of psychiatrists to serve the state. Because of the discrepancy between IRM SQ and HMC scenarios and the TX Scenario, these results need to be followed closely over the next several years to see which results prove to be the most accurate.

Forecasting supply appears simple, but it is influenced by many factors. As Feil, Welch and Fisher[7] reported:

> Even though the measurement of entrance and exit from the profession is a generally accepted approach to forecasting supply, minor differences in assumptions create great discrepancies over time.

Non-Physician Providers - Year 2006 Requirements

The non-physician providers analyzed in this report were the physician assistants, nurse practitioners, nurse midwives, clinical nurse specialists, social workers and psychologists. The number of these non-physician providers required to meet the needs of the Texas population and support the health care delivery system varied among the three scenarios and the different professional types (see Table 2-16). The supply of physician assistants and nurse midwives should be just about right to meet their primary care requirements in 2006. However, the supply of nurse practitioners will be slightly less than the number required.

Table 2-16. Comparison of Year 2006 Non-Physician Provider IRM3.1 Requirements and Supply Projections Using Historical Licensing Board Data.

Provider Type	IRM3.1 Scenarios 2006			TX Projected Supply from Trend Data
	SQ*	HMC	TX	
Primary Care				
Primary Care Physician Assistants	1,153	1,098	1,019	1,028
Nurse Practitioners	3,936	4,007	3,932	3,415
Certified Nurse Midwives	424	429	386	424
Mental Health				
Psychologists	5,655	5,225	4,780	8,145
Clinical Nurse Specialists **	381	352	322	816
Social Workers	5,588	5,163	4,723	11,359

Source: Health Professions Resource Center, 1999.
*SQ = Status Quo scenario; HMC = High Managed Care scenario; TX = Texas scenario
**Psychiatric/mental health/substance abuse area of practice

Based on the mixed results between requirements and supply, a close observation of psychologists, social workers and clinical nurse specialists is called for over the next few years. The analysis indicates that the supply will be approximately two times the requirements for these provider types. The model does not take into account the contribution of licensed professional counselors and marriage and family therapists. A question to be answered is whether the incorporation of these professions

into the model would result in a more appropriate requirements estimate for mental health providers.

Trends Affecting Workforce Demand

There are a number of trends that will change not only how health care is delivered but also who delivers health care.

General Population Demographics

Texas has one of the largest youth populations and one of the largest elderly populations. The health care needs of these population groups could influence demand for pediatric specialists, internal medicine physicians, orthopedists, pharmacists, and geriatricians.

Workforce Demographics

The health care workforce is aging. This can be seen in the data presented in this chapter, specifically for rural practitioners. The problem of an aging workforce has been highlighted as a core issue in the nursing shortage.

Recruitment into the health professions is being hampered by higher paying high tech jobs. The competition for younger workers is intense.

Technology

Medicine relies more and more on technology and a workforce trained to manage and operate specific equipment. For example, the Department of Labor projects that the United States will need 50,000 more radiological technicians by 2006. These types of technology specific workforce shortages may increase.

Genetic engineering holds a great deal of promise for new ways to treat acute or chronic diseases. Expansion of this technology could lead to new classifications of health care professionals and decrease the demand for certain other types of health care workers.

Workplace Environment

The health care workplace has been a very dynamic one for the past decade. The results have led to less than optimal working conditions for many health care practitioners. The work environment is one factor influencing health care workers decisions to leave their profession, while also affecting recruitment into the health professions.

Continued monitoring of the Texas health professions workforce supply and demand as well as the above environmental factors is critical if Texas is to ensure a quality health care workforce for Texas and thereby maintain quality care for its citizens.

Endnotes

1. *Physician Distribution and Health Care Challenges in Rural and Inner-City Areas*, 10th Report of the Council on Graduate Medical Education, U.S. DHHS, February 1998.

2. *Physician Work Force Strategy for Texas*, A report to the subcommittees on Health and Human Services and Education of the House Appropriations Committee. Texas Department of Health and the Texas Higher Education Coordinating Board, pg. 29, 1995.

3. *1999 AAOA Physician Assistant Census Survey for Texas*, American Academy of Physician Assistants, Alexandria, VA.

4. Peter I. Buerhaus, Douglas O. Staiger and David I. Auerbach, "Implications of an Aging Registered Nurse Workforce," *Journal of the American Medical Association*, Vo. 283, No. 22, June 14, 2000.

5. Don R. Miller, *Health and Nurses in Texas - The Supply of Registered Nurses: First Look at Available Data*, Texas Institute for Health Policy and Research and the Center for Health Economics and Policy at the University of Texas Health Science Center at San Antonio. In partnership with the Texas Nurses Foundation, Vol. 1, No. 1, Winter, 2000.

6. Donald L. Libby, *Modeling Interdisciplinary Primary Care Workforce Requirements for States: An Example from Wisconsin*, Policy Paper 96-4, June, 1996, Wisconsin Network for Health Policy Research, Madison, WI.

7. Feil, Elizabeth C., H. Gilbert Welch, Elliott S. Fisher, "Why Estimates of Physician Supply and Requirements Disagree," *Journal of the American Medical Association*, May 26, 1993, Vol. 269, No. 20, ppg. 2659 - 2663.

Sources for Health Insurance Data:

Private Insurance, 1999: The IRM3.1 national default percentage (7.8 percent) for rural managed care was used. HMO information was obtained from the Texas Department of Insurance. HMO data is collected by the HMO Service Area. The total enrollment count by HMO Service area was for 3rd quarter of 1999 (September 1999). After all other insurance distributions were determined the remaining total was the private fee for service total.

Medicaid and Medicare Enrollment, 1999. This insurance total was obtained from U.S. Health Care Financing Administration (HCFA) and the Texas Department of Health Bureau of Managed care.

Uninsured, 1999: Texas Health and Human Services Commission.

Exhibit 2-1
Texas Population by Type of Health Insurance, 1999

	Insurance Category	LOCATION				TEXAS TOTAL			
		URBAN		RURAL		Population	Percent of State Population Total	Total per Insurance Type	Percent of State Population
		Population	* Urban Percentage	Population	Rural Percentage				
Private Insurance	HMO only	3,485,072	20.6%	237,511	** 7.8%	3,722,583	18.6%	11,193,445	56.0%
	Fee for Service	6,176,733	36.4%	1,294,129	42.5%	7,470,862	37.4%		
Medicaid	Managed Care	400,134	2.4%	30,450	1.0%	430,584	2.2%	1,845,265	9.2%
	Fee For Service	1,151,288	6.8%	263,393	8.6%	1,414,681	7.1%		
Medicare	Managed Care	286,947	1.7%	27,405	0.9%	314,352	1.6%	2,147,868	10.7%
	Fee For Service	1,334,135	7.9%	499,381	16.4%	1,833,516	9.2%		
Uninsured		4,116,110	24.3%	692,740	22.8%	4,808,850	24.0%	4,807,672	24.0%
Total		16,950,419	100.0%	3,045,009	100.0%	19,995,428	100.0%	19,994,250	100.0%

* Percent of column total

** Estimate based on national statistics, actual Texas data not available.

Appendix A
Ad Hoc Committee on Health Personnel Data

A report given in response to the *1999-2004 Texas State Health Plan* goal:

Goal 1: Ensure that the needed number of health care professionals are educated and trained.

Objective 1.1: Improve coordination of data collection and statewide planning efforts.

Report to the Statewide Health Coordinating Council

February 10, 2000

Texas Statewide Health Coordinating Council
Ad Hoc Committee on Health Personnel Data
Member List

David A. Valdez, M.D., Co-Chair
HMO Representative
SHCC Member

PJ (Schneider) Wright, Co-Chair
Public Member
SHCC Member

Bruce A. Gunn, Ph.D.
Health Professions Resource Center
Texas Department of Health

Jane McFarland
Health Professions Council

Sherry Lee
Board of Examiners of Psychologists
Austin

Adela N. Gonzalez, M.P.A.
University of Texas Health Science Center at Fort Worth

Rumaldo Z. Juarez, Ph.D.
School of Health Professions
Southwest Texas State University

Stacey Silverman
Health Affairs Division
Texas Higher Education Coordinating Board

Craig H. Blakeley, Ph.D., M.P.H.
School of Rural Public Health
Texas A&M University
Health Science Center

Barbara J. Miller
State Occupational Information Coordinating Committee,
Texas Workforce Commission

Don R. Miller, Ph.D.
Center for Health Economics and Policy
University of Texas Health Science Center at San Antonio

Marcia Collins
Medical Education Department
Texas Medical Association

Whitney Bischoff, Dr.P.H., R.N.
School of Nursing
Texas A&M University, Corpus Christi

Virginia Kennedy, Ph.D.
Management and Policy Sciences
UT School of Public Health, Houston

Richard Schirmer
Texas Hospital Association

Staff:
Suzanne Adair, Ph.D.
Office of Policy and Planning, Texas Department of Health

Ad Hoc Committee on Health Personnel Data

INTRODUCTION

Over half a million workers comprise the health care workforce in Texas. They provide health care in various settings and services that cover the full spectrum of the health care delivery system. The Statewide Health Coordinating Council's workforce arm, the Health Professions Resource Center (HPRC), currently tracks the supply trends for state licensed health professionals.

Given the diversity, rapid growth and constant evolution of the health personnel workforce, there is an increasing need to maintain a comprehensive database that includes demographic information as well as basic licensure information. For example:

- Who are they (e.g., physician assistants)?
- Where do they work (e.g., hospitals)?
- What are their characteristics (e.g., gender)?
- What type of training do they have (e.g., associate degree)?
- How many are there (e.g., number per 100,000 population)?
- How many should there be now and in the future (e.g., 20 percent increase in the number of graduates)?

To assess the status of the current workforce and to forecast the requirements for health professionals in the future, reliable, accurate, complete and timely health professions data must exist and be readily accessible to workforce planners. A common set of data elements collected on all of the licensed health professions would ensure the establishment of a comprehensive database. Timely, complete and accurate data allow for the following types of analyses:

- Evaluating the effects of various forces on the requirements for health care personnel.
- Tracking trends in the supply and requirements for personnel.

- Monitoring the annual changes in health professions education pipelines.
- Reporting the annual distribution and composition of the health care workforce.
- Evaluating the effects of public policies on health care professional education, recruitment and retention.
- Planning new educational programs and funding streams.
- Determining performance measures at state educational institutions.

Legislative Charge to the Statewide Health Coordinating Council

The Texas Health and Safety Code, §104.0421, directs the Statewide Health Coordinating Council to work with "professional licensing agencies to develop uniform standards for health professional data collected by those agencies, to enable the Council to maintain a comprehensive health professional database." It specifies that, "the Council shall retrieve data on health professionals from the appropriate licensing agencies...and enter (into) agreements...concerning the identification, acquisition, transfer and confidentiality of data."

High priority is to be placed on collecting and disseminating data on health professions in acute shortage areas, on nursing personnel and on health professions needs in rural areas. The legislation states that, at a minimum, the data must include the number and distribution of health professionals; their licensure or certification status; information on their specialty areas, if applicable; and trends or changes in license holders according to number or geographic distribution.

In implementing the requirements of the Health and Safety Code, §104.0421, the Council sought to bring about the coordination of health professions training and workforce development activities in Texas identified in the *1999-2004 Texas State Health Plan*. This plan addressed seven goals for ensuring that Texas residents are served by a high quality health care workforce, both now, and in the future. The Council appointed the Ad Hoc Health Personnel Data Advisory Committee to accomplish the first of these seven goals - *to ensure that the needed number of health care professionals are educated and trained.* The Ad Hoc Committee was to accomplish this through implementing strategy 1.1.1 of the Texas State Health Plan:

> Appoint a Health Personnel Data Advisory Committee to provide guidance and improve the coordination and integration of data collection, analysis and statewide health care workforce planning efforts.

According to the statute, the Council is directed to use the health workforce data to monitor and evaluate long-term regional, statewide, and local heath needs. The Council shall use this information for developing workforce goals and recommendations relating to health education, training and regulation. The Health Professions Resource Center is to use the data to publish reports concerning the educational and employment trends for health professions, the supply of and demand for health professionals, and other issues, as necessary, concerning health professions in this state. It is generally accepted that, based on this legislation, state legislators felt that quality health personnel data and workforce analyses are important for determining sound policy and fiscal management of state dollars for the education and training of health professionals in Texas.

BACKGROUND

The Status of Health Professions Data in Texas

State licensing boards focus on the collection of data required to implement their licensure responsibilities. Few of the boards collect adequate information for conducting basic workforce supply studies, planning, or policy-making. Table A-1 contains a list of the types of data elements necessary to perform different levels of workforce analysis. Many boards regard the collection of data beyond the minimum required in their regulatory function to be outside of their statutory requirement. Not all boards, however, follow such a strict interpretation of their enabling acts. For example, the Texas State Board of Medical Examiners (TSBME) and the Texas Board of Nurse Examiners (TBNE) have considered it in their best interest to collect more comprehensive data on their licensees.

Minimum Data Set

To meet the legislative charge of §104.0421, the Ad Hoc Committee convened a data subcommittee to review the data elements currently collected by the boards and to develop a proposed Minimum Data Set (MDS) that could be used as a common framework by all licensing boards for the collection of licensee data. Many of these

data elements were selected directly from the TSBME and the TBNE data elements collected on their licensees. The proposed minimum data set was presented to the Ad Hoc Committee and revisions were made based on input from the committee and the boards. Table A-2 includes the final version of the list of data elements proposed in the MDS.

The MDS elements were selected to answer the most basic and salient questions customers have about health workforce. These basic data elements allow for the analytical compatibility and comparability of data over time and across professions. Although no one workforce method can reliably forecast the supply and requirements for health personnel in the future, the MDS is essential for conducting even the simplest of workforce supply studies and for measuring the state's progress in the recruitment and retention of health personnel.

The MDS should be integrated into the existing data sets already being collected on state licensees. The assumption is that basic workforce information is needed by all boards in order to answer the many questions they receive from their licensees, state legislators, and other customers. Many of these customers need health professions data to satisfy state and federal mandates, and, in many cases, the licensing boards are the only sources of such data. The principal types of customers the Ad Hoc Committee determined to be most in need of the data elements in the MDS are as follows:

- State legislators and state agencies
- Professional associations
- Educational institutions
- Agencies concerned with issues of primary care and medical under-service
- Managed care organizations, hospitals and other health care employers
- Consumer and citizen advocacy groups
- Health workforce policy researchers

Upon the advice of licensing board staff and attorneys, ad hoc committee members, and other state and federal workforce planners, the proposed data set was kept to a minimum to ensure better compliance by health professionals who must complete this information on their license application or renewal form. Limiting the MDS to "need to know" rather than "nice to know" data about health professionals limits

the number of questions the applicant or licensee must answer and the amount of data processing needed to be done by the boards.

The ad hoc committee discussed whether the data fields on the application or renewal forms should be mandatory for licensure or renewal. Some Texas boards and boards in other states have found that most health professionals respond to the questions on their application or renewal forms regardless of whether the fields are mandatory or voluntary. Given the increase in personnel costs required to monitor the completion of all data elements if they are mandatory for licensure, the committee does NOT recommend that the licensing or renewal of a professional's license be dependent upon the completion of all data elements. There are also legal considerations that prohibit making the collection of age, gender, race/ethnicity data elements mandatory.

The MDS represents basic or core descriptors common to all professions and is not entirely sufficient for conducting more sophisticated workforce analyses. More specialized data elements such as compensation, retirement planning, employment benefits, and practice patterns are proposed to be collected through the use of survey tools. Most of the boards indicated they were willing to assist the Council by enclosing surveys in their license renewal applications.

Barriers to Implementing the Proposed Minimum Data Set

To determine the feasibility of implementing the MDS, the Ad Hoc Committee mailed a survey to licensing board staff and attorneys and asked them to reply to questions concerning the implementation of the MDS by their boards. Licensing board staff answered questions about the applicability of the MDS data fields to their professions; the fiscal and workload impact to their boards if the MDS were implemented; the possible use of optically scanned license application and renewal forms; their willingness to include a one to two page workforce survey tool with their renewal forms; and the ramifications (cost, personnel, etc.) of collecting MDS information as mandatory versus voluntary information. Licensing Board attorneys replied to legal questions about implementing the MDS. These questions concerned the possible violation of laws governing the boards pursuant to the collection of the MDS; the possible violation of any confidentiality laws if the MDS were implemented; whether the collection of the MDS data elements could be mandated

by law as a condition for licensure or renewal; and, whether implementing the MDS would violate their boards' current rules.

The following barriers to implementing the MDS were identified:

- The cost for staff, printing, additional programming, and equipment upgrades were considered barriers to implementation. State Appropriations Act, Article VIII, would require many of the boards to significantly raise their licensing fees to cover costs incurred in implementing the MDS.
- State employment (FTE) caps prohibit the hiring of new staff to implement the MDS
- Concern that the collection and release of privacy data (social security number, race/ethnicity, etc.) by the boards to other state agencies would violate state Open Record Acts and Privacy Acts

Although many board staff indicated that it would be simpler if the Council were to collect MDS data by survey, research by the Ad Hoc Committee indicated that the development and collection of multiple surveys of health professionals would be cost prohibitive (see Table A-3).

Other states have found that costs related to the development and routine administration of the surveys required for effective planning have been determined to be prohibitive. In addition, the effectiveness of that collection methodology is questionable given the historically poor survey return rates. Thus, the use of survey tools to collect basic health personnel data would be cost prohibitive and less reliable when compared with collection of the MDS through license application or renewal forms. However, as mentioned earlier, surveys would be useful for the collection of data for special projects or studies such as the salaries and benefits of health professionals, multiple practice address issues, and practice patterns.

Proposed Implementation of MDS

The Ad Hoc Committee used information provided by the licensing boards staff to determine which data elements were missing from their licensee databases. A list of these data elements is presented in Table A-4. It was suggested in the Ad Hoc Committee that if the HPRC were to contract with the licensing boards to collect the data, barriers such as the FTE cap, the structure of the boards' appropriations, and the current fee collection system could be surmounted. The Ad Hoc Committee

proposes that the Texas Legislature appropriate funds to the HPRC to contract with the licensing boards to collect the existing and missing data elements.

The HPRC would implement the MDS in a priority order. Priority order for implementation was determined by consulting with the Higher Education Coordinating Board, the Center for Rural Health Initiatives, an academic representative of allied health programs and a representative of an academic health center. Collection of survey data high priority professions would be funded for implementation as soon as funding was appropriated, low priority professions would be funded at a later date. The intent would be that all of the licensed health professions in Texas would be collecting the MDS by 2006. Table A-5 includes a list of these professions in order of priority.

Licensing board staff also expressed concern about the privacy of the data collected in the MDS, especially the social security number. Licensing boards have been unwilling to provide this critical data element to the HPRC and other state agencies because of HB 692 passed by the 76th Texas Legislature that prevents the release of the social security number under the open records act. Board attorneys indicated that the social security number and other privacy data may be available to other state agencies since a transfer of information from one governmental body to another is considered an intra-governmental transfer. The receiving agency is required to maintain the same confidentiality statutes as the original holder of the information.

The social security number is important to the Council and other state agencies because it allows the accurate identification of health professional licensees within the state. Since a licensee's name and address may change over time, and nicknames and variants for given names may be used by licensees, the social security number is the only reliable data element that allows state agencies to follow the location and distribution of health care personnel across the state. State health professions schools have an interest in these data, and in some instances, a state requirement, to determine where their graduates locate upon graduation, how many remain in the health professions field, and how likely are health personnel of various racial/ethnic backgrounds to serve populations with similar racial/ethnic backgrounds. Other state agencies need the social security number to determine an important workforce supply variable – the number of Texas trained graduates employed in Texas versus the number of health professionals practicing in Texas who were trained at out-of-

state institutions. Given the importance of the social security number as the personal identification data element, the Ad Hoc Committee recommends an amendment to HB 692 that would clarify the transfer of this data element.

Finally, to meet the requirements of state statute, the Ad Hoc Committee recommends that a memorandum of agreement between the Health Professions Resource Center and each licensing board be developed. These agreements should focus on the identification, collection, acquisition, transfer and confidentiality of data.

The Ad Hoc Committee acknowledges that revising existing data collection systems is difficult and costly. The Ad Hoc Committee has had excellent cooperation and input from the licensing boards and the Health Professions Council. The recommendations proposed are the result of a collaborative effort to meet the Council's legislative mandates and the boards' resource needs to implement the MDS.

AD HOC COMMITTEE RECOMMENDATIONS

Based on the meetings and surveys with licensing board staff, the Ad Hoc Committee developed four recommendations to ensure that the state has the ability to maintain a comprehensive database of health professionals in Texas.

Recommendation One: Amend the Health and Safety Code, §105.003, to include the data elements listed in Attachment A as minimum data to be requested from each health professional licensed in Texas.

Recommendation Two: Appropriate funds to the Statewide Health Coordinating Council to be used to contract with the state health professions licensing boards for them to collect the minimum data set.

Implementation of the minimum data set would be on a priority basis as determined by the Statewide Health Coordinating Council. Any licensing board entering into an interagency contract to collect the minimum data set may exceed their FTE cap for the purpose of providing data collection and processing support to the Council.

The contract will specify services to be provided and include sufficient funds to fully support the FTE's hired or contracted by the agency

Recommendation Three: Implement the MDS in any new licensing system for a healthcare professional licensing board that results from the licensing system analysis study by the Department of Information Resources (House Bill 1, 76th Legislative Session, Section 1-67, Department of Information Resources, Rider #6) should be able to accommodate the recommended MDS.

Recommendation Four: Amend H.B. 692, 76th Texas Legislative Session, to allow for the disclosure of the social security number and other licensing board data including, but not limited to, gender, date of birth, and race/ethnicity to the Health Professions Resource Center, other state agencies and state universities.

Release of such licensing data should be subject to any confidentiality requirements and guidelines outlined by the open records laws and privacy laws of Texas.

Recommendation Five: Develop a Memorandum of Understanding between the Health Professions Resource Center and each of the health professions licensing boards:

1) Annual acquisition of data
2) Disposition and ownership of board licensee data
3) Collection of fees for databases
4) Disclosure of data that are subject to the open records law
5) Collaborative efforts for collection of additional needed workforce data.

Table A-1. Levels of Health Personnel Workforce Studies

Type of Workforce Analysis	Hierarchy - Level of Data and Analysis		
	Basic Data & Analyses	**Intermediate Data & Analyses**	**Advanced Data & Analyses**
Supply of Personnel	License Counts Employment Counts National Trends: Practitioners Employment State Trends: Practitioners Employment Association Data: Members General Data	New professionals Education Pipeline: Enrollments Degrees Trends Adjustments: Age Gender Practice FTE Specialty Sub-state Regions Migration Patterns Projections	Special Surveys: Providers Educators Practitioners Special Problems: Rural Areas Inner Cities Small Area Studies: Zip codes Cites & towns Special Districts Travel Time Integrated Models Credential Changes Practice Patterns
Requirements for Personnel	Ratios of Personnel: To population To patients To beds, etc. Historical Trends: Hospitalizations Office Visits Employment Stats: Providers Government Standards & Norms: Baselines Targets	Demand Factors: Age Income Facility Changes: New Facilities Closed Facilities New Services Needs vs. Demand: Underserved Special Populations Substate Regions Indirect measures: Salary Trends Recruiting Vacancies	Special Problems: Inner city Rural AIDS STDs Preventive Care Illness patterns Special Surveys: Practitioners Employers Patients Public Integrated Models Utilization Studies: 3rd Party Payers Productivity Regulations

Slight Modification of a Table from: Wing, Paul and Edward S. Salsberg. Data Systems to Support Health Personnel Planning and Policymaking: A Resource Guide for State Agencies. The New York State Department of Health and the U.S. Department of Health and Human Services, pg. 72 (Figure 2. Health Personnel Analysis Hierarchy), October 1992.

Table A-2. List of 37 Workforce Data Elements in the Minimum Data Set

1) Last Name
2) First
3) Middle Name
4) Social Security Number
5) License (Certification, Registration) Number
6) License Issuance Date
7) Method of Licensure
8) Registration Status
9) Gender
10) Race /Ethnicity (single field; or, Hispanic origin/Race/Ethnicity in two different fields)
11) Date of Birth (single field; or, separate fields for year, month & day of birth)
12) Place of Birth (state/foreign country)
13) Mailing Address
14) Mailing City
15) Mailing State
16) Mailing Zip Code
17) Basic Health Professions Degree - Professional degree required for entering profession
18) Basic Health Professions Degree - School Location
19) Basic Health Professions Degree - School name
20) Basic Health Professions Degree - Graduation Year
21) Highest Health Professions Degree - Highest professional degree
22) Highest Health Professions Degree - School Location
23) Highest Health Professions Degree - School Name
24) Highest Health Professions Degree - Graduation Year
25) High School Location - Tex County, other State or other Country
26) Primary Specialty or Work Area
27) Secondary Specialty or Work Area
28) Primary Practice Site - Specialty (e.g., family practice, etc.)
29) Primary Practice Site - Address
30) Primary Practice Site - City
31) Primary Practice Site - State
32) Primary Practice Site - Zip Code
33) Primary Practice Site - County FIPS Code
34) Primary Practice Site - Hrs/week at location
35) Primary Practice Site - Employment setting type (Rural Health Clinic, hospital, etc.)
36) Second Practice Site (SPL) - Zip Code
37) Second Practice Site - County FIPS code

Table A-3. Comparison of Three Scenarios for Collecting Health Care Professions Data in Texas

SCENARIO 1	COST	PROS	CONS
BOARD SCENARIO Boards add missing MDS data elements into current databases and collect all MDS data on licensing and/or renewal forms.	Implementation - Yr 1 $1,793,000 Maintenance - Yr 2-5 $3,938,000 Total - $5,731,000	Return rates for data collection forms (licensing/ renewal) approach 100%. Builds on existing systems. Data needs of the U.S. DHHS's HPSA program (for complete licensee data) are satisfied. Boards keep current with profession specific database variables (e.g., specialties, settings, degrees, etc.) MDS data elements are not mandatory for licensure.	Must modify existing databases/ forms. Must overcome implementation barriers: 1) State Comptroller's lock box system for collecting licensing fees and data has licensing form size limitations that could be exceeded. 2) State FTE cap for hiring staff. 3) Inadequate computer systems, office space and staffing.
SCENARIO 2	**COST**	**PROS**	**CONS**
BOARD-HPRC SURVEY SCENARIO Health Professions Resource Center collects missing MDS data with a survey attached to renewal forms.	Implementation - Yr 1 $2,024,000 Maintenance - Yr 2-5 $8,096,000 Total – $10,120,000 According to Texas SOICC, the costs for conducting a survey under Scenarios 2 would approximate the cost for Scenario 3.	Boards do not change their existing system. Since surveys are attached to licensing or renewal forms, return rates could meet U.S. OMB standard rate of 75% for reporting labor statistics if extensive follow-up work with non-responders is done.	Data needs for U.S. DHHS HPSA program and the Texas Legislature will not be met with a 75% return rate. Survey costs are high and remain constant for initial and subsequent years. HPRC is not staffed or funded for developing and conducting surveys. HPRC must be able to collect the SSN number in order to link survey data to board licensee data for analysis.
SCENARIO 3	**COST**	**PROS**	**CONS**
HPRC SURVEY SCENARIO Health Professions Resource Center collects ALL MDS data with a survey tool, independent of the boards.	Implementation - Yr 1 $2,024,000 Maintenance - Yr 2-5 $8,096,000 Total – $10,120,000	Boards would not have to change their existing systems.	Survey reports indicate that return rates of 10-40% are typical unless extensive follow-up work with non-responders is done. HPRC resource needs for data entry are increased. Without increased resources, HPRC would not be able to conduct specialized workforce studies such as addressing compensation and practice pattern issues. It would be difficult for HPRC to keep current with Board changes in data variables such as specialties, practice settings and degrees for 32 licensing boards.

NOTES:

Board staff for nine professions (Chiropractor, Physical Therapist, Occupational Therapist, Optometrist, Physician, Physician Assistant, Acupuncturist, Pharmacist, Psychologist) submitted costs for implementing the MDS. The costs were determined based on computer costs (new equipment and programming), office supply costs (printing, postage, etc.) and data entry or administrative staff costs (new FTEs for implementing and maintaining the MDS data elements).

Cost estimates were computed on a cost per licensee figure for each board. Costs will vary by board because the number of missing data elements and the number of professionals licensed varies with each board. The number of missing data elements by board ranges from 2 to 12 data elements, the average being 8. However, since each survey must include 10 identifier fields such as name, license number, social security number and address, the smallest survey form needed to collect missing fields would be comprised of at least 12 of the 37 data elements.

Costs for First Year of Implementation. The cost range for implementing the MDS for those boards responding was $2.17 (Board of Physical/Occupational Therapists) to $ 51.06 (Texas State Board of Examiners of Psychologists) per licensee. The average of these nine professions was $3.26. Thus, the first year costs for implementing the MDS by all Boards (Scenario 1) is $1,793,000 using a cost estimate of $3.26 per licensee and 550,000 licensees.

Costs for Second – Fifth Year. The first implementation year was more costly than the subsequent or "out-years" because many items such as programming, revision of licensing forms and initial personnel costs were applicable only to the first year. The principal costs in the "out-years" were for data or administrative personnel salaries and was calculated to be 55% of the first year costs based on data from the Boards of Optometry, Pharmacy, Psychology and Physical/Occupational Therapy. The range for the "out-year" costs compared to the initial year costs was 40% to 63%. Thus, the "out-years" average cost was calculated to be $1.79 ($3.26 x 0.55 = $1.79).

Survey Data.

The cost for implementing the Scenarios 2 and 3 were based on the cost for conducting surveys reported to the committee from other state agencies.

Out-of-state Cost Estimates. Workforce centers in Wisconsin (Bureau of Health Information) and New York (Center for Health Workforce Studies) were questioned as to the cost for collecting workforce data on health care licensees. Wisconsin collects data on 18,000 physicians and charges each a fee of $5.00, the amount that they have determined to minimally cover the cost of the surveys. New York survey costs average about $2 per person. The average cost for these two workforce centers to collect workforce data is $3.50.

In-state Cost Estimates. The Texas Medical Association (TMA) conducts several types of surveys. Postage rates, data entry and analysis of a 4-page survey cost $2.14 per person. Thus, the total cost is $2.37 per person.

The University of Texas at Houston conducts surveys on health professionals and has determined the cost for conducting a survey is $5 per person.

Texas State Occupational Information Coordinating Committee (SOICC) of Texas Workforce Commission was consulted and advised that Scenarios 2 and 3 would not be significantly different in costs. Texas SOICC has extensive experience managing workforce survey data.

Table A-4. MDS fields missing from current state licensing board databases.

State Licensing Board	Missing MDS Fields		
Acupuncturists	High School Location Primary Practice Site- Activity	Primary Practice Site- County Primary Practice Site- Hours Primary Practice Site- Setting	Second Practice Site- Zip Code Second Practice Site- County
Athletic Trainers	Gender Race-Ethnicity Place of Birth Basic Professional Degree (all)	High School Location Primary Practice Site- Activity Primary Practice Site- County Primary Practice Site- Setting	Primary Practice Site- Hours Second Practice Site- Zip Code Second Practice Site- County
Audiologists	Gender Race-Ethnicity Place of Birth	Primary Specialty Secondary Specialty Primary Practice Site- Specialty Primary Practice Site- county	Primary Practice Site- hours Second Practice Site- Zip Code Second Practice Site- County
Chiropractors	Race-Ethnicity Place of Birth	High School Location Primary Practice Site- Activity Primary Practice Site- Hours	Primary Practice Site- Setting Second Practice Site- Zip Code Second Practice Site- County
Contact Lens Dispensers (Permit Program)	Method of Licensure Gender Race-Ethnicity Place of Birth	High School Location Primary Practice Site- County Primary Practice Site- Hours	Primary Practice Site- Setting Second Practice Site- Zip Code Second Practice Site- County
Counselors, Professional	Gender	Race-Ethnicity	
Dentists	Race-Ethnicity Basic Professional Degree- Location	High School Location Primary Practice Site- setting	
Dental Hygienists	Method Licensure Race-Ethnicity High School Location	Place of Birth Basic Professional Degree - Site Primary Practice Site- Hours	Primary Practice Site- Activity Second Practice Site- Zip Code Second Practice Site- County
Dietitians	Gender Basic Professional Degree (all) Race-Ethnicity	Place of Birth High School Location Primary Practice Site (all)	Second Practice Site- Zip Code Second Practice Site- County
Fitters and Dispensers of Hearing Instruments	Gender Race-Ethnicity	Place of Birth High School Location	Primary Practice Site- hours Second Practice Site- County
Marriage and Family Therapists	Place of Birth Gender	Race-Ethnicity High School Location	Primary Practice Site- hours Second Practice Site- County
Massage Therapists	License Issue Date Method of Licensure Race-Ethnicity Place of Birth	High School Location Primary Practice Site- county Primary Practice Site- hrs	Primary Practice Site- Setting Second Practice Site- Zip Code Second Practice Site- County

State Licensing Board	Missing MDS Fields		
Medical Laboratory Practitioners (Voluntary Registry)	Method of Licensure Gender Race-Ethnicity	Place of Birth High School Location Primary Practice Site (all)	Second Practice Site- Zip Code Second Practice Site- County
Medical Physicists	Gender Race-Ethnicity	High School Location Primary Practice Site-Hours	Primary Practice- Setting Second Practice Site- Zip Second Practice Site- County
Medical Radiologic Technologists	Gender Race-Ethnicity	Highest Professional Degree Primary Practice Site-Hours	Primary Practice Site-Setting Second Practice Site-Zip Code Second Practice Site-County
Midwives, Direct Entry	Race-Ethnicity Basic Professional Degree- School Basic Professional Degree- Year Basic Professional Degree- Location	High School Location Primary Practice Site-Address Primary Practice Site- City Primary Practice Site-State	Primary Practice Site- Zip Code Primary Practice Site- Hours Second Practice Site- Zip Second Practice Site- County
Nurses, Licensed Vocational	Place of Birth Basic Professional Degree- School Highest Professional Degree (all)	High School Location Primary Practice Site (all)	Second Practice Site- Zip Code Second Practice Site- County
Nurses, Registered	Place of Birth High School Location Primary Pract. Site-Specialty	Primary Pract. Site-Address Primary Pract. Site- City Primary Pract. Site- State	Primary Pract. Site-Hours Second Practice Site- Zip Code Second Practice Site- County
Occupational Therapists	High School Location Highest Professional Degree-School Highest Professional Degree-year	Primary Practice Site-Hours Primary Practice Site-Setting	Second Practice Site- Zip Code Second Practice Site- County
Opticians (Voluntary Registry)	Method of Licensure Gender Race-Ethnicity Place of Birth	High School Location Primary Practice Site-county Primary Practice Site-Hours	Primary Practice Site- Setting Second Practice Site- Zip Code Second Practice Site- County
Orthotists and Prosthetists	Gender Race-Ethnicity Basic Professional Degree (all)	Highest Professional Degree (all) High School Location Primary Practice Site-Hours	Primary Practice Site- Setting Second Practice Site- Zip Code Second Practice Site- County
Optometrists	Place of Birth Basic Professional Degree- School	High School Location Primary Practice Site-Hours	Second Practice Site- Zip Code Second Practice Site- County
Perfusionists	Gender Race-Ethnicity	Place of Birth High School Location	Primary Practice Site-Hours

State Licensing Board	Missing MDS Fields		
Physicians	Highest Profess. Degree- School Highest Profess. Degree- Location	Highest Profess. Degree- School Name Highest Profess. Degree- Graduation Year	Second Practice Site- County Primary Practice Site- Setting
Physician Assistants	Method of Licensure Basic Professional Degree High School Location	Primary Practice Site- county Primary Practice Site- Hours Primary Practice Site- Setting	Primary Specialty Second Practice Site- Zip Code Second Practice Site- County
Physical Therapists	Gender High School Location	Primary Practice Site (all fields) Second Practice Site- Zip Code	Second Practice Site- County
Podiatrists	Method of Licensure Place of Birth High School Location	Basic Profess. Degree- Location Primary Practice Site- county Primary Practice Site- Hours	Second Practice Site- Zip Code Second Practice Site- County Primary Practice Site- Setting
Psychologists	Gender Race-Ethnicity Place of Birth Basic Professional Degree – Site	Highest Profess. Degree- School Basic Professional Degree- year Highest Professional Degree (all) High School Location	Registration Status Primary Practice Site (all) Second Practice Site- Zip Code Second Practice Site- County
Social Workers	Gender Race-Ethnicity Place of Birth	Basic Professional Degree (all) Highest Profess. Degree- School High School Location	Secondary Specialty Primary Practice Site- Hours Second Practice Site- Zip Code Second Practice Site- County
Respiratory Care Technicians	Gender Race-Ethnicity	Place of Birth High School Location	Primary Practice Site- Hours Second Practice Site- Zip Code Second Practice Site- County
Speech-Language Pathologists	Gender Race-Ethnicity Place of Birth	High School Location Primary Practice Site- county	Primary Practice Site- Hours Second Practice Site- Zip Code Second Practice Site- County

Table A-5. Health Professions by Priority Group for Implementing the MDS

Level 1 Priority Group

- Audiologists
- Chiropractors
- Dentists
- Dental Hygienists
- Dietitians
- Licensed Vocational Nurses
- Medical Radiologic Technicians
- Occupational Therapists
- Optometrists
- Pharmacists
- Physicians
- Physician Assistants
- Physical Therapists
- Psychologists
- Registered Nurses (including advanced practice nurses)
- Respiratory Care Practitioners
- Speech Language Pathologists
- Social Workers

Level 2 Priority Group

- Acupuncturists
- Athletic Trainers
- Direct Entry (Documented) Midwives
- Fitters and Dispensers of Hearing Instruments
- Licensed Professional Counselors
- Marriage & Family Therapists
- Massage Therapists
- Medical Physicists
- Orthotists / Prosthetists
- Perfusionists

Appendix B
Academic Health Centers

This appendix contains the Academic Health Centers' responses to a survey about their curricula and activities that would forward the *1999-2004 Texas State Health Plan* goal:

Goal 4: Create a health care workforce trained and equipped to use education and prevention as the primary approach to helping Texans achieve optimal health.

Objective 4.1: Increase the implementation of prevention activities in the health care community through the academic curriculum.

Texas Statewide Health Coordinating Council

February 2000

THE TEXAS A&M UNIVERSITY SYSTEM
HEALTH SCIENCE CENTER:
Baylor College of Dentistry
College of Medicine
School of Rural Public Health

1. What efforts/initiatives have been taken to emphasize prevention in your institution's health professions education and training?

School of Rural Public Health: Being a school of public health, the curriculum emphasizes prevention throughout the curriculum. Prevention is particularly emphasized in the courses involving the program areas of "Social and Behavioral Health" and "Environmental and Occupational Health."

College of Medicine: Preventive medicine has been a relevant theme coursing throughout the curriculum in the College of Medicine since it's beginning over 25 years ago. This includes both basic and clinical science courses required in years I-IV. Over the past decade a four-year theme of preventive medicine has been developed and is both horizontally and vertically integrated within an interdisciplinary course, "Becoming a Clinician." In 1998, the dean requested a survey be completed that addressed the portions of the curriculum focused on preventive medicine and public health. The questions utilized were derived from materials obtained from the Office of Medical Education at Harvard School of Medicine, Texas Department of Health and Texas Medical Association. The results of the survey clearly indicate that the College of Medicine is delivering a significant amount of information on preventive medicine over the current four-year curriculum. Additionally, in 1999 the College approved new curricular goals and objectives, following national trends that clearly increase the importance of preventive medicine as a constituent part of the medical curriculum. These new goals and objectives insure that this important topic will remain a priority in our continually evolving curriculum. See Exhibit A.

Baylor College of Dentistry: Prevention is an integral part of the pre-doctoral curriculum at Baylor College of Dentistry (BCD). The following didactic courses have a strong preventive component:

Principles of Epidemiology and Prevention (1st year)
Principles of Dental Public Health (1st year)
Applied Preventive Dentistry (2nd year)

This is reinforced for the third year students in Clinical Preventive Dentistry. Students integrate principles of prevention into the treatment plans of all their patients.

In addition, the BCD / Department of Veterans Affairs dental public health residency is one of only 20 such programs in the United States. This program's prerequisites are a dental degree and an MPH degree. Mastery of the philosophical and technical aspects of prevention are core objectives of the program.

Prevention is the leitmotif of BCD's outreach efforts. BCD recently received $500,000 from Crystal Charities and the Baylor Oral Health Foundation to implement a pit and fissure sealant program in the Dallas area. Dental students and dental hygiene students apply the sealants under faculty supervision.

2. *What curriculum changes have been made in the areas of community and public health, epidemiology, population-based medicine, working in multidisciplinary teams, and cultural competency? Does your institution have model programs/ curriculum for any of the above?*

School of Rural Public Health: The distance education MPH program has been revised to reflect three major areas: (a) core public health competencies; (b) financial management, program management, and budgeting; and (3) community assessment, planning, implementation, and program evaluation.

Each of the areas of concentration – epidemiology, biostatistics, health policy and management, occupational and environmental health, and social and behavioral health—have similarly revised their curricula to reflect a strong practice orientation, including multidisciplinary perspectives, emic views of community, cultural competency, and an in depth knowledge of public health interventions. The MPH with a concentration in epidemiology, for example, has recently added an

epidemiologic practice course to emphasize the uses of epidemiology in health status assessment, monitoring, and evaluation.

College of Medicine: The questionnaire also demonstrated that community and public health, epidemiology, and cultural competency are and will continue to be essential parts of the curriculum. The College pioneered a very successful student preceptorship dependent upon community-based faculty at its inception almost 25 years ago. More recent surveys clearly indicate that components of the curriculum address population-based medicine and working in multi-disciplinary teams are also integral parts of our curriculum. The importance of multi-disciplinary teams involved in patient care is an essential component of today's medical education. Specifically, the College incorporates medical students, PharmD students, nurse practitioners, PA students, clinical nurse specialists and/or social workers into working teams with staff and resident physicians. Cultural competency has recently been identified as an area needing additional attention in our curriculum. A sustained emphasis on epidemiology and evidence-based medicine continues to be integrated across the four-year curriculum.

Baylor College of Dentistry: Among the changes in the pre-doctoral dental public health curriculum have been a re-sequencing of courses to expose first year students to community-based activities. For the past three years, students in Principles of Dental Public Health have been divided into groups to research community-based dental public health programs. They present a poster session to the entire school on the programs. In addition, nicotine cessation education has been emphasized as an appropriate and critical role for dental professionals.

Traditionally, a Dental Public Health Residency has been a one-year, in residence program with a strong research component for dentists with an MPH degree. Because dentists graduate with substantial debt and training stipends are small, it has been difficult to attract motivated candidates. BCD has developed an off-site (multi-year) program for dentists employed in public health environments. The employing agency is an active participant in the program and the resident's research is focused on areas of interest to the agency. This has the potential to contribute substantially to rebuilding the dental public health infrastructure in the United States. As an example, its graduates have served as: state dental director; Regional Dental Consultant for HRSA; worked in community health centers; served in the

Epidemiologic Intelligence Service. The program has received national recognition and its expansion is currently funded by HRSA.

Further, BCD requires that all students, faculty, and staff attend a "Welcoming Diversity Program," the purpose of which is to develop cultural sensitivity and competency.

3. Has your institution implemented any new methods/programs for evaluating or testing the competency of health professionals in the above areas? Please describe.

School of Rural Public Health: The School is participating in the Association of Schools of Public Health's current project that is determining the competencies that should be achieved through the curriculum of schools of public health in the various graduate degree programs available. These competencies should be completed and agreed upon by 2001.

The School is also implementing guidelines for a major paper as the culminating experience for MPH students. The major paper will be based on practicum experiences of students, and is designed to provide students with the opportunity to apply public health knowledge and skills, and to reflect on their field experience.

College of Medicine: Although there are no new methods/programs for evaluating/ testing the competencies of our students in these areas, questions on these topics comprise a portion of nearly all comprehensive exams and OSCE's.

Baylor College of Dentistry: Not applicable to BCD.

4. Has your institution been able to increase its clinic and community-based training sites? For comparison purposes, document the number and location of sites as of September 1996 and the number and location of sites existing as of September 1999. What model programs does your institution have in this area?

School of Rural Public Health: The School does not provide "clinical" training. The students in the current Master of Public Health degree program have a required practicum, i.e., field experience in a rural community or involving rural health issues,

that is 3-6 semester hours in duration. The School is new and started this practicum with its initial curriculum development in 1999.

College of Medicine: Our institution has been able to increase its clinic and community-based training sites in some areas (Family Medicine, Internal Medicine and Pediatrics), but not others (OB/GYN, Psychiatry and Surgery). See Table B-1.

Baylor College of Dentistry: There has been an increase in community-based training sites from 14 sites in September 1997 to 23 sites to date. Dallas is located in a metroplex that provides access to a number of quality community-based training sites from hospitals to community clinics. See Table B-2.

Table B-1. Texas A&M School Of Medicine/Clinic Training Sites

DEPARTMENTS	1996	1999
FAMILY MEDICINE	Bellmead, Belton, CS, Gatesville, Killeen, Round Rock, Santa Fe, Taylor, and Waco	Bellmead, Belton, CS, Gatesville, Georgetown, Hewitt, Killeen, Round Rock, Santa Fe, Taylor, and Waco
INTERNAL MEDICINE	3rd year – Main Clinic, VA 4th year – CS, Darnall, and VA	3rd year – Main Clinic, Round Rock, and VA 4th year – CS, Darnall, Main Clinic, VA, and elective in Georgetown
OB/GYN	Darnall, Main Clinic, and 4th year elective in CS	CS, Darnall, Main Clinic, and VA
PEDIATRICS	Main Clinic	Driscoll, Killeen, Main Clinic, and Waco
PSYCHIATRY	Darnall, Main Clinic, Temple VA, and Waco VA	Darnall, Main Clinic, Temple VA , and Waco VA
SURGERY	Main Clinic and VA	Main Clinic and VA

Table B-2. Community-Based Training Sites/September 1996 To Present
Baylor College Of Dentistry

Student	Program	Site	Existing as of Sep 1996	Sites since Sep 1996	Description
Dental	Predoctoral Public Health Science	Social Services Community Activities (see attached list)	NA	NA	Community health requirement
Dental	Predoctoral Oral Surgery	Scottish Rite Hospital – Dallas	Y		Rotation 1 week
Dental	Predoctoral Oral Surgery	Parkland Hospital – Dallas	Y		Rotation 1 week
Dental	Predoctoral Oral Surgery	Veteran's Administration Hospital – Dallas	Y		Rotation 1 week
Dental	Predoctoral Pediatric Dentistry	Children's Hospital – Dallas		Y	Special clinical program
Dental Hygiene	Baccalaureate	DeHaro Saldivar – Dallas	Y		Rotation
Dental Hygiene	Baccalaureate	James and Louis Addison Kiwanis Dental Center –		Y	Rotation Created 2000
Dental Hygiene	Baccalaureate	Indian Health Sites (details available) Oklahoma - 4 sites	Y		Preceptorship
Dental Hygiene	Baccalaureate	Indian Health Sites (details available) Oklahoma - 6 sites		Y	Preceptorship
Dental Hygiene	Baccalaureate	Community Educational Activities (see att. list)	NA	NA	Community health requirement
Resident	Advanced Education in General Dentistry	Dental Health Program – Dallas		Y	Rotation
Resident	Advanced Education in General Dentistry	Denton State School – Denton	Y*		*Discontinued 1999
Resident	Endodontics	Children's Hospital – Dallas	Y		Rotation 8 days
Resident	Oral Surgery	Scottish Rite Hospital – Dallas	Y		Rotation 1 month
Resident	Oral Surgery	Parkland Hospital – Dallas	Y		Rotation 1 month
Resident	Oral Surgery	Veteran's Admin. Hospital – Dallas	Y		Rotation 1 month
Resident	Oral Surgery	Medical City Hospital – Dallas	Y		Rotation 1 month
Resident	Orthodontics	Children's Medical Center of Dallas		Y	Rotation Weekly-Cleft palate
Resident	Pediatric Dentistry	Children's Medical Center of Dallas		Y	Fellowship created in 1997
Resident	Pediatric Dentistry	Dental Health Program (Bluitt Flowers and East Dallas) – Dallas		Y	Rotation
Resident	Pediatric Dentistry	Mesquite Community Hospital – Mesquite		Y	Created in 1999
Resident	Pediatric Dentistry	Baylor University Medical Center – Dallas		Y	Created in 1999 Palatal protectors
Resident	Periodontics	Scottish Rite Hospital Dallas	Y		Rotation
Resident	Periodontics	Veteran's Admin. Hospital – Dallas	Y		Rotation
Resident	Periodontics	Children's Medical Center of Dallas	Y		Call - weekly
Resident	Prosthodontics	Veteran's Administration Hospital – Dallas	Y		Rotation

One model program being implemented is the "Dallas County Sealant Initiative" funded by the Crystal Charity Ball in Dallas. This initiative plans to have 2,500 students receive sealants (protective resin for the chewing surfaces of the tooth to prevent decay) annually for three years. This will have a tremendous impact on school-aged children toward improving the oral health of these students. Funding for this initiative began on April 1, 2000.

A second distributed model of community-based training is the current activity of Baylor's pre-doctoral and dental hygiene students in community-based preventive programs. Students have a service commitment that places them in a variety of settings in the community. These settings range from health fairs and oral cancer awareness and detection to oral health screenings and educational presentations in the public schools. While not detailed on the attached chart there were 70 activities in 1996-1997 and 121 in 1998-1999 for the pre-doctoral students. There were 27 activities in 1999 for the dental hygiene students.

A third distributed model of community-based training is the "By the Roots," an oral health curriculum for K-6. This program has a series of modules that enhance the awareness of the student to his/her oral health. These modules, in a timely fashion, reveal to the students useful information about dentistry and good oral preventive practices.

5. Are your medical and nursing schools using the Agency for Health Care Research and Quality Putting Prevention Into Practice (PPIP) concepts and resources (e.g. Health Risk Profile)? How are they being used? PPIP materials can be accessed through the AHCPR website www.ahcpr.gov/ppip/.

School of Rural Public Health: Not applicable

College of Medicine: Currently these materials are not being utilized. However, materials from other sources are. There is an increased emphasis on the use of algorithms and evidence-based medicine.

Baylor College of Dentistry: Not applicable

6. What state or legislative policy recommendations (besides increases in funding) would be instrumental in promoting the accomplishment of this Goal and Objective for the state of Texas?

School of Rural Public Health: Set institutional performance measures in this area and support special items that target this goal/objective.

College of Medicine: Continue to request updates on progress. It would not be appropriate for the state to legislate curriculum in medical schools.

Baylor College of Dentistry: Set institutional performance measures for these goals and objectives. Request for reporting of these measures in LAR preparation. Support special items that target these goals and objectives.

7. How would your institution use increases in funding to advance this Goal and Objective at your institution?

School of Rural Public Health: Support the human and physical infrastructure needs to expand distance education in public health education that focuses on community health, prevention, and other health of the public-related areas. The school is currently delivering, through distance education, training in public health, community health, and prevention to Tyler, Mt. Pleasant, Marshall, Lufkin, and McAllen. An off-campus MPH program is scheduled to start in Temple, and a distance education MPH will be delivered to Corpus Christi beginning in fall, 2000.

The school has participated in an approved grant application to the Health Resources and Services Administration (HRSA) – with North Texas and the University of Texas Schools of Public Health – to deliver public health training to the existing public health workforce in Texas.

The school is also participating with the Texas Public Health Leadership Institute in a grant submission to the Texas Department of Health to provide leadership training in public health.

College of Medicine: No response to this question

Baylor College of Dentistry: Increases in funding would be used to provide the personnel and infrastructure necessary to support and extend external training programs for undergraduate and graduate dental students, and support for distance education. These training opportunities would focus primarily on community health, prevention, and certain other public health issues. The long term goal of these programs is to achieve the Healthy People 2010 goals for oral health, particularly with respect to reductions in dental decay, increased placement of preventive sealants, and increasing the number of school-based health centers with oral health components and health centers with oral health service components. Baylor College of Dentistry is already active in these areas, having recently begun a $400,000 school-based sealant program as training for undergraduate dental and dental hygiene students. The school's Center for Telehealth currently provides distance education/consultation with remote sites in South Texas. Increased funding would serve to maintain and extend these programs, as well as allowing for new initiatives currently under development, such as an injury-prevention program for high school athletes which links mouth guard fabrication with tobacco education and cessation information.

THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER HOUSTON:
Medical School
School of Nursing
School of Public Health
Dental Branch

1. What efforts/initiatives have been taken to emphasize prevention in your institution's health professions education and training?

Medical School

- The Medical School has incorporated concepts of prevention in undergraduate courses such as *Fundamentals of Clinical Medicine* during the problem-based learning. The students are also exposed during their clinical training years on a case-by-case basis.

- Several faculty members are active in the Cancer Teaching and Curriculum Enhancement in Undergraduate Medicine (CATCHUM) project in conjunction with seven other Texas medical institutions. The project was funded by the National Cancer Institute and emphasizes cancer education and screening.

School of Nursing

- *Health Promotion through the Lifespan.* A clinical course for all first semester senior nursing students.

- *Community Health Nursing Practice.* The emphasis of this course is on health prevention, education and promotion, prevention and cultural diversity. The course incorporates the Healthy People 2000 National Health Objectives. In addition, the students are able to synthesize and apply their didactic content through a teaching project to a community agency and a debate on Healthy People 2000 Objectives in their clinical course.

- Management of Cancer Prevention and Detection is completely dedicated to cancer prevention and education of the public regarding cancer risks.

- *Primary Prevention in Individuals, Families and Communities.* This course is designed to highlight content in primary and secondary prevention as it relates to advanced practice with communities, families and individuals. The course explores interdisciplinary research relevant to health promotion, disease pre-

vention and screening. Students work with families of diverse structure, economic and cultural backgrounds across the health/illness continuum.

- *Perinatal/Neonatal Nursing for Healthy and At-Risk Clients.* This course emphasizes health promotion; risk assessment, and primary and secondary prevention.

- *Management of Pathological Conditions of the Pregnant Woman and Neonate* The curriculum explores issues of comprehensive health promotion and screening for woman of childbearing age and the newborn. The course discusses research findings, theoretical models and their social context.

School of Public Health

- The *Medicine/Public Health Initiative* is an effort to bring the two fields closer together in the training of professionals with an emphasis on prevention.

- The *Society and Health Initiative* has resulted in the formation of the Texas Foundation for Society and Health, which emphasizes prevention of disease in populations, using policy as well as evidence-based medicine and related interventions to improve health.

- The School of Public Health has ten research centers, all of which focus on prevention of disease and promotion of health. The largest is the Center for Health Promotion Research and Development. Other centers include the Center for Health Policy Studies, Center for Infectious Disease, Center for Prevention of Injury and Violence, Center for Medical and Public Health Chronobiology, Coordinating Center for Clinical Trials, Epidemiology Research Center, Human Nutrition Center, Human Genetics Center, Texas Prevention Center and Southwest Center for Occupational and Environmental Health.

Dental Branch

- In the Doctor of Dental Surgery (DDS) curriculum, dental students are provided didactic and clinical instruction in all aspects of preventive dentistry. This begins in the first year of dental school with the problem-based course, *Dental Public Health I: Introduction to Dental Prevention.*

- In the second year, dental students provide preventive dentistry education to elementary age school children in the Houston Independent School District.

- In the spring semester of the second year, dental students participate in *Dental Public Health II: Behavioral Context-Dental Patient Management.*

- The third year courses *Planning Programs for Populations* and *Dental Public Health* address such issues as water fluoridation and preventive dental care for disadvantaged populations.

- The third year clinical experience provides an opportunity for students to treat special patients including medically and physically handicapped and the financially disadvantaged. Prevention is emphasized during this treatment.

- During the fourth year, dental students treat medically compromised patients at the Dental Branch. The clinical class provides dental treatment including preventive services at one of three extramural clinic sites: Brownsville Community Health Center, Brownsville, TX; City of Laredo Health Department, Laredo, TX; and Rusk Elementary School (HISD), Houston, TX. Students in advanced general dentistry programs and advanced specialty programs emphasize prevention at the Bering Dental Clinic (AIDS/HIV). Dental students emphasize prevention while treating patients on the UT-Houston Dental Branch Mobile Dental Van.

- Prevention in the dental hygiene profession and the UT-Houston Dental Hygiene Program is always of utmost importance. A majority of the classes for the dental hygiene students emphasize prevention in specific areas. The information from the lectures is then transferred into the clinical setting where the students learn to apply the information. A few of the topics taught are nutritional counseling, brushing and flossing, application of pit and fissure sealants, and topical fluoride application. Students must perform each task at a competent level in order to be considered for graduation.

2. *What Curriculum changes have been made in the areas of community and public health, epidemiology, population-based medicine, working in multidisciplinary teams and cultural competency? Does your institution have model programs/ curriculum for any of the above.*

UT-Houston is currently working on several multidisciplinary model programs that encompass the institution. A feasibility study has been finalized that makes

recommendations for the establishment of Interdisciplinary Health Professions Education. The report will be presented to the Southern Association of College and Schools in the Spring 2000. The recommendations include creating interdisciplinary courses and requiring all medical professional students to complete at least one of the courses in order to graduate.

The *Frontiers in Interdisciplinary Health Care* course also provides an opportunity for UT–Houston students to interact with students in the other health professions. This course is organized in a "team" format. The teams are composed of students who are enrolled in the schools within the UT-Houston Health Science Center as well as students enrolled in a variety of colleague institutions including the University of Houston and Texas Woman's University. Each team typically has representative students from medicine, dentistry, nursing and public health as well as a variety of allied health, biomedical sciences, pharmacy, and nutrition/dietetics sciences.

The UT-Houston Health Care Team Competition is a program that emphasizes an interdisciplinary educational approach to problem solving that involves not only the UT-Houston Health Science Center schools but also representation from the University of Houston College of Pharmacy, Health Law and Policy Institute and the Graduate School of Social Work. The competition is designed to illustrate an interdisciplinary approach to health care.

The Medical School and the School of Public Health are working together to offer the MD/MPH Program. Students select electives in public health as part of their medical curriculum. The courses are taken in the third and fourth year medical school years. Public health practica, electives, and other enrichments are offered as part of the rest of the medical school curriculum.

Medical School

- Students are required to take a course in epidemiology during their fourth year of medical school. A non-credit elective has been offered over the past two years, which is open to all students. Both the required and elective courses have a strong emphasis on community and public health and population-based medicine. These topics are also incorporated into the problem-based cases in the *Fundamentals of Clinical Medicine.*

- Students are introduced to the concept of working in a multidisciplinary setting when they begin their first formal training during the *Introduction to Clinical Medicine* given in the first year of medical school. The preceptor portion of the course is provided in a community setting. This experience is enhanced during the second year when students spend one afternoon a week in a clinical setting as part of the *Physical Diagnosis* course. During the third year clerkships the students are active participants in the clinical care of patients working in multidisciplinary teams.

- The medical students are ethnically diverse and have initiated several noncredit electives directed to educate the classes as a whole on patient/medical issues encountered when dealing with specific populations. Elective courses have been offered dealing with treating the Hispanic patient, community screening and the Asian community and alternative medicine. In addition, the patient population in the greater Houston metropolitan area, as represented in the teaching clinics and hospitals, provides a rich cultural exposure to patients from all socioeconomic levels.

School of Nursing

- Community and public health epidemiology are integral components of both the *Health Promotion through the Lifespan* and *Community Health Nursing Practice* courses. These classes utilize a multidisciplinary approach in the clinical settings and application of content.

- The *Perinatal/Neonatal Nursing for Healthy and At-Risk Clients* have gone to multidisciplinary nursing teams. The problem based learning team comprises women's health, neonatal and perinatal students. Cases deal with cultural competence in the issues related to pregnancy in other cultures.

- The *Issues in Aging* course has several lectures pertaining to cultural competency and the interdisciplinary cases that accompany the course have a strong cultural component.

- There has been a change to incorporate epidemiology into the research courses on the graduate level especially in regards to the *Management of Cancer Prevention and Detection* course. The oncology clinical courses place heavy emphasis on cultural issues as they relate to cancer prevention; detection, treatment and long term/palliative care issues.

School of Public Health

- The Acres Home Community/University of Texas-Houston Health Science Partnership is a model program that works in a low-income, minority area to improve the health of citizens. The initiative furnishes opportunities for students as well as faculty to work in interdisciplinary teams. Cultural competency is a main area of instruction that students learn first hand.

- A course on *Social and Behavioral Aspects of Health* is offered to teach students about cultural competency, in addition to the Acres Home project.

- The School of Public Health's program in San Antonio has a course titled *Community-Based Assessment*. It is designed to place interdisciplinary teams of students into community settings to assist local citizen groups or health agencies to systematically assess the needs, assets and capacity of the community. Cultural competency is a feature of the course in two ways: first, the multi-ethnic, bilingual population in Bexar County is a living laboratory for the students to practice effective communication especially listening skills; and training on perspectives in the community is provided.

Dental Branch

- In the DDS curriculum didactic instruction and clinical experiences encompass community and public health, epidemiology, population-based medicine, working in multi-disciplinary teams and cultural competency.

- Over the past three or four years, the Dental Branch has restructured its behavioral science curriculum and renamed the Department of Health Promotion and Dental Care Delivery to better coordinate preventive dentistry and dental public health issues and topics. The department is now The Department of Dental Public Health and Dental Hygiene.

- The following courses and clinics provide an integrated logical approach to these areas:

  Ethics in Dentistry
  Dental Public Health Introduction to Preventive Dentistry
  Dental Public Health II-Behavioral Context-Dental Patient Management
  Communication in Dentistry
  Managing a Contemporary Dental Practice

Dental Public Health V: Planning Programs for Populations
Dental Public Health IV: Dental Public Health
The New Graduate as Manager,
Clinical Conference
Dental Public Health Clinic
Dental Public Health Clinic.

- Students enrolled in the *Dental Hygiene Community Health Course* must define a community project. To receive credit they must select an area of need, design a program and then implement it — meeting the goals and objectives.

The Compromised Dental Patient

- The Dental Branch also offers an Advanced Education Program in Dental Public Health. Students in this program interact closely with the School of Public Health. Their major focus is in the area of community and public health, epidemiology, population-based dentistry, working in multidisciplinary teams and cultural competency.

3. Has your institution implemented any new methods/programs for evaluation or testing the competency of health professionals in the above areas?

Medical School

- The Objective Structural Clinical Exam (OSCE) process and the fourth Year Competency exam are new programs using standardized patients. The programs have been implemented, but are not used exclusively to evaluate the competency of the students.

School of Nursing

- Cultural competency on the theoretical basis by use of discussion questions and case studies are used in the School of Nursing. The preceptorship students are observed regarding cultural competency during their interactions with interdisciplinary teams. Faculty visits and log entries are also evaluated.

- • Additionally, the *Community Health Nursing Practice* and the *Health Promotion through Lifespan* courses have implemented a quantitative method of evaluating students in the clinical settings. The clinical faculty for these courses

meets regularly to share methods of evaluating students' progress and work efforts. Faculty also has the opportunity to objectively evaluate the clinical components of one another's students.

School of Public Health

- The school offers outreach education to personnel in regional and county health departments, using interactive television and computer-based instruction. A total of 70 health professionals have been taught and evaluated in terms of course performance. Courses include epidemiology, biostatistics, behavioral science, environmental science, and management and policy sciences.

Dental Branch

- The DDS Program has a competency-based curriculum in which108 competencies must be met. Basic science courses provide the foundational knowledge and pre-clinical courses provide the foundational skills for the students to meet these competencies. The competency document is presently under revision by the Dental Branch Curriculum Committee.

- The Dental Hygiene Program has been competency-based for several years. Students have specific criteria that they must achieve in order to demonstrate competency.

4. Has your institution been able to increase its clinic and community-based training sties? For comparison purposes, document number and location of sites as of September 1996 and number and location of sites existing as of September 1999. What model programs does your institution have in this area?

(See Table B–3 for the list of affiliations for 1996 and 1999.)

Medical School

- The Medical School has been able to institute audio/video linkages between the Medical School and all the Harris County Hospital District community clinics at which the students are assigned. These linkages will be used to enhance the education of our students, provide community patient education sessions, and enhance community faculty education and support for patient care.

Table B-3. University of Texas Health Science Center

September 1, 1996.
Total number 221

Major

Herman Hospital
Lyndon B. Johnson General Hospital
St. Joseph Hospital,
Harris County Psychiatric Center
Texas Heart Institute,
St. Luke's Episcopal Hospital,
Memorial Hospital Southwest
San Jacinto Methodist Hospital in Baytown,
Shriner's Hospital,
Texas Children's Hospital
The University of Texas M. D. Anderson Cancer Center
Southwest Center for Occupational Health and Safety
University of Houston
Rice University,
Baylor College of Medicine
University of Houston–Downtown
Houston Baptist University
Prairie View A&M
Houston Community College
College of the Mainland (nursing);
Texas Woman's University
University of Houston
NE Louisiana State University
Louisiana State University
Wayne State University
Samaritan Pastoral Counseling Center at Clear Lake
UT Medical Branch

Other Affiliations

AMI Brownsville Medical Center
Brighton Gardens by Marriott
Affiliated Anesthesia Association
Alief Independent School District
American Medical International, Inc.
ARA Living Centers of Texas, Inc.
Associated Speech and Language Services
Baptist Hospital of Southeast Texas
Baylor University Medical Center
Bayou Glen Nursing Home
Bellaire General Hospital
Belle Park Hospital
Bering Dental Center
Blinn College
Boston University
Brackenridge Hospital
Brazos Presbyterian Homes, Inc.
Briarwood School
Brighton Garden
Brooke Army Medical Center
Brownsville Community Health Center
Cancer Counseling, Inc.
Capitol Anesthesiology Association
Casa de Ninos
Casa Juan Diego
Cenikor Foundation
Center for Multiple Handicapped Children
Center for Psychiatric Medicine
Center for the Retarded, Inc.
Center for Women's Health
Central Texas Medical Foundation
Charles University of Prague, Czechoslovakia
Charter Medical Corporation
Charter Hospital of Kingwood
Chicano Family Center
Children's Mental Health Services of Houston, Inc. Children's Respiratory Summer Camp Fndn.
Citizens General Hospital
City of Bellaire
City of Houston Health Department
City of Laredo Health Department
City of Pasadena
City of West University Place
Clarewood House
Clear Lake Hospital
College Misericordia, Dallas, Pennsylvania
Communities in Schools
Cook Ft. Worth Children's Medical Center
Creighton University, Omaha, Nebraska
Cypress Creek Hospital
Cypress Fairbanks Independent School District
Cypress Fairbanks Medical Center Hospital
Deer Park Independent Schoo. District
Denson Community Health Services, Inc.
Department of Veterans Affairs Medical Center

Depelchin Children's Center
Diagnostic Center Hospital
Easter Seal Society of Harris/Ft. Bend Counties
Epic Parkway Hospital
Fielding Institute
Fort Bend Hospital
Fourth Ward Clinic, Inc.
Frontier School of Midwifery
Georgetown University Medical Center
Golden Age Manor
Good Neighbor Health Care Clinic
Government of India
Gulf Coast Dialysis Clinic
Gulf Coast Regional Blood Center
Gunma University (Japan)
Haffkine Institute (Bombay, India)
Harris County Children's Protective Services
Harris County Health Department
Harris County Hospital District
HCA Beaumont Neurological Hospital
HCA Gulf Pines Hospital
HCA Medical Center Hospital
HCA Valley Regional Medical Center
HCA West Houston Medical Center
Heights Hospital
Hermann Park Manor
Hidalgo County Health Department
Holly Hall
Hospice Care, Inc.
Houston Area Women's Center
Houston Cardiovascular Rehabilitation Center
Houston Child Guidance Center
Houston Eye Clinic/Houston Microsurgical Center
Houston Hospice
Houston International Hospital
Houston Independent School District
Houston Northwest Medical Center Hospital
Houston Women's Health Care Center, Inc.
Independence Hall
Institute for Rehabilitation and Research
Institute of Clinical Toxicology
Institute of Hematology
Jewish Community Center
Jewish Family Service
Katy Independent School District
Kelsey Seybold Clinic, P.A.
King's College (London, England)
Klein Independent School District
Knapp Medical Center
Lamar Consolidated Independent School District
Laurel Wood Hospital
Leggett Memorial Hospital
Marriage and Family Therapy; Center for Education
McAllen Medical Center
Medical Center Del Oro Hospital
Memorial City General Hospital Corporation
Memorial Hall School
Memorial Hospital System
Mental Health and Mental Retardation Authority of Harris County
Methodist Hospital
Methodist Retirement Services, Inc.
Mission Hospital
Mississippi Medical Center
Montgomery County Hospital District
Montgomery County Medical Education Foundation
Montrose Clinic
National Institutes of Health, Clinical Center
National Multiple Sclerosis Society
New Age Hospice of Houston, Inc.
North Forest Independent School District
North Harris Montgomery Community College
Obstetrics and Gynecology Associates
Outpatient Healthcare, Inc. *dba* Travis Center
Outpatient Surgery
Park Plaza AMI Hospital
Pasadena Bayshore Medical Center
Pasadena Independent School District
Planned Parenthood Center
Procare Health Services
Renilda Hilkemeyer Child Care Center
Rio Grande Regional Hospital
Rosewood General Hospital
Sam Houston Memorial Hospital
Sam Houston State University
San Jacinto College District
San Jacinto College South
San Jose Clinic
Seven Acres Jewish Geriatric Center
Sharpstown General Hospital
Shell Oil Co.—DPMC
Sheltering Arms
Sickle Cell Association of the Texas Gulf Coast
South Texas Hospital
Southwest Community Health Clinic
Spring Branch Independent School District
Spring Branch Memorial Hospital
Spring Shadows Pines Residential Care Facility

St. Dominic Nursing Home
St. Elizabeth Hospital
St. John's School
Stafford Meadows Hospital
Stephen F. Austin University
Tel Aviv University (Israel)
Tenneco, Inc.
Texas Department of Health
Texas Department of Mental Health/ Mental Retardation
Texas Department of Public Health
Texas Home Health, Inc.
Texas Institute for Behavioral Medicine and Neuroscience
Texas Institute for Reproductive Medicine and Endocrinology, P.A.
Texas Tech University Health Sciences Center
The Forum at Memorial Woods
The Hospice at the Texas Medical Center
The Shoulder, Inc.
Timberlawn Psychiatric Hospital
Tokyo Dental College
Tomball College
Tomball Community Hospital
Tripler Army Medical Center, Hawaii
US Public Health Service Hospital
US Sports Academy
United Way Family Services Association
University of California at San Francisco, Fresno at Atascadero State Hospital
Universidad de Chile (Santiago, Chile)
Universidad de Guadalajara (Mexico)
University of New England
University of Texas at Austin
University of Texas Health Science Center at San Antonio
Urban Affairs Corporation, Inc.
Valley Baptist Medical Center
Valley Regional Medical Center
Veterans Administration Medical Center
Villa Northwest Convalescent Center
Village Women's Clinic
Visiting Nurses Association
West Houston Medical Center
West Oaks Hospital
Westbury Hospital
The Woman's Hospital of Texas
Women's Center
Woodlands Place Nursing Center, Inc.
YMCA at Texas Medical Center
York Plaza Hospital

September 1, 1999
Total 199
Major

Memorial Hermann Hospital
Memorial Hermann Children's Hospital,
Lyndon B. Johnson General Hospital
The University of Texas M. D. Anderson Cancer Center;
St. Joseph Hospital;
Harris County Psychiatric Center;
St. Luke's Episcopal Hospital; Memorial Hermann
Southwest Hospital;
Shriners Hospital for Children-Houston;
Texas Children's Hospital
The Texas Institute for Rehabilitation and Research (TIRR).
Veterans Administration Medical Center;
Ben Taub Hospital
Methodist Hospital
Spring Branch Medical Center.
Southwest Center for Occupational Health and Safety
University of Houston,
Rice University,
Baylor College of Medicine
College of the Mainland
Houston Baptist University
Prairie View A&M (nursing)
Houston Community College
Texas Woman's University
Lee College
Stephen F. Austin University
UT Medical Branch
UT-Austin
Texas Southern University
San Jacinto College South
Sam Houston University
DeBakey High School for Health Professions

AMI Brownsville Medical Center
Brighton Gardens by Marriott
Affiliated Anesthesia Association
Alief Independent School District
American Medical International, Inc.
ARA Living Centers of Texas, Inc.
Associated Speech and Language Services
Baptist Hospital of Southeast Texas
Baylor University Medical Center
Bayou Glen Nursing Home
Bellaire General Hospital
Belle Park Hospital
Bering Dental Center
Blinn College
Boston University
Brackenridge Hospital
Brazos Presbyterian Homes, Inc.
Brairwood School
Brighton Garden
Brooke Army Medical Center
Brownsville Community Health Center
Cameron County Health Department
Cancer Counseling, Inc.
Capitol Anesthesiology Association
Casa de Ninos
Casa Juan Diego
Cenikor Foundation
Center for Multiple Handicapped Children
Center for Psychiatric Medicine
Center for the Retarded, Inc.
Central Texas Medical Foundation
Charles University of Prague, Czechoslovakia
Charter Medical Corporation
Charter Hospital of Kingwood
Chicano Family Center
Children's Mental Health Services of Houston, Inc. Children's Respiratory Summer Camp Fndn.
Citizens General Hospital
City of Bellaire
City of Houston Health Department
City of Laredo Health Department
City of Pasadena
City of West University Place
Clarewood House
Clear Lake Hospital
College Misericordia, Dallas, Pennsylvania
Communities in Schools
Community Partners–Rusk Elementary School
Cook Ft. Worth Children's Medical Center
Creighton University, Omaha, Nebraska
Cypress Creek Hospital
Cypress Fairbanks Independent School District
Cypress Fairbanks Medical Center Hospital
Deer Park Independent School District
Denson Community Health Services, Inc.
Department of Veterans Affairs Medical Center
Depelchin Children's Center
Diagnostic Center Hospital
Easter Seal Society of Harris/Ft. Bend Counties
Epic Parkway Hospital
Fielding Institute
Fort Bend Hospital
Foundation for Orthopaedic Athletic and Reconstructive Research
Fourth Ward Clinic, Inc.
Frontier School of Midwifery
Georgetown University Medical Center
Golden Age Manor
Good Neighbor Health Care Clinic
Government of India
Gulf Coast Dialysis Clinic
Gulf Coast Regional Blood Center
Gunma University (Japan)
Haffkine Institute (Bombay, India)
Harris County Children's Protective Services
Harris County Health Department
Harris County Hospital District
Harris County Jail
Harris County Psychiatric Center
HCA Beaumont Neurological Hospital
HCA Gulf Pines Hospital
HCA Medical Center Hospital
HCA Valley Regional Medical Center
HCA West Houston Medical Center
Heights Hospital
Hermann Park Manor
Hidalgo County Health Department
Holly Hall
Hospice Care, Inc.
Houston Area Women's Center
Houston Cardiovascular Rehabilitation Center
Houston Child Guidance Center
Houston Community College System
Houston Eye Clinic/Houston Microsurgical Center
Houston Hospice
Houston International Hospital
Houston Independent School District

Houston Northwest Medical Center Hospital
Houston Women's Health Care Center, Inc.
Independence Hall
Institute for Rehabilitation and Research
Institute of Clinical Toxicology
Institute of Hematology
Interfaith Ministries
Jewish Community Center
Jewish Family Service
Katy Independent School District
Kelsey Seybold Clinic, P.A.
King's College (London, England)
Klein Independent School District
Knapp Medical Center
Lamar Consolidated Independent School District
Laurel Wood Hospital
Lee College
Leggett Memorial Hospital
Louisiana State University
Marriage and Family Therapy; Center for Education
McAllen Medical Center
M. D. Anderson Cancer Center
Medical Center Del Oro Hospital

Dental Branch

- The community-based training activities for the Dental Branch have decreased over the last few years due to a loss in the DDS class sizes.

School of Public Health

- The School of Public Health places a particular emphasis on giving students community-based experience at supervised training sites. All M.P.H. and Dr.P.H. students are expected to have a planned, supervised and evaluated practice experience that applies the knowledge and skills acquired through course work.

- Effective July 1999, the School's community based Public Health Program completed its program website. This site includes a newly constructed access database, which enhances the student's ability to search for appropriate internship sites as well as the program's ability to organize and analyze information, including the number of clinic and/or community-based training sites available for practica.

- The *American Cancer Society (ACS) Collaborative Evaluation Fellows Project* has received a foundation grant to fund evaluation projects that are carried out by students in the school of public health in collaboration with local ACS units.

- The *Health Policy Internship* provides staff services to Texas Legislators during the fall and spring semester. UT-HSPH sponsoring faculty provides academic supervision, technological assistance, and consultation to the student and legislator to whom they are assigned on health topics related to the intern's assigned responsibility. Four competitive internship opportunities are offered every other year and coincide with the Texas State legislative session.

- The *Comparative Health Care Internship Program* in London, England is a joint program between Richmond, the American International University in London, and the University of Texas Health Science Center Houston. The ten-week program takes place in London from June 2, 2000 to August 12, 2000. Seminars with preceptors are planned for the entire group during the first two weeks of the program and often include discussions and meetings held regularly at the London School of Hygiene and Tropical Medicine. Participation in this program will allow the student to expand their knowledge of health care in another country, to develop their research expertise and to deepen their knowledge of specific aspects of health care.

5. Are your medical and nursing schools using the Agency for Health Care Policy and Research Putting Prevention into Practice (PPIP) concepts and resources (e.g. Health Risk Profile)? How are they being used? PPIP materials can be accessed through the AHCPR website: www. ahcpr.gov/ppip/

The Medical School gives the faculty the PPIP guidelines for the development of course materials. The school also offers a prevention course within the family practice curriculum for fourth year students. The course provides the student with experience related to primary prevention, screening, risk factor assessment and consultation related to lifestyle management.

6. What state or legislative policy recommendations (besides increases in funding) would be instrumental in promoting the accomplishment of the Goal and Objective for the state of Texas?

- Create state-funded preventive medicine residencies for physicians through the Texas Department of Health and Higher Education Coordinating Board.
- Require a prevention component as a part of all CNE/CME (Continuing Nurse Education/Continuing Medical Education) training overseen by the Board of Nursing Examiners and Board of Medical Examiners, respectively.
- Encourage all health professions education programs in the state to include a prevention module or component in their curriculum, if there isn't one already.

- Before health care providers can become Medicaid providers, require them to indicate how they would emphasize prevention when caring for patients.

7. How would your institution use increases in funding to advance this Goal and Objective at your institution?

- Support the research activities of the Texas Prevention Research Center; particularly those research projects that focus on prevention in a culturally and ethnically competent manner.
- As a part of the Society and Health Initiative, UT-Houston would focus on *population* related prevention research, which contrasts with most prevention research that focuses on the *individual* as the key to prevention. The population focus can identify and explicate those societal factors that can be important in preventing illness and disease. Components of this research agenda might include the following:
- Population prevention research funding for junior faculty and post-doctoral fellows wishing to pursue this type of research.
- Community health center pilot to study and assess population-level prevention interventions.
- Since the University is in the midst of considering recommendations regarding Interdisciplinary Health Professions Education (e.g., the SACS Study), funds could be used to support those components of the curriculum that relate to or focus on prevention training. For example, prevention-related cases and projects could be supported and included in both the 'Frontiers of Interdisciplinary Care' course and the 'Practice of Interdisciplinary Health Care' practica.

UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO:
Medical School
Dental School
School of Nursing
School of Allied Health Sciences

1. What efforts/initiatives have been taken to emphasize prevention in your institution's health professions education and training?

Medical School: Topics on disease prevention are presented throughout the four-year curriculum in the Medical School and are discussed with appropriate disease categories. Students also learn the practical application of disease prevention in multiple outpatient clinics where they learn how to discuss and implement preventive interventions.

Dental School: There are several major areas of prevention that are emphasized in the Dental School: Dental caries/ periodontal disease, oral cancer, injury prevention and general health (evidence of hypertension, excessive sun exposure, tobacco use, substance abuse, physical abuse (child or adult), or other issues that are noted on patient's medical, dental and social histories or found on a clinical exam. All departments are involved in these efforts in one way or another, but certain departments take the primary responsibility. These are Community Dentistry (caries), Periodontics (periodontal disease), Dental Diagnostic Science (history and exam finding for oral cancer and general health), General Dentistry (follow up on all areas in the senior year) and Pediatric Dentistry (for all the above in children). Injury prevention is covered in Prosthodontics (mouth guards for sports injuries), Oral Surgery (general trauma), Endodontics (injury to teeth) and Pediatric Dentistry (trauma for children). Freshman students learn about preventive dentistry for individuals and the community, and general physical evaluation. Students also go to elementary schools to monitor a fluoride rinse program. Sophomore students build on their didactic work from the freshman year and learn how to do a caries risk assessment, how to incorporate a nutritional analysis into the caries risk assessment and how to evaluate the periodontium. Junior students do a complete history and head and neck exam, a caries risk assessment, and a periodontal assessment on all their patients. They develop a specific preventive plan for caries, instruct patients on removing

plaque and calculus, and counsel or refer patients with other problems where preventive intervention would be important. They also have a rotation to an elementary school where they place sealants in children's teeth. The senior students incorporate all they have learned into the management of their patients.

School of Nursing: The School of Nursing has always had an emphasis on community assessment in order to focus on illness prevention and health promotion activities to enhance student learning. Clinical learning activities such as screening skills (hearing testing, vision screening, scoliosis screening), nutrition assessment and patient teaching are emphasized as educational threads in every course.

Prevention is a primary educational thread in all five graduate program clinical majors. Prevention and educational teaching are emphasized for the individual, family, and the community. Health Fairs are frequently used educational tools that allow students to put education into practice.

School of Allied Health: Prevention and health promotion always have been hallmarks of the allied health professions. Even the various accrediting bodies require theory and practice in health promotion and prevention strategies for individuals and populations. Examples of our activities other than the traditional classroom instruction include:

a. Health screenings for diabetes/anemia at community events and at UTHSCSA sponsored events.
b. All departments present health promotion and prevention strategies to the public at health fairs throughout the San Antonio and South Texas Region.
c. The Department of Emergency Medical Technology sponsors a citywide educational program at a shopping mall at which citizens are taught Basic Life Support techniques.
d. Dental hygiene students and faculty conduct oral cancer screenings and topical fluoride application programs are conducted at area schools and centers.
e. A research project was completed by the Department of Respiratory Care which demonstrated that a disease management strategy, utilized by the respiratory therapist in the home, improved the health of children with severe asthma. The technique also reduced the economic impact of the disease by reducing the number of hospital days, emergency room visits, and office calls. This is prevention and health promotion.

f. Occupational Therapy provides community-based instruction on measure to prevent birth defects and the impact of deprived environments on the development of infants and young children.

g. Occupational Therapy and Physical Therapy provide community-based instruction on proper body mechanics at work to prevent work-related injuries.

h. Smoking cessation, weight control and diabetes management programs are conducted by allied health faculty and students.

2. *What curriculum changes have been made in the areas of community and public health, epidemiology, population-based medicine, working in multi-disciplinary teams, and cultural competency? Does your institution have model programs in curriculum for any of the above?*

Medical School:

Community and Public Health - Fourth year medical students have an opportunity to accomplish a four week elective with Dr. Claudia Miller, Associate Professor, Department of Family Practice. This elective stresses health concerns in the Texas/ Mexico border region and students have a first hand experience in public health and the environment in a community setting. First year students are paired with a community physician with whom they work one afternoon every five weeks.

The Family Practice Clerkship (mandatory six weeks) in the third year stresses preventive medicine and medical students must complete projects in this area.

Epidemiology - There is a mandatory six-week course in epidemiology for the fourth year medical students.

Cultural Competency – The Medical Hispanic Center of Excellence under the direction of Dr. Martha Medrano, is developing a curriculum for cultural competency. In addition, the first year medical students are introduced to this topic with example case scenarios. This occurs within the new Clinical Integration Course.

Dental School: We are in the process of a curriculum review. Before the review was undertaken, guiding principles for the Dental School curriculum were established by the Curriculum Planning Committee and endorsed by the faculty council. One of these principles states that the dental education program.... "will reflect a

philosophy of preventive oral health and health promotion for communities and individuals." As we evolve our curriculum, this guiding principle will be a goal.

School of Nursing: The School of Nursing undergraduate program curriculum has always had a semester long community health nursing course that focuses on community assessment, epidemiology, disease prevention, and cultural effects of health and illness. The undergraduate curriculum is currently under revision. A community-based curriculum is being developed.

The graduate nursing curriculum offers a number of community and public health focused programs and courses. The addition of the Master of Science in Nursing and Master of Public Health (MSN /MPH) dual degree graduate program major allows nurses in any clinical major to earn a MPH with fewer credit hours. Family Nurse Practitioner and Community and Health Care Systems in Nursing majors have coursework focusing on assessment of populations and communities. Family Nurse Practitioner and Pediatric Nurse Practitioner clinical major courses include objectives that focus on epidemiology and cultural competency. A graduate core course, Nursing Leadership, includes objectives on cultural competency and on multi-disciplinary teamwork. Elective courses are available to all graduate and undergraduate students: Pain Management, Death and Dying, Hispanic Health Care, Courses specific to several clinical majors that focus on population-based health care: Social Cultural Concepts in Public Health in the MSN/MPH major and Public Health Sciences in the Family Nurse Practitioner major.

School of Allied Health: Student clinical and fieldwork experiences have moved from tertiary care centers, such as hospitals, to include many more experiences with community-based health agencies. Such agencies include community health centers, public health clinics and agencies, environmental health agencies, skilled nursing facilities, home health care agencies, etc. However, it should be noted that allied health is experiencing major critical changes with agencies that have been faithful in providing student clinical instruction. The Balanced Budget Act of 1997, some managed care programs, and HCFA regulations have greatly affected the economic aspects of clinical instruction. Agencies have no incentive to participate in health professions student education. In fact, they will be economically penalized for having students in their facility. This has a direct negative impact on our educational programs.

The use of multidisciplinary teams is reflective of quality patient care. Students in allied health have opportunities to take core classes together, such as ethics and statistics. The faculty is now working on clinical assignments and affiliation agreements with agencies that will place students from various professions in the same environment for patient care. Due to the complication of multiple schedules for eight different departments, significant calendar changes need to be made for such clinical experiences to be successful. However, this is a necessary and integral part of the future curriculum for allied health professions students.

Cultural competency is critical in our community and in our educational programs. Such content is included in coursework and in clinical practice. Medical Spanish is a part of our educational efforts as an elective for those who do not speak Spanish.

Model Program: Respiratory Care has developed a model program for the management of asthmatic children. The program and model is being presented at the American Association of Chest Surgeons in October 1999. Texas Medicaid is now reimbursing respiratory care due to the success of this approach.

3. Has your institution implemented any new methods/programs for evaluating or testing the competency of health professionals in the above areas? Please describe.

Medical School: We have not implemented any new methods/programs for evaluating or testing health professionals.

Dental School: The Dental School requires dental students to demonstrate competency in obtaining and evaluating the medical history, taking and evaluating vital signs, and performing a complete head and neck exam including radiographs and a cancer-screening exam. They must be able to take all the information and make a diagnosis and develop a plan for management and/or referral. Students also must demonstrate competency, specifically, in assessing caries risk and periodontal disease and developing and implementing a prevention plan. Students must discuss with patients the findings, the recommendations for therapy, alternate treatment plans and risks and benefits for all options. Competency criteria have been developed and students are evaluated accordingly.

School of Nursing: The Masters program has developed criteria based on stated terminal objectives that evaluate therapeutic nursing interventions, communication, and critical thinking. These areas are evaluated at the end of the student's final clinical course by the student as self-evaluation, the supervising faculty, and the student's preceptor.

The undergraduate program is currently piloting a partnership program using competency based testing.

School of Allied Health: No new evaluation programs have been developed. The only exception is the measures used to assess the outcomes of disease management techniques for children with asthma.

4. Has your institution been able to increase its clinic and community-based training sites? For comparison purposes, document number and location of sites existing as of September 1999. What model programs does your institution have in this area?

Medical School: The only significant addition of clinical sites are the approximately 100 community physicians in San Antonio that teach first year medical students in their offices/clinics for five half-days per year.

Dental School: (See Table B-4.)

School of Nursing: Both the undergraduate and graduate programs have initiated model training programs:

The undergraduate nursing program has initiated a Bridge program at University Health Care System where students are paired with a Registered Nurse in a nursing area of their choice. These students are then usually hired to work at University Health Care System after graduation. Other similar partnerships that enhance student learning are in place at both the Methodist Health Care System and Hospice of San Antonio and South Texas.

Graduate nursing students have partnered with graduate students from the School of Public Health in a jointly taught community assessment course.

The School of Nursing had 231 student clinical and training sites/agencies in September 1996. In September 1999, there are 281 such sites/agencies.

Table B-4. Texas Statewide Health Coordinating Council Effort Report

4. Has your institution been able to increase its clinic and community-based training sites? For comparison purposes, document number and locations of sites as of September 1996 and number and location of sites existing as of September 1999. What model programs does your institution have in this area? None,

UTHSCSA DENTAL SCHOOL
CLINICAL & COMMUNITY-BASED TRAINING SITES

Training Site/Location	FY 1996	FY 1997	FY 1998	FY 1999
Alamo Area				
Clinical Training Sites	10	11	10	9
Hospital Training Sites	3	5	5	5
School-Based Training Sites	11	11	25	31
Community Agency Train Sites	0	1	3	3
Other/Private Practice Train Sites	N/A	40	82	88
Nursing Home Facility/Train Sites	3	2	1	N/A
University/Training Sites	2	2	1	0
WGB Area				
Clinical Training Sites	1	2	3	3
MRGB Area				
Clinical Training Sites	3	3	6	7
LRGV Area				
Clinical Training Sites	7	6	6	5
School-Based Training Sites	0	1	0	0
East Texas Area				
Hospital Training Sites	N/A	1	2	2
Other/Private Practice Train Sites	N/A	1	4	4
Southwest Texas Area				
Clinical Training Sites	0	0	0	2
Other Texas Area				
Clinical Training Sites	2	4	1	3
Other/Private Practice Train Sites	N/A	33	37	36
University/Training Sites	1	1	1	1

N/A = Not Available

School of Allied Health: The numbers of clinical and community-based training sites remain somewhat constant over time. In 1996, we had approximately 450 affiliation sites and in 1999 we have over 575. One reason for an increase includes the desire to move from hospital and tertiary care settings to community-based settings. The most influential reason numbers of community-based sites have increased is the inclusion of two new academic programs between 1996 and the present: respiratory care and physician assistant studies. The PA program alone has increased the number of preceptorship sites by about 58. They include community-based clinics and private physician practices. With the exception of occupational therapy and physical therapy, our clinical and community sites are throughout South Texas, including many border communities. OT and PT have clinical sites throughout the region and country. It should be noted that most certification, registration and licensure examination for allied health professionals include questions and scenarios related to community-based intervention programs, public health measures, epidemiology, and cultural competency.

5. Are your medical and nursing schools using the Agency for Health Care Policy and Research Putting Prevention Into Practice (PPIP) concepts and resources (e.g. Health Risk Profile)? How are they being used? PPIP materials can be accessed through the AHCPR website: www.ahpr.gov/ppip/.

Medical School: We have not yet begun to utilize the resources from the Agency for Health Care Policy and Research Putting Prevention Into Practice (PPIP).

Dental School: Not Applicable

School of Nursing: As part of Community Health Nursing course, every student plans and implements a teaching project in some area related to disease prevention, health promotion, and health education. Examples of such projects:

Nutrition for health and health promotion
Exercise for health promotion
Violence Prevention
Student teaching projects
Teaching bicycle helmet safety
Seat belt use

Teaching the importance of Immunizations for personal and public health
Breast self exam; Testicular self evaluation
Environmental safety
How each individual can contribute to preventing Ozone Days
Pesticide use and its effect to the individual, the environment, and the world
Testing water supply - people who use well water
Food safety

Nursing student association groups conduct volunteer projects that emphasize prevention and health promotion. For example, students from one nursing association mentor high-risk, low-income students in one elementary school. Their projects range from nutritional information and healthy eating habits to seat belt safety.

School of Allied Health: Not applicable at this time.

6. What state or legislative policy recommendations (besides increases in funding) would be instrumental in promoting the accomplishment of this Goal and Objective for the state of Texas?

Medical School: State or legislative policy recommendations are not necessary to accomplish this Goal and Objective for the State of Texas. These are important issues that will be addressed and accomplished.

Dental School: No Response

School of Nursing: Increased partnerships between educational institutions and community organizations like schools/ churches/ businesses/ and organizations such as Rotary Clubs and Chambers of Commerce.

Depending on the size of school district, there should be at least one school based health clinic with a nurse practitioner for every four schools.

School of Allied Health: Provide financial incentives, like tax credits, etc., for community-based health agencies and clinics to accept allied health students into their facilities for clinical and patient care instruction. This partnership has to be

solidified and enhanced if allied health education in Texas is to survive the many changes in federal regulation, etc. New ways of clinical instruction may have to be found. Provide targeted curriculum recommendations for the unique and common medical problems in Texas. Simplify the application process for all State-managed healthcare programs, i.e., CHIP, WIC, etc. Make needed health-related statistics easily accessible to educational programs and health care providers so that targeted efforts may be more easily measured and assessed. Healthy Community 2010 is a good example, but for our specific needs.

7. How would your institution use increases in funding to advance this Goal and Objective at your institution?

Medical School:
The Medical School would utilize increases in funding to hire faculty and staff in order to accomplish this Goal and Objective.

Dental School: No Response

School of Nursing: Increase in funding would allow the School of Nursing to establish school-based clinics where Family Nurse Practitioner and Pediatric Nurse Practitioner students could practice as well as teach. Undergraduate students could also use their clinics to practice health promotion and offer health promotion classes to students, parents and teachers. School based clinics are excellent sites for conducting clinical research. School of Nursing faculty can serve as consultants in the establishment of school-based clinics. School of Nursing Faculty and students could practice and teach in these clinics.

Increase research being conducted at the School of Nursing to determine the effectiveness of current educational/ prevention strategies and interventions.

School of Allied Health: Increases in funding would be used to conduct research concerning interdisciplinary primary and secondary intervention programs. For instance, we were funded in 1994 for a primary intervention program aimed at preventing diabetes in Mexican-American children. We had a variety of health professionals participating as well as Clinical Laboratory Science students A UT System program similar to the one they offer for grants in distance education could be very

helpful to get such programs off the ground or expanded. We would use additional funding to conduct more research studies on the relationship of disease management and overall health and prevention of sequelae to common diseases found in Texas. We need to conduct many more studies like the study conducted on children with asthma and diabetes. This is the key to allied health contributions in prevention and health promotion. It also provides economic savings to the state, payor and patients. Increase community-based educational programs with other educational institutions. UTHSCSA has an obligation for all of South Texas. The School of Allied Health Sciences would link with educational partners, like community colleges and other UT system institutions, to increase community-based health promotion efforts and community-based intervention projects. Hire an epidemiologist to work specifically with allied health faculty for evaluation efforts and research design to improve our efforts. Several UT allied health schools could share such a person. We could communicate through technology, etc., but the expertise is needed. Costs could be kept to a minimum.

UNIVERSITY OF TEXAS MEDICAL BRANCH IN GALVESTON:
School of Medicine
Preventive Medicine and Community Health
School of Nursing Baccalaureate Program and Master's Nursing Program
School of Allied Health Sciences

1. What efforts/initiatives have been taken to emphasize prevention in your institution's health professions education and training?

Medical School: The Master of Science Program in Preventive Medicine and Community Health (PMCH) has been remodeled to meet the accreditation criteria of the Council on Education in Public Health (CEPH) as an MPH equivalent. This program in public health emphasizes population-based approaches to promoting community health and is oriented to preparing physicians in our three Preventive Medicine Residency Programs along with selected other licensable health professionals such as nurses.

The department's CATCHUM Project is a consortium of the eight Texas Medical Schools dedicated to educating undergraduate medical students about cancer prevention and screening. Based at the University of Texas Medical Branch Educational Cancer Center and the Department of Preventive Medicine and Community Health, the CATCHUM Project is funded by the National Cancer Institute (Grant # 1 R25 CA65618). It provides, through the Internet (hftp://www.catchum.utmb.edu/index.htm) traditional educational resources on various topics in a variety of formats ranging from lectures to problem-based learning. Assessment and evaluation materials are also located on the web page ranging from objective knowledge tests to objective structured clinical examinations. Faculty development programs are offered annually on pertinent topics (clinical preceptor training in 1999) and links to and other resource materials are available for downloading.

- The Graduate Program in Preventive Medicine and Community Health has established curricula in Environmental Toxicology, Socio-medical Sciences, Human Nutrition, Compartmental Modeling, Rehabilitation Science, Clinical Science, and Preventive Medicine (MPH Equivalent). In addition to its regular

courses, the program offers short courses in Aerospace Medicine, Occupational Medicine, and Correctional Health. Routine Grand Rounds are presented in Aerospace Medicine, Occupational Medicine, and General Preventive Medicine. In the Medical School, much of the material presented in the traditional Department based course has been integrated into the *Practice of Medicine* course, which runs throughout the entire first two years of the curriculum. The Environmental Toxicology material presented in the traditional course is now included in the *Pathobiology* Course.

- PIVICH sponsors and participates in several initiatives that emphasize the importance of prevention and public health strategies in health professions training.
- The *Commit to Quit* program provides strategies for smoking cessation through classes and individual counseling, and also provides education for health professionals and the general public on the dangers of smoking and smoking cessation.
- PIVICH has collaborated with the Galveston Partnership for Better Living, a community-based non-profit organization, to develop a "Children's Report Card" and a "Seniors' Report Card" that provide valuable statistical and demographic information used by health care professionals to improve the health of targeted groups in the community.
- The Department also sponsors the "Galveston Safety Net", an internet-based social and health care services directory that is used by local health care providers for resource and referral.
- PMCH, in cooperation with the Department of Surgery, has developed an Injury Prevention Program that routinely provides information to health professionals, students and the general public.
- Our Toxics Assistance Program has collaborated with the East Texas Area Health Education Centers (AHEC) under a contract from the Agency for Toxic Substances and Disease Registry (ATSDR). Through this project, a curriculum was developed for one-day workshops to educate physicians and other primary health care providers on issues related to diagnosis, prevention and treatment of illnesses caused by exposure to toxic substances in the environment.
- PIVICH sponsors the "Tar Wars" program for Galveston Independent School District 5th Grade classes, in cooperation with the Texas Department of Health and the American Academy of Family Physicians. While the program targets

smoking prevention for students, it also provides training for schoolteachers, counselors and administrators.

School of Nursing:

- The baccalaureate nursing course, *Nursing: The Community*, emphasizes a shift from care at the individual and family level to aggregate level care and program planning. The focus of planning care and programs for aggregates is primary prevention. The levels of prevention are emphasized in this course and in other senior nursing level courses as well, such as mental health nursing, but are introduced in the early phases of the baccalaureate-nursing curriculum as well.
- The Master's Program for nurse practitioners in primary care has had a strong health promotion and community component for over ten years. It is considered a "pioneer" program for this emphasis. All students enrolled in the primary care track complete a community assessment, analyze the data, develop a program plan, and prepare a proposal for funding of the proposed program. This process is continued over a one-year period in conjunction with the clinical application courses.

School of Allied Health Sciences: The SAHS programs have incorporated units of health/prevention issues in to many of their courses. Students participate in community activities to foster prevention e.g. health fairs.

2. *What curriculum changes have been made in the areas of community and public health, epidemiology, population-based medicine, working in multi-disciplinary teams, and cultural competency? Does your institution have model programs/curriculum for any of the above?*

Medical School: Starting in the fall of 1998, the Medical School initiated a problem based learning curriculum that replaced a lecture-based curriculum with one that uses small groups, minimal lectures, and a variety of other student directed learning activities. This provided the opportunity to take the Preventive Medicine topics that were primarily taught in a ten week concentrated block to be integrated into the entire first two years of medical school education. For example, this meant that topics such as Smoking Prevention and Cessation could be taught in the context of the study of the pulmonary system. Within the *Practice of Medicine* course,

biostatistical topics that permit students to appreciate and critically read the medical literature are presented early on, rather than at the end of the second year in the PM&CH course block. The Environment Toxicology section of the PM&CH course block is now presented as part of the Patho-biology course. The goal is to integrate Preventive Medicine topics into the curriculum so they are introduced as a natural part of the practice of medicine rather than a distinct stand-alone topic that could be compartmentalized outside the mainstream of medical practice.

Course Title: *Epidemiology in Action* (Graduate School of Biomedical Sciences)

Description: This course is a bifurcated course with lectures provided by experts in the field of public health practice affiliated with the Centers for Disease Control and Prevention through Emory University. This segment will cover the following topics: Descriptive epidemiology and biostatistics, Analytic epidemiology, Epidemic investigations, Public Health surveillance, Interpretation and communication of data, Surveys and sampling, Computers and Epidemiologic Information training, and Discussions of selected prevalent diseases. In conference and discussion, these topics will be expanded to cover operational aspects of epidemiologic investigations, interventions, the communication of findings particular to the public and media outlets, and special topics such as investigations in health care facilities, childcare environments, and international venues.

Learning Strategies: The text to be used in the first segment is *Epidemiology of Public Health Practice* by Friis/Sellers. Each presenter will individually distribute handouts and articles on specific topics. The text to be used in the second segment is *Field Epidemiology* by Gregg. Case study problems on epidemiology and surveillance will be worked-on and facilitated by MD/Epidemiologists at CDC, UTMB - Galveston, or the Galveston Health District. Status: New elective course. Offered: Fall, annually

Course Title: *Community Health Practice* 1 - 2 credits (fall - semester) & *Community Health Practice* 2 - 2 credits (spring - semester) (Graduate School of Biomedical Sciences)

Description: The expectation is that the student will integrate the information learned in the academic curriculum in the context of a hosting organization that

is concerned with an aspect of public health in various environments such as communities, workplaces, or institutions. This will be accomplished through systematic analysis of issues, incorporation and appropriate use of data, and applications of subject matter expertise contained in the MPH equivalent curriculum (such as biometry, epidemiology, social and behavioral sciences, management and policy sciences, and environmental sciences). Learning Strategies: Lecture, discussion. Status: New required course Offered: Fall & Spring, annually

Course Title: *Issues in Preventive Medicine and Public Health* (Graduate School of Biomedical Sciences)

Description: This course is designed to provide theoretical and practical information that will prepare the student to participate in leadership roles in the delivery of modern population-based preventive services and public health programs. Learning Strategies: Lecture, discussion Status: Remodeled required course Offered: Spring, annually

School of Nursing: Baccalaureate nursing education has a long history of including public health concepts as part of the curriculum. The current baccalaureate-nursing curriculum includes community/public health concepts such as epidemiology, population-based nursing, working with interdisciplinary teams, and attention to cultural competence. The public health nursing course, *Nursing: The Community*, requires students to conduct a community assessment and plan a primary prevention project based on identified community needs. A poster session highlights their proposed intervention project at the end of the course. Last year (1999), three baccalaureate-nursing students attended the American Public Health Association meeting in Washington, DC and participated in the Public Health Nursing Section student poster session. Two of the UTMB student posters received first and second place student poster awards.

Another example is a learning strategy highlighting work with interdisciplinary teams in the Rehabilitation and Home Health course. In this course, students visit patients in their home and work with the inpatient interdisciplinary team to coordinate care and follow-up.

The Master's program for nurse practitioners in primary care includes community and public health, epidemiology, population-focused practice, working with multidisciplinary teams, and a focus on cultural competency. Much of this content is incorporated into the three-course sequence, *Community as Partner,* which includes the process of working with the community to determine needs and strengths and developing a program to address those needs. These courses have been part of the curriculum of over ten years. The sequence of courses serves as a model for nurse practitioner programs across the U.S. The courses are being used in a National Organization of Nurse Practitioner Faculty (NONPF) project to determine how to integrate such content into all nurse practitioner education.

In order to make the course more accessible to our numerous commuter students (we've had commuters from El Paso to New Orleans and from Nacogdoches to Laredo), the three-course community health sequence was adapted for delivery on the worldwide web last year. All students who take the course now do so on the web. To date outcomes of theses courses are similar to the traditional classroom, face-to-face, method.

School of Allied Health Sciences: The SAHS has completed an 18-month project "Curriculum 2000 Taskforce." This taskforce identified common competencies in these areas needed by all health providers. The next phase is implementation of these competencies across the school curriculum. Programs used interdisciplinary case histories for discussion.

3. Has your institution implemented any new methods/programs for evaluating or testing the competency of health professionals in the above areas? Please describe.

Medical School: The CATCHUM Project has an online testing service in the area of cancer epidemiology, risk factors, prevention, and clinical detection and screening. Learners log on take an objective knowledge test and receive a score with a reading list linked to concepts that need remediation. Additionally, there are Objective Structured Clinical Examinations on the 13 most prevalent cancers seen in clinical encounters that allow assessment of competence in clinical prevention and screening.

School of Nursing: No. Evaluation is primarily at the course level; however, long-term follow up of graduates would illustrate the use of the community-focused

concepts in practice. The date, such information is anecdotal (e.g., the graduate whose first assignment at her new position in the Valley was to do a needs assessment and write a grant which she did successfully. Or the graduate in El Paso whose needs assessment lead to the opening of a clinic for indigent children).

4. Has your institution been able to increase its clinic and community-based training sites? For comparison purposes, document number and location of sites as of September 1996 and number and location of sites existing as of September 1999. What model programs does your institution have in this area?

Medical School: The Piney Woods AHEC and The Department of Preventive Medicine and Community Health at UTMB-Galveston are partners in developing a community based cancer prevention and early detection model program for rural East Texas. The Community-based Cancer Prevention and Control Program is a pilot program funded by the Texas Cancer Council. The program is being delivered at work sites through a network of employers. One employer in each of four targeted counties has been selected to participate in the pilot program. Cancers targeted by the program include lung, breast, prostate, colorectal, and skin. The project addresses the need for the adoption of more healthful lifestyles and habits of daily living and includes educational programs on tobacco cessation, nutrition, alcohol/drug use, stress/coping, sun awareness, and screening. A cancer health risk assessment is also being given to employees at each site and is being used to help tailor cancer prevention programs specific to each company and as a baseline assessment measure. In addition, the program includes a parallel continuing education program for health care providers aimed at increasing cancer detection activities by promoting age, gender, and ethnicity specific screening appropriate to the needs of the participants.

The PIVICH *Commit to Quit* smoking cessation program provides community based "train the trainer" training sessions through a partnership with the East Texas AHEC program. Health care professionals are trained to conducting smoking cessation programs in their local communities.

PMCH, in cooperation with the Department of Surgery, provides programs and presentations on injury prevention to community-based health professionals through our Injury Prevention Program.

The following community-based training sites support our Preventive Medicine Residency Program:

Table B-5. Aerospace Medicine Residency Program
Practicum Phase Rotations

1. NASA/Johnson Space Center
2. Kelsey-Seybold
3. Federal Aviation Administration, Civil Aeromedical Institute
4. Brooks Air Force Base, San Antonio
5. Garratt's Flying Service
6. United Airlines
7. Texas Department of Health
8. US Coast Guard Air Station Houston
9. Yale University
10. Delta Airlines
11. Kennedy Space Center

General Preventive Medicine Residency Program
Practicum Phase Rotations

1. Public Health Rotation with Texas Department of Health in Austin
    A. Communicable Disease Control
    B. Chronic Disease
    C. Environmental Health and Consumer Protection
    D. Epidemiology - POC's
    E. Public Health Administration
    F. Public Health Clinic Operation
2. Galveston County Health Department
3. Occupational Medicine at NASA Kelsey-Seybold Clinic
4. TDCJ Hospital
5. Rotations in outlying units of TDCJ
    A. Primary Care prison unit
    B. Prison psychiatry
    C. Women's prison health care
6. Jail Medicine at the Harris County Jail
7. Texas Department of Health, Public Health Rotation, Region 5 & 6
8. University of Texas Health Science Center at San Antonio

Occupational Medicine Residency Program

Practicum Phase Rotations

1. Exxon
2. University of Texas Health Science Center at Tyler
3. Institute for Rehabilitation and Research
4. Kelsey-Seybold

School of Nursing: Our clinical training sites have remained relatively stable for the past three years. We utilize public health departments, school health programs, and occupational health sites in Galveston and Harris counties. A few of the sites are listed below:

Occupational Health Sites

Union Carbide Health Services
Oxychem - Bayport
Oxychem - Chocolate Bayou
Oxychem - Pasadena
NASA, Occupational Medicine Clinic
El Paso Energy Company
Sterling Chemical Company
Amoco Chemical Health Services, Chocolate Bayou
Lubrizol Company
Goodyear Tire and Rubber

School Sites

Hitchcock Independent School District
La Marque Independent School District
Galveston Independent School District
Clear Creek Independent School District
Friendswood Independent School District
Santa Fe Independent School District
Dickinson Independent School District
Angleton Independent School District
Pasadena Independent School District

Health Department Sites

Galveston County Health Department
Harris County Health Department

School of Allied Health Sciences: SAHS has over 600+ affiliation sites throughout Texas. This number of sites has been approximately the same for the last year. Underserved and rural areas have been reached by offering some web-based programs.

5. *Are your medical and nursing schools using the Agency for Health Care Policy and Research Putting Prevention Into Practice (PIP) concepts and resources (e.g. health Risk Profile)? How are they being used? PPIP materials can be accessed through the AHCPR website: www.ahcpr.gov/ppip*

Medical School: The Texas Department of Health, Texas Medical Association, and Blue Cross & Blue Shield of Texas have established a partnership oriented to providing training and technical consultation to prepare clinical environments that would serve as appropriate learning sites for health professions students. This preparation based on a train-the-trainer model includes preparing a significant number of clinicians and other staff to serve as preceptors and mentors in prevention oriented health professions education. This initiative has been led by faculty in the department.

School of Nursing: Not at the baccalaureate level. However, these concepts are being incorporated into graduate nursing courses. Most definitely being used in the primary care nurse practitioner program. In fact, one of our faculty served on a committee to develop the PPIP guidelines. Students use the Guide to Clinical Preventive Services as well as the health risk profile as an integral part of their practice.

School of Allied Health Sciences: The SAHS Physician Assistant Studies program is using the above policies.

6. *What state or legislative policy recommendations (besides increases in funding) would be instrumental in promoting the accomplishment of this Goal and Objective for the State of Texas?*

Medical School: Tax incentives for HMOs to provide prevention-training sites for health professions students. Require HMOs to provide more health promotion and disease/injury prevention services.

School of Nursing: Health promotion and primary prevention services for mental and physical health available for all residents of the state.

School of Allied Health Sciences: Increase efforts to recruit students from all areas of the state particularly the rural and underserved. Assist or support students from rural areas. Increase our utilization of telemedicine and partnership with clinical affiliates.

7. How would your institution use increases in funding to advance this Goal and Objective at your institution?

Medical School: Faculty recruitment, faculty development, infrastructure - Web-based design and distance learning.

Nursing School: The recruitment of faculty with strong public health backgrounds or the development of faculty currently at UTMB to interface with community sites for the promotion of health promotion and primary prevention goals.

School of Allied Health Sciences: Funding could be used for: 1) increasing technical means of communication to remote areas; 2) increase utilization of telemedicine; 3) support student housing and travel costs in rural areas and to sites for prevention screening activities.

THE UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER AT DALLAS

1. What efforts/initiatives have been taken to emphasize prevention in your institution's health professions education and training?

Preventive education is integrated into all four years of the medical school curriculum, beginning with the first year *Introduction to Clinical Medicine* course. Prevention is an important component of care in the primary clinical areas where medical students and residents receive clinical training. An NIH grant has been received to increase teaching in cardiovascular preventive nutrition and is being implemented.

2. What curriculum changes have been made in the areas of community and public health, epidemiology, population-based medicine, working in multi-disciplinary teams, and cultural competency? Does your institution have model programs/curriculum for any of the above?

UT Southwestern has made public health a very visible and important part of the University with implementation in September 1998 of an on-campus satellite branch of the UT Houston School of Public Health, offering curriculum and programs leading to the Master of Public Health (MPH) degree. This program has substantially enhanced the numbers of both public health faculty and students, and is becoming the base for public health affiliations with medical school departments and faculty in education, research, and community service.

Another important element in community health is the teaching hospital affiliation with Parkland Memorial Hospital, and its program of Community Oriented Primary Care (COPQ clinics throughout the Dallas community. The COPC's are a teaching and clinical care resource for medical school faculty and students.

3. Has your institution implemented any new methods/programs for evaluating or testing the competency of health professionals in the above areas? Please describe.

UT Southwestern makes extensive use of objective structured clinical examinations (OSCE's), which incorporate prevention. The Medical School has implemented a

pre- and post- knowledge exam on prevention for the ambulatory internal medicine course.

4. Has your institution been able to increase its clinic and community-based training sites? For comparison purposes, document the number and location of sites as of September 1996 and the number and location of sites existing as of September 1999. What model programs does your institution have in this area?

The use of community sites varies widely across curricular and specialty lines. Data is being developed to examine extent and effectiveness in the fields of internal medicine, family practice, obstetrics- gynecology, and pediatrics.

5. Are your medical and nursing schools using the Agency for Health Care Policy and Research Putting Prevention Into Practice (PPIP) concepts and resources (e.g. Health Risk Profile)? How are they being used? PPIP materials can be accessed through the AHCPR website: www.ahcpr.gov/

The Medical School uses the Putting Prevention Into Practice (PPIP) materials extensively in family practice residency training programs and student clerkships.

6. What state or legislative policy recommendations (besides increases in funding) would be instrumental in promoting the accomplishment of this Goal and Objective for the state of Texas?

The Legislature has studied for several years the development of a formula-based funding system for health sciences education including state funding for graduate medical education (GME) training programs. Implementation of this system would provide incentives for medical schools to concentrate on outcomes measures as opposed to process volume measures, and would help the "preventive medicine" initiative in the long run.

7. How would your institution use increases in funding to advance this Goal and Objective at your institution?

Further implementation is often a funding issue. The key element is protected faculty time to develop and implement curriculum, in this instance for both classroom and clinic-based programs in prevention.

TEXAS TECH UNIVERSITY HEALTH SCIENCE CENTER:
Medical School
School of Nursing

1. What efforts/initiatives have been taken to emphasize prevention in your institution's health professions education and training?

Medical School: In the medical school curriculum, TTUHSC addresses prevention throughout the four-year medical student curriculum via several different courses by several different departments. For instance, in the first year, students receive four hours of lecture on assessment and intervention regarding sedentary lifestyles, poor nutrition, and nicotine abuse. The second year curriculum includes a total 27 lecture hours on risk factors associated with chronic diseases, along with prevention and screening. The Pathology course offered during this second year delivers approximately sixteen hours of lectures and case conferences, including a review of preventive factors including diet, tobacco, exercise, atherosclerosis and cholesterol. An additional 18 hours are offered during the third year to the clerkship students in Internal Medicine, Family Medicine, and Pediatrics. The 4th year students in each of these programs receive additional training in the prevention, diagnosis, treatment, and management of chronic diseases.

The Department of Family and Community Medicine is especially proud of its efforts to promote physician behavior aimed at addressing smoking cessation among clinic patients. Under the direction of Dr. C. Alvin Jones, the Department researched and implemented a process aimed at training residents to understand the benefits of smoking cessation to the patients' health, and to provide residents with both skills and on-going system support so they can help their patients become non-smokers. Results of this project were presented at meetings of the Society of Teachers of Family Medicine and the Texas Academy of Family Physicians.

The TTUHSC is involved in a variety of ongoing community outreach programs that address chronic diseases. A number of faculty members are involved with the local chapter of the American Heart Association and serve on its speaker's bureau. A joint conference with the American Heart Association is planned for this fall and will focus specifically on issues related to diet, medication, and exercise in the prevention of diabetes and CVD among Hispanics. Likewise, a number of our Kellogg

sites are emphasizing the prevention of hypertension among Hispanics, and students at these clinics have gone into the local high schools and junior high schools to address tobacco use prevention.

2. What curriculum changes have been made in the areas of community and public health, epidemiology, population-based medicine, working in multi-disciplinary teams, and cultural competency? Does your institution have model programs/curriculum for any of the above?

Medical School: The Texas Tech University School of Medicine (TTUSOM) has modified the curriculum to provide clinical experiences for 1st year students. Classroom lectures are combined with a series of rotations with community preceptors in ambulatory primary care offices. Students learn to obtain a health history, understand the social/family/cultural context of illness, and begin to develop patient education/counseling skills to intervene in modifying behavior. These students learn the importance of understanding the epidemiology of diseases within a community/ practice population. They learn the importance for physicians to know and work with available community resources in a multidisciplinary approach to patient care. These concepts are reinforced in preventive medicine lectures/exercises in year one and in epidemiology/biostatistics lectures in year two. We believe that the first year ICARE (Integrated Community Ambulatory & Related Experiences) is a model program in these areas.

School of Nursing: In 1996 the School of Nursing revised its curriculum to include additional community-based health care activities. The original community health course was split into two courses. The first course is theory-based and includes an emphasis on epidemiology; the second course is clinical and focuses on implementation. The upper level courses in Management and Leadership both emphasize the importance of working with other health care professionals as part of a multi-disciplinary team. Senior nursing students participate in a preceptorship with a nurse manager in an agency and actually "shadow" the nurse manager as he or she works on a team.

A Health Assessment course has also been added to the School of Nursing curriculum to train students in conducting risk profiles for clients birth to end of life. Additional community health care activities have been added in the areas of Maternal/Child

Health and Psychiatry. Students address prevention issues through their participation in well-baby and prenatal clinics. They also attend activities like local Alcoholics Anonymous meetings for training in issues surrounding alcohol and drug abuse.

In addition, the Texas Tech University Health Sciences Center and the University of North Texas Health Sciences Center are in the beginning states of developing a joint distance education program leading to the Masters in Public Health. Further details will be made available as plans for the degree program progress.

3. Has your institution implemented any new methods/programs for evaluating or testing the competency of health professionals in the above areas? Please describe.

Medical School: In the School of Medicine, no new methods/programs for evaluations have been implemented yet but the planning committees for ICARE and Preventive Medicine/Biostatistics/Epidemiology will be working to develop objective tools for evaluation. Currently, course content in Preventive Medicine/ Epidemiology/Biostatistics is evaluated using multiple-choice questions in a UMSLE format.

School of Nursing: The School of Nursing has implemented a midlevel exam during the sophomore year, in addition to the comprehensive exit exam given during the senior year.

4. Has your institution been able to increase its clinic and community-based training sites? For comparison purposes, document the number and location of sites as of Sept. 1996 and the number and location of sites existing as of September 1999. What model programs does your institution have in this area?

Medical School: In September 1996 TTUSOM participated in the Statewide Preceptorship Program and used approximately 15 community local preceptors. With the implementation of ICARE, we are now using approximately 60 community preceptors.

5. Are your medical and nursing schools using the Agency for Health Care Policy and Research Putting into Practice (PPIP) concepts and resources (e.g. Health Risk Profile)? How are they being used? PPIP materials can be accessed through the AHCPR website.

Medical School: The Department of Family and Community Medicine at TTUHSC received funding from the Texas Department of Health to implement the U.S. Preventive Task Force Guidelines on Prevention into its teaching clinics. Also known as "Putting Prevention Into Practice," these guidelines focus largely on risk factors for CVD and provide opportunities for both medical students and patients to benefit from an increased emphasis on health promotion and disease prevention.

6. What state or legislative policy recommendations (besides increases in funding) would be instrumental in promoting the accomplishment of this Goal and Objective for the state of Texas?

General Response: In order to promote the accomplishment of the stated Goal and Objective, the state needs to adopt policies that would encourage and provide incentives for the expansion of new technologies in health care and telecommunications, especially those policies benefiting the elderly and residents of rural areas.

An example of such a policy would be telemedicine reimbursement for education and prevention, such as diabetes education and smoking cessation.

Academic medical centers have traditionally been tertiary care centers with a focus on medical care to the ill rather than on using prevention and education to achieve optimal health. Policies that ask for measured proof of graduate's competencies would be a key in changing institutional focus. Collection and publication and data comparing successes could foster competition and extra efforts to avoid a bottom ranking. A policy recommendation establishing a minimum number of hours of faculty contact during each year of medical and resident education would help to ensure attention to this area.

7. How would your institution use increases in funding to advance this Goal and Objective at your institution?

General Response: An increase in funding would enable TTUHSC to increase its efforts in education and prevention in four targeted areas:

1) Aging
2) Rural Health
3) Diabetes
4) Border Health

Increased funding could be used to develop innovative programs in these areas. Funding should allow purchasing of model materials from established successful programs. Additional faculty would be helpful to implement new program initiatives, possibly with funding for faculty at the four regional campuses.

UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER AT FORT WORTH:

Texas College of Osteopathic Medicine
School of Public Health

1. What efforts/initiatives have been taken to emphasize prevention in your institution's health professions education and training?

Several major initiatives have been taken to emphasize prevention at the University of North Texas Health Science Center at Fort Worth. A graduate degree program in public health was established in 1995 and expanded to include the creation of a School of Public Health (SPH) in September 1999. The SPH will be instrumental in implementing prevention efforts across all health professional training programs at UNT Health Science Center. A major collaborative effort involves the DO-MPH program, in which students at the Texas College of Osteopathic Medicine (TCOM) will be able to acquire a master's degree in public health while undertaking the medical curriculum. Further, the SPH will result in the training and placement of public health professionals across the state of Texas. The Health Sciences Library has also committed to increasing its holdings in books, journals, and media in support of our expanded public health curricula.

2. What curriculum changes have been made in the areas of community and public health, epidemiology, population-based medicine, working on multi-disciplinary teams, and cultural competency? Does your institution have model programs/curriculum for any of the above?

Several new programs have been established in these areas at UNT Health Science Center. Curricula in public health have been greatly expanded with the establishment of our graduate program in public health and its expansion to the SPH. Within the SPH, track 4pecializations exist in community health, epidemiology, and six other areas. There are also dual degree programs involving collaborations among public health, medicine, dentistry, and other health professions. These curricula address a broad spectrum of areas in public health, including population-based medicine, working on multidisciplinary teams, and cultural competency. In addition, a new medical curriculum is being implemented at TCOM, with a major expansion in

content relative to public health, population-based medicine, epidemiology, evidence-based medicine, and cultural competency in interacting with patients.

3. Has your institution implemented any new methods/programs for evaluating or testing the competency of health professionals in the above areas? Please describe.

Several programs have been used to help test the competency of health professionals in the above areas. In preparing for re-accreditation by the Joint Commission for the Accreditation of Healthcare Organizations, UNT Health Science Center has implemented regular evaluation of its health care professionals for quality improvement purposes. These quality programs place substantial emphasis on preventive medicine and related competencies, such as multi-disciplinary teamwork and cultural sensitivity. With the implementation of a new medical curriculum at TCOM, new programs for testing the competency of medical students have been developed. These evaluations focus on creating valid and reliable measures of student performance, using highly practical clinical scenarios. Further, with the establishment of the SPH and the Physician Assistant (PA) program, novel programs for evaluation of public health professionals and physician assistants are currently being developed and refined.

4. Has your institution been able to increase its clinic and community-based training sites? For comparison purposes, document number and location of sites as of September 1996 and number and location of sites existing as of September 1999. What model programs does your institution have in this area?

UNT Health Science Center has been able to increase its clinic and community-based training sites over the last three years. The curricular expansion in public health over these years has resulted in numerous clinic and community agency collaborations through the placement of students in practical field study projects, capstone course assignments, program planning and evaluation, and student performance of independent study, special problems, and thesis research projects. Clinically, major increases in patient volume have been realized through affiliations with local health departments and Federal prison programs. There is no formal database that provides a specific comparison of September 1996 and September 1999.

5. Are your medical and nursing schools using the Agency for Health Care Policy and Research Putting Prevention Into Practice (PPIP) concepts and resources (e.g. Health Risk Profile)? How are they being used? PPIP materials can be accessed through the AHCPR website: www.ahcvp.gov/ppip

TCOM students at all levels are being exposed to PPIP concepts. First- and second-year students receive classroom education in these and related concepts. In addition, they receive instruction on the findings of the U.S. Preventive Services Task Force, as disseminated in the *Guide to Clinical Preventive Services.* Further, they receive instruction in population-based medicine and communicable disease control using the resources provided by the Texas Department of Health. Third- and fourth-year students in primary care clinical rotations receive additional reinforcement of these concepts.

6. What state or legislative policy recommendations (besides increases in funding) would be instrumental in promoting the accomplishment of this Goal and Objective for the state of Texas?

The accomplishment of this Goal and Objective for the state of Texas may be promoted in several ways. First, the Texas Department of Health may wish to increase student accessibility of its prevention-related resources by increasing the online availability of these documents. Second, institutes of higher education may be induced to put greater emphasis on their prevention curricula by reallocating funding to those programs that provide educational programs in support of the Goal and Objective. This would not require an increase in funds, but rather a shift in funding from those programs with an emphasis on treatment to those with an emphasis on prevention. Third, legislative incentives may be provided for collaborations of academia with government, philanthropic organizations, and various industries, such as managed health care, pharmaceuticals, etc.

7. How would your institution use increases in funding to advance this Goal and Objective at your institution?

At UNT Health Science Center, this Goal and Objective could be advanced in several ways with increased funding. First, educational resources may be purchased or upgraded to support these programs. Second, faculty development programs may be provided. Third, additional student training programs may be established, including a Public Health/ Preventive Medicine residency, new dual degree programs involving public health and preventive medicine, continuing education programs, and health professional development programs.

EXHIBIT B-1

CURRICULAR GOALS AND OBJECTIVES FOR TEXAS A&M UNIVERSITY SYSTEM HEALTH SCIENCE CENTER COLLEGE OF MEDICINE (TAMUSHSC-COM) 1999

(As Approved by the Academic Council, September 2, 1999)

Medicine in general, and medical education in particular, must always be responsive to scientific developments, changing practice patterns, and evolving societal needs. It is critical that medical educators understand and respond appropriately to these changes. As part of the ongoing process of monitoring and upgrading the medical curriculum of the TAMUHSC-COM, the curricular goals and objectives described in this document have been established to reflect the changing parameters described above. Likewise, maintenance of the historically high quality medical training our students receive at the TAMUSHSC-COM is of paramount importance in the ongoing process of curricular improvement.

To accomplish concomitantly the described goals of meaningful curricular improvement and maintenance of high academic standards, the goals and objectives described below for the TAMUSHSC-COM medical curriculum are based on the following:

- The guidelines set forth within the Medical School Objectives Project (MSOP), which were published by the Association of American Medical Colleges (AAMC) in 1998;
- The unique curricular requirements of the TAMUSHSC-COM, based both on historical mission objective and the expanding role of the COM in providing the best possible health care to all citizens of the state of Texas.

The College of Medicine will develop the necessary pedagogy and the appropriate assessment methods to ensure that the students have attained the knowledge, abilities, and characteristics outlined in this document, and at the level of competency set by the faculty. To ensure that these goals are met, the faculty will do the following:

- Develop specific, integrated, educational objectives to be attained by our medical students at defined points within the curriculum;
- Ensure that the objectives are system-oriented rather than discipline-based, and are consistent with: 1) those outlined in the MSOP document, 2) the Goals and Objectives set forth in this document, and 3) the recommendations of the Dean's Committee on Curriculum, which were adopted by the Academic Council on December 3, 1998 as COM policy;
- Identify, develop, and implement appropriate testing methods to ensure attainment of stated educational objectives;

- Impart to the students the required professional knowledge, skills, and attributes using methods that will include, but not be restricted to, individual faculty contact and mentoring, role modeling, computer-based programs and simulations, self-directed learning, small group sessions, problem-based learning, case-based teaching, lectures, and laboratory and clinical experiences.

The College of Medicine must ensure that graduating students possess a modern, relevant, integrated scientific knowledge base and be able to apply that knowledge to the practice of medicine. To ensure the acquisition of this knowledge base, each student will demonstrate, to the satisfaction of the faculty, the following:

- Knowledge of the normal structure and function of the major organ systems of the human body, and how these major organ systems interact;
- Knowledge of the molecular, biochemical, cellular, and system-specific mechanisms that are essential to the maintenance of homeostasis;
- Knowledge of the various causes (genetic, developmental, psychologic, metabolic, toxic, microbiologic, autoimmune, neoplastic, degenerative and traumatic) of maladies that afflict humans, and the mechanisms for their effects (pathogenesis);
- Knowledge of the altered structure and function (pathology and pathophysiology) of the body and its major organ systems that are seen in various diseases and conditions;
- An understanding of, and ability to use, the scientific method in establishing 1) the causation of disease and 2) the efficacy of traditional and nontraditional therapies.

The College of Medicine must ensure that each student develop the requisite clinical skills of an undifferentiated physician. To ensure that this goal is met, each student will demonstrate, to the satisfaction of the faculty, the following:

- The ability to obtain an accurate and complete medical history that covers all essential aspects including issues related to age, gender, and socioeconomic status;
- The ability to perform both a complete and an organ-system specific examination, including a mental status examination;
- The ability to perform routine technical procedures, including the following: venipuncture, insertion of an intravenous catheter, arterial puncture, thoracentesis, lumbar puncture, insertion of a nasogastric tube, insertion of a urethral catheter, and suturing lacerations;
- The ability to interpret the results of commonly used diagnostic studies;
- Knowledge of the clinical, laboratory, radiologic, and pathologic manifestations of common maladies;
- The ability to combine knowledge base, investigative skills, and deductive reasoning to be proficient in clinical problem solving;
- The ability to construct appropriate diagnostic and therapeutic management strategies for patients with common acute and chronic medical, surgical, and psychiatric conditions, and those requiring both short and long-term rehabilitation;
- The ability to recognize and outline an initial course of management for patients with serious conditions requiring critical care;

- Knowledge of the causative factors of pain, the relief of pain and ameliorating the suffering of patients with pain;
- The ability to listen attentively and communicate effectively, both orally and in writing, with patients, patients' families, colleagues, and others with whom physicians must exchange information in carrying out their clinical responsibilities.

The College of Medicine must ensure that graduating medical students possess the necessary altruism and professional characteristics to render compassionate and empathic care to their patients. To ensure the acquisition of these characteristics, the students must demonstrate, to the satisfaction of the faculty, the following:

- Knowledge of the historical, legal, religious, and cultural aspects of medicine and the development of an appreciation for past and contemporary social and trans-cultural issues;
- Development of moral reasoning skills derived from the principle of justice for all;
- Knowledge of the theories and principles that govern ethical decision making and the major ethical dilemmas in medicine, particularly those that arise at the beginning and end of life, and those that arise from the rapid expansion of medical knowledge;
- Compassionate, non-judgmental treatment of patients, and respect for their privacy and dignity;
- Honesty and integrity in all interactions with patients' families, colleagues, and others with whom physicians must interact;
- An understanding of, and respect for, the roles of other health care professionals, and of the need to collaborate with them in caring for individual patients, and in promoting health;
- A commitment to advocate, at all times, the interests of patients over self;
- An understanding of the threats to medical professionalism posed by the potential conflicts of interest inherent in some financial and organizational arrangements in the practice of medicine;
- The capacity to recognize and accept limitations in one's own knowledge and clinical skills, and an unyielding commitment to improve continuously personal knowledge and ability.

The College of Medicine must ensure that graduating students understand and demonstrate both the leadership responsibilities and duties of a physician in promoting, maintaining, and improving the health of individuals and populations. To ensure the acquisition of these attitudes and behaviors the students much demonstrate, to the satisfaction of the faculty, the following:

- A basic understanding of population health as it relates to epidemiology, biostatistics, disease prevention/health promotion, health care organization, management and financing, and environmental and public health;
- Knowledge of the important non-biological determinants of poor health and of the economic, psychological, social, and cultural factors that contribute to the development and/or continuation of maladies;

- Knowledge of the epidemiology of common maladies within a defined population, and the systematic approaches useful in reducing their incident and prevalence;
- The ability to identify individuals at risk for disease or injury, to select appropriate tests for detecting patients in the early stage of disease, and to determine strategies for responding appropriately;
- Knowledge of various approaches to the organization, financing, and delivery of health care;
- The willingness, ability, attitude and skills to assume or defer leadership roles, both in medicine and society, when appropriate;
- A commitment to provide care to patients who are unable to pay and to advocate access to health care for members of traditionally underserved populations.

The College of Medicine must ensure that students have the opportunity for early exposure and continued experiences in Rural Primary Care as an encouragement to practice in this clinical setting. To ensure that this goal is met, the faculty will provide the following experiences:

- Preceptor experiences with physicians in small towns and rural areas;
- Exposure to primary care physicians, both as teacher in the classroom and as mentors in a clinical setting;
- Meaningful interactions with both faculty and students of the School of Rural Public Health;
- Participation in both medical and nonmedical rural community activities.

The College of Medicine must ensure that graduating students possess the necessary training and skills in medical informatics to generate, collect, analyze, utilize and communicate appropriate biomedical information. To ensure that students possess the requisite knowledge and skills, the students must demonstrate, to the satisfaction of the faculty, the following;

- Knowledge of, and the ability to use, the information resources and tools available to support lifelong learning;
- Ability to assess critically biomedical information and data to support optimal medical decision-making;
- Ability to enter, retrieve and analyze patient-specific information from a clinical information system;
- Ability to select and utilize information resources for professional and patient education, and transmit that knowledge in oral, written, and electric forms;
- Ability to utilize information technology in managing the cost of medical care for individuals, populations, and society.

Appendix C
Ad Hoc Committee on Community Competencies for Health Professionals

A report given in response to the
1999-2004 Texas State Health Plan goal:

Goal 6: Create a health care workforce that works with communities and in partnership with federal and state governments to have the greatest impact on the health of citizens.

Objective 6.2: Develop the skill level of health professionals in working with communities.

Report to the Statewide Health Coordinating Council

January 13, 2000

Texas Statewide Health Coordinating Council
Ad Hoc Committee on Community Competencies for Health Professionals
Member List

Judy Petty Wolf, Chair
SHCC Member
U.T. Health Science Center

Joaquin G. Cigarroa, M.D.
SHCC Member
Texas Higher Education Coordinating Board

Laura Prendergast Gordon
SHCC Member
Public Member

Elizabeth Anderson, Dr.P.H., R.N., FAAN
Texas Nurses Association
U.T. Medical Branch Galveston

Kay Bartholomew, M.P.H., Ed.D.
U.T. School of Public Health
Center for Health Promotion
Research and Development

Martin Basaldua, M.D.
Texas Higher Education Coordinating Board

Jose Bayona, M.D.
University of Texas Medical School

Natalie Burkhalter, M.S., R.N., C.S., FNP, CCRN
Texas A&M International University

Dolores H. Carruth, M.D.
Texas Higher Education Coordinating Board

Laurie O'Neal, M.Ed.
Lake Country Area Health Education Center

Jimmie Roach, R.S.
Environmental and Consumer Health
Texas Department of Health

James Robinson, III, Ed.D.
Department of Social and Behavioral Health
Texas A&M University

Dana Smith, M.P.A.
Greater Houston Area Health Education Center

Susan Stappenbeck, M.P.H.
Alamo Area Health Education Center

Fernando Treviño, Ph.D.
University of North Texas, Forth Worth

Yolanda Whittaker-Hilliard, M.D.
African-American Medical Society of Texas

Mary Walker, R.N., Ph.D., FAAN
Texas Healthcare Trustees

Staff: Donna C. Nichols, M.S.Ed., CHES
Director, Public Health Promotion

Ad Hoc Committee on Community Competencies For Health Professionals

INTRODUCTION

The 1999-2004 Texas State Health Plan, developed by The Texas Statewide Health Coordinating Council (SHCC) envisions a Texas where all citizens are able to achieve their maximum health potential. To meet this challenge, Texas needs a well-trained, competent community health workforce. The Texas State Health Plan addresses community health workforce issues through a series of goals, objectives and strategies for workforce planning, regulation and policy development. Goal Six of the Texas State Health Plan speaks to creating a health workforce that works with communities and in partnership with federal and state governments to have the greatest impact on the health of citizens. From this goal and its subsequent objective of developing the skill level of health professionals in working with communities, a SHCC Ad Hoc Committee on Community Competencies for Health Professionals was formed and charged with deliberating the issues associated with core competencies and with developing action-oriented, policy recommendations, which will integrate these competencies into the existing and future health care workforce of Texas.

Key community health professionals from universities, professional organizations and associations, coordinating boards, health education centers, private practice and hospitals were selected and invited to represent diverse health care interest areas, professional backgrounds, geographic locations and populations of the state of Texas. These professionals, many of whom have contributed to the national dialogue mentioned throughout this report, have also provided the collective wisdom and insight necessary to shape the Texas vision for a quality health care workforce.

BACKGROUND

Much work has already been done to identify workforce competencies, particularly, at the national level. For example, competencies have been identified for graduate

programs, leadership institutes, health-related professions, specialized job functions and skill bases. To provide some context to this report, many in public health have been concerned about the future of public health and the education and training needed to reorient the public health workforce. The Institute of Medicine in 1988 issued the Future of Public Health. This report provided the impetus for a number of initiatives. In 1998, the Pew Health Professions Commission issued its fourth report on Recreating Health Professional Practice for a New Century that emphasized the need for health competencies to be integrated in the training and re-education of all health professional practice. Other groups such as the Kellogg and Robert Wood Johnson Foundation have contributed to the national dialogue by identifying community-based public health competencies and specialized job function competencies respectively. In addition, many disciplines have developed taxonomies of educational objectives that could be translated into competency descriptions. Other documents such as Core Competencies for the Synergistic Practice of Medicine and Public Health, Community Stewardship: Applying the Five Principles of Contemporary Governance, and Collaborative Competence in the Public Health Agency: Defining Performance at the Organizational and Individual Employee Levels were used in framing the competencies and recommendations included in this report. Complete citations of all referenced materials are included in the attached bibliography.

It is widely accepted that core community competencies for health professionals are critical to providing any and all of the essential public health services and that performance of these competencies can:

1. Be defined in both organizational and individual terms;
2. Help define the institutional culture necessary to support enhanced performance;
3. Complement the transition of health systems at all levels to the population focused model of health promotion and disease prevention;
4. Include both public and private sector partners equally in creating systems that sustain community health;
5. Be observed in practice;
6. Be described in behavioral terms; and,
7. Be part of a continual process of organizational/individual performance improvement.

For the purposes of this report, the SHCC Ad Hoc Committee on Community Competencies for Health Professionals chose to define competency as the knowledge, skills, and abilities demonstrated by community health professionals and workers that are critical to the effective and efficient function and delivery of community health services.

Dimensions of Community

The SHCC Ad Hoc Committee on Community Competencies for Health Professionals recognized early on the necessity of cross collaboration with other SHCC ad hoc committees including those studying issues concerning the community model, minority health and cultural competency and consumer health. Principles of community health were established by the SHCC Ad Hoc Committee on Community Model and shared with the Ad Hoc Committee on Core Competencies. These principles provided the framework for defining community health professional/ worker and the dimensions of community heath. In addition to this cross collaboration, qualitative information was gained through responses to focus group questions. This qualitative information, gained from numerous focus groups held across the state, helped substantiate and shape the core competencies delineated in this report. Focus group results are contained in an appendix to the report by the SHCC Ad Hoc Committee on Community Model.

Key Assumptions and Operating Principles

The SHCC Ad Hoc Committee on Community Competencies for Health Professionals began its work by discussing several key assumptions with respect to the committee charge. These discussions led to the following operating principles. Core community competencies:

- Must be applicable across all health professions, including all community health workers;
- Must be continuous throughout any curriculum;
- Must take a social ecological approach;
- Must be at least valued by faculty and organizational leaders if not modeled;
- Will need champions and resources to move from policy recommendations to real time actions;
- Are service-based;
- Must address how and where they are to be applied;

- Are to be defined in plain language and expressed in behavioral terms;
- Must integrate cultural competency into all competencies and must be achieved well before any community health experience; and,
- Must support and complement Texas' essential public health services.

Community Competencies For Health Professionals

Community Competencies Common to All Health Professionals

The Vision and The Reality

We embrace a well-trained, competent workforce, that is capable of practicing in the community at multiple organizational and institutional levels and settings, and to that end it is our vision. Competencies are future-focused rather than problem-focused and are needed to advance the principal health paradigm of population-based prevention through partnerships and collaboration. The target audiences are those individuals who need continuing education and professional development, in addition to those who are currently enrolled in schools preparing health care professionals. The reality is that it may be necessary to rethink how and what we provide through our current training approaches and where we engage health professionals in the learning process especially in the community. To change the current mindset will require an enlargement of the health professional's education to include system, organizational and population skills.

Community Competencies and Their Definitions

Definitions have been crafted to speak to all health professionals and workers who practice in the community. In its deliberations, the SHCC Ad Hoc Committee on Community Competencies for Health Professionals found that core competencies could be characterized into two groups—1) competencies which are integral to or the foundation for all other competencies and 2) those competencies which could be considered tools for health practice in the community. The core competencies below have been categorized into these groups.

Foundation Competencies

1. **Cultural Awareness and Sensitivity**

   Definition: Integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used

in appropriate cultural settings to increase the quality of service and improve outcomes.

Competency: Understand the importance of cultural competency in health practice, accept differences, and convey the desire and willingness to help and serve everyone, regardless of language, color, or ability to pay.

2. **Communication**

Definition: Effective exchange of information among health care professionals, community groups, leaders and individuals.

Competency: Communicate with community groups, in a clear and effective manner, both orally and in writing, to contribute to the community's health.

3. **Systems Thinking**

Definition: The capacity to recognize and evaluate the interdependence of factors associated with complex problems.

Competency: Promote a strategy that supports the understanding and solving of complex health issues at the individual and community level.

4. **Leadership**

Definition: Ability to inspire action in others and act as a catalyst to enhance the health of the community.

Competency: Enable goal achievement through others by using such skills as role modeling, lifelong professional development, community stewardship, and systems thinking.

5. **Education of Self and Others**

Definition: Effective delivery, learning and sharing of information and experiences to enhance community health.

Competency: Continue to learn and help others to learn by creating and supporting environments conducive to learning and by seeking opportunities to educate self and others.

Competencies as Tools

6. **Information Management**

   Definition: Integration, management and communication of individual and community health information and data through electronic systems and resources.

   Competency: Use technology to access, communicate, and manage data and information.

7. **Public Advocacy**

   Definition: Active involvement in concert with the community to create and promote policies, programs, services and resources that protect the health and welfare of its residents.

   Competency: Act as a champion on behalf of or in concert with the community to promote and protect the health of its residents.

8. **Community Organization and Development**

   Definition: Development of collaborative efforts among community individuals, groups, stakeholders and organizations to affect a specific community change.

   Competency: Understand the assets, capacity and readiness of communities to improve and support community health.

9. **Community Assessment**

   Definition: Process to determine the health of a community.

   Competency: In partnership with the community, identify and assess strengths and resources to improve community health.

10. **Strategy Development**

    Definition: Capacity to apply public health principles such as disease prevention and health promotion to essential services.

    Competency: Apply appropriate and culturally relevant population-based interventions aimed at positive health behavior change.

11. **Program Evaluation**

    Definition: Ability to determine if programs/strategies/activities have made a difference in the community's health.

    Competency: Compare and analyze the impact of programs/strategies/activities on the health of a community.

12. **Quality Assurance**

    Definition: A process by which standards or guidelines are developed and monitored to improve health outcomes.

    Competency: Assume responsibility for services and health outcomes at all levels.

AD HOC COMMITTEE RECOMMENDATIONS

The SHCC Ad Hoc Committee on Community Competencies for Health Professionals recognizes the importance of the work that has been done at the national level and also is cognizant of the formative work that has been initiated by state organizations and agencies. This Committee's work provides a unique Texas, as well as interdisciplinary, perspective. It is meant to reinforce and complement those skills that are currently taught in schools preparing health care professionals. In addition, these policy recommendations suggest that core competencies be used for retooling existing curricula, if necessary, and for establishing the context for continuing education. Emphasis, regardless of professional level, is placed on mastering the competencies identified in this report. Specific policy recommendations are:

Recommendation One: Evaluate current course of study in professional schools to determine whether or not they are adequately preparing students to meet the challenges of health practice in the community.

Recommendation Two: Require a significant amount of work in community service settings as part of health professional programs.

Recommendation Three: Integrate core competencies into professional associations' accreditation, certification and licensure processes, benchmarks for graduation, entry into professional practice and continuing competence.

Recommendation Four: Request the Texas Department of Health to serve as a leader in the implementation of these competencies in the public health workforce and to act as a resource to private/public sector institutions and organizations.

Recommendation Five: Explore resources for expanding access to technology in support of community health in collaboration with both public and private sectors.

Recommendation Six: Establish opportunities for collaborative action research to further refine, diffuse and disseminate the core competencies.

Bibliography

American Hospital Association, *Community Stewardship: Applying the Five Principles of Contemporary Governance*, American Hospital Association, Chicago, Illinois, 1998.

Committee on Professional Education, American Public Health Association. "Criteria and Guidelines for Accrediting Schools of Public Health," *American Journal of Public Health*, Washington, DC, 1966, 56(1): 308–318.

Gebbie, K.M. and Hwang, I., *Preparing Currently Employed Public Health Professionals for Changes in the Health System*, Columbia University School of Nursing, Center for Health Policy and Health Services Research, New York, New York, 1998.

Halverson, P.K., Nicola, R.M., and Baker, E.L., "Performance Measurement and Accreditation of Public Health Organizations: A Call to Action," *Journal of Public Health Management and Practice*, Frederick, Maryland, 1998, 4(4): 5–7.

Healthy Communities: New Partnerships for the Future of Public Health, National Academy Press, Washington, DC, 1996.

Institute of Medicine, *The Future of Public Health*, National Academy Press, Washington, DC, 1998.

Keck, C.W., "Core Competencies for the Synergistic Practice of Medicine and Public Health," Josiah Macy, Jr. Foundation Conference on Education for More Synergistic Practice of Medicine and Public Health, Palm Beach, Florida, 1998.

Mays, G.P., Halverson, P.K., and Miller, C.A. "Assessing the Performance of Local Public Health Systems: A Survey of State Health Agency Efforts," *Journal of Public Health Management and Practice*, Frederick, Maryland, 1998, 4(4): 63–78.

Nelson, J.C., Essien, J.D., and Latoff, J.S., "Collaborative Competence in the Public Health Agency: Defining Performance at the Organizational and Individual Employee Levels," Presentation given at Prevention 97: Research Linkages Between Academia and Practice, Atlanta, Georgia, 1997.

Pew Health Professions Commission, *Recreating Health Professional Practice for a New Century*, The Fourth Report of the Pew Health Professions Commission, San Francisco, California, December 1998.

Public Health Leadership Society, *Development of the Public Health Workforce: A Preliminary Compendium of National Resources*, Public Health Leadership Society, Center for Health Leadership, Washington, DC, 1998.

Statewide Health Coordinating Council, *The Texas State Health Plan 1999-2004: Ensuring A Quality Health Care Workforce for Texas*, Texas Department of Health, Austin, Texas, 1998.

Appendix D
Texas Department on Aging

A report given in response to the *1999-2004 Texas State Health Plan* goal:

Goal 5: Reduce disparity in health status among all population groups and enhance their access to quality health care by developing a diverse and culturally competent workforce.

Objective 5.2: Develop a workforce equipped to meet the needs of Texas' aging population

Texas Statewide Health Coordinating Council

February 10, 2000

The Texas Interagency Aging Policy Council

"A Healthy Aging Texas" Subcommittee

Member List

Christy Fair, Assistant Director
Division of Policy & Planning
Texas Department on Aging

Glenda Rogers, Director
Area Agency on Aging of
the Capitol Area

Pat Craig
Texas Department of Mental Health
and Mental Retardation

Paula Mixson, L.M.S.W.
Texas Department of Protective
and Regulatory Services

Lucretia Dennis-Small, M.P.A.,
Planner
Texas Workforce Commission

Tina Janek, Director
Office of Community Transportation
Services
Texas Health and Human Services
Commission

Klaus Madsen, Policy Analyst
Texas Institute For Health Policy
Research

George Kelemen-B., Policy Specialist
Division of Policy & Planning
Texas Department on Aging

Galen Brewer, M.P.A.
Program Coordinator
Behavioral Health Services
Texas Department of Mental Health
and Mental Retardation

John Garvin, Strategic Planner
Texas Department of Housing and
Community Affairs

Gregg Ukaegbu, M.P.A., Planner
Office of Policy and Planning
Texas Department of Health

Nora Cox Taylor
Policy/Regulatory Analyst
Workforce Development Division
Center For Rural Health Initiatives

Karl Urban, Strategic Planner
Texas Health and Human Services
Commission

Gary Williams
Texas Department of Transportation

A Healthy Aging Texas: What Will It Take?

INTRODUCTION[1]

On New Year's Day, 2011, Texas will wake to a demographic and cultural milestone. That year marks the official beginning of the baby boomer generation's entry into retirement age. How will this generation, with its education, privilege, culture and its lifetime of habits change the way we perceive aging and how our social institutions and markets respond to it? Are Texans preparing themselves now for the best possible health outcomes as they age?

Aging is a biological fact and a normal part of the life cycle. The effects of aging are amplified when the aging person is poor, living alone, lacking social support, does not have adequate housing, or is one major illness away from being disabled. The realities that age imposes on an individual's health, and the concomitant challenges it presents to functional independence, cannot be ignored. At the same time, the debilitating conditions associated with aging are neither universal nor inevitable. We are beginning to appreciate that a number of factors that make the difference between wellness and ill health are within our control. As the segment of the Texas population beyond age 65 grows, these realities make it imperative that the issues of healthy aging are elevated in the public health policy arena.

A key to meeting the challenges of the future requires proactive and preventive decisions by Texans now. The actions taken by today's baby boomers can alleviate or prevent the health conditions that are most debilitating and life-shortening in the elder years, such as heart disease, stroke, emphysema, Type II diabetes and some cancers. The entire state population can benefit from adopting healthier lifestyles and promoting health policies that support a better quality of life for older persons. Emphasis should be placed on finding innovative approaches that will consider the characteristics of the state's aging population, their needs, and the roles of the individual, society, and government in achieving good health in old age.

Providing young and aging citizens with appropriate information to encourage better personal health practices offers one approach. Mobilization of our state resources to prepare for managing the inevitable health status challenges of an aging population can yield greater potential health cost savings well into the next century.

Perhaps our biggest challenge and our greatest opportunity lies in exploring how the social fabric of the communities of Texas, our attitudes and the quality of our intergenerational relationships can be brought to support longer, healthier and more productive lives. The concerns of an aging population will push into the center of the public policy arena as the state enters the 21st century. The discussion of strategies to achieve wellness in our aging population must move forward.

State Leaders Lead The Discussion

Indeed, Texas lawmakers have been taking notice of these issues since at least the 75th Legislative session.

In Senate Concurrent Resolution 36,[2] the Texas Department Aging was charged with:

> ...promoting public and private action and conducting studies to help senior Texans achieve their highest level of economic and personal self-sufficiency, social involvement, dignity, and good health;.

In its report issued in October 1998,[3] the Texas Senate Interim Committee on Health and Human Services noted that:

> Because the number of individuals 85 years of age and older is growing at such a rapid pace, the need for health care services and daily living assistance will increase significantly.

It was also in the fall of 1998 that the Statewide Health Coordinating Council (SHCC) issued its charges that form the basis of this report. Strategy 5.2.1 of Objective 5.2 of the *Texas State Health Plan* charged TDoA and the Interagency Aging Policy Council (IAPC) to further explore these issues and provide recommendations that will better prepare state government to meet the needs of an aging Texas. Specifically, the TDoA and IAPC were to:

- Identify the health needs of an aging population.
- Forecast health professionals/specialties that will be needed to fulfill the health care needs of an aging population.
- Study and recommend health care policies and practices that enable individuals to age successfully.

One year after these charges were issued, Dr. Ben Raimer, the Chair of the SHCC, addressed the Senate Committee on Health Services,[4] which was itself charged with analyzing the preparedness of the Texas health care workforce to meet the health care needs of Texans beyond the year 2000. In his testimony Dr. Raimer spoke of telemedicine as a possible solution to the "mal-distribution of health services" in Texas, and the need for the state to not only aim health education and prevention messages at patients, but to practicing health care professionals as well.

BACKGROUND

The Health Needs of An Aging Population

> Minimizing the risk of disease and disability is of life long importance, but some of the risks change with aging and, therefore, so do the means reducing them.... The incidence of specific disease also changes with age, and the presence of certain chronic disease becomes more likely.— John Rowe and Robert Kahn, *Successful Aging*, 1998

The Texas Department of Health cites these ten diseases as the most prevalent currently in the older population of Texas:[5]

- Heart Disease — The leading cause of death for Texans over the age of 65.
- Cancer (all Cancers combined) – The second leading cause of death among Texans 65 and older. Lung cancer was the deadliest cancer, followed by prostate cancer both overall second and second among men. Breast cancer was the second leading cause of cancer death among women. Combined, heart disease and all cancers accounted for 63 percent of all deaths among Texans between the ages of 65 and 74.
- Stroke – 448.4 out of every 100,000 Texans 65 and older die from stroke each year.

- Chronic Obstructive Pulmonary Disease (COPD) — The fourth leading cause of death among Texans 65 and older. According to 1998 figures from the American Lung Association, it is climbing quickly as a primary cause of death among the elderly.
- Diabetes – The prevalence of this disease among older Texans is a growing trend. According to the Texas Behavioral Risk Factor Surveillance System's (BRFSS) survey of the Health Status and Behavior of Adult Texans conducted between 1990 and 1995, both the total numbers and percentage of older Texans with diabetes will rise as the baby boom generation enters the over 60 age group. The survey further predicted that by the year 2000, 50 percent or more persons over 60 will be diabetic.
- Pneumonia and Influenza – 203.3 out of every 100,000 Texans 65 and over died as a result of pneumonia or flu, according to 1997 figures.
- Falls, Accidental Injuries and Poisonings – Falls were the leading cause of serious injury and accidental death among older persons in the U.S. in 1994.[6] Among Texans over age 65, there were 829 Medicare hospital discharges due to hip fractures per 100,000 beneficiaries in 1995. Additionally, for every 100,000 Texans 65 and over, 95.5 died as a result of an injury or poisoning.
- Alzheimer's Disease and Related Disorders – One in ten Texans over 65, and nearly half over 85 have Alzheimer's disease or a related form of dementia.[7] Alzheimer's disease is often listed as a contributing or secondary cause of death among older people.
- Disabilities – Currently 30 percent of the aging population in Texas have functional limitations in three or more activities of daily living.[8]
- Arthritis – Arthritic conditions can manifest themselves in over 100 inflammatory and degenerative conditions that damage the joints. Arthritis leads to a limitation in every day activities and movements and is the number one cause of disability in America.

In addition, the IAPC has identified the following health-related conditions prevalent in Texas and regards them as critical health needs of an aging population:

- Mental Retardation and Developmental Disabilities – This population is growing and more are living to be older citizens, creating a need for continued care. Many are now outliving their parents, who have been their primary caregivers.

- Depression and other Mental Illnesses – It is estimated that up to 25 percent of the older population in the U.S. suffer from significant symptoms of mental illness. Depression is the most common treatable mental illness among older persons. Suicide is often the result of untreated depression, and this year the Surgeon General stated that the suicide rate is highest in the 85+ age group, nearly twice the overall national average.
- Substance Abuse – Alcohol and prescription drug misuse affects as many as 17 percent of the older adult population (Substance Abuse and Mental Health Services Administration, 1998). Substance abuse among older people is usually manifested after a life-altering event, such as the loss of a spouse or close friend. Only recently has this condition been identified as a problem among this age group.

The National Institute of Mental Health epidemiologic catchment area surveys indicate that suicide, anxiety, and alcohol and drug abuse rates in the elderly are only about one-fourth to one-third of those projected for the baby boomers as they become older adults.[9]

How Many Health Care Professionals and Specialists Will We Need?

> The needs of older adults, especially the frail or impaired, require a health care workforce knowledgeable about the systems and services of care with which the elderly interact, and the skill to provide care with these systems. The complexity of problems common to older adults often demands the knowledge and skills beyond that of individual practitioners. These competencies must be learned.[10]

In 1992 the Bureau of Health Professions reported that in the previous five years, various studies consistently portrayed health professionals as unequipped to meet the present and future health care needs of older Americans. Faculty are not prepared to teach geriatrics and gerontology; curricula of basic and graduate level education do not include aging content; limited discipline-specific aging research is being conducted; and few health care professionals are choosing to care for the elderly. Little reward, professional or financial, is being given to those who care for the elderly. And, as the Bureau of Health Professions notes, these obstacles will have far reaching effects in the near future, when as much as two-thirds of a health care professional's time may be devoted to the care of the elderly.[11]

Before the Texas Senate Committee on Health Services or the SHCC can truly assess the readiness beyond the year 2000 of our state's health care work force, it will need to regard an important fact: currently the elderly already account for a disproportionately large share of the use of physicians' time, prescriptions, and acute hospital admissions.[12] As baby boomers age the number of seniors requiring health care services will increase, and the demand will be greater than it currently is, just in terms of sheer numbers. What is difficult to project, however, is how the current lifestyle practices and generally better health of baby boomers will impact these statistics proportionately. Will heart disease, cancer and stroke still be the top three diseases of the elderly in 2025? Or will baby boomers – who are smoking far less, exercising far more and generally eating better, move those statistics to the back?

The Texas Department on Aging is in the process now of analyzing the results of a 1999 survey it conducted on baby boomers, in which some questions address boomers' utilization of preventive health practices, such as annual check ups and screenings. In addition, the Texas Department of Health maintains a monthly database that examines the prevalence of selected risk factors, e.g., smoking, diabetes, overweight, etc., among Texans aged 18 and above. Both these bodies of information should be closely studied and a trend analysis conducted to better forecast the health care work force needs of the future.

A fact illustrated in the regular surveys of 20,000 Medicare beneficiaries (approximately 99 percent of the 65 and over population), conducted by The National Long Term Care Surveys, is that advances in medicine are redefining the statistics among the elderly right now. The latest results available for the yearly survey (1994) show a continued decrease in the number of older persons unable to take care of themselves as a result of a chronic condition or disease. Although the yearly decrease is only one or two percent, the downward trend has remained consistent since 1982. A 1996 New York Times article describes the observations of Dr. Richard Suzman, Director of Demographic Research at the National Institute on Aging. Dr. Suzman observed that what this data could mean is that a rapidly growing elderly population does not necessarily equal the economic drain that it has been projected to be. (Trends reflected in the National Long Term Care Surveys show that even with the increased life spans of our population, the per capita costs of the Medicare program might be far less than expected due to better health and quality of life.) Dr. Suzman further

points out that, although people are living longer, there will continue to be a need for programs like the Medicare.

Although the cost and financing of health care is a debate much larger than this report, it does bear noting that many experts believe that there is cost-saving potential in a geriatrically prepared personnel, whose training would equip them to apply appropriate interventions that can forestall need for high-tech, high cost treatment.[13]

As stated, the IAPC believes that forecasting the number of health care professionals needed for an aging population demands further study, specific to Texas. In general however, experts within the IAPC note an urgent need for the *current* and emerging workforce to gain additional education and put into practice skills specific to the current needs of older Texans.

Health Care Policies for Successful Aging

> It's time to dispel the false and discouraging claim that old age is too late for efforts to reduce risk and promote health.—Drs. Rowe and Kahn, *Successful Aging*.

According to Drs. Rowe and Kahn, successful aging is defined by the ability to maintain three key factors within one's life:

- Low risk of disease and disease-related disability – Referring not only to the absence of disease or illness, but also to the absence of the risk factors for particular diseases.
- Maintaining mental and physical function – Maintaining a high level of overall functioning requires both physical and mental abilities that are substantially independent of each other. These abilities tell us what a person is capable of, not necessarily what they do. Successful aging needs to go beyond potential and needs to involve activity.
- An active engagement with life – This takes many forms, but *Successful Aging* is most concerned with two – relationships and behavior that is productive.

Drs. Rowe and Kahn further establish that it is a combination of all three of these factors in one's life that represents successful aging, and that each of these factors is itself a combination of factors.

Preventive health practices and screenings are probably one area in which all aspects of the health care sector (treatment, health care financing whether government or private, facilities and personnel) are affected. As a result of practicing preventive health, there is possible reduction in expenses and needs for prolonged medical treatment, hospitalizations, or other acute medical treatment decrease. Preventive health practices and screenings seem to be very crucial components in equipping Texas' health care professionals to meet the needs of our aging population.

The benefits of preventive health practices and screenings have proven to lessen the incidence of certain conditions such as flu and pneumonia, which can develop into more severe conditions, sometimes resulting in death; as well as successfully detecting and treating other conditions such as breast and prostrate cancer. A concerted effort on the part of all parties involved in the health care sector to promote preventive health practices and screenings will undoubtedly have a positive effect on the quality of life of our aging population. Such an effort will also have a tremendous positive impact on the health care sector in terms of ability to handle demand and overall expense.

But what about "maintaining mental and physical function" and "continuing engagement with life" so emphasized by Drs. Kahn and Rowe? The IAPC felt so strongly about such things as the influence of adequate housing, life long learning, meaningful and productive work, etc., upon one's overall health, that some general observations about these issues are addressed in the "Additional Policy Areas Related to A Healthy Aging Texas," section of the this report.

Access to Health Care—One Fundamental Issue

As Dr. Raimer noted to the Senate Health Services Committee in the fall of 1999, prevention and technology may well be our best defenses for a healthy state, because—as the IAPC notes—*where the services are and getting to them* is a critical problem for Texas.

In dozens of public hearings held by both the Health and Human Services Commission and the Texas Department on Aging throughout the state in 1999, transportation services were cited by citizens, advocates and professionals as one of the top most unmet needs across Texas communities. The Texas Health and Human Services Commission, in its 1998 report *Community Transportation in Texas,*[14] substantiates this concern. The report describes two major pressures challenging our state's community transportation system:

- A change in the type of services demanded because of social initiatives like welfare-to-work, an increasingly aging population, and suburban development causing a "spatial" or geographic mismatch between demand and services; and
- ...as the number of [transportation] programs climbs, the duplication of effort and inefficiency also climb.

Moreover, a 1995 National Personal Transportation Study predicted that as the baby boomer generation ages, travel limitation associated with declining health will place an added strain on existing transit (demand) services, and, collectively, mobility may decline.

In crafting its response to the SHCC regarding the first charge, *identify the health needs of an aging population,* the IAPC found itself returning over and over again to the issue of transportation, or more simply, the ability of people to get to where the services are. The IAPC concluded that transportation is, in a very real sense, a chief service need related to health care access among older Texans. Therefore, the IAPC asserts here that state leaders should turn their attention to the ongoing analysis and recommendations issued by the Health and Human Services Commission.

Paying for Health Care—Another Fundamental Issue[15]

While most older Texans qualify for Medicare coverage for routine curative care at age 65, a large number still cannot afford the co-payments and deductibles associated with the program. Supplemental insurance is a costly option and prohibitive for many. Moreover, Medicare does not pay for prescription drugs, causing an alarming number of frail and low-income older people to have to choose between medicines and rent, or food. Some HMOs who offer Medicare products offer drug benefits, but

HMOs are available only in select areas of the state, and Texas has recently suffered a staggering "pull-out" of HMOs from the Medicare business altogether.

Medicaid and related benefits such as the Qualified Medicare Beneficiary benefit are also options, but only if the older person meets certain income limits. Fixed incomes put large numbers of Texas seniors over those limits, yet still they are financially strapped.

And then there is the segment of younger elderly who are not yet eligible for Medicare, but do not have private insurance, mostly people who are out of the labor force before age 65.

Previously some of these early retirees could expect continued employer-sponsored retiree health insurance until age 65, but lately employer coverage for them has fallen significantly, due to businesses' concerns about future financial liability from such coverage (Alpha Center, 1998).

The number of aging Texans who will fall into this coverage gap vary not only as a function of demographic growth, but also by socioeconomic employment trends. These include early retirement, layoff of older employees, dropping of retirement coverage by employers, and the retirement of employees from jobs that had never offered health care benefits at all.

Finally, and perhaps most critical in our state, older people and people with disabilities often need health-related services that support their functional needs, (and their overall health) but they are not considered "medically necessary" services, and therefore not covered by Medicare and other benefits. Long-term care insurance poses another option here, but once again, availability and cost loom as barriers.

INTERAGENCY AGING POLICY COUNCIL RECOMMENDATIONS

Recommendation One: Establish partnerships between federal and state government entities and the managed care and insurance industries to formulate initiatives that will result in aggressive promotion of preventive health practices and screenings. As part of its federal mandate to serve as a visible advocate for

older persons, the Texas Department on Aging should call upon the Medicare program and encourage it to continue its progressive trend of covering the cost of a variety of health screenings, in addition to adding more health screenings to the list of benefits.

Recommendation Two: Call upon the Health Care Financing Administration (HCFA) and Congress to include prescription drug coverage in the Medicare program. Additionally,

- The Texas Legislature and the Texas Department of Human Services should increase the existing prescription drug coverage available through the state Medicaid program.
- The legislature should consider funding a prescription drug pilot program that would benefit older Texans that are forced to pay full price for their prescriptions as a result of being caught in the gap of not being poor enough to qualify for Medicaid benefits, and at the same time not able to afford a Medigap policy with a prescription benefit or enrollment in a Medicare HMO (where available). The legislature should call on the Health and Human Services Commission, Texas Department of Human Services, the Texas Department on Aging and area agencies on aging, and various providers to formulate a proposal for such a program, which would establish eligibility criteria and scope of coverage. The proposal for such a program should be based on analysis of similar program models in other states, such as Pennsylvania, Minnesota or Illinois. This pilot program would serve as a gauge of feasibility for statewide implementation of such a program.

Recommendation Three: Include injury/fall prevention messages in the Texas Department on Aging statewide public awareness campaigns.

Recommendation Four: The Texas Department on Aging and the Texas Department of Health should jointly analyze in depth the current health habits and risk factors of Texas baby boomers. The two agencies should examine the Texas Department on Aging's 1999 Baby Boomer study and the Texas Department of Health's Behavioral Risk Factor Surveillance data, as well as any follow-up studies.

Recommendation Five: Promote and/or create incentives for students to choose geriatrics either as a specialty or sub-specialty.

- Emphasis should be placed on mental health issues, particularly in recognizing and treating depression and substance abuse.

Recommendation Six: Conduct a geographic analysis of the top 25 counties in Texas with the lowest ratio of physicians and other health care professionals to the 60 + population, as well as to the 40 - 60 population. This will serve as an initial step in identifying the areas of the state currently most in need of adequately trained health care professionals, in addition to indicating potential needs over the next 20 years as the bulk of the baby boomers comprise the 60+ age group.

Recommendation Seven: Explore mechanisms that encourage the insurance industry to provide greater emphasis on preventive care for all ages.

Recommendation Eight: Explore the feasibility of replicating all-inclusive care projects such as the El Paso PACE project should be aggressively studied; federal barriers relating to solvency requirements for nonprofit agencies to operate such projects should be analyzed and solutions offered.

Recommendation Nine: Create a single point of contact in the Texas Department of Health to coordinate with the Interagency Aging Policy Council, the area agencies on aging and other organizations concerned with aging health issues.

Recommendation Ten: Support policies and funding that increase public health promotion and support intergenerational, societal and family social support programs. Particular focus should be given to minority families.

Additional Policy Areas Related to A Healthy Aging Texas

Employment Opportunities: There should be vigorous promotion of life-long learning and meaningful employment opportunities for older students and workers by educating employers, offering worker re-training and employment opportunities.

Affordable Housing: The IAPC and the SHCC should work explicitly with the Texas Department of Housing and Community Affairs in the continued development of affordable housing with easy access to health care settings.

Volunteerism: Volunteer programs that provide services related to good health (such as transportation, respite care, etc.) and that offer seniors opportunities to stay mentally and physically engaged should be enhanced. Examples of model volunteer programs include Family Pathfinders, RSVP and others.

Endnotes

1. Texas Department of Health, *Aging Texas Well: A Health Perspective*, 1999.

2. Zaffirini, Judith, et. al, *S.C.R. No. 36*, 75th Texas Legislature, 1997.

3. Zaffrini, Judith, et. al, Senate Interim Committee on Health and Human Services, *Interim Report to the 76th Legislature,* 1998.

4. Raimer, Ben, MD, Testimony before the Senate Interim Committee on Health Services, November 1999.

5. Texas Department of Health, compiled statistics from 1997 and 1999; with citations from the Center for Disease Control.

6. U.S. Preventive Services Task Force, 1994.

7. National Alzheimer's Disease and Related Disorders Association, Inc., 1998.

8. Texas Department on Aging, 1998.

9. Health Resources & Services Administration, *A National Agenda for Geriatric Education,* White Papers, Volume 1, 1998.

10. Ibid

11. Ibid.

12. Texas Department of Health, 1991.

13. Health Resources & Services Administration, *A National Agenda for Geriatric Education,* White Papers, Volume 1, 1998.

14. Texas Health and Human Services Commission, in collaboration with the University of Texas, *Community Transportation in Texas,* December 1998.

15. Texas Department of Health, *Aging Texas Well: A Health Perspective (excerpt),* 1999.

Acknowledgements

The Texas Interagency Aging Policy Council advises the Texas Department on Aging on how the agency can best serve as a source of expertise and information on aging policy issues for the legislative and executive branches of state government. Council members are listed below:

Texas Health and Human Services Commission

Texas Department of Mental Health and Mental Retardation

Texas Department of Protective and Regulatory Services
(Adult Protective Services)

Texas Workforce Commission

Texas Department of Health

Texas Department of Human Services

Texas Department of Housing and Community Affairs

Texas Center for Rural Health Initiatives

Texas Department of Transportation

Texas Institute for Health Policy Research

Texas Association of Area Agencies on Aging

Texas Criminal Justice Policy Council

Texas Department of Insurance

AARP of Texas

The primary authors for this report are: George Kelemen-B (TDoA), Gregg Ukaegbu (TDH), and Christy Fair (TDoA).

The IAPC sincerely thanks Dr. Robert Kahn for his guidance and consultation in compiling this report.

Appendix E
Ad Hoc Committee on Recruitment and Retention of Health Professionals

A report given in response to the *1999-2004 Texas State Health Plan* goal:

Goal 3: Address the maldistribution of health professionals.

Objective 3.2: Increase access to care through the coordination of recruitment and retention activities

This chapter is excerpted from the ad hoc committee's report. Copies of the full report are available from the Center for Rural Health Initiatives.

Report to the Statewide Health Coordinating Council

December 2, 1999

Texas Statewide Health Coordinating Council
Ad Hoc Committee on Recruitment and Retention of Health Professionals
Member List

Robt. J. "Sam" Tessen, MS, Co-Chair
Executive Director
Center for Rural Health Initiatives

Joe Frush, Co-Chair
Hospital Representative
Statewide Health Coordinating Council

Cathy Celestino
Texas Higher Education Coordinating Board

Connie Berry
Texas Department of Health

Claude Williams, DDS
Director of Community Outreach
Baylor College of Dentistry, Texas A&M University System

Henri Migala
North Central TX Division
East Texas AHEC
University of North Texas Health Science Center at Fort Worth

Kathleen Becan-McBride
Community Outreach and Education
University of Texas
Houston Health Science Center

Ruth Ann Herrera, NP
Texas Nurse Practitioners

Richard Branson, PA
Texas Academy of Physician Assistants

Richard Hoeth, FACHE, CAE
Rural Health and Hospital Affairs
Texas Hospital Association

Marcia Collins
Texas Medical Association

Lee Lane
Texas Department of Health

Jon Phillips
Center for Telemedicine
Texas Tech University Health Science Center

Greg Herzog
Texas Academy of Family Physicians

Janis Ritter
Piney Woods Area Health Education Center (AHEC)

Joy Hedrick
Coastal Area Health Education Center (AHEC)

Ashley Davila
Texas Department of Health

Leonel Vela, MD
Texas Tech University Health Science Center

Tom Roehrig
Texas Medical Association

Staff: Center for Rural Health Initiatives

Ad Hoc Committee on Recruitment and Retention of Health Professionals

INTRODUCTION

Charge to the Committee

In the 1999-2004 Texas State Health Plan the Statewide Health Coordinating Council (SHCC) established a goal to "address the maldistribution of health professionals" (Goal 3). Objective 3.2 for this goal was to "increase access to health care through the coordination of recruitment and retention activities." To achieve this objective the SHCC created an ad hoc committee to assess the effectiveness of current recruitment and retention efforts of health professionals in rural and underserved areas and recommend ways to improve coordination of those programs.

The SHCC further charged the committee to:

1. Identify practice issues and barriers to recruiting and retaining providers in underserved areas;
2. Evaluate the effectiveness of recruitment/retention efforts;
3. Determine strategies for improving access to primary care and ways to measure performance in this activity; and
4. Make recommendations for coordination of activities and/or modification to programs to increase access to medical care.

The ad hoc committee was formed and their findings to the above charge are presented in this report.

BACKGROUND

The availability of qualified health care practitioners and providers in rural areas of Texas directly affects access to health care services for rural citizens. There is no access to primary health care services without a consistent, reliable source for the

recruitment of those health care professionals. An equally critical and often overlooked component of the access equation is the necessity of retaining those professionals in the rural communities after recruitment. These are two different yet distinctly connected processes.

A number of barriers to both the recruitment and retention of health care professionals exist. They include:

* Professional isolation;
* On call status and lack of temporary relief services;
* Quality of life issues;
* Lack of career opportunities, for self and spouse;
* Difficulty accessing related healthcare services, e.g. pharmacies, specialists, therapies, behavioral health;
* Lack of access to the latest medical technology and telecommunications capabilities;
* Language and cultural barriers;
* Family unhappiness or dissatisfaction; and
* A general misperception of the realities of rural health care practice.

These issues must be addressed if recruitment and retention efforts are to be successful.

Recruitment

Recruitment strategies fall into any or all of three approaches.

- Practice-environment strategies
- Medical education strategies
- Applicant-pool strategies

Practice-environment strategies aim to influence the practice decisions of health care professionals after completion of training. They consist of a variety of measures that include: offering special financial incentives to practitioners for practicing in shortage areas; strengthening the physician recruitment and practice infrastructure in rural and/or underserved communities; and attempting to make practice in these communities more attractive.

These strategies have the quickest payoff because they are targeted toward health professionals who have already completed their education. Examples include scholarship and loan repayment programs, matching practitioners with available openings, subsidies for practice in rural areas such as incentive programs, telemedicine programs to establish health care connections, and *locum tenens* or temporary relief services.

Loan repayment programs for physicians administered by the Higher Education Coordinating Board and for physician assistants administered by the Center for Rural Health Initiatives provide financial incentives for professionals choosing rural practice. The Texas Department of Health operates a web-based Clearinghouse for Health Professionals providing assistance to both practitioners and those recruiting. The Center for Rural Health Initiatives is developing the Texas PRAIRIE DOC program, which is a comprehensive recruitment approach, involving communities and other partners and participants.

Medical education strategies aim to promote graduates' interest in practicing in rural and/or underserved communities by providing them with experience in caring for underserved populations during their training. The rationale for these programs is that health professional's decisions about where to locate their practice may be influenced by their training experience. These strategies complement practice-environment strategies because they give students and resident's practical experience with underserved communities and provide faculty role models who can inspire or reinforce their commitment to practice in rural and/or underserved communities.

Examples of these strategies would include the preceptorship and rural rotation programs administered by the Texas Higher Education Coordinating Board. The Statewide Family Practice Preceptorship Program actively promotes exposure of medical students to family medicine and includes off-campus experiences. The University of North Texas Health Science Center at Fort Worth and Texas Tech Health Science Center actively rotate medical students and residents in rural communities. The new 1-2 Residency Program developed by the Texas Tech Health Science Center involves a full two-year experience in a rural setting. Non-physician practitioners such as physician assistants and nurse practitioners are also receiving exposure to rural health practice in their academic training programs.

Applicant-pool strategies provide interventions to identify, prepare, and recruit individuals who may be predisposed to care for rural and/or underserved populations because of personal characteristics, such as being a member of an ethnic or racial minority group, or having been reared in a rural area. The best indicator of a health care professional's future choice to practice or work in a rural area is the fact of prior residency in a rural area by the individual or spouse of the individual. These programs include:

* Academic enhancement – strengthening scholarship especially in math and science;
* Motivational and career counseling;
* Mentoring – providing guidance from peers, senior students, and faculty;
* Research apprenticeships;
* Building partnerships between academic health centers and K-16 schools; and
* Admissions preparation such as focused preparation for the Medical College Admissions Test, application procedures, etc.

There are a number of innovative programs in academic institutions and programs in the state designed to recruit and retain rural students in health professions education programs. Representative programs include efforts by the Texas Department of Health's Office of Border Health, Texas A&M University System's Partnership for Primary Care, and the Medical School Familiarization Program through the University of Texas Medical Branch at Galveston.

Finally, a significant contributor to the exposure of students and residents to rural practice is the community level support services provided by the Area Health Education Centers (AHECs). These efforts are currently more organized in East and South Texas. The AHEC's have a comprehensive health workforce development program that includes recruiting, identifying clinical training sites, continuing professional education, and community planning for workforce development and recruitment.

There are a number of programs and services being developed and/or implemented across Texas, but these continue to lack a single, comprehensive, collaborative approach to the recruitment process (See end of this chapter for Table E-1).

Retention

The area of retention has been almost totally neglected and only now is it beginning to be understood for the long-term value it holds for ongoing access to care in rural communities. Retention often only becomes an issue after a practitioner has made the decision to leave a community or has actually left. At that point, it is obviously too late for that practitioner Recruitment efforts without appropriate retention focus can relegate communities to a revolving door of practitioners and recruitment efforts. The lack of any comprehensive retention awareness and/or training for the leaders and citizens of rural communities leaves those rural citizens to fend for themselves in the retention arena, often when other communities and recruiters are actively recruiting their practitioners. The Texas PRAIRIE DOC Program has developed the structure and the beginnings for a community-based retention service that will train community leaders, health care professionals and consumers in early and ongoing techniques to focus on retention efforts at that community level.

Retention is significantly affected by the reimbursement rates for services provided to patients by practitioners. The financial viability of a practice and the resultant financial quality of life for the practitioner and his or her family is a constant variable. Rates for reimbursement are based upon decisions made generally outside the realm of influence of the practitioner, particularly in the Medicare and Medicaid programs. Managed care programs offer the practitioner some opportunity to negotiate for reimbursement rates, although this can be a negative process if the managed care company wants to focus on patient services in more highly populated or density areas. When managed care selectively contracts with providers to a point where patients must leave a community to obtain approved provider services, the health care delivery infrastructure in the patient's community, including the practitioner's practice, is threatened.

The federal designation process for underserved designations affects the ongoing availability of resources and/or financial incentives to rural practitioners. This can have a direct effect on the viability of rural practices and the decision to maintain those practices.

The use of modern telecommunications technology offers the potential for innovative approaches to retention strategies, particularly when coupled with clinical resources available through academic health science centers, medical schools, tertiary care

centers and regional health care facilities. The availability of such services is greatly influenced by state and federal policies regarding access to such services by providers. A significant barrier exists in that only non-profit providers have access to state and federal telecommunications grant programs while the most prevalent type of primary health care providers in rural communities are physician practices, which are technically for-profit, and thus ineligible for these grants.

Finally, the role of long term retention of health care practitioners in the economic health and infrastructure of a rural community is beginning to be understood and addressed.

AD HOC COMMITTEE RECOMMENDATIONS

Recruitment

Primary Recommendations:

Recommendation One: Selection of medical and other health professional students specifically from rural and underserved areas. This should include physicians (MDs, DOs), Physician Assistants, Nurse Practitioners, and certified nurse midwives. Adoption or adaptation of a successful model already field-tested would be advantageous. There would have to be specifically outlined requirements that such students would have to fulfill a rural practice obligation upon completion of training, although studies suggest a significantly higher proportion voluntarily choose such a setting because of their personal background.

Recommendation Two: Development of statewide coordinated recruitment and retention efforts in a collaborative partnership of state agencies, medical schools, professional associations, AHECs, and others, coordinated by the State Office of Rural Health - the Center for Rural Health Initiatives, utilizing the Texas PRAIRIE DOC Program.

Recommendation Three: Development of a state-specific set of criteria to make a Health Professional Shortage Area (HPSA) determination should be pursued. Such a set of criteria should take into consideration unique geographic, demographic, health status, socio-economic, and other factors. A site-specific eligibility set of criteria is a possible approach already being discussed. The development of such a criteria should be done by the Center for Rural Health

Initiatives as the State Office of Rural Health in coordination with the Texas Department of Health's Primary Care Provider Resources Program.

Recommendation Four: Support development of telecommunication, tele-education and telemedicine and the reduction of financial barriers to the financial sustainability of this infrastructure, e.g. costs for hardware, line charges for transmission of data signals. The use of tele-education to students in rural community schools could assist in both developing their career interest but also reinforce their decision to return to the rural community to practice or work. A related area that must be addressed is the availability of this technology to the single most pervasive provider of rural health care services, the physician practice or rural health clinic that is technically classified as 'for profit.' A precedent exists in that these providers already accept public monies through the reimbursement by government for Medicare and Medicaid services provided to patients.

Secondary Recommendations:

- Recognize and promote health care at the community level as a significant community development and economic development generator and partner. Assessment of economic indicators and interventions should include health care as a prime need.
- Track post-residency or program completion by practice/work site selection and annual follow-up for up to 5 years. Data collection should be coordinated and reported to the State Legislature.
- Expand health professions recruitment programs to include non-physician practitioners, e.g. physician assistants and nurse practitioners because these non-physician practitioners sometimes have a better record of moving to and staying in rural areas.
- Implement additional mentorship programs and financial support for those programs. The preceptorship program mentioned in the report is under-funded and not inclusive of the broad definition of primary care providers. Of the 760 rural rotations last year, only 88 did rural rotations because the program is full, has a waiting list, and is under funded.
- Provide employment opportunities for the spouses and partners of health care professionals being recruited requires innovative and multi-faceted approaches, including recognition of the issues and involvement by the

Texas Workforce Commission with communities in the recruitment process.

- Appropriate state funds to leverage National Health Service Corps (NHSC) programs for other health professionals, specifically including physician assistants and nurse practitioners. State match for NHSC placement programs of these health professionals should be instituted, through the Higher Education Coordinating Board.
- Develop and implement a "Top Doc" recognition program to honor those community physicians who tirelessly provide rural community site training and supervision for medical students and residents. This could be modeled after the new program at the University of Texas Medical Branch in Galveston.
- Develop a seamless system approach to developing interest in health care professions at the grade school level and high school level (e.g. health professions 'summer camps' as found in some areas of the state, e.g. East Texas and South Texas AHECs), medical students and residents 'adopt' rural community schools for role modeling with school students, and partnerships between health professionals training programs and local rural schools in order to provide resources for health career interest in the schools and develop relationships for those students to foster their movement into health professions careers.
- Link health professions training programs with rural communities offers the opportunity for each to learn from the other and provide an opportunity for communities to input their needs (short term and long term) into training programs.
- Recognize that the availability of trained, qualified ancillary health care professionals is a critical component to both recruitment and retention of primary care providers. Coordination between training programs for the broadest range of health care professions could assist in working to maintain adequate supply, e.g. Registered Nurses.

Retention

Primary Recommendations:

Recommendation One: Develop of a comprehensive, community-based retention program based upon the premise of training local citizens to know how to retain their practitioners will result in localized retention, utilizing the Center for Rural Health Initiative's Texas PRAIRIE DOC Program as a foundation.

Recommendation Two: Develop of an inter-state agency work group to develop and implement an agenda to facilitate health professional retention awareness and interventions, including Center for Rural Health Initiatives, Texas Department of Health, Texas Department of Economic Development, Texas Department of Agriculture, and others.

Recommendation Three: Develop medical school and academic health science center services that would provide ongoing peer consultation, training, and communication for health care professionals in rural areas. Such services could include mini-fellowships, locum tenens services, telemedicine, and community faculty involvement.

Recommendation Four: Explore the feasibility of a physician relief service for rural physicians. A study of this issue is currently being undertaken by the Center for Rural Health Initiatives at the direction of the 76th Legislature.

Secondary Recommendations:

Recommendation One: Develop retention training efforts for community leaders and health care providers along with development of retention resources, templates, manuals, etc. Utilization of existing models should be explored, such as community-based health promoters, community "encourager," and involvement of family of the provider in retention efforts.

References

American College of Physicians, "Rural Primary Care," *Annals of Internal Medicine,* 1995.

Center for Rural Health Initiatives/Texas Academy of Family Physicians, Rural Physician Relief Services Survey: Summary of Results, Austin, TX, 1995.

Center for Rural Health Initiatives, Texas Physician Recruitment and Integrated Retention Initiatives Extending Docs Out to Communities (Texas PRAIRIE DOC Program), Austin, TX, 1999.

Center for Rural Health Initiatives, Various maps delineating data supplied by a variety of sources, Austin, TX, 1999.

Cullison, S., Reid, C. and Colwill, J., "Medical School Admissions, Specialty Selection, and Distribution of Physicians," *Journal of the American Medical Association*, 1976.

Grumbach, K, Coffman, J, Liu, R, Mertz, E., "Strategies for Increasing Physician Supply in Medically Underserved Communities in California," California Policy Research Center, Berkeley, CA, 1999.

Health Resources and Services Administration, Bureau of Primary Health Care, General Information on the National Health Service Corps, Washington, D.C., 1997.

Hicks, L, and Glenn, J., "Rural Populations and Rural Physicians: Estimates of Critical Mass Ratios, by Specialty," *The Journal of Rural Health*, 1991.

Kindig, D, and Ricketts, T., "Determining Adequacy of Physicians and Nurses in Rural Populations: Background and Strategy," *The Journal of Rural Health*, 1991.

Looney, S, Blondell, R, Gagel, J and Pentecost, M., "Which Medical School Applicants Will Become Generalists or Rural-Based Physicians?" *Journal of Kentucky Medical Association*, 1998.

Makuc, D, Haglund, B, Ingram, D, Kleinman, J. and Feldman, J., "The Use of Health Service Areas for Measuring Provider Availability," *The Journal of Rural Health,* 1991.

National Rural Health Association, "Physician Recruitment and Retention," Kansas City, MO, 1998.

Pathman, D., "Estimating Rural Health Professional Requirements: An Assessment of Current Methodologies," *The Journal of Rural Health*, 1991.

Rabinowitz, H, Diamond, J, Markham, F, and Hazelwood, C., "A Program to Increase the Number of Family Physicians in Rural and Underserved Areas," *Journal of the American Medical Association*, 1999.

Texas Department of Health, Bureau of State Health Data and Policy Analysis, various data, Austin, TX, 1999.

Texas Department of Health, Health Professions Resource Center, Clearinghouse for Health Professionals, Austin, TX, 1999.

Texas Higher Education Coordinating Board, Physician Education Loan Repayment Program, Austin, TX, 1998.

Texas Medical Association, "Sourcebook: Primary Care Physician Education in Texas, Report of the Subcommittee on Primary Care," Austin, TX, 1997.

Texas Medical Association, "Sourcebook: Primary Care Physician Education in Texas, Report of the Special Committee on Primary Care," Austin, TX, 1995.

Texas Medical Association, "Texas Physician Workforce Profile: Residents & Fellows Completing Training in Texas, 1996 Survey," Austin, TX, 1997.

Texas Medical Association, "The Physician Workforce in Texas: Implications for Medical Education. Report of the TMA Council on Medical Education," Austin, TX, 1999.

Texas State Board of Medical Examiners, Data on physician distribution by licensure information, Austin, TX, 1999.

Texas Statewide Family Practice Preceptorship Program, TSFPPP – Texas Statewide Family Practice Preceptorship Program, Houston, TX, 1999.

U.S. General Accounting Office, Report to Congressional Requesters: Physician Shortage Areas – Medicare Incentive Payments Not an Effective Approach to Improve Access, Washington, D.C., GAO/HEHS-99-36, 1999.

Weiner, J., "HMOs and Managed Care: Implications for Rural Physician Manpower Planning," *The Journal of Rural Health*, 1991.

Table E-1. Current Programs and Services

Provided By	Programs/ Services	Specifics of Services Provided	Impacted/ Awarded	Rural	HPSA	Under-served
Center for Rural Health Initiatives	Texas PRAIRIE DOC Program	Comprehensive recruitment and retention program with emphasis on community-based efforts, including Job Opportunity Registry, Locum Tenens Job Opportunity Registry, HealthFind, Primary Care Resident Practice Evaluation Training, Primary Care Provider Practice Site Evaluation Checklist, and other services	New program	X		
Center for Rural Health Initiatives	Outstanding Rural Scholar Recognition Program	Loan forgiveness, 50% of loan from community and 50% state match; assists communities to "grow their own." Student provides year of health care in their sponsoring community for each year a loan is received.		X		
Center for Rural Health Initiatives	Medically Underserved Community - State Matching Incentive Program	Matching grant of up to $25,000 to a community to assist in setting up a new primary care practice site in the community.	FY 1999 7 awards	X		
Center for Rural Health initiatives	Texas Health Services Corp.	Stipend to residents enrolled in an accredited family practice, general internal medicine, general pediatrics, or general obstetrics/gynecology residency program who contracts to provide services in a medically undeserved area for at least one year for each year that stipend was received.	FY 98 2 awards	X	X	X
Center for Rural Health initiatives	Locum Tenens: Clearinghouse	Parallel list of practices/communities looking for locum tenens coverage and of physicians willing to work in locum tenens agreements.	List averages 2 communities and 4 providers.	X		
Center for Rural Health initiatives	Visiting Physician (locum tenens) study	Legislatively mandated study to determine feasibility of a rural locum tenens program; study to include medical schools (AHSC), professional physician associations, and rural physicians	New program	X		
Center for Rural Health initiatives	HealthFind	Annual forum for communities to market themselves to residents and physicians; also includes Pas and NPs	1997 & 1998; 62 communities 119 physicians, 64 mid-level practitioners	X		
Center for Rural Health initiatives	Community Scholarship Program	Provides scholarships in rural Health Professional Shortage Areas to fund the health professional education of 3rd and 4th year medical students, physician assistants, and nurse practitioners that commit to practice in the sponsoring community.		X	X	
Center for Rural Health initiatives	Physician Assistant Loan Reimbursement Program	Loan reimbursement up to $5,000 for Physician Assistants who have worked in rural area for at least 12 months; maximum of 18 awards per year.	FY 98 - 17 awards	X	X	X

Provided By	Programs/ Services	Specifics of Services Provided	Impacted/ Awarded	Rural	HPSA	Under-served
Department of Health and Human Services (federal)	Nursing Education Loan Repayment Program	Eligible registered or advanced practice nurses (nurse practitioners, nurse midwives, nurse anesthetists). Payment of 60% of principal and interest of qualifying nursing loans for a 2 year commitment of fulltime clinical services in a public hospital, community health center, rural health clinic, or public or nonprofit health facility determined to have a critical shortage of nurses.				
National Library of Medicine, Houston	National Network/Library of Medicine Outreach & Training Services	Outreach for training, Grateful Med software and demonstration, document delivery through Lonesome Doc, Internet connectivity training				
Texas Department of Health	Clearinghouse for Health Professions	Clearinghouse for physicians, physician assistants, and nurse practitioners seeking collaborative practice opportunities; information kept active for four months.	7 health professionals currently on list (August 1999)			
Texas Department of Health Community Health Provider Resources provides info; waivers administered through USDA	J-1 Visa Waiver Program	Foreign physicians may remain in the United States after completion of their training under a J-1 visa. The waiver permits the non-immigrant to remain and convert the temporary visa into an occupational visa. Sites must be in a rural, whole county HPSA or MUS; providers must practice primary care at the site for a three period.	1998: 39 J-1 Visa Waivers	X	X	X
Texas Department of Health through a cooperative agreement with Health Services Resources Administration. (federal)	National Health Services Corp	Scholarship and Loan forgiveness for primary care providers (physicians, physician assistants, nurse practitioners, certified nurse midwives, dentists, dental hygienists, and mental health professionals). Sites must be located in a Health Professional Shortage Area. Providers are obligated for a two year period, renewable by one year increments after the first two year period. Up to $25,000 per year for up to five years, plus 39% of the award amount for tax liability.	1998: 62 awards		X	
Texas Higher Education Coordinating Board	Professional Nurses' Student Loan Repayment Program	Eligible licensed nurse who has practiced in Texas for at least one year in a position which requires the services of a licensed professional nurse; priorities based on criteria including geographical area of nursing practice, practicing in a area with an acute nursing shortage, and others, maximum of $2000 annual repayment.	16 awards per year; $32,000			

Provided By	Programs/ Services	Specifics of Services Provided	Impacted/ Awarded	Rural	HPSA	Under-served
Texas Higher Education Coordinating Board	Physician Education Loan Repayment Program for Residents & Faculty of Tx. Family Practice Residency Training Program	Loan repayment for undergraduate, graduate, or medical education, cannot be a loan from relatives or physician's insurance company or pension plan; have unrestricted license to practice in Texas, be second or third year Family Practice resident in an approved Residency Training Program or be a fulltime faculty member in a Texas Family Practice Residency Program, or be a fulltime faculty member who completed a Texas Family Practice Training Program on or after 7/1/95; show strong commitment to practice medicine in a Texas HPSA or rural community.	38 awards for 1999	X	X	
Texas Higher Education Coordinating Board	Physician Loan Education Repayment Program	Loan repayment for undergraduate, graduate, or medical education, must be licensed to practice in Texas, no disciplinary action, have completed one year of medical practice in an economically depressed or rural medically undeserved area; maximum total repayment is $18,000 (half state, half federal), maximum of five years (see below for more details)	FY 1999 113 awards	X	X	
Texas Higher Education Coordinating Board	Statewide Medical Student Preceptorship Program	$500 stipend to medical student who completes a 4 week preceptorship in primary care (Family Medicine, General Pediatrics, General Internal Medicine)	Approx. 600 students/year			
Texas Higher Education Coordinating Board, Medical School Primary Care Depts.	Primary Care Residency Programs	Reimbursement to departments for one-month rotation time a resident spends in an approved off-campus site; Family Medicine site must be in a rural area, with population under 30,000	FY 1999: 205	X		
Texas State Board of Medical Examiners	Rural Physician Registry	Working collaboratively with the Center for Rural Health Initiatives' Texas Prairie DOC program through respective medical specialty societies.	New program	X		
Texas State Board of Medical Examiners	Texas Physician Placement Service	Community profile (of community seeking a physician) matched with physician (seeking practice opportunity) profiles; profiles then sent to opposite parties for contacting				
AHEC, Tech-Prep	Pre-Medical Rural Training	Exposure to various aspects of the medical fields through classes, camps, on-site visits, for high school students.	Difficult to quantify, each AHEC unique.			

Provided By	Programs/ Services	Specifics of Services Provided	Impacted/ Awarded	Rural	HPSA	Under-served
Office of Primary Care Education, UTMB	Generalist Physician Initiative (Robert Wood Johnson Foundation)	Administers program for promoting substantial increase in number of resident and medical student graduates who can choose primary care careers with emphasis on placing at least 15% of these individuals in rural and undeserved communities; required of all UTMB medical students. CCE - all 1st and 2nd year medical students spend 1/2 day per month in community primary care practice. Multidisciplinary Ambulatory Clerkship requires 12-week community-based rotation in primary care during third year of medical school.				
Primary Care Departments	Resident Rural Rotations	Off-campus, community-based clinic experience; stipend provided by the Texas higher Education Coordinating Board	FY 1999: 205	X		
Telecommunications Infrastructure Fund	Telecommunications/Telemedicine	Electronic link to medical school campus physicians; features e-mail connections to departments, and access to medical library CD ROMS.	Approx. 4,301 sites served in one year.			
Texas Prairie DOC Program	Physician Availability Subscription Service	Subscribers receive monthly lists of physicians/residents seeking medical practice opportunities in Texas (fee based)	71 subscribers currently (Aug. 1999)	X		
Texas Prairie DOC Program, TMA Seminars, Professional Association continuing education materials	Practice Management Assessment & Assistance	Technical assistance for practice operations, personnel management, finances, legal, contracting, managed care, billing/coding, etc.	Partially available since Feb. 1999	X		
Center for Rural Health Initiatives; Texas Prairie DOC Program	Effective Matching of Physician & Community	Training for community/practice leaders on realistic evaluation of potential of recruitable physicians and how to 'match' physician, spouse, family with community and its cultural, financial, educational, professional, social, religious and other components of daily life.	Available since Feb. 1999; 2 communities to date.	X		
Center for Rural Health Initiatives; Texas Prairie DOC Program	Community Recruiter Program	Empowering and training a local resident to be responsible to work with and coordinate community efforts to recruit and retain a physician, to target community resources for the financial survival of the practice.	New program for CRHI.	X		
Center for Rural Health Initiatives; Texas Prairie DOC Program	Provider Spouse & Family Recruitment and Retention	Training of community personnel on importance of and techniques for working with the spouse/partner and family of the physician for recruitment and then ongoing involvement for retention.	Previously available outside the CRHI, available through CRHI since Feb. 1999	X		

Provided By	Programs/ Services	Specifics of Services Provided	Impacted/ Awarded	Rural	HPSA	Under-served
Center for Rural Health Initiatives; Texas Prairie DOC Program	Recruitment & Retention Training	Intensive, on-site training in effective recruitment and retention techniques for communities; also regional training workshops for community personnel; ongoing support through other services. Example: Specific assistance and material for organizing a Recruitment Committee effectively and maintaining it.	Available since Feb. 1999; 2 communities.	X		
Center for Rural Health Initiatives; Texas Prairie DOC Program	Community "Encourager" Health Promotion Program (promotion of use of local health services)	Utilization of a community resident to develop strategies and coordinate the development of local health promotion and utilization for increased community self-reliance on and retention of its health care services.	New program	X		
Center for Rural Health Initiatives; Texas Prairie DOC, AHEC	Rural Site Visit Program	Community - sponsored opportunities for physician/spouse/family to assess the community and practice as well as for community to assess physician, for purposes of an effective match.	Available since Feb. 1999, current still evolving.	X		
Center for Rural Health Initiatives; Texas Prairie DOC Program and R.W. Johnson Foundation's East Texas Rural	Community Health Services Development	Organizing local health care professionals and community individuals to determine their own realistic health care needs and developing strategies for supporting a health care delivery system that responds to those needs. Example: needs assessment checklist and formula under development.	New program.	X		

Appendix F
Ad Hoc Committee on Minority Health

A report given in response to the *1999-2004 Texas State Health Plan* goal:

Goal 5: Reduce disparity in health status among all population groups and enhance their access to quality health care by developing a diverse and culturally competent workforce.

Objective 5.1: Develop a Diverse and Culturally Competent Health Workforce in Texas.

Report to the Statewide Health Coordinating Council

January 13, 2000

Texas Statewide Health Coordinating Council

Ad Hoc Committee on Minority Health

Member List

Karl Urban, M.P.Aff.
Chair and Texas Health and Human Services Commission Representative
Member, Statewide Health Coordinating Council

Adena Loston, Ph.D.
Co-Chair
President, San Jacinto College South Houston, Texas
Member, Texas Statewide Health Coordinating Council

Charles T. Ku, D.D.S.
Member, Texas Statewide Health Coordinating Council

Kevin H. McKinney, M.D.
Houston Medical Forum
Assistant Professor of Internal Medicine UTMB

Clemelia Richardson, M.S.W.-A.C.P.
Director of Behavioral Health Services
People and Partnership, Houston Texas

Darryl Williams, M.D.
Exec. Dir., TEXAS TECH AHEC
Texas Tech University Health Sciences Center at El Paso

John Nava, M.D.
Vice President
Mexican American Physicians Association, San Antonio

R.J. Dutton, Ph.D.
Director, Office of Border Health
Texas Department of Health

Janet Leubner, M.B.A.
Program Administrator
Center for Rural Health Initiatives

Lois Linn, Ph.D.
Provost Rio Grande Campus
El Paso Community College

Budge Mabry
Director
UT System Dental & Medical Application

Paula R. Mitchell, R.N.C., M.S.N., Ed.D.
Dean, Health Occupations
El Paso Community College

Staff

Renato Espinoza, Ph.D., M.P.H.
Researcher, Office of Policy and Planning

Gregg E. Ukaegbu, M.P.Admin.
Planner, Office of Policy and Planning

Ad Hoc Committee on Minority Health

INTRODUCTION

Despite advances in medicine, public health practice, and medical technology the health status of the different racial and ethnic groups have not experienced the same gains found in the health status of the Anglo population. Two strategies to address disparities are (1) increasing the representation of minority healthcare providers, and (2) enhancing the cultural competency of all providers. They should be part of a comprehensive longterm state and national effort to achieve the goal of reducing or eliminating the disparities in minority health status.

Texas State Health Plan 1999-2004

The Texas Statewide Health Coordinating Council identified and documented some of the health disparities found among the state's minority population in the *1997-1998 Texas State Health Plan Update.*[1] In the *1999-2004 Texas State Health Plan*, the Council sought to address the reduction of the disparities in minority health status by encouraging the development of a diverse and culturally competent health workforce in Texas. To that end, it set up an ad hoc committee on minority health to address Goal 5 of the *1999-2004 Texas State Health Plan*: **"Reduce disparity in health status among all population groups and enhance their access to quality health care by developing a diverse and culturally competent work force."** The ad hoc committee was charged to report its findings and recommendations to the Council by January 2000.[2]

The Ad Hoc Committee on Minority Health

The Ad Hoc Committee on Minority Health, which was made up of members of health professions, higher education, health education administrators, and a social work professional, decided to direct their efforts on the accomplishment of the following key elements of their charge:

- Develop goals and strategies for the recruitment and retention of minorities in health care professions and
- Propose standards for culturally competent health care practice and practitioners.

The committee focused their research on factors that affect the health status of minorities. They hosted a symposium on June 17, 1999, featuring presentations by experts on minority health, consumer testimonies and input, during a question and answer session. Topics covered in the symposium were:

- Recruitment and retention of minorities in the health workforce
- Programs/policies to increase minority representation in the health workforce
- Policy implications of Hopwood on the health workforce
- Medical schools' admission formulae
- AHEC efforts in the recruitment and retention of the under-represented and disadvantaged
- Strategies to reduce the disparities in minority health

The information from these sources increased the committee's confidence that the implementation of these two strategies can make a significant contribution to the improvement of the health status of minorities.

BACKGROUND

Overview Of Health Disparities In The Minority Population

Health Disparities in the Nation

Blacks, Hispanics, Asian and Pacific Islanders, and American Indians/Alaska Natives, (the U.S. recognized minority populations) have poorer health status compared to the majority population. As a group, they tend to experience lower life expectancy, have greater prevalence of chronic diseases, less than optimal outcomes for pregnancy, and a higher incidence of cardiovascular diseases.[3]

These disparities are illustrated on Table F-1, which shows selected examples of the higher incidence of certain illnesses and clinical conditions, including infant mortality, experienced by racial and ethnic populations in the nation.

As Table F-1 shows, clear disparities in age-adjusted mortality rates continue to exist for racial and ethnic minorities. Cancer and heart disease are particularly adverse for Blacks. Although Hispanics have better outcomes on those diseases, they suffer from a high diabetes death rate. Infant mortality rates are over two times higher for Blacks than for Whites. The death rate from HIV/Aids for Blacks in 1997 was three times that of Hispanics, and more than six times that of Whites for the same period.[4]

Table F-1. Age Adjusted Death Rates by Ethnicity in the U.S.

1997 Age Adjusted Death Rates for Selected Causes of Death per 100,000 Population United States			
Disease	**White**	**Black**	**Hispanic**
Cancer	122.9	165.2	76.4
Heart Disease	125.9	185.7	86.8
Diabetes	11.9	28.9	18.7
HIV/AIDS	3.3	24.9	8.2
Infant Mortality*	6.1	14.2	6.0

* Infant mortality per 1000 live births.
Sources: U.S. Department of Health and Human Services. Health. United States 1999.
National Vital Statistics Report, Vol.47, No.9, Nov.10 , 1998
National Vital Statistics Report, Vol.47, No.19, 1999

There are many factors that impact minorities' access to health care, but even for those minorities that have access to the system of care, there are some indications the level of services they receive may be influenced by race and gender. Results of a controlled study published in 1999 by the *New England Journal of Medicine*, demonstrated clear biases in physician's recommendations for catheterization of patients of different race and sex who presented the same types of chest pain.[5]

The importance of issues related to minority health is reinforced in the U. S. Department of Health and Human Services document, *Healthy People 2010 Objectives: Draft for Public Comment*:

> Compelling evidence that race and ethnicity correlate with persistent, and often increasing, health disparities among U.S. populations demands national attention. Indeed, despite notable progress in the overall health of the Nation, there are continuing disparities in the burden of illness and death experienced by Blacks, Hispanics, American Indians and Alaska Natives, and Pacific Islanders, compared to the U.S. population as a whole. The demographic changes that are anticipated over the next decade magnify the importance of addressing disparities in health status.[6]

National Initiatives to Address Health Disparities

Following the 1997 Healthy People 2000 Review, federal leadership in the form of funding, technical assistance and research has been energized to increase attention to disparities. That report showed that there were more than 50 Healthy People 2000 objectives where one

or more racial/ethnic minority group experienced a 25 percent or more disparity with the HP 2000 target. Objectives include death rates from chronic diseases, such as coronary heart disease and stoke, various cancers and diabetes, death rates from intentional and unintentional injuries, maternal and child health indicators, such as infant and maternal deaths, low birth weight, complications of pregnancy, deaths, incidence and prevalence of preventable infectious diseases, as well as behavioral risk factors, such as cigarette smoking, drug and alcohol abuse, and others.[7]

The development of the new set of Healthy People 2010 Goals and Objectives has involved a large number of public and private national and state organizations and agencies, professional organizations, advocacy organizations and their membership in a consortium that has provided opportunities to participate in the process to thousands of dedicated people throughout the nation.[8]

In order to support meeting Goal 2, **"Eliminate Health Disparities"** of the Healthy People 2010 initiative, the Health Resources Services Administration (HRSA) plans to fund "Centers of Excellence" to focus on the study of causes and strategies for improving the health status of racial and ethnic minority populations in the country, and thus eliminate some of the sources of the health disparities.[9]

Within the framework of *Healthy People 2010 Objectives: Draft for Public Comment*, President Clinton committed the agencies under the department of Health and Human Services to increase their efforts towards eliminating disparities in the areas of infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, and childhood and adult immunizations by the year 2010.[10]

The Health Resources Services Administration's Bureau of Primary Health Care launched the "Campaign to Ensure Total Health Care Access and Eliminate Disparities." This initiative is envisioned to be a state-based community-driven health care campaign to ensure 100 percent access and zero percent disparities by organizing key groups and helping communities meet their health needs through partnerships with safety net providers. Organizations joining the campaign include the Robert Wood Johnson Foundation, the Community Development Corporation and the Coalition for Healthier Cities and Communities.[11]

Another major source of federal initiatives and special grant programs is the Centers for Disease Control and Prevention (CDC). The CDC has embraced the Healthy People 2010

Goals and Objectives and will be using them in their block funding to states to encourage special efforts by states and communities to address the disparities in the health status of minorities.

The Robert Wood Johnson Foundation and the Kaiser Family Foundation are major sources of private foundation resources and leadership in minority health issues. Their "Opening Doors" initiative addresses increasing access to health care for minorities and disadvantaged populations.[12]

Health disparities in Texas

These national efforts serve as the context for state-level initiatives such as that expressed in Goal 5 of the *1999-2004 Texas State Health Plan*, "*...to reduce disparity in the health care status and enhance their access to quality health care by developing a diverse and culturally competent workforce."*[13]

To a great extent, the health status of minorities in Texas mirrors that of the nation. Table F-2 presents the mortality rates for the same selected illnesses and clinical conditions as presented in national information. As shown, in 1997 in Texas the health outcomes of Blacks were consistently worse than those of Whites in all areas. Hispanics exceeded Whites in their diabetes and HIV/AIDS death rates.

Table F-2. Age Adjusted Death Rates by Ethnicity in Texas

1997 Age Adjusted Death Rates for Selected Causes of Death per 100,000 Population, Texas			
Disease	**White**	**Black**	**Hispanic**
Cancer	127.6	183.2	94.1
Heart Disease	144	219.2	118.4
Diabetes	12.4	35.2	32
HIV/AIDS	3.9	19.6	5.1
Infant Mortality*	5.8	10.9	6.0

* Infant Mortality is the number of infant deaths per 1000 live births.
Source: Texas Department of Health, Bureau of Vital Statist ics.
Texas Vital Statistics 1997

Initiatives to Address Health Disparities in Texas

The Texas Department of Health is the principal source of state funding and initiatives to increase access to health care for disadvantaged and minority populations in Texas. The department works in close cooperation and partnership with other agencies, community organizations, professional associations, advocacy groups, foundations and businesses to advance the improvement of the well being of all Texans, including minorities and disadvantaged segments of the population.

The *1999-2003 Texas Department of Health Strategic Plan* addresses health disparities directly under its goals relating to Medicaid services, promoting equitable access and prevention and promotion.

The various Medicaid programs are provided to individuals who qualify on the basis of income. Therefore, they tend to serve a significantly higher proportion of minority clients, who are over-represented among the low-income population. Increasing this population's access to health care services is expected to improve health outcomes.

The implementation of the Children Health Insurance Program (CHIP), with state and federal funds, will provide many more children health insurance by including children living in families up to 200 percent of the federal poverty level. Access to preventive health care, screening, and immunizations for these children should result in better overall health, and increase protection against premature death.[14]

Under the Texas Department of Health goal to Promote Equitable Access, special efforts are made to develop community-based solutions to enhance access to primary care and preventive health services. By targeting disadvantaged communities and encouraging the involvement of a broad range of community agencies and organizations, these programs tend to reach a larger proportion of the minority population in those communities.[15]

One of the Texas Department of Health's Office of Minority Health (OMH) missions is to assist minority communities and organizations in the development and implementation of health care access solutions at the local level. This is done through training and technical assistance to community organizations and by supporting the development of minority health networks that can be effective partners with other local organizations. The OMH also works with programs within the Texas Department of Health and with other federal, state and

local agencies and organizations to coordinate and facilitate access to minority communities through its central office and minority health coordinators in four of the eight regions of the state.[16]

In addition to the Texas Department of Health, a number of state and local foundations provide support to programs designed to expand access to heath services to all minority and disadvantaged populations.

There are also several research and demonstration programs carried out by universities and health science centers funded by federal agencies, who seek to improve access of minority and disadvantaged populations, such as migrant workers and *colonia* residents to health services.

Developing a Diverse and Culturally Competent Workforce in Texas

The goal of the SHCC to reduce disparity in health status among all population groups and enhance their access to quality health care implies the pursuit of two distinct but mutually supportive strategies.

In support of both the diversity and the cultural competency strategies, Dr. Steve Murdock, Director of the Texas Data Center at Texas A & M University, states that:

> While it is not imperative that the racial/ethnic status of health care personnel mirror that of the patient population, there will be an increasing demand for the diversification of the health workforce in Texas. The broad ethnic diversity of Texas calls for a workforce that is, at best, an ethnic/cultural reflection of the population, and at least, well educated in the cultures, customs, and health beliefs of the major population segments it serves.[17]

Diversity in the workforce at the National Level

Leading the efforts for increasing the diversity of the nation's workforce, the Pew Health Professions Commission issued its fourth report in 1998 entitled "Recreating Professional Practice for a New Century." Their second recommendation, addressing all professional groups, was entitled "Ensure that the health professional workforce reflects the diversity of the nation's population." It reads:

> It is essential that the nation's health profession workforce represent the cultural diversity that is and will become even more significant part of this society. This is not a quota borne out of a sense of equity or distribution of justice, but a principle that the best health care is delivered by those that fully understand a cultural tradition. The next generation of health professionals should represent the nation. Not only would renewed commitment to diversity be the fairest way to accommodate all potential medical practitioners, it would be in the best interest of those parts of the population that bear the greatest burdens of poor health. Students that come from medically under-served communities have demonstrated a much greater willingness to return to them to practice. By knowing the language and mores of the population they serve, they offer a more complete and effective kind of care.[18]

Historically, Blacks and Hispanics have been under-represented in the health professional workforce. Recognizing the need to increase the numbers of minority professionals, in 1991 the American Association of Medical Colleges launched an initiative, "Project 3000 by 2000" as a commitment from mainstream institutions to recruit and train 3,000 minority physicians by the year 2000.[19]

Not much progress has been made since then. In an October 29, 1999 press release, the American Association of Medical Colleges reports that in 1999, the percentage of under-represented minority applicants to medical schools fell by almost seven percent to a low of 4,176 applicants. The number of total applicants and under-represented minority applicants represent the lowest figures since 1992.[20]

With respect to other health-related professions, the May/June 1999 newsletter published by the U.S. Department of Health and Human Services Office of Minority Health was devoted to the discussion of the disparate representation of minorities in the nation's health workforce. After examining data for a number of health-related professions and occupations, Kamat concludes that "...major discrepancies persist in the representation of racial and ethnic minorities within the Nation's health professions workforce."[21]

Data on the national level reviewed by Kamat show that Blacks, Hispanics, American Indians, and Alaskan Natives constitute ten percent of the nation's health workforce, compared to 25 percent of the total population.[22] Despite the variations among minorities in specific health professions, Blacks and Hispanics are greatly under-represented in professions that require extensive training such as medicine, dentistry, and pharmacy.[23]

However, they are only slightly under-represented in professions that require substantial formal academic training. In dietetics for instance, Blacks constitute 18.2 percent. They also make up 24 percent of the social workers, and are close to parity among psychologists relative to their percentage in the population.[24] That is not the case when it comes to orderlies and nurse aides, where Blacks are over-represented. Hispanics are relatively well represented as dental assistants, and medical appliance technicians, but are not as well represented in professions that require higher level academic education.

In 1998, the Council on Graduate Medical Education, in its report *Minorities in Medicine,*[25] cited findings of studies that support increasing the number of minorities in the health workforce to reduce health disparities. In part, findings show that:

- Black and Hispanic physicians tended to practice in areas with high percentage of Black and Hispanic residents.
- Black physicians cared for more patients covered by Medicaid, and Hispanic physicians cared for more uninsured patients.

It is clear that minority physicians make an important and unique contribution by providing minorities and disadvantaged patients increased access to culturally competent health care services.

National data on current student enrollment in selected health professions does not suggest that a correction of the under-representation is under way. National enrollment into medical schools show a rising trend of minority enrollment in allopathic medical schools from 1950 to 1995. However, enrollment declined in 1996 and 1997 for all minorities except Asian Americans.[26]

In an October 29, 1999 press release,[27] the Association of American Medical Colleges (AAMC) reports that overall, the applicant pool for U.S. medical schools declined for the third straight year to 38,534, a drop of six percent. In 1996, the number of applicants to medical school reached an all time high of nearly 47,000. Despite the fluctuation in the number of applicants, the number of matriculating first-year medical students has remained roughly the same over the past 20 years. In 1999, 16,221 individuals entered medical school. In 1999, the percentage of under-represented minority applicants fell by seven percent to a low of 4,176 applicants. The number of total applicants and under-represented minority

applicants represent the lowest figures since 1992. Dr. Jordan J. Cohen, MD, President of the AAMC, summarizes the findings:

> Despite the medical community's efforts to encourage minorities to pursue careers in medicine and the growing need for a diverse physician workforce, the numbers continue to decline. The AAMC and others must redouble their efforts to curtail this downward trend.[28]

Minority enrollment in other health professions schools is still relatively low. Kamat concludes his analysis of national data on a larger number of health professions by stating that, "...no health profession can boast Black, Hispanic, or American Indian/Alaska Native enrollment at parity with the U.S. population".[29]

The Pew Health Professions Commission fourth report issued in 1998 proposes that to create a diverse workforce, the following actions must be taken:

- Admissions policies in professional schools must supplement their academic standard for entry with other criteria for admission, such as ethnicity, cross-cultural experience and commitment to community service.
- Universities and academic health centers should actively engage the broader K-12 educational system to provide exposure to the sciences and health professions to populations who are under-represented in those fields.[30]

By following these recommended actions, it will be possible to improve admission policies, and improve the inadequacies in pre-college preparation in mathematics and the sciences,[31] and reverse the generally weaker academic preparation for the rigors of professional studies that minority children receive from elementary to high schools,[32] and decrease the higher minority drop out rates[33] from the health professions development pipeline. Without such actions, a reversal of these trends is unlikely.

Diversity in Texas Health Professionals

Two health professions are examples of the under-representation of minorities in the Texas health workforce. In Tables F-3 and F-4, primary care physicians and nurses illustrate the disparities in the representation of minority professionals in the current Texas healthcare workforce.

Table F-3. Population and White, Black and Hispanic Physicians as Percent of Total Number of Physicians for 1998[1]

Race\Ethnicity	1998 Population	% of 1998 Population	% of 1998 Physicians
White	10,966,761	56.9	68.9
Black	2,249,537	11.5	3.8
Hispanic	5,870,804	29.9	12.2
Total	19,649,800		

(1) Data provided by the Health Professions Resource Center

Table F-4. Population and White, Black, and Hispanic Nurses as Percent a of Total Number of Nurses for 1998 [1]

Race\Ethnicity	1998 Population	% of 1998 Population	% of 1998 Nurses
White	10,966,761	56.9	80.1
Black	2,249,537	11.5	6.2
Hispanic	5,870,804	29.9	6.3
Total population 1998	19,649,800		

(1) Data provided by the Health Professions Resource Center

In 1998 Blacks constituted 11.5 percent of the population of the state, but were only 3.8 percent of all primary care doctors. In 1998 the Hispanic population in the state was 29.9 percent, while Hispanic primary care doctors constituted only 12.2 percent of all doctors. Similar patterns as those of primary care physicians are found in data available for Texas nurses. In 1998 the Black population was 11.4 percent of the total population, and Black nurses were only 6.2 percent of the total number of nurses registered in the state. For Hispanic nurses, the gap is even greater. In 1998 Hispanics were 29.9 percent of the total population, whereas Hispanic nurses were only 6.3 percent of the total nurses in the state.

In Texas, there was a dramatic decline in minority enrollment in medical schools following the *Hopwood* decision by the Fifth Court of Appeals in 1997, which eliminated race and ethnicity considerations in the admission to higher education professional schools in Texas. It also coincided with the voter approval of Proposition 209 in California, which generally prohibited discrimination or preferential treatment based on race, sex, color, ethnicity, or national origin in public employment, education, and contracting.[34]

A 1998 report from the Texas Higher Education Coordinating Board states:

> Generally, the 1998 application and offers data show a slight rebound in minority participation from the significant declines in 1997 but there are still problems. [Medical] Institutions are working to adjust their admissions and recruitment processes to increase the numbers; however, their success has been limited.[35]

Texas higher education institutions have made efforts to increase the number of minority professionals to correct the current under-representation of racial\ethnic minorities, in particular Blacks and Hispanics in the health professions, especially in Medicine, a profession that requires longer years of study.[36]

Almost all Texas medical colleges have programs designed to encourage under-represented minority students pursuing careers in medicine and the health professions. These programs are very similar in the strategies used at various levels in the "educational pipeline" that leads from secondary school graduation to application and entrance into professional schools. They target minority students by exposing them to the health professions, and by providing or strengthening the requisite skills necessary for success at each stage of the pipeline. For example:

- Texas A&M University's Bridge to Medicine MCAT Program (BTM) for disadvantaged college students offers participants an intensive academic study program designed to reinforce knowledge in Biology, General and Organic Chemistry, Physics, and Mathematics. The program also enhances critical study skills and further develops skills in reading and writing. Under the instruction of Texas A&M University faculty, students will build on their knowledge and strengths, and refine their test-taking skills in preparation for the Medical College Admissions Test (MCAT).
- A Summer Medical Enrichment Program was developed at Texas A&M to increase the number of high school students interested in the health professions. Students currently enrolled in their sophomore or junior year of high school are provided the opportunity to participate in a one-week summer enrichment program visiting the Texas A&M University System Health Science Center, College of Medicine.
- The University of North Texas has pipeline programs which begin with K-12 programs for elementary through high school, and continues for college students preparing for medical or biomedical research careers, and culminates in programs

for graduate students entering studies for the doctoral degree. The school also participates in Health Careers Opportunity Program (HCOP) and Summer Multi-cultural Advanced Research (SMART).

- The University of Texas Medical Branch in Galveston has a well-developed medical school familiarization program, recognized as a model nationwide. It is designed to provide disadvantaged undergraduates a realistic experience in the requirements of medical, dental, and allied health sciences. Funded by the U.S. Department of Health & Human Services under the Health Careers Opportunity Program (HCOP), the program seeks to build diversity in the healthcare fields through a series of integrated programs collectively known as Strategies & Techniques Applied to Recruit & Retain Students (STARRS). The activities of the six programs within the STARRS Project provide students from disadvantaged backgrounds the opportunity to enhance their academic skills and the support needed to successfully compete, matriculate, graduate and ultimately go on to rewarding careers in the health care industry.[37]

Outside the universities, but working in close cooperation with them, the network of Texas Area Health Education Centers (AHEC's) and Dr. Mario Ramirez working in South Texas have been exemplary in directing minority youth interest to the health professions.

- The East Texas AHEC's Health Careers Promotion program provides high school students the knowledge, skills and experiences to make informed choices about entering health careers.
- Dr. Mario Ramirez's MED ED program uses workshops, mentors, seminars, intensive skills acquisition and improvement summer camps to fortify high school students' interest in the health careers.
- The Health Science Technology program of the Texas Education Agency offers a comprehensive curriculum with the objective of attracting high school students into the health professions.
- The federally funded Health Careers Opportunities Program (HCOP) is one of the major providers of support for programs in the Allied Health Professions, which tend to be located in four-year and community colleges. HCOP programs provide summer institutes to recruit and prepare high school graduates for admission and completion of a variety of allied health professions. Some programs allow community college students to transfer to four-year baccalaureate degree programs and then to graduate schools. The student population at community colleges tends to be more diverse in terms of race and ethnicity, and to contain a large proportion of adults.

Increasing the numbers and proportions of under-represented minorities in the health professions will increase the supply of health providers and practitioners who share cultural knowledge, including a common language with their patients can use their awareness of the cultural dynamics of the patients they serve to provide quality services.[38]

The ad hoc committee believed that these examples provide models of successful experiences that should be supported because it is critical to support students as early as possible in the education pipeline to develop the academic skills necessary for health professions study.

The recommendations section of this document presents some specific strategies that can be pursued and programs that can be implemented and expanded to meet the challenges set forth by this component of the overall charge to the SHCC Committee on Minority Health.

Achieving Culturally Competent Health Care Practice and Practitioners

Another strategy proposed to help reduce the disparities in minority health is to develop more culturally competent delivery systems and workforce. The members of the ad hoc committee believed that the concept of cultural competency is important to address health disparities. The members also believed that the term can be misleading because the term "competency" could be interpreted as implying that there is a base knowledge to be learned that makes a professional culturally competent. As the following discussion of the concepts underlying cultural competency indicates, cultural competency is related to attitudes and approaches to the delivery of health services as much as specific knowledge and abilities, such as a different language.

Concepts

Cultural competence is defined as "...a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among health professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations."[39] Operationally defined, cultural competency is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.[40] Cultural competency is more than the linguistic ability to speak another language, or to understand and be understood by others. It involves listening and learning; emphasizing attitudes such as respect; values, such as acceptance of differences; and behaviors that convey the desire and willingness to help and serve everyone, regardless

of language, color, or ability to pay.[41] The word *culture* is used because it implies the integrated patterns of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups.[42] Cultural knowledge is only one component of cultural competency; it refers to familiarization with selected cultural characteristics, history, values, belief systems and behaviors of the members of another ethnic group.[43] Being competent in cross-cultural functioning means learning new patterns of behavior and applying them in the appropriate settings.[44] Valuing diversity means accepting and respecting differences. People come from very different backgrounds, and their customs, thoughts, ways of communicating, values, traditions and institutions vary accordingly.[45]

Cultural competency promotes an atmosphere conducive for optimum patient/provider relationships. Furthermore, a culturally competent workforce can reduce some of the communications barriers that impair practitioner/patient interpersonal relationships, as well as the understanding of each others' messages and assumptions, which often results in negative outcomes such as misdiagnoses, unnecessary diagnostic tests, practitioner frustration, patient dissatisfaction, and poor compliance with post treatment instructions.[46]

Strategies

The American Medical Association has stressed the need for a culturally competent health workforce to meet the health needs of diverse people within the nation.[47] The Pew Health Professions Commission agreed in their third report with the substantial body of literature which contends that "culturally sensitive care is good care". Following that assertion, they recommended that health professional schools must ensure that the students they train reflect the ethnic diversity of the society, and make cultural sensitivity a part of every student's educational experience.[48]

The National Center for Cultural Competence, a national leader in the development of training materials and guidelines for implementing cultural competency in the health and human services, provides further elaboration on the impact of culture on the quality of health care.

The following patient-provider issues substantiate the need for primary health care organizations to develop policies, structures, practices and procedures to support the delivery of culturally and linguistic competent services to all patients:

- The perception of illness and disease and their causes varies by culture.
- Diverse belief systems exist related to health, healing and wellness.
- Culture influences help seeking behaviors and attitudes toward health care agencies and providers.
- Individual preferences affect traditional and non-traditional approaches to health care.
- Patients must overcome personal experiences of biases within health care systems.
- Health care providers from culturally and linguistically diverse groups are under-represented in the current health services delivery system.

The National Center on Cultural Competency proposes that cultural competency is a necessity for all health providers, but in particular for health personnel who provide primary health care and prevention services in clinical settings. The following are compelling reasons for striving to achieve cultural competency at the individual and organizational levels:

- To respond to the current diversity of the population and the demographic changes that have been forecast for the U.S. in terms of net growth of the minority populations in number and as a proportion of the total population.
- To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds.
- To improve the quality of services and health outcomes.
- To meet legislative, regulatory and accreditation mandates.
- To gain a competitive edge in the market place.
- To decrease the likelihood of liability/malpractice claims.

The conceptual framework of the cultural competence model used by the National Center on Cultural Competency is based on the following beliefs:

- There is a defined set of values, principles, structures, attitudes and practices inherent in a culturally competent system of care;
- Cultural competence at both the organizational and individual level is an ongoing developmental process; and
- Cultural competency must be systematically incorporated at every level of an organization, including the policy-making, administrative, practice and consumer/ family levels.

The National Center on Cultural Competency has developed and published several tools and guidelines to assist organizations and individuals in their self-assessment to determine where they are in a continuum of cultural competency.[49]

Finally, the Pew Health Professions Commission,[50] in their Fourth Report on Recreating Health Professional Practice, writes:

> America's population is becoming increasingly diverse as we move towards the 21st Century. During the course of their careers, practitioners should go out of their way to encounter individuals and communities whose values and beliefs about health and health care differ from their own. To provide effective care, health practitioners must understand how culturally learned values and customs affect people's health beliefs and practices. Such practices might include the use of non-traditional, alternative and complementary therapies. It may also give the caregiver reason to study and master a foreign language. Health professionals must use their knowledge to collaborate with individuals and communities to provide health care that is sensitive to and consistent with cultural values, beliefs and customs.

Texas Initiatives

In 1992, the Texas Department of Health received a Special Programs of Regional and National Significance (SPRANS) grant to establish the Maternal\Child Health National Resource Center on Cultural Competency (MCH/NRCCC). Until 1998, the MCH/NRCCC operated a 12-state consortium that provided training and technical assistance, developed assessment tools, and published a diversity curriculum for use in schools of social work, with plans to adapt it for expanded use by other professional schools.

To meet the needs of the current workforce, the (MCH/NRCCC) developed a curriculum to conduct cultural competency self-assessments on demand to programs and other state agencies. After the end of the MCH grant in 1998, work has continued in Texas by Texas Department of Health's Texas Center on Cultural Competency, which has conducted numerous cultural competency assessments for TDH programs and other agencies, and has followed up with training based on those assessments.

In 1997-98 The Texas Center on Cultural Competency assisted the Bureau of Medicaid/ Managed Care to incorporate guidelines and standards for cultural and linguistic competence into the contracts for the implementation of the Medicaid/Managed Care expansion beyond the initial pilot sites.

In 1998 TDH's Bureau of HIV\STD, using federal funding and with assistance from the Texas Center on Cultural Competency initiated the development and implementation of a comprehensive system of cultural competency training for all of their outreach workers and contractors. A product from this work is a well-developed cultural competency curriculum and a core staff qualified to conduct "train-the-trainer" workshops to expand the reach of cultural competency training to new workers throughout the state.

The information presented supports a strategy for increasing the cultural competency of both agencies and of all members of the current workforce. This strategy recognizes that most care will take place in multi-cultural settings where it is not always possible to match a patient with a provider of the same race or ethnicity. No group or professional category should be singled out for special training. The models used by both the National Center on Cultural Competence and the Texas Center for Cultural Competency start with an agency self-assessment, which includes the identification of their own human resources and those of the community they serve.

Summary

All of the programs mentioned in the section on diversity indicate that there are already substantial efforts to expand the diversity of the state's health care work force. Efforts to improve the cultural competency of the current work force have been centered on the public health work force and to some extent to the health care workforce in HMO's who provide Medicaid services under contract with the Texas Department of Health. However, it is also clear that these efforts have not been sufficient to meet the needs of the present, much less those of the future.

The most accepted scenario predicts that the Texas population will nearly double by 2030 from the 1990 baseline of about 17 million to about 34 million by 2030. By 2008, no ethnic group will account for more than 50 percent of the entire Texas population. The minority population will propel the expected growth, accounting for 87.5 percent of the total increase. Hispanics will increase by 258 percent from the 1990 baseline; Blacks will increase by 62 percent, while Anglos will experience a 20.4 percent of the net increase.[51] By 2030, minorities will constitute the majority in Texas population.[52]

Although it has been found that minorities tend to choose a provider of their own racial and ethnic group,[53] the reality in most health care settings is that neither clients nor providers

may have that choice. Therefore, cultural competency will be expected from all health providers and agencies.

At the very least, a diverse and culturally competent health workforce can increase the quality of care through promoting and supporting the attitudes, behaviors, knowledge and skills that are needed to work respectfully and effectively with patients of diverse cultures.[54] This kind of workforce will be instrumental in helping to decrease the disparities in minority health.

The reality of the disparities in minority health status has been well documented. The incentives for immediate action and solution to the issues of minority health in Texas can be found in the above projections about the state's demographic future, current health status of minorities within the state, and expected pressures of a larger and more diverse population on our health care system in terms of cost, availability, and quality. To meet these challenges, we need to improve our health care human resources through the recruitment and retention of minorities, and by assuring the cultural competency for all health care providers.

As has been documented earlier, health experts have placed much confidence in the recruitment and retention of minorities into the health professions, and in enhancing the cultural competency of the health workforce as appropriate policy options for addressing the generally poor health status of minority populations. The SHCC Ad Hoc Committee on Minority Health believes that this is a course of action that will be beneficial to the state of Texas based on the documentation presented.

The objective of these strategies is not to have health professionals of one ethnicity serving only patients of the same ethnicity, rather they should be part of a comprehensive public health strategy aimed at making significant progress in the improvement of the health status of not only minority populations, but that of all Texans. They are not a panacea, but promising solutions to a pervasive problem. The committee based its decisions on their meetings, a public symposium, research, and input from various sources throughout the state and the nation. The Committee submits the following recommendations:

AD HOC COMMITTEE RECOMMENDATIONS

Recommendation One: Improve the teaching of mathematics and science knowledge and skills to students in all stages of the education pipeline in order to better prepare them for health careers.

A. Increase funding for the development, and/or enhancement of remedial and enrichment programs that have proven successful in helping students at the elementary, secondary, and higher education levels succeed in school. Emphasis should be placed on funding institutions that have historically served minority populations.
B. Develop cooperative partnerships with Independent School Districts and the Texas Education Agency for the development and of faculty, curriculum and intervention strategies to improve the teaching of mathematics and sciences at the elementary and secondary school level to ensure that Texas' children have the knowledge and skills to succeed academically at the community college or university level.
C. Evaluate the effectiveness of minority recruitment and retention programs. Degree completion, licensure/certification, and job placement should be tracked as measures of success.

Recommendation Two: Increase funding for loans, grants, scholarships, and fellowships to assist minority and disadvantaged students seeking degrees in the health professions. Academic Health Centers, Area Health Education Centers, Community Colleges, and health professions associations should plan, implement and strengthen programs to meet Healthy People 2010 goals and strategies for increasing the numbers of minorities in health professions.

Recommendation Three: Provide training and continuing professional education in cultural competency and include practice opportunities that foster and support attitudes, behaviors, and skills necessary to work effectively and respectfully with patients of diverse cultures.

Recommendation Four: Fund the Texas Department of Health's Office of Minority Health to review the Healthy People 2010 goals and strategies related to reducing disparities

in health status in minority populations and promote and coordinate efforts for their adoption by programs within the Texas Department of Health and programs at other Health and Human Service agencies and other private and public organizations.

End Notes

1. Texas Statewide Health Coordinating Council. *Texas State Health Plan Update*; Texas Department of Health, Austin, 1996.

2. Texas Statewide Health Coordinating Council, *1999-2004 Texas State Health Plan: Ensuring a Quality Healthcare Workforce for Texas*, Texas Department of Health, Austin, 1998.

3. Levine, D.M., et al., "Community-Academic Health Center Partnerships for Underserved Minority Populations: One Solution to a National Crisis," *Journal of the American Medical Association*, 1994, 272: 4.

4. National Center for Health Statistics. Health, United States, 1999 with Health and Aging Chartbook (D.H.H.S. Pub. No. PHS) 99-1232. Hyattsville, Maryland: 1999.

5. Schulman, Kevin A., et al., "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization." *The New England Journal of Medicine*, 1999, 340: 8.

6. U.S. Department of Health and Human Services, *Healthy People 2010 Objectives: Draft for Public Comment.* Washington D.C.: G.P.O., 1998.

7. Ibid

8. Ibid

9. HRSA Press Release, October 23, 1999.

10. U.S. Department of Health and Human Services, *Healthy People 2010 Objectives: Draft for Public Comment.* Washington D.C.: G.P.O., 1998.

11. HRSA Press Release, February 18, 1999.

12. Robert Wood Johnson Foundation and the Henry J. Kaiser Family Foundation. *Opening Doors: Reducing Socio-cultural Barriers to Health Care Initiative.* Washington D.C. 1997

13. Texas Statewide Health Coordinating Council, *1999-2004 Texas Statewide Plan: Ensuring a Quality Healthcare Workforce for Texas*, Texas Department of Health, Austin, 1998.

14. Texas Department of Health, "Public Health: Everyone, Everyday, Everywhere." *1999-2003 Strategic Plan*, 1998.

15. Ibid.

16. Texas Department of Health, Office of Minority Health, *Minority Health Brochure*. Austin, Texas, 1998.

17. Murdock, Steve H., et al. *Texas Challenge: Population Change and the Future of Texas*. Texas A&M University Press: College Station, 1996.

18. Ibid

19. Nickens, Herbert and Timothy Ready, "Project 3000 by 2000: Expanding Our Network", *Closing the Gap*, Office of Minority Health Resource Center, U.S. Department of Health and Human Services, May/June 1999.

20. AAMC Press Release, October 26, 1999.

21. Kamat, Miguel R., "Educating Health Professionals: Are We Failing Minorities?" *Closing the Gap*, U.S. Department of Health and Human Services, Office of Minority Health Resource Center. May/June 1999.

22. Kamat, Miguel R., op cit.

23. Ibid.

24. Ibid.

25. U.S. Department of Health and Human Services, 1998 Council on Graduate Medical Education, *Twelfth Report: Minorities in Medicine.*

26. Kamat, Miguel R., op cit.

27. AAMC Press Release, October 26, 1999.

28. Ibid.

29. Kamat, Miguel R., op cit.

30. Pew Health Professions Commission, *Fourth Report: Recreating Health Professional Practice for a New Century*, San Francisco, California, December 1998.

31. Girotti, Jorge A, "The Urban Health Program to Encourage Minority Enrollment at the University of Illinois at Chicago College of Medicine." *Academic Medicine*, 1999, 74: 4.

32. Wilson, John E., and Lucy Murphy, 1999. "Premedical and Predental Enrichment Program for Minority Students, 1969-1996 at Meharry Medical College," *Academic Medicine*, April 1999, 74: 4, 88-91.

33. Lewis, Cynthia, "A State University's Model Program to Increase the Number of Its Disadvantaged Students Who Matriculate into Health Professions Schools," *Academic Medicine*, 1996, 71:10

34. Nickens, Herbert, op cit.

35. Texas Higher Education Coordinating Board, Office of Access and Equity. *Report on the Effects of the Hopwood Decision on Minority Applications, Offers, and Enrollments at Public Institutions of Higher Education in Texas.* Austin, Texas, 1998.

36. Texas Medical Association, *The Physician Workforce in Texas: Implications for Medical Education.* Austin, Texas, 1999.

37. University of Texas Medical Branch at Galveston, *Starrs: Health Careers Opportunity Programs*. Available online: http://www.sahs.utmb.edu/studentaffairs/ hcopstarrs/ cophome.html, Accessed: December 10, 1999.

38. American College of Obstetricians and Gynecologists, *ACOG Committee Opinion: Cultural Competency in Health Care*, Vol. 62, 1998.

39. Cross, et al., *Towards a culturally competent system of care*, Volume 1. Washington, D.C., Georgetown University, Child Development Center, CASSP Technical Assistance Center, 1989

40. Davies, K., *Exploring the intersection between cultural competency and managed behavioral health care policy: Implications for state and county mental health agencies.* Alexandria, VA: National Technical Assistance Center for State Mental Health Planning, 1997.

41. Office of Minority Health, U.S. Department of Health and Human Services, *Cultural and Linguistic Competence Standards and Research Agenda Project.* Available online: http://www.omhrc.gov/WhatsNew/cultural1.htm. Accessed, December 10, 1999.

42. King, Mark A., et al., "How is Cultural Competence Integrated in Education." CECP Web page.

43. Ibid.

44. Ibid.

45. Ibid.

46. Woloshin, Steven, et al., "Language Barriers in Medicine in the United States," *Journal of the American Medical Association*, 1995, 273: 9.

47. American Medical Association, *Cultural Competency Compendium: Racial and Ethnic Disparities in Health Care*, 1999.

48. Ibid.

49. Georgetown University Child Development Center: National Center for Cultural Competence, *Getting Started... Planning, Implementing and Evaluating Culturally Competent Service Delivery Systems in Primary Health Care Settings.* Available online: http://www.dml.georgetown.edu/depts/pediatrics/gucdc/nccc8.html. Accessed October 15, 1999.

50. Pew Health Professions Commission, *Fourth Report: Recreating Health Professional Practice for a New Century*, December 1998.

51. Murdock, Steve H., op cit.

52. Archer, William R., Commissioner, Texas Department of Health, Presentation before the Texas Board of Health, October 14, 1999, Austin, Texas.

53. Komaromy, et al., "The Role of Black and Hispanic Physicians in Providing Health Care for Under-Served Populations," *The New England Journal of Medicine*, 1996, 334:20.

54. Ibid.

Appendix G
Ad Hoc Committee on Models for Community Health Practice

A report given in response to the *1999-2004 Texas State Health* Plan goal:

Goal 6: Create a health care workforce that works with communities and in partnership with federal and state governments to have the greatest impact on the health of citizens.

Objective 6.1: Design systems in which local communities are empowered to plan and direct intervention that have the greatest positive impact on the health of citizens.

Texas Statewide Health Coordinating Council

January 13, 2000

Texas Statewide Health Coordinating Council

Ad Hoc Committee on Models for Community Health Practice

Member List

Demetria Montgomery, M.D.
Committee Chair and SHCC Member
Texas Department of Health

Joan Biggerstaff, SHCC Member
Public Member

Vijay Ganju, Ph.D., SHCC Member
Texas Department of Mental Health
& Mental Retardation

Chris Kazen Attal
Diocese of Austin
Seton East Community Health Center

Maxine Hammonds-Smith, Ph.D. CFLE
Texas Southern University

Teresa M. Hines, M.P.H.
Health Education Training Centers
Alliance of Texas

Gus Kennedy
Communities in Schools

Amy Wong Mok
Asian American Alliance in Austin
School of Social Work
University of Texas at Austin

Yolanda C. Padilla, PhD
University of Texas at Austin

Ernie Parisi
Llano Memorial Healthcare System

Tracy Randazzo
Texas Hospital Association

Mitchell F. Rice, PhD
Texas A&M University

T. A. Vasquez
Austin Independent School District

Support Staff

Sheila Marie Austin
Texas Department of Health, Public Health Promotion

Michael G. Messinger
Texas Department of Health, Public Health Promotion

Kristin Rosacker
Texas Department of Health, Texas Volunteer Health Corps

Ad Hoc Committee on Models for Community Health Practice

INTRODUCTION

The 1999-2004 Texas State Health Plan, developed by the Texas Statewide Health Coordinating Council (SHCC), envisions a Texas where all citizens are able to achieve their maximum health potential. Goal six of the Health Plan speaks to creating a health workforce that partners communities with federal and state governments to achieve the greatest impact on the health of citizens.[1] In keeping with this goal, the Ad Hoc Committee on Models for Community Health Practice was charged to design systems which empowers local communities to plan and direct interventions that have the greatest impact on the health of their residents and all Texans.

When beginning its work, the Committee pursued the charge by striving to understand and determine what was in its feasible scope of action. To arrive at and submit concrete, achievable recommendations, the Committee focused on relationships between diverse communities and the wellness workforce, enabling communities to:

- Apply broader concepts of health and the wellness workforce which encompasses a holistic state of well-being, reflecting an optimal quality of life for all Texans.
- Identify methods for researching the root causes of health status at the community level.
- Facilitate collaboration among diverse populations and segments of the community (e.g., police, academic institutions, businesses, health and social services, etc.) to address community health issues.
- Select methods to identify new and existing local leadership for developing a holistic community health agenda.
- Determine the local community's expectations from public, nonprofit, and private entities to support their community health efforts and develop methods to enhance these relationships.

Working Definitions

To establish a common base from which to work, the Committee identified and agreed on the following definitions that underpin its activities and work products.

- **Community Assessment** - regular collection, analysis, interpretation and communication of information about health conditions, risks and assets in a community. [2]
- **Community Health** - a condition of the collective whole of the community which encompasses the interrelationship between the spiritual, mental, physical, and social elements that embody an individual's ability to optimize their potential for wellness. It acknowledges the relationship between individuals, families and their environment.
- **Health** - a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. [3]
- **Health Continuum** - a theoretical spectrum ranging from birth to death that supports potential changes of health status.
- **Health Workforce** - licensed or certified health professionals as listed on page C-3 of the *1999-2004 Texas State Health Plan, Ensuring A Quality Health Care Workforce for Texas*. This definition has been expanded to include the increasing range of community health practitioners, providers and leaders who promote therapies and practices that have been viewed as outside of the traditional medical model. The Committee determined this ever expanding group may be better defined as a **Wellness Workforce** and it will be referred to as such throughout this document. Additionally, every member of the community has a role in the wellness workforce.
- **Root Cause** - underlying factor at the individual, family, community and state levels that have the greatest impact in shaping health attitudes, behaviors and conditions.

BACKGROUND

The Committee recognized the residents of the diverse communities across Texas as experts on the health of their communities. Therefore, it was fundamental to include their thoughts, concerns, ideas and wishes in any legitimate planning that seeks to build partnerships between community members and the wellness workforce. To ensure community inclusion, the Committee sought the expertise of representatives

of community-based organizations, conducted focus groups, researched a variety of topics, and offered supplemental information and expertise to Texas communities. Based on this input, the committee defined core principles of community health and addressed the importance of health planning in improving the health of communities.

Core Principles of Community Health

Community health is predicated upon a foundation of commitment, involvement, and social justice. It encompasses the spiritual, mental, physical, and social elements that embody an individual's ability to optimize their full potential to improve their quality of life. This broad foundation of community health was a prevalent theme in the focus groups and was represented in participants' statements regarding community health, such as: "wholeness," "balance," "yin and yang," "mind, body and spirit" and "We can take more responsibility for our community." Every individual member must take responsibility to make healthy choices and be committed to creating an environment that is nurturing, inclusive, and conducive to optimal health. A healthy community achieves social equity by encouraging people to feel connected to one another and to care for each other willingly and with compassion. To that end, the Committee developed the following guiding principles as a baseline to be adapted by communities and stakeholders.

Community health is the shared responsibility of all members of the community working collaboratively to develop an infrastructure that:

- Is owned by the community and not imposed upon the community;
- Uses as its foundation the values, knowledge, and resources within the community;
- Makes data accessible at community, city, and state levels in a manner that is easily understood;
- Requires the development and active support of responsive social policy at the federal, state, and local levels;
- Addresses the health continuum, including prevention, health education, health promo-tion, management of chronic conditions, and care for illnesses;
- Provides the tools needed to manage a healthy lifestyle;

- Educates the community on the methods available to assess community health status and assists in creating proactive solutions based on identified community health priorities;
- Honors cultural and ethnic diversity; and,
- Results in a system that is available, accessible, acceptable, and sustainable by the diverse
  community it serves.

Accepting the above core principles:

- Fosters compassionate connectivity;
- Creates the realization that health is everyone's concern; that individuals and the community share the responsibility of taking care of one another;
- Motivates individuals to make healthy choices and respects individual choice;
- Encourages employers to develop both health policies (insurance coverage) and healthy policies (reasonable work hours, vacation time, and wellness activities); and,
- Defines the terms *family* and *health care provider* in a broad sense.

These core principles of community health serve as the foundation for a broader concept of health and the wellness workforce.

Broader Concept of Health and the Wellness Workforce

A common theme pervasive in presentations to the Committee and in the focus groups was the need for individuals, the community, and policy makers to acknowledge and support the concept that the community's health is multidimensional and encompasses spiritual, mental, physical, and social elements. Data gathered during the community focus groups affirmed that approaches to health improvement rooted in cultural beliefs and practices should be accepted by mainstream health systems as a viable part of the health continuum. For example, a participant stated, "[the health system] needs to be open to accepting different types of treatment." It is important that we acknowledge the role culture and ethnicity play in determining which providers, practitioners, or services are considered first-line health interventions by specific populations.

For example, committee members representing diverse cultures and beliefs noted that the term "alternative medicine" does not accurately or sensitively reflect the role of Eastern practices in Asian American communities. Neither does the term "non-traditional medicine", since these practices may be traditional for that community. Terminology in community health must evolve to reflect the diversity of Texas communities.

The committee also noted the increasing use of practices that have been termed as "alternative medicine" in the general population. It was recommended that more research is needed to understand and educate practitioners and the public regarding the safety and effectiveness of these options.

The Health and Wellness Workforce

Acknowledging a broader concept of health requires expanding the list of possible partners in the wellness workforce. This expanded list must include licensed or certified health professionals including the increasing range of community health practitioners, providers and leaders whose work has been viewed as outside of the traditional medical model. Focus groups supported the concept of a broader health and wellness workforce through the following statements addressing who is responsible for their health: "self, family, peers, co-workers, employers and everybody else keeps us healthy," "a workforce that mirrors our community" and "needs to be one of the people; someone who understands, lives with and knows the people." This expanded list must reach beyond the traditional mindset and into the community itself. Table G-1 includes potential partners identified in Committee discussions and in focus groups. It is not intended to be an exhaustive list of partners.

The next step is to promote this broader vision. Promoting broader concepts of health and the wellness workforce requires marketing to health care providers and communities using a targeted approach that ensures acceptance and investment. A comprehensive campaign could include the following activities:

- Conduct forums to explore a community's definition of health and determine their expectations of the wellness workforce.
- Develop advocates who already are trusted and recognized as catalysts or champions in their respective communities from the ranks of informal and

formal community leaders (e.g., faith community, government, grassroots, etc.).

- Gain the endorsement of state and local officials to promote efforts and to serve as campaign spokespersons to underscore the value and importance of these campaigns.
- Develop partnerships between traditional and non-traditional health plans and with professional licensing boards to advance broader concepts of health and the wellness workforce.
- Initiate and facilitate dialogue between health insurance plans, primary care specialists and health educators regarding the development of partnerships emphasizing preventive health practices (e.g., offering incentives and reimbursement schemes to cover preventive care measures and behaviors).
- Build collaboration between the Texas Department of Health and educational entities to redesign and incorporate wellness-oriented curricula in grades Kindergarten-12. A similar strategy would be used to expand curricula for health care professions (e.g., schools of public health, community nursing and social work) to include broader concepts of health and the wellness workforce.

It is important to acknowledge that community health improvement is an ongoing process. In addition to recognizing the importance of the assessment process, the Committee acknowledges the necessity to use the information gathered to determine community identified goals, implement action plans and intervention strategies and evaluate their effectiveness. Finally, due to the dynamic nature of communities, it is crucial to include all sectors in collaborative efforts striving towards optimal community health.

In summary, the committee recognizes the following concepts in defining the health workforce:

- There is a central core health workforce composed of an expanded list of professionals and paraprofessionals devoted to core health fields;
- There is an even broader "wellness workforce" which contributes to the health of the community and includes all who contribute to the community's quality of life, including community leaders, families and individuals.

- Communities in their unique culture and traditions may have their own perceptions regarding the wellness workforce. A better understanding of this workforce is needed in order to better serve and protect the health of the community.

Community Assessment

The focus groups supported the need for the gathering and sharing of community information by stating the need for: "easy access to trends and other statistics," "knowing what works with your community to change behavior," "knowing limitations and resources" and "re-evaluating what we are doing." This in-depth inventory provides a clear picture of where the community stands at the time of the assessment and a launching pad to achieve optimal health status. The wellness workforce has an obligation to offer resources, information and skills development to aid communities in their assessment efforts.

By embracing a broader concept of health and the wellness workforce approach, the community is now prepared to look critically at their health status and strive for a self-defined goal. A comprehensive assessment would capture a snapshot of existing strengths and challenges that impact optimal health. Community assessments must originate at the community level. It is critical to conduct a comprehensive inventory of assets, deficits and risks as defined by the community before determining strategies and policies.

A thorough community assessment must look at all levels of community health efforts. The first of the ten essential public health functions, "Monitor health status to identify community health problems," speaks directly to the process of community assessment. So do the functions that deal with "informing, educating, and empowering the public about health issues," and "mobilizing community partnerships to identify and solve health problems." These essential functions have now been codified into state law through House Bill 1444 passed in the 76th legislative session.

Assessment tools such as The National Public Health Performance Standards, which are based on the ten essential public health functions, focus on how public health professionals and their health care partners work with a community to assess needs, develop plans, and implement strategies to improve the health of a community. These

processes are an essential first step to working positively with communities and building community partnerships. To ensure the effectiveness of these strategies, a community must identify the true source of its issues. By examining assets and deficits at their root it is possible to replicate positive and prevent adverse events.

Other tools can be used to assess and paint a picture of a community's health. Those attempting to understand and address events or trends that impact the community often overlook Root Cause Analysis. A cursory look at the events or trends may not reveal the core issue. However, closer examination may point to a root cause that will identify the underlying factors that shape health attitudes, behaviors and conditions. Although there are many approaches and methods for determining root cause it is necessary to look to methods lay people and professionals alike can understand and implement. The committee recommends a community adopt a user-friendly tool. For example the "5W1H" method, a problem solving technique involving asking "Why?" five levels deep, then asking "How?" we can prevent this from happening again.[4] Asking "Why?" five times is a simple, yet effective, method of going beyond the surface of an event to determine the ultimate cause. Then by asking "How?" the community may begin to plan and implement intervention strategies and sustainable solutions.

Conclusion

To support the proposed recommendations, it is imperative that policy makers work with communities to create an infrastructure that facilitates and encourages change that is positive, dynamic, fluid and sustainable. This infrastructure must empower individuals and communities by removing barriers that hinder positive change and by linking community members with capacity building resources. By embracing these concepts a community will be able to apply information gathered through comprehensive assessments to develop a broader concept of health and an expanded wellness workforce which is rooted in a common vision of community health. This broader understanding health and the wellness workforce approach will ultimately lead a community to their goal of optimal health.

AD HOC COMMITTEE RECOMMENDATIONS

Recommendation One: Encourage communities to adopt a common vision of community health that speaks to the uniqueness, assets and needs of each community member.

Responsibilities:

- Informal leaders and mentors
- Neighborhood associations
- Faith/spiritual leaders
- Planners and officials
- Health professionals

Recommendation Two: Adopt and support a broader concept of health and the wellness workforce.

Responsibilities:

- Traditional providers
- Professional associations and organizations
- Planners and officials
- Health professionals
- Communities

Recommendation Three: Conduct community-driven assessments with emphasis on the investigation of root causes.

Responsibilities:

- Informal leaders and mentors
- Technical assistance from trained professionals (e.g., state and local agencies, schools of public health, etc.)

Acknowledgments and Contributions

The Ad Hoc Committee on Models for Community Health Practice acknowledges with deep appreciation the persons who participated in the focus groups. Thank you for graciously sharing your time, thoughts and energy with enthusiasm and candor. Moreover, thank you for trusting us to be responsible stewards of your contributions.

Austin - 2 groups - Asian American Alliance and Texas Hospital Association Committee on Quality Indicators and Patient Information

Castro County - 1 group - Anglo - Health Outlook Planning Education (rural community group)

San Elizario -1 group - Latino - community health workers (conducted in Spanish)

Houston - 3 groups - African American - VISTA volunteers / retired professionals and non professionals

Laredo - 1 group - Multi-ethnic - health professionals

McAllen - 2 groups - Latina - single moms / single women without children

Presentations

Father Jaime Case, Executive Director
El Buen Samaritano
Topic: Overview of El Buen Samaritano, a community based organization

John E. Evans, Deputy Commissioner
for Community Health and Prevention
Texas Department of Health
Topic: Cultural Diversity in Communities

Phyllis Griffith, Retired Parish Nurse
Topic: Parish Nursing/Congregation Health Ministries

Maxine Hammonds-Smith, Director
Center for Aging/Intergenerational Wellness
Texas Southern University
Topic: The Three Cs (Church, Campus and Community) Model

Gus Kennedy, Executive Director
Communities in Schools
Topic: Overview of Communities in Schools in Hidalgo and Willacy Counties

Demetria Montgomery, MD, Associate Commissioner
for Community Dynamics and Prevention Strategies
Texas Department of Health
Topic: Public Health Principles and Underlying Determinants of Health of a Community

Tracy Randazzo, Director of Health Care Quality
Texas Hospital Association
Topic: Use of A Framework For a Root Cause Analysis and Action Plan in Response to a Sentinel Event form as a tool for determining root causes

Donald A. Sweeney, DED, Associate Professor
Department of Landscape Architecture and Urban Planning
Texas A&M University
Topic: Resources on Building Community Models

T.A. Vasquez, Community Liaison
Austin Independent School District
Topic: After School Program at Zavala Elementary School

Endnotes

1. Statewide Health Coordinating Council. *The Texas State Health Plan 1999-2004: Ensuring A Quality Health Care Workforce for Texas.* Austin, TX, 1998.

2. Institute of Medicine. *Improving Health in the Community: A Role for Performance Monitoring.* National Academy Press, Washington, D.C., 1997.

3. Last, John A. *A Dictionary of Epidemiology, Third Edition.* International Epidemiological Association, New York, 1995.

4. Perkinson, Larry. "Adding value to behavior-based data", Penton Publishing, Inc. 1996.

Other Sources

Centers for Disease Control. *Texas State Health Profile.* Atlanta, GA, 1998.

St. David's Foundation. *The Root Cause Project Briefing to Health Leadership Committee.* Austin, TX, 1999.

Texas Department of Health, Coalition Task Force. *Coalition Building: A Healthy Community is Everyone's Business.* Texas Department of Health, Austin, TX, 1996.

Texas Department of Health, Community Oriented Primary Care. *Community Assessment Guidelines and Resources.* Austin, TX, 1998.

Texas Department of Health, Health Promotion Project Standards Task Force. *Quality in Health Promotion.* Austin, TX, 1996.

Texas Department of Health, *External Assessment,* Austin, TX, 1999.

Texas Department of Health, Texas Volunteer Health Corps. *Road Map to a Healthier Neighborhood.* Austin, TX, 1999.

Table G-1. Examples of Partners for the Wellness Workforce *

Public Safety Personnel	Department of Public Safety personnel Emergency Medical Technicians Firefighters Police officers
Local/State Government	City council members City planners Elected officials Health officers (public health, community health, occupational health) Policy writers
Higher Education System	Administrators Board members Professors Student representatives
Religious/Spiritual Community	Clergy/Spiritual Advisers Parish Nurses/Congregation Health Ministries
Primary through High School Educational System	Administrators Coaches Guidance counselors Health educators School board members Student representatives Teachers
Complementary Medicine Specialists	Acupuncturists Herbalists Homeopaths Meditation/relaxation specialists Message therapists Naturopathy practitioners
Families	Community Health Workers Family care-givers Grandparents Parents
Business Community	Chambers of Commerce Corporate CEOs Insurance providers Small business owners
Consumer Groups	Advocates for Responsible Disposal in Action Better Business Bureau, Inc. Public Citizen Texas Texas Citizen Action Taking Texas to 2000 Texans for Public Justice Texas Alliance of Human Needs

* Not an all-inclusive list.

Appendix H
Ad Hoc Committee on Consumer Information

A report given in response to the *1999-2004 Texas State Health* Plan goal:

Goal 7: Develop the health care partnership between consumers and health care professionals through increased access to health care information.

Objective 7.1: Enable consumers to make better health care decisions.

Report to the Statewide Health Coordinating Council

January 13, 2000

Texas Statewide Health Coordinating Council

Ad Hoc Committee on Consumer Information

Member List

Jacinto P. Juarez, Ph.D.
SHCC Member and Committee Chair
Texas Health Care Information Council

Susan Galindo, M.Ed., CCC/SLP
SHCC Member
Health Professional Representative

Judge James A. Endicott, Jr.
SHCC Member
Public Member

Jane Basey, Ph.D.
Consumer Advocate

Geana Bassham, M.A./CCC
Brazos Valley Rehabilitation Center

Gail Bellamy, Ph.D.
Scott and White Hospital

Rod Bordelon, J.D.
Office of Public Insurance Counsel

Diana Dinsdale
Medshares Home Health Care

Jude Filler
Texas Alliance for Human Needs

Jamie Garanflo
Board of Medical Examiners

Robert J Hastings, M.A.
Texas Tech University Health Science

Mike Hill
American Cancer Society

Karen Hodge
March of Dimes - Central Texas

Jim Loyd
Texas Health Care Information Council

The Honorable Glen Maxey
Texas House of Representatives

Camille Miller
Texas Institute for Health Policy Research

Sandra K. Oliver, R.N., Ph.D., C.N.S.
Scott and White Health Plan

Jerry Patterson
Texas Association of Health Plans

Audrey Selden, J.D.
Texas Department of Insurance

Carey Smith, M.S., R.D., L.D.
Piney Woods AHEC

Jon Turton
St. Joseph's Regional Rehab Center

Lorenza Zuniga
Texas Tech AHEC

Jeffery Hill, JP
State Board of Dental Examiners

<u>Staff</u>

Mary C. Soto, M.S.Ed, Office of Policy and Planning

Nicholas L. Hoover, M.P. Aff., Office of Policy and Planning

Ad Hoc Committee on Consumer Information

INTRODUCTION

The *Texas State Health Plan*, developed by the Statewide Health Coordinating Council (SHCC), lays the groundwork for ongoing health workforce planning and education. The Plan recommended a number of ad hoc committees to achieve this goal. These ad hoc committees were organized for the purposes of collecting information and data for recommendations and actions to be presented in updates to the State Health Plan in 2001 and 2003. The Consumer Information Ad Hoc committee was charged to study issues related to consumer health information in the state of Texas. On January 27, 1999, SHCC Chair Ben G. Raimer, M.D. appointed Jacinto P. Juarez, Ph.D. to chair the ad hoc committee and to guide them through a process "to develop guidelines, principles and standards for a consumer-oriented health care partnership".

The work of the 22 member ad hoc committee included a study of the following system-wide issues:

- roles and responsibilities of State of Texas agencies and councils in providing consumer information;
- roles of the private and private, non-profit organizations in providing consumer information;
- private and public-private partnerships to provide and enhance consumer information;
- national landmark work on consumer information; and
- successful consumer information models operating in other states.

Specific topics studied by the ad hoc committee included:

- use of informatics to get health messages to the public;
- choice of health plans and providers, consumer report cards on services; and,
- congressional debate on a patients' bill of rights and responsibilities.

At the conclusion of the six month study, the ad hoc committee hosted a workshop entitled "Exploring Quality Consumer Health Information in Texas". This workshop featured national speakers from the Agency for Health Care Policy and Research, presenters from the states of California, Maryland and Florida, as well as a panel of Texas experts and health care consumers. The workshop provided an opportunity for the ad hoc committee to solicit input from a wide variety of health professionals and health care consumers which resulted in the recommendations contained in this report. Also included in this report is a discussion of the trends impacting the state of consumer information, an overview of Texas agencies and organizations involved in consumer health information efforts, and a description of other states' innovative strategies to enhance the quality of health information available to consumers.

BACKGROUND

One of the goals of the Statewide Health Coordinating Council is to "develop the health care partnership between consumers and health care professionals through increased access to health care information".[1] The traditional relationship of health care provider and consumer has not expected nor relied on consumers to exercise their responsibilities as decision makers in treatment.[2] The health care environment has become more complex. Advances in health care diagnostics, added to the availability of often conflicting information, and because of the increasing analytical sophistication of health consumers, a new paradigm needs to be developed in the relationship between health care consumers and providers. The need for development of the consumer-provider partnership has become critical. The consumer and the health care provider will be expected to have a high level of skill and knowledge. The consumer will use these skills in making decisions that will impact their health and health care.

The consumer is an individual who purchases, uses, maintains, and disposes of health related products, and services. A health care consumer should use information to access, evaluate and make decision regarding their health and health care.[3] As better and more detailed information becomes available, consumers should also be able to make better informed decisions about providers of care.

There is a vast array of health and health care decisions facing consumers including the choice of healthy/unhealthy behaviors, insurance coverage, type of health plan,

providers, treatment options and health care compliance.[4] A closer look at each of these areas will help to understand how the infrastructure of consumer information in Texas can be improved.

Choice of healthy/unhealthy behaviors

Lifestyle choices significantly affect the risk of disease or injury, health-related costs and dependency on the health care system. They include diet, exercise, weight control, and alcohol intake, as well as use of inappropriate drugs or tobacco, stress management, and other preventive health practices.[5]

Choice of insurance coverage

There are a number of ways to obtain insurance, with the availability, cost, and affordability of insurance based on each individual's circumstances. Almost 90 percent of insured individuals under the age of 65 obtain coverage from an employer or group-sponsored health plan. However, workers at firms with fewer than 10 employees have less than a 50 percent chance of being offered health insurance benefits, while agricultural workers have only about a 33 percent chance.[6] In the government-sponsored U.S. market, Medicare, Medicaid, and health coverage related to military service cover one quarter of the population. Regardless of the source of insurance, consumers should seek out information on costs and coverage to best protect themselves and to minimize their financial expenses.

Type of plan

Only a slight majority of Americans have a choice of more than one health plan from their employer, and those who do, typically can choose between a health maintenance organization and fee-for-service. The degree of choice, however, varies by health plan sponsor.[7] There is a growing trend for states to provide report cards on health plans designed to assist consumers in evaluating and choosing a health plan.

Providers

Most managed care health plans today have large networks of physicians and other health care providers that offer an array of treatment locations and specialties. Consumer information on providers is often through the advice and recommendation of family and friends, but government agencies are now becoming a source of information and profiles on health care providers.

Treatment options

More consumers are choosing to play an active role in their choice of treatment. As growing numbers of consumers are becoming as informed as possible about their health and medical needs and are active in discussions about the options and relative merits of any treatments under consideration. This type of consumer involvement in treatment selection is likely to increase both patient compliance and consumer satisfaction.[8]

Patient compliance

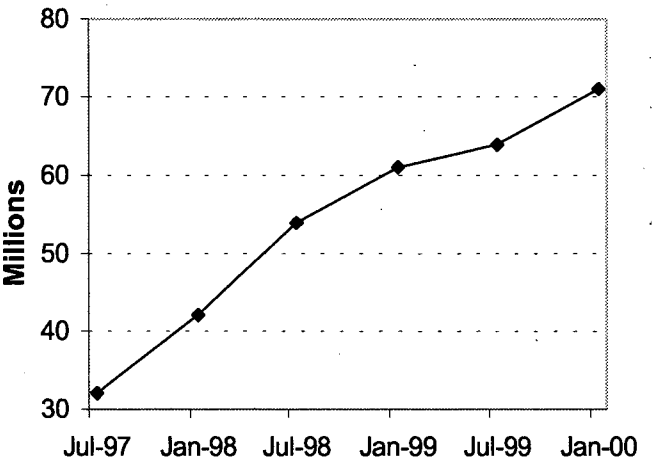
A consumer's decision to comply with recommended treatments and preventive care can make an enormous difference in health outcomes. Patient compliance is a major issue in the effectiveness of treatment. A significant percentage of prescription drugs are not taken correctly, and failure to comply with treatment regimens is a significant factor in re-hospitalization among the chronically ill. These issues of non-compliance, similar to the issue of poor lifestyle choices should be addressed in part through good consumer information/education programs sponsored by health plans and government agencies.[9]

As concluded by the February 19, 1997 Scott and White Assembly "America's Health Seeking Solutions for the 21st Century," health professionals and consumers alike agreed that health care in the 21st century, must include certain key elements: it must be collaborative with consumers, it must be integrated with many providers, and it must be complementary with public and private initiatives to ensure the public's health.[10] The task of 21st Century health care should be to help people optimize health over a lifetime - to sustain maximum physical, mental, and emotional capacity. Care should be designed to facilitate consumer convenience and satisfaction. Quality should be measured in patient-centered outcomes, such as satisfaction surveys and functional status indicators and information should be integrated in a manner that represents a seamless system to the consumer.[11] In order for the consumer in the 21st Century to be a full partner in this collaborative endeavor, they must be prepared to deal with a complex health care environment. Some of the most important influences will be as follows.

Changes in the Health Care System

Changes in the health care delivery system over the past five years have dramatically altered the manner in which many Americans receive health care services. The growth of managed care and of integrated systems of providers has modified decades-old relationships among patients, providers and plans. Less noticed is an equally important change, namely, the more frequent instances of cooperation between public and private purchasers in the collection, interpretation, and dissemination of health information. The increase in collaboration can be seen as an outgrowth of the broader trends of accountability, consumerism and performance measurement.[12]

Figure H-1. Online Adults Growth Trends: 1997 to Present



Source: Cyber Dialogue, http://www.cyberdialogue.com/resource/data/ic/index.html

Emerging Information Technology

Internet sites and the media have become significant sources of information for patients. According to Cyber Dialogue in 1999, over 25 million people accessed the Internet for health and medical information.[13] See Figure H-1. Recent estimates put the number of health-related Web sites at over 15,000 and growing.[14] Information about specific health conditions dominates the type of research consumers do on the Internet. Table H-1 is a breakdown of the type of online information sought by consumers visiting health Web sites.

Table H-1. Type of Information Accessed

Type of Information	Percent of Users Accessing Information (of 100%)
Diet and nutrition	49%
Women's health	41%
Fitness	36%
Doctors	22%
Elderly care	13%
Specific conditions	73%
Pharmaceuticals	42%
Alternative medicine	37%
Children's health	30%
Health insurance	14%

Source: Cybercitizen Health 1999, a Deloitte Consulting Study

In this technology-rich environment, consumers have easier access to health information and the role of health professionals and health organizations is evolving from being a supplier of health care information to also being a source to help interpret information. This interpretation role is critical to help consumers make informed decisions.

Web sites now provide a wide range of clinical and diagnostic information; opportunities to purchase products and services; interactions among consumers, patients and health care professionals; and the capability to build a personalized health record.

A survey commissioned by the California Health Care Foundation (CHCF) and the Internet Healthcare Coalition (IHC) reports that Internet users are wary of the information they share relating to their personal health information.[15] The results indicated that seventy-five percent of those seeking health information on the Internet are concerned or "very concerned" about the sites with which they've registered, sharing their personal health information without permission with a third party.

Despite the level of concern Internet users have about their medical privacy, 70 percent of survey respondents did not know whether there are laws protecting medical information on the Internet. While 33 percent of Internet users think government should regulate health Web sites, another 30 percent believe the sites should be regulated, but are not sure by whom, while 20 percent believed the industry should be self-regulated.[16]

The survey indicated that consumer/user confidence is boosted if a site:

- Is recommended by the user's doctor;
- Has published a privacy policy that states information will not be shared with advertisers, other sites or marketing partners;
- Gives user opportunity to see who has access to user's profile;
- Allows user to make choices about use of information.[17]

Research conducted by Janlori Goldman and Zoe Hudson of the Health Privacy Project at Georgetown University and Richard Smith, an Internet security expert,

looked at privacy policies and practices of 21 of the most heavily trafficked health sites on the Internet. Their research revealed the following five key finding:

1. Visitors to health Web sites are not anonymous, even if they think they are.
2. Health Web sites recognize consumers' concern about the privacy of their personal health information and have made efforts to establish privacy policies; however, the policies fall short of truly safeguarding consumers.
3. There is inconsistency between the privacy policies and the actual practices of health Web sites.
4. Consumers are using health Web sites to better manage their health but their personal information may not be adequately protected.
5. Health web sites with privacy policies that disclaim liability for the actions of third parties on the site negate those very policies.[18]

The results of both of theses research studies shows the convergence of technology and health insurance has raised new privacy concerns that need to be addressed by the emerging online health industry. According to John Mack, President and co-founder of the Internet Healthcare Coalition

> Before the entire online community can truly utilize the full potential of the Internet for health care applications, consumer and content providers alike must come to a consensus on the ethical principles that will move the industry forward.

Patient Bill of Rights and Responsibilities

The Patient Bill of Rights and Responsibilities was a hotly debated topic in 1999 in the United States Congress. The primary concept of the Patient Bill of Rights and Responsibilities is:

First, to strengthen consumer confidence by assuring the health care system is fair and responsive to consumers' needs, provides consumers with credible and effective mechanisms to address their concerns, and encourages consumers to take an active role in improving and assuring their health.
Second, to reaffirm the importance of a strong relationship between patients and their health care professionals.

Third, to reaffirm the critical role consumers play in safeguarding their own health by establishing both rights and responsibilities for all participants in improving health status.

The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry was created by President Clinton to "advise the President on changes occurring in the health care system and recommend measures as may be necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system". The Commission, co-chaired by the Secretary of Health and Human Services, Donna E. Shalala, and the Secretary of Labor, Alexis M. Herman, has stated the following principles to guide the development of legislation/policy affecting the rights of consumers and providers:

All consumers are created equal. A Bill of Rights and Responsibilities should apply to all consumers. It should include all those who have private insurance, purchase their own insurance, work for companies that have self-funded health plans, and those who work for companies that purchase insurance for their employees and dependents, as well as beneficiaries of such public programs as Medicare, Medicaid, the Department of Veterans Affairs, and the Department of Defense, and Federal, State, and local government employees. Finally, to the extent possible, these rights should include those who have no health insurance but use the health care system.

Quality comes first. Wording in patient rights and responsibilities policy needs to address improvement in quality of care and of the system that delivers that care.

Identify and preserve what works. There are elements of managed care and of indemnity coverage that must be changed to protect the rights of consumers. But there also are elements of each system that have improved quality and expanded access. Preserve what works while we address areas that can and should be improved.

Costs matter. The President's Commission sought to balance the need for stronger consumer rights with the need to keep coverage affordable. In some circumstances these rights may create additional costs for employers, health plans, federal, state, and local governments and consumers. Ultimately, consumers may bear these costs in the form of lower wages, higher prices, higher taxes, or reduced health care benefits. The Commission believes some components of the Bill of Rights may also enhance

the efficiency and effectiveness of the health care marketplace. While these efficiencies cannot be well calculated, they may help to offset some cost increases.[19]

Whether such a bill becomes law, or is an aspirational goal, it seems clear that better information and dissemination of health information is necessary if the consumer is to make informed and responsible decisions about their health, Texas agencies charged with protecting the rights of consumers should adopt these principles to guide programs and services.

Consumer Health Information Agencies and Organizations in Texas

The following governmental, private non-profit agencies, and private sector health care providers disseminate health care information to consumers in Texas. The ad hoc committee surveyed the types of information and the roles and responsibilities of entities providing information in an effort to understand what exists and identify what is already working and where deficiencies exist. Exhibit H-1 provides the URLs for a number of federal, state agency and Texas University sites.

State Agencies

The Texas Office of Public Insurance Counsel (OPIC) is an independent state agency created by the Texas Legislature to represent the interests of insurance consumers. OPIC represents consumers in hearings before the Texas Department of Insurance, the State Office of Administrative Hearings, other state agencies, and in the courts. OPIC is statutorily required to represent the interests of consumers relating to insurance rates, rules, policy forms, and other related issues. A major function of OPIC is the publication of annual HMO Report Cards. This "report card" documents a survey commissioned by the counsel to measure the level of satisfaction expressed by Texas HMO consumers and is designed to help consumers make informed choices when choosing an HMO. The report also serves to inform consumers of their rights and responsibilities when dealing with HMOs.

The Texas Department of Insurance (TDI) plays a vitally important role in the provision of consumer information and consumer protection in Texas. TDI publishes information on how to choose a health plan and specific information on health plans and HMOs, provides education on what is in the

market place, informs the public on the rights and responsibilities of consumers, and provides an avenue for consumers to file complaints against insurance companies. TDI also licenses and investigates companies that offer health insurance.

The Texas Health Care Information Council (THCIC) was established in 1995 by the Texas legislature to be a statewide health care data collection system. THCIC collects data on health care charges, utilization, provider quality, and outcomes to facilitate the promotion and accessibility of cost-effective, quality health care. The following mandates are part of THCIC's enabling legislation:

- Direct the collection, dissemination, and analysis of data;
- Contract with the Texas Department of Health to collect data from health care providers;
- Avoid duplication of other data collection;
- Review public health data collection programs and recommend consolidations;
- Determine a format for health care providers to submit data;
- Develop and implement a methodology to collect and disseminate data reflecting provider quality;
- Assure that data collected is made available and accessible; and
- Educate the public regarding the interpretation and understanding of information that is made available.

THCIC produces two major reports based on Texas specific information received from the Health Plan Employer Data and Information Set (HEDIS). HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information needed to reliably compare the performance of managed health care plans. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking, asthma and diabetes. The latest version of HEDIS includes a standardized member satisfaction survey. It is sponsored, supported and maintained by the National Committee for Quality Assurance.

Your HMO Quality Check-up: A Consumer's Guide is designed with consumers in mind. Each report provides locally-relevant performance data on a few commonly understood measures provided by basic service HMOs. Data is reported only on those commercial HMOs available during 1998 in that regional marketplace.

Straight Talk on Texas HMOs is designed as a resource for Employee Benefits Managers and consumers. This report contains performance data on all HMOs serving Texas beginning in 1997. Data is provided on the complete subset of HEDIS measures required for reporting to THCIC. This report is also of value to policy makers and to HMOs setting benchmarks for improvement.

The Health Professions Council is composed of representatives from 14 health related professional licensing entities. An important function of the Council is to establish and operate a toll-free telephone complaint system to provide assistance and referral services for persons making a complaint relating to a health profession regulated by the state (1-800-821-3205). The council is planning to offer these services on the Internet in the very near future.

The Texas State Board of Medical Examiners offers a dial-up verification system for health care providers and consumers to access information regarding physicians, permit holders, temporary licensees, applicants, acupuncturists, and physician assistants registered or licensed by the Board. Instructions on how to use the dial-up system are available at http://www.tsbme.state.tx.us/verif/interon.htm. The Board is also statutorily charged to receive reports of claims and lawsuits against physicians that are based on allegations of professional liability. These reports provide a detection system that may identify recurring patterns of unacceptable health care.

The Texas Department of Health is the repository for selected health data. The Bureau of Licensing and Compliance tracks the licensing of health facilities and the licensing and certification for 18 health-related professions. The Bureau of Vital Statistics records all the births, deaths, marriages and divorces in Texas. The Bureau of State Health Data and Policy Analysis analyzes and disseminates health data and information in support of health

policy development, program planning and evaluation, and health related research activities. Available patient level databases are integrated and linked to enhance analysis of public health issues. Information on uncompensated care and community benefits provided by Texas hospitals are collected and analyzed. Data based policy tools such as Texas Health Facts incorporate information from throughout the department and from outside sources. The Health Professions Resource Center analyzes education and employment trends for health professions and administers shortage area designation programs to improve access to primary care throughout the state. TDH also maintains data on Medicaid activities.

Private Non-Profit Agencies

The American Association of Retired Persons (AARP) is a wealth of information for mature and elderly health care consumers. AARP provides information to its 32 million members on a variety of health related topics including: wellness and prevention; health Insurance options; Medicare: caregiving and nursing homes options; legislative Issues; and research into health related issues impacting retired persons. AARP maintains a web site called *Explore Health* (http://www.aarp.org/ healthguide/home.html) that provides detailed information on a wide variety of health topics that might have an impact on older Americans.

The Texas Association of Health Plans is a coalition of health care plans, single-service HMOs and physician organizations from throughout the state. The association provides answers and information for consumers with common questions about health plans. TAHP provides information to consumers addressing their rights and responsibilities as a member of a health plan including information disclosure, access to emergency services, and standardized complaints and appeals procedures. TAHP publishes a health plan directory that provides specific plan information on virtually all Texas-licensed HMO plans.

The Texas Medical Association advocates for health care concerns in the Texas Legislature and before state regulatory agencies. TMA worked in the most recent Texas Legislature on behalf of consumers by supporting a sweeping body of laws to protect patients' rights within managed care plans

and expansion of the Children's Health Insurance Program. TMA also provides hundreds of opportunities each year for physicians to gain continuing medical education, maintains one of the largest private medical libraries in the state and conducts frequent public education campaigns on important health issues.

The Texas Nurses Association provides information to nurses, the news media, and the public about issues important to health care and the practice of nursing. It also makes available to the public consumer tips for more effectively interfacing with health care systems. TNA is an American Nurses Credentialing Center and approves and provides continuing nursing education. It is both a resource and leadership model for its membership of registered nurses.

The Texas Hospital Association offers information to the public concerning health care issues, such as health insurance coverage, access to health care services, and state and federal public health programs designed to assist low-income Texans. THA and its more than 453-member institutions work with others to raise awareness of public health issues, such as immunizations, organ donation, advance directives and breast-feeding. THA is a resource for its members, the news media and the public to obtain information regarding Texas hospitals and health systems

The Texas Institute for Health Policy Research is the Texas Hospital Association's nonprofit public policy development/research foundation investigating future health care delivery and financing options. Through research and information dissemination, the Institute is attempting to develop policy options for consideration by future decision makers. The Institute's data will be used by both public and private sectors to redesign health care delivery and financing systems that facilitate community-focused care, enhance personal health status and result in improved clinical outcomes.

Consumers Union provides information to enhance consumer protection and education. Their information products on the Internet include: Choosing a Health Plan Tip Sheet; Health Care Affordability; Health Care for Children;

Health Care Plans and Managed Care; Health Care Reform; and Conversion of Nonprofit Health Care Organizations into For-profit Corporations.

Texas Alliance for Human Needs serves as a clearinghouse providing data, testimony, technical assistance and materials and serves as a link to national issue coalitions. The Alliance initiated and facilitated the creation of rural health care coalitions around the state.

The Texas Mental Health Consumers is an advocacy organization for mental health consumers and their families. TMHC provides information on patients' rights and responsibilities with in the Texas mental health system.

Private Sector Health Care Providers

The efforts of governmental and private non-profit entities to provide consumer information are complimented by the tremendous volume and resources offered by private sector health care. Health plans, hospitals, physician groups, drug companies, medical device makers, and other commercial operations provide the public with tremendous amounts of data and information. Some of this information is intended for selling the consumer a product or providing a positive image of the company. But there is a great deal of information provided by the public sector which is placed there in the public interest. Below are descriptions of some representative private/ non-profit medical providers.

Texas Health Resources is a partnership between Harris Methodist Health System and Presbyterian Healthcare Resources. THR operates 14 hospitals in the greater Dallas/Fort Worth metropolitan area. In addition, the system offers a web site to provide information to the community so that information is available in a format useful in making health care decisions. The system offers many community programs and education including: Asthma education program for school-aged children and their parents; the Cancer Resource Library; Genetic Risk Assessment Program offers free individual counseling to quantify an individual's cancer risks and aid in developing individual preventive strategies; ASAP! Health Risk Assessment is a health survey that patients may take via telephone or on-line, which asks about current health status and lifestyle, and then provides a report identifying

patient strengths, areas for improvement, and suggestions for actions to improve or protect your health. THR also offers a variety of support groups for patients to exchange information and concerns (http://www.texashealth.org/index.html).

Scott and White Clinic, Hospital, and Health Plan, form one of the largest multi-specialty group practices in the U.S. A model of integrated health care, Scott & White combines a 515-physician Clinic, a 486-bed Hospital and a Health Plan, which supervises the healthcare for more than 163,000 Central Texans. Scott and White has a commitment to prevention and patient education. Scott and White's "On Call" is a 24 hour health information service. Information can be accessed in three ways: patients may access on-line information through their web-page; patients can listen to pre-recorded health information over the telephone; and or a patient may talk to a registered nurse when questions or symptoms occur and there is a need for medical advice (http://www.sw.org/).

Seton Health Care Systems (Daughters of Charity) operates, among many other consumer oriented activities, a web site called "Good Health." This site is an online resource for consumer information about well-ness, fitness, disease prevention and medical. They also produce a free magazine also called "Good Health" which offers a variety of consumer oriented information to consumers looking for a higher level of wellness and health. Seton also offers classes to the public on health related topics (http://www.goodhealth.org/).

Health Oriented Internet Companies have been appearing and multiplying all over the World Wide Web. The typical health oriented web site will contain many similar elements such as: chat rooms; disease specific on-line support groups; articles on prevention and treatment; avenues for asking the advice of nurses and physicians; links to commercial drug, medical device, insurance/HMO companies; treatment updates, conference summaries and many other features. While some have a strong proprietary emphasis, consumers can find a great deal of information available through these commercial sites. A few examples of these include Medscape (primarily

aimed at physicians and health professionals), DrKoop.com, MedWeb, Healthgrades.com.

There are numerous private and public organizations in Texas providing quality health information, but the sheer magnitude of the system may make it difficult for consumers to readily access services and information.

States Providing Innovative Consumer Information Systems

Texas has taken important steps toward developing a system of consumer health information that is comprehensive and accessible. Establishment of the Texas Health Care Information Council can be seen as the cornerstone on which this system is built. The 76th Texas Legislature saw the passage of House Bill 110, giving the public access to profiles on physicians, and of House Bill 3021, which established a "Health Care Ombudsman" that will operate a statewide clearinghouse for health care information. These recent developments show the increasing support for consumer information efforts in Texas. However, the system is far from complete and far from comprehensive.

Other states have established innovative programs in the field of health care informatics that are worthy of study. While some of these programs are not specifically aimed at the health care consumer, the existence of these programs are necessary building blocks to a consumer oriented health care system. Having data available to researchers, providers, advocates, and other concerned professionals for their use and analysis, will translate into usable information being made available to the individual health consumers.

For instance, the availability of hospital discharge data may not necessarily be of aid to the health care consumer trying to make a decision about his or her health care. However, once this information is available, it can be translated into a usable form by the health informatics professionals. The availability of data for analysis will lead to the availability of usable information to health care consumers.

Not all state health care information systems are similar, but most states have: electronically linked state and local health departments; have major disease/event registries and data collection providers; retrospective linkages of data-sets; and health professions license verification system. The information listed below was complied

by the Agency for Health Care Policy and Planning "Internet Registry of State Efforts to Integrate Health information".

State and Local Health Department Network Infrastructure: Several states have linked their local and state computer systems to provide greater ease in data gathering and data base development. These systems are used as decision support systems that integrate several health databases and attempt to enhance connectivity between state and local health departments via e-mail and electronic conferencing capabilities. States have allowed the public to access information with analytical, graphing, and mapping tools via the Internet.

Major Registries, Data Collection Across Providers: Many states that have been active in this area maintain a number of health registries, including but not limited to hospital and out-patient discharge data bases, registries for birth, death, cancer, birth defects, congenital anomalies, weapons related injuries, lead poisoning, etc. These databases have been made accessible to the public while being cognizant of concerns about privacy and confidentiality of information.

Retrospective linkages of data sets: Many states have initiated systems that connect different registries and databases in order to enhance longitudinal patient records. These linkages are also used for program surveillance, evaluation and for outcomes research. The ability to link hospital and out-patient discharge data bases, registries for birth, death, cancer, birth defects, congenital anomalies, weapons related injuries, lead poisoning, those involved in research can gain more complete and thorough insight into public health and individual risk factors. The existence of data available to professionals for analysis will enhance their ability to provide accurate and understandable information for public consumption.

Health Professions License Status and Complaint Verification System: On-line license status and complaint systems are available in many states. Most states have systems set up by individual licensing boards. In states which have boards housed in a centralized licensing agency, such as California, the query will check all licensure databases.

The following state programs are excellent examples because they are: 1) innovative in their approach or 2) use governmental/education/private partnerships.

Maryland

The state of Maryland is currently engaged in a number of activities involving or supporting health data integration. One of Maryland's most important innovation is their successful efforts to determine and provide information needed by different users of the system. Reports are tailored for different audiences depending on the need and level of knowledge of the consumer/ provider group.

The Health Care Access and Cost Commission (HCACC) maintains a data set that collects physician encounter data from payers. The Health Resources Planning Commission maintains data sets that collect and report utilization and charge data on non-hospital based facilities, including long-term care, sub acute care, and home health care. The level of information is much broader than most states. Reports are made available to the public on-line and hard copy.

Immunization Tracking System: This is a system being developed to track childhood immunizations in the state of Maryland and to facilitate the sharing of patient-specific immunization records across public and private providers.

California

Statewide Immunization Information System: a system being developed to connect county-level immunization tracking systems which collect patient – specific demographic and clinical information related to childhood immunizations.

Common Application Transaction System: an on-line enrollment and self-declared eligibility system that will create a program database that includes basic demographic and eligibility data and will be shared with all Primary Care and Family Health programs. This ties into a Statewide Client Index designed to link multiple data sets for tracking Health and Welfare Agency clients across time and programs.

Healthcare Data Information Corporation: a non-profit corporation developing a community health information network to support electronic data transmission of health-related data. Tele-Conferencing, Tele-Collaboration, Tele-Management and Tele-Reporting: a project to place desk-top video conferencing equipment in 11 rural counties and pilot pen-based computers in one rural county.

California Telehealth/Telemedicine Coordination Project Planning Committee (TTCPPC): While not specifically consumer oriented, the program committee's actions can have a great impact on accessibility of information. This is committee of health care stakeholders, formed by the Department of Health Services, to foster and coordinate the development of integrated public and private telehealth/telemedicine networks and applications throughout California.

Minnesota

Minnesota Health Data Institute (MHDI) – MedNet: a network infrastructure that facilitates the exchange of information between broad-based coalition of insurers, providers, and other interested parties, including state government.

New York

The New York Department of Health World Wide Web Home Page: a tool that provides access to selected health department data including hospital discharge data and leading cause of death data.

Washington

Access-only data system for hospital inpatient data: a system, in the early design phase, which would allow Department of Health staff and local health departments' on-line access to hospital inpatient data.

CHILD Profile System: a health promotion and immunization tracking system focused on ensuring that children receive the preventive health services they need, from birth to age six.

Community Health Information Partnership: Washington's Foundation for Health Care Quality has been awarded a grant from the John A. Hartford Foundation to work on a number of integration related projects focusing on electronic commerce, quality assessment, and consumer affairs.

Health Services Information System: Under 1993 legislation, the Department of Health developed a data plan for a statewide Health Services Information System (HSIS) to support and monitor the effectiveness of health reform. Although the legislation was repealed, is demonstrates the progression of integration efforts in the state of Washington.

Washington State Department of Health Standardization: the Department of Health has a statutory charge to develop standards for health data content, coding and transmission. This is occurring in coordination with pilot activities and the Interagency Quality Committee.

This is not an exhaustive list of innovative programs throughout the nation, but an examination of initiatives that could help set state standards for health data. This overview described how states improved their consumer information systems. The following are recommendations drafted by the Consumer Information Ad Hoc Committee calling for specific actions to strengthen the Texas consumer information system.

AD HOC COMMITTEE RECOMMENDATIONS

Recommendation One: The Texas Health Care Information Council should develop a clearinghouse that provides one-stop access to health and insurance-related information. There is a wealth of information about health available to consumers, not only from state agencies, but also from community-based organizations, advocacy groups and the private sector. This information should be maximized and coordinated to provide seamless access to information.

Information is only of value if it gets into the hands of the people who need it, in a form that it can be used. A number of agencies and organizations in Texas compile information that could help consumers make important health care and insurance decisions. But consumers are not likely to know which agencies to contact and may be frustrated by the difficulty and amount of time involved to access it. A clearinghouse, using a variety of outreach strategies (Internet, 1-800 line, etc.) can provide one-stop, access to health and insurance-related information is needed in the state of Texas.

This clearinghouse would include an Internet website providing links to agencies and organizations that compile and publish information beneficial to consumers making health care and insurance decisions. Consumers visiting the site would access general information published by one agency, register complaints to another agency and browse through quality of care information published by yet another agency. The site would be seamless to the user. The clearinghouse's development and maintenance would be the responsibility of the Texas Health Care Information Council.

Recommendation Two: The governor, in conjunction with other state leaders, should designate the Texas Health Care Information Council as the agency to coordinate and organize the information available from state agencies and state entities involved in consumer health information activities (i.e.: Texas Health Care Information Council, Office of Public Insurance Counsel, Texas Department of Insurance, Licensing Boards, and the Texas Department of Health). The Consumer Information Ad Hoc Committee strongly urges that the Texas Health Care Information council serve as the lead agency and receive funding appropriate to carry out this role.

Responsibilities should include:

(1) collecting and analyzing data relevant to consumer information and consumer choice;
(2) providing and disseminating data related to consumer choice of health plan, provider and treatment options; and
(3) recommending methods for organizing data relevant to consumer information and consumer choice.

End Notes

1. Statewide Health Coordinating Council, *Texas State Health Plan 1999-2004: Ensuring a Quality Health Care Workforce for Texas*, 1999.

2. Ibid.

3. Cancer Web On-Line Medical Dictionary at http://www.graylab.ac.uk/cancerweb.html

4. Taylor, Roger S. "What's Missing in Today's Consumer Choice Discussions?" *Medical Care Research and Review*, Vol. 56, Supplement 1 (1999), Sage Publications, 60-66.

5. Ibid.

6. Ibid.

7. Ibid.

8. Ibid.

9. Ibid.

10. The Scott and White Assembly,. "America's Health: Seeking Solutions for the 21st Century", February 19-22, 19997, sponsored by Scott and White Memorial Hospital and Scott, Sherwood and Brindley Foundation, and the LBJ School of Public Affairs.

11. Agency for Health Care Policy and Research, U.S. Department of Health and Human Services. "Americans as Health Care Consumers: The Role of Quality Information: Highlights of a National Survey". 1996 (www.ahcpr.gov:80/qual/kffhigh.htm)

12. Milbank Memorial Fund and the Reforming States Group. "Public-Private Collaboration in Health Information Policy, June, 1999 (www.milbank.org/mrinfopolicy.html)

13. Cyber Dialogue. The Internet Consumer at www.cyberdialogue.com

14. Health Information Resource Center World Wide Web Awards at www.healthawards.com

15. California Healthcare Foundation. *e*Health Reports "Ethics Survey of Consumer Attitudes about Health Web Sites at http://ehealth.chcf.org.

16. California Healthcare Foundation at http://ehealth.chcf.org

17. Ibid.

18. Ibid.

19. United States Department of Labor. "Progress in Implementing the Patient's Bill of Rights at the Department of Labor: A Report to the Vice President of the United States." November 2, 1998. (http:\\www.dol.gov/dol/pwba/public/pubs/rpt198.htm)

Exhibit H-1
Texas State Agency, University Health Center, and Federal Health Consumer Information Internet Links

Institution	URL	Description
State Agencies		
Texas Department of Health	http://www.tdh.state.tx.us/	Variety of information concerning preventive health, health insurance, treatment, and Medicaid.
Texas Health Care Information Council	http://www.thcic.state.tx.us/Publications.htm	Provides publications and reports to the public and employers on HMO's and other issues relating to hospital performance.
Texas Department on Aging	http://www.tdoa.state.tx.us/	Information concerning health insurance and health care for the aging population.
Texas Department of Insurance	http://www.tdi.state.tx.us/	Consumer oriented information on health insurance.
Office of Public Insurance Counsel	http://www.opic.state.tx.us/	Consumer oriented information on health insurance.
Texas State Board of Medical Examiners	http://www.tsbme.state.tx.us/	Information on license verification and filing complaints on physicians.
Texas University Health Science Centers		
University of Texas Medical Branch - Galveston	http://www.utmbhealthcare.org/	One Focus ~ Your Health Electronic Newsletter providing articles and links concerning consumer health.
University of Texas Health Science Center at San Antonio	http://www.uthscsa.edu/patient.html	List of links to health consumer information web sites.
The University of Texas Southwestern Medical Center at Dallas – Health Watch	http://www.swmed.edu/home_pages/library/consumer.htm	Health Watch is a public service of the Office of News and Publications & the library at UT Southwestern Medical Center at Dallas.
The University of Texas Health Center at Tyler – Patient Care	http://library.uthct.edu/patient.htm	Provides health care information links to consumers.
The University of North Texas Health Science Center at Fort Worth (UNTHSC) – Patient Care	http://www.hsc.unt.edu/patientcare/	Provides information about the range of services offered by the UNTHSC.
Texas Tech University Health Science Center (TTUHSC): Patient Care Index	http://www.ttuhsc.edu/Home/patientcareindex.htm	Lists services available at TTUHSC campuses in Lubbock and Odessa.
Texas A&M Health Science Center (TAMHSC) – Scott & White Hospital	http://www.sw.org/ptinfo/ptinfo.htm	In association with TAMHSC, Scott & White Hospital and Clinic provides information and links for consumers concerning specific disease treatment and prevention, physician directory, and support groups.
Baylor College of Medicine – Consumer Center	http://www.bcm.tmc.edu/pa/consumer.htm	Information from Baylor College of Medicine concerning research news, general healthcare information, sports medicine, requests for research participants, and a public health series.
M.D. Anderson Cancer Center	http://www.mdanderson.org/	Offers information on cancer prevention and treatment, patient expectations, practice guidelines, and other information for consumers and professionals.
University of Texas at Houston (UTH) Health Science Center	http://www.uth.tmc.edu/index/health.html	Provides basic information on health care services offered by UTH.

Exhibit H-1
Texas State Agency, University Health Center, and Federal Health Consumer Information Internet Links – Page 2

Federal Agencies	URL	Description
Agency for Health Care Research and Quality (AHCRQ)	http://www.ahcpr.gov/consumer/	The Consumers & Patients page of the AHCRQ site offers links and information to health consumers and professionals on conditions and diseases (including consumer versions of clinical practice guidelines), health plans, prescriptions, prevention & wellness, and other topics.
Center for Disease Control and Prevention: Health Topic A to Z	http://www.cdc.gov/health/diseases.htm	Health Topics A to Z provides a listing of disease and health topics found on the CDC Web site.
Health Finder: U.S. Department of Health and Human Services	http://www.healthfinder.gov/	Healthfinder® is a free gateway to reliable consumer health and human services information developed by the U.S. Department of Health and Human Services. The site offers links to selected online publications, clearinghouses, databases, web sites, and support and self-help groups, as well as the government agencies and not-for-profit organizations that produce reliable information for the public.
Medline Plus Health Information: National Institutes of Health	http://medlineplus.nlm.nih.gov/medlineplus/	Medline Plus offers up-to-date, quality health care information from the National Library of Medicine at the National Institutes of Health. This service provides access to extensive information about specific diseases and conditions and also has links to consumer health information from the National Institutes of Health, dictionaries, lists of hospitals and physicians, health information in Spanish and other languages, and clinical trials.
Health Care Financing Administration (HCFA)	http://www.hcfa.gov/audience/benes.htm	HCFA's consumer information for Medicare, Medicaid and the Children's Health Insurance Program.
Federal Consumer Information Center	http://www.pueblo.gsa.gov/health.htm	Federal health information available via regular mail, e-mail or download.
The National Health Information Center (NHIC)	http://nhic-nt.health.org/	NHIC refers health professionals and consumers who have health questions to those organizations that are best able to provide answers.

Appendix I
Participation in SHCC Ad Hoc Committees

Participation

Elizabeth Anderson, Dr. P.H., R.N., F.A.A.N.
Texas Nurses Association

Chris Kazen Attal
Diocese of Austin/Seton East Community Health Center

Kay Bartholomew, M.P.H., Ed.D.
U.T. School of Public Health

Martin Basaldua, M.D.
Texas Higher Education Coordinating Board

Jane Basey, Ph.D.
Consumer Advocate

Geana Bassham, M.A./CCC
Brazos Valley Rehabilitation Center

Jose Bayona, M.D.
University of Texas Medical School

Kathleen Becan-McBride
University of Texas Houston Health Science Center

Gail Bellamy, Ph.D.
Scott and White Hospital

Connie Berry
Texas Department of Health

Whitney Bischoff, Dr. P.H., R.N.
Texas A&M School of Nursing

Craig H. Blakeley, Ph.D., M.P.H.
Texas A&M University Health Science Center

Rod Bordelon, J.D.
Office of Public Insurance Counsel

Richard Branson, P.A.
Texas Academy of Physicians Assistants

Galen Brewer, M.P.A.
Texas Department of Mental Health/ Mental Retardation

Natalie Burkhalter, M.S., R.N., C.S., F.N.P., C.C.R.N.
Texas A&M International University

Catherine Celestino
Texas Higher Education Coordinating Board

Marcia Collins
Texas Medical Association

Pat Craig
Texas Department of Mental Health/ Mental Retardation

Ashley Davila
Texas Department of Health

Edna DeLaGarza
Texas Higher Education Coordinating Board

Lucretia Dennis-Small, M.P.A.
Texas Workforce Commission

Diana Dinsdale
Medshares Home Health Center

R.J. Dutton, Ph.D.
Texas Department of Health

Christy Fair
Texas Department on Aging

Jude Filler
Texas Alliance for Human Needs

Jamie Garanflo
Board of Medical Examiners

John Garvin
Texas Department of Housing and Community Affairs

Adela N. Gonzalez, M.P.A.
University of Texas Health Science Center - Fort Worth

Ed Gruber
Texas Nurse Practitioners

Bruce A. Gunn, Ph.D.
Texas Department of Health

Maxine Hammonds-Smith, Ph.D., C.F.L.E.
Texas Southern University

Robert J. Hastings, M.A.
Texas Tech University

Joy Hedrick
Coastal Area Health Education Center

Ruth Ann Herrera
Texas Nurse Practitioners

Greg Herzog
Texas Academy of Family Physicians

Jeffery Hill, J.P.
State Board of Dental Examiners

Mike Hill
American Cancer Society

Teresa M. Hines, M.P.H.
Health Education Training Centers Alliance of Texas

Karen Hodge
March of Dimes

Richard Hoeth, F.A.C.H.E., C.A.E.
Texas Hospital Association

Tina Janek
Texas Health and Human Services Commission

Rumaldo Z. Juarez, Ph.D.
Southwest Texas State University
George Kelemen-B.
Texas Department on Aging

Gus Kennedy
Communities in Schools

Virginia Kennedy, Ph.D.
University of Texas School of Public Health

Lee Lane
Texas Department of Health

Sherry Lee
Board of Examiners of Psychologists

Janet Leubner, M.B.A.
Center for Rural Health Initiatives

Lois Linn, Ph.D.
El Paso Community College

Jim Loyd
Texas Health Care Information Council

Budge Mabry
UT System Dental and Medical Application

Klaus Madsen
Texas Institute for Health Policy Research

The Honorable Glen Maxey
Texas House of Representatives

Jane McFarland
Health Professionals Council

Kevin McKinney, M.D.
University of Texas Medical Branch – Houston

Henri Migala
University of North Texas Health Science Center at Fort Worth

Barbara J. Miller
State Occupational Information Coordinating Committee

Camille Miller
Texas Institute for Health Policy Research

Don R. Miller, Ph.D.
University of Texas Health Science Center – San Antonio

Paula Mitchell, R.N.C., M.S.N., Ed.D.
El Paso Community College

Paula Mixson, L.M.S.W.
Texas Department of Protective and Regulatory Services

Amy Wong Mok
Asian American Alliance
University of Texas

John Nava, M.D.
Mexican American Physicians Association

Sandra K. Oliver, R.N., Ph.D., C.N.S.
Scott and White Health Plan

Laurie O'Neal, M.Ed.
Lake Country Area Health Education Center

Yolanda C. Padilla, Ph.D.
University of Texas

Ernie Parisi
Llano Memorial Healthcare System

Jerry Patterson
Texas Association of Health Plans

Jon Phillips
Texas Tech University Health Science Center

Tracy Randazzo
Texas Hospital Association

Mitchell F. Rice, Ph.D.
Texas A&M University

Clemelia Richardson, M.S.W.-A.C.P.
People and Partnership

Janis Ritter
Piney Woods Area Health Education Center

Jimmie Roach, R.S.
Texas Department of Health

James Robinson, III, Ed.D.
Texas A&M University

Tom Roehrig
Texas Medical Association

Glenda Rogers
Capitol Area Agency on Aging

Richard Schirmer
Texas Hospital Association

Audrey Selden, J.D.
Texas Department of Insurance

Stacey Silverman
Texas Higher Education Coordinating Board

Carey Smith, M.S., R.D., L.D.
Piney Woods Area Health Education Center

Dana Smith, M.P.A.
Greater Houston Area Health Education Center

Susan Stappenbeck, M.P.H.
Alamo Areas Health Education Center

Nora Cox Taylor
Center for Rural Health Initiatives

Robert J. "Sam" Tessen, M.S.
Center for Rural Health Initiatives

Fernando Treviño, Ph.D.
University of North Texas

Jon Turton
St. Joseph's Regional Rehab Center

T.A. Vasquez
Austin Independent School District

Leonel Vela, M.D.
Texas Tech University Health Science Center

Mary Walker, R.N., Ph.D., F.A.A.N.
Texas Healthcare Trustees

Yolanda Whittaker-Hilliard, M.D.
African-American Medical Society of Texas

Claude Williams, D.D.S.
Baylor College of Dentistry
Texas A&M University System

Darryl Williams, M.D.
Texas Tech Area Health Education Council

Gary Williams
Texas Department of Transportation

Lorenza Zuniga
Texas Tech Area Health Education Council

Appendix J
Summary of Legislation Related to Health Care Workforce

Summary of Legislation Related to Health Care Workforce
76th Legislative Session

Bill Author	Synopsis	SHCC Goal
HB 1 General Appropriation Act (Junell)	An article VIII rider requires Health Professional Council (HPC) member agencies located in the Hobby building to transfer funds to HPC for purchase of an electronic imaging system for shared use. A rider on the Department of Information Resources (DIR) appropriation gives DIR $134,000 to conduct a Regulatory Systems and Comparative Analysis study of the common licensing system operated by the several of HPC boards and the study outcome could impact most, if not all, member agencies.	
HB 27 Goolsby	Requires physicians to furnish a copy of a patient's complete medical record in 15 business days. Requires TSBME to adopt rules concerning appointed custodians of patient records. (Current law allows 30 days and a physician can refuse if harmful to patient.)	Goal 7
HB 110 Maxey	Establishes a physician profile to be created and maintained online for public access. Also requires a feasibility study be completed by 1/1/00 to determine cost and methodology to establish similar profiles for Chiropractors, Dentists, Occupational Therapists, Optometrists, Pharmacists, Physical Therapist, Podiatrists, and Psychologists.	Goal 2
HB 573 Pitts	Changes state law to permit a medical license holder to complete up to half of the informal continuing medical education credit by providing volunteer medical services at a site serving a medically underserved population that is not the primary practice site of the license holder.	Goal 2
HB 595 Maxey	Allows question of test question in a closed meeting.	
HB 692 Janak	Social Security numbers of an applicant or holder of a license to practice in a specific profession are considered confidential and are not subject to disclosure under open records law.	Goal 2
HB 749 Van de Putte	Prohibits sale of infant formula or baby food, drugs, or contact lenses, including disposable lenses, at a flea market unless the person selling the items is authorized in writing to sell the item at retail by the manufacturer. (A TDH permit is required to sell contact lenses in Texas and purchaser must have fully written prescription.)	Goal 2
HB 923 Coleman	Updates and clarifies language regarding the regulation of licensed professional counselors and provides for a license renewal system whereby licenses expire on various dates during the year.	Goal 2
HB 1051 Brimer	Authorizes therapeutic optometrists to treat glaucoma under consultation with an ophthalmologist. Full implementation will not occur until early next year.	Goal 2

Bill Author	Synopsis	SHCC Goal
HB 1194 Turner	Expands the definition of "rural area". Requires a system that arranges for or provides health care services on a capitated, prepaid basis to obtain a certificate of authority under the Texas Health Maintenance Organization Act. Allows the Commissioner of Insurance to waive requirements of theTexas HMO Act relating to mileage, distance, and network adequacy and scope. Removes a requirement to establish an advisory committee (leaving it permissive instead)	SHCC Vision
HB 1342 Maxey	Implements interstate compact for multi-state regulation of nursing for Board of Nurse Examiners (BNE) and Board of Vocational Nurse Examiners (BVNE). Removes BVNE requirement for LVN program length to be at least 12 months. After 1/1/00, a Texas license will allow Texas nurses to practice in all states that are a party to the compact.	Goal 2
HB 1398 Coleman	By January 1, 2000, Health and Human Services Commission (HHSC) must establish a regional health care delivery system pilot program to coordinate the use of health care resources in a region. By January 1, 2003, HHSC must submit a written report relating to the pilot program to the Governor, Lt. Governor, and the Speaker of the House.	SHCC Vision
HB 1444 Delisi	Defines essential public health services. Creates grants for essential public health services to be administered by Texas Department of Health (TDH), subject to the availability of funds, grants will be awarded to cities, counties, public health districts, or other political subdivisions. Grants must be distributed equally between urban and rural areas. Grantees must appoint a local health authority and may appoint a local health board. Requires TDH, subject to the availability of funds, to provide essential public health services for populations for which a municipality, county, public health district, or other political subdivision is not receiving a grant. Requires TDH, in cooperation with grantees, to evaluate essential public health services provided and the adequacy of funding for these services and report to the Governor and Legislature each odd-numbered year. Requires TDH, subject to the availability of funds, to establish a public health consortium of health science facilities to: develop curricula to train public health workers; conduct research on health outcomes; develop performance standards for local public health entities; and study and improve the technology available to local public health entities. Allows a county with a population of at least 2.8 million to require a trained food manager to be on duty during the operating hours of a food establishment.	Goal 6

Bill Author	Synopsis	SHCC Goal
HB 1513 Maxey	Redefines "public use data" to include patient level data that has had patient identifying information removed and that identifies physicians only by use of uniform physician identifiers. Requires the Health Care Information Council (HCIC) to establish a committee which has experience in ethics, patient confidentiality, and health care data to approve requests for information and to adopt rules regarding the release of patient data.	Goal 7
HB 1864 Capelo, Shapleigh	Requires TDH to set up committee to study frameworks for promotional use and preparation, to establish and operate a training and certification program by January 2000.	Goal 1
HB 1945 Junell	Creation of permanent funds for public health purposes conducted by institutions of higher learning. Directs the board of regents of the UT System to administer the fund (permanent funds for public health purposes conducted by institutions of higher learning). Lists institutions to receive funds. Outlines allocation of distribution. Requires annual reporting to the Legislative Budget Board. Establishes separate permanent endowment funds for certain institutions and allows the governing board to administer the fund. Establishes a permanent fund for Higher Education, Nursing, Allied Health, and other Health-related programs. Establishes a permanent fund for Minority Health Research and Education.	Goal 1
HB 1987 McCall	Permits the Board of Medical Examiners to accept an appropriate licensure examination given by another entity.	Goal 2
HB 2025 Pickett	Provides that a Border Health Institute be established in the city of El Paso. Requires the institute to operate in a manner that facilitates or assists the activities of international, national, regional, or local health related institutions working in the Texas-Mexico border region to deliver health care and conduct research.	Goal 1
HB 2085 McCall	Sets forth provisions regarding the continuation of the Texas Department of Health until September 1, 2011. Requires Texas Board of Health to develop, publish, and to the extent allowed by law, implement a comprehensive strategic and operational plan. Requires TDH to comprehensively study the impact that the state's Medicaid managed care program has had on each of the populations served by TDH and on all health care providers, clinics, and hospitals by 11/1/00.	SHCC Vision

Bill Author	Synopsis	SHCC Goal
HB 2202 Tillery	Permits a school district to design a cooperative health care program model that may provide for the delivery of conventional health services and disease prevention of emerging health threats specific to the district. Permits establishment of Local Health Education and Health Care Advisory Council to ensure local community values are reflected in the operation of a Public School Health Center (PSHC) and is providing health education in the district. Permits establishment of a PSHC by a school district upon recommendation of Local Health Education and Health Care Advisory Council. Permits contracting with a third party to provide services.Requires PSHC staff and parent/guardian to jointly identify health-related concerns of a student that may be interfering with thestudent's well-being or ability to succeed in school. Requires parental/guardian consent to receive services; consent may be limited to specific services. Prohibits reproductive service, counseling, referrals. Permits school district to request assistance in establishing and operating a PSHC from any community public health agency, which must cooperate considering available resources. Requires good faith effort by PSHCs to coordinate with existing health care systems and medical relationships in the community if located in county with less 50,000 or in a medically underserved area. Requires PSHC to notify student's primary care physician prior to providing a service; must obtain approval of student's primary care physician if student is covered by Medicaid, CHIP, private health insurance, or a private health benefit plan. Permits TDH Commissioner, based on the availability of funds, to award up to $250,000 per biennium in grants to a district providing matching funds, with preference to districts in rural areas or with low per student property values.	Goal 4
HB 2382 Coleman	Requires the Board of Physical Therapy Examiners to authorize licensee peer organizations to evaluate and approve continuing education courses in accordance with the established process.	Goal 2
HB 2394 Maxey	Allows licensure by endorsement for applicants in good standing as a therapeutic optometrist in another state or U.S. territory. Must have passed an exam that is equivalent to the Texas exam and meet other requirements.	Goal 2
HB 2636 Gray	Allows TDH to assess registration fees on persons who perform radiological procedures.	

Bill Author	Synopsis	SHCC Goal
HB 2641 Gray	HHSC must submit a report by December 15, 2000 relating to regulatory programs conducted by the Texas Department of Health. Included in the report, HHSC must consider whether (1) a new agency should be established to administer regulatory programs related to health-related professions and (2) the duties of the Health Professions Council should be expanded to encompass all or some of the health-related regulatory program.	Goal 2
HB 2824 Gray	Authorizes each of the 11 boards of the TDH Licensing and Certification Division to exercise the subpoena authority relating to witnesses and documents, to administer oaths, and to seek enforcement power in Texas district courts.	Goal 2
HB 3083 Telford	Allows licensed home and community support services agencies in Texas to accept orders for care from physicians located in states bordering Texas.	Goal 2
HB 3155 Wolens	Nonsubstantive changes to current law, codifying the law into the Occupations Code, using more modern language, eliminating language no longer in effect and rearranging sections with the Code. Agencies must update all rules, forms, etc. where current law is cited.	
HB 3216 McCall	Requires the Board of Medical Examiners, to administer the collection, verification, maintenance, and storage of information relating to physician credentials, and the release of that information to health care entities or to the designated credentials verification organization authorized by the physician to receive that information.	Goal 2
SB 215 Duncan	Provides volunteer health care provider immunity from civil liability under specified conditions. Includes currently practicing and retired physicians, nurses, pharmacists, dentists, and dental hygienists.	Goal 2
SB 310 Cain	Expands the size of the Board of Examiners of Occupational Therapists, authorizes more authority for certain administrative functions, and increases the variety of enforcement tools.	Goal 2
SB 374 Zaffirini	Requires HHSC, DHS, and TDoA to assist Texas Communities in developing comprehensive, community-based support and service delivery systems for long-term care services. HHSC serves on a workgroup that will assist DHS and MHMR in studying coordination of planning and services between the two agencies in providing long-term care services. HHSC directs and requires the Texas Planning Council for Developmental Disabilities and the Office for the Prevention of Developmental Disabilities to prepare a joint biennial report on the state of services to persons with disabilities in this state.	SHCC Vision

Bill Author	Synopsis	SHCC Goal
SB 413 Madla	Increases post degree contact hours for licenses of marriage and family therapists and creates a licensing designation for a marriage and family therapist "associate".	Goal 2
SB 445 Moncrief	Requires the Health and Human Services Commission (Commission) to develop a state-designed child health plan program to obtain health benefits coverage for children in low-income families and to ensure that the program is designed and administered in a manner that qualifies it for federal funding. Requires the Texas Department of Health to administer the plan under the direction of the Commission.	SHCC Vision
SB 524 Moncrief	Allows public access to "warning letters" issued to licensees by the Board of Dental Examiners and makes warning letters part of a disciplinary action of the Board.	Goal 2
SB 556 Nelson	Authorizes licensed qualified health care professionals, within the scope of the professional's licensure, to refer health care service to occupational therapists.	Goal 2
SB 590 Truan	Requires the establishment of the Texas A&M University System Coastal Bend Health Education Center and provides guidelines for its operation. Authorizes the center to provide undergraduate and graduate clinical education, or certain other levels of health care education work, in an area determined appropriate by the board. Requires the Regents of the Texas A&M University System to implement the Act only if the legislature appropriates money specifically for that purpose.	Goal 1
SB 730 Madla	Amends Pharmacy Act providing authority, beginning 9/1/01, to register pharmacy technicians and establish training/education requirements; allowing biennial licensing of pharmacists/pharmacies, and requiring reporting of malpractice claims.	Goal 2
SB 780 Madla	Establishes concept of pharmacy peer review committee.	Goal 2
SB 964 Lucio	"Housekeeping" bill for Board of Dental Examiners. Clarifies that contract management service companies may not require action or decisions that affect the quality of care through their contracts. Eliminates requirement that dental hygienist be supervised by an employing dentist, allowing a hygienist to be supervised by supervising dentist and to give care in settings such as public health clinics.	Goal 2
SB 1131 Madla	Amends hospital-licensing law to allow a hospital to extend privileges to Advanced Practice Nurses and Physician Assistants. Amends definition of a designated agent on the Dangerous Drug Act to allow a physician to designate a licensed vocational nurse or person with education equivalent to or greater than required for an LVN to communicate prescriptions of APNs or PAs.	Goal 2

Bill Author	Synopsis	SHCC Goal
SB 1207 Cain	Rewrites the licensure section of the Medical Practice Act for clarification purposes, consolidates relevant subsections, and deletes obsolete wording. This bill also establishes provisions regarding the board and the licensure of physicians, while providing penalties for violations of the Act.	Goal 2
SB 1223 Moncrief	Authorizes licensed vocational nurses to be certified to practice acupuncture for certain limited purposes.	Goal 2
SB 1233 Nelson	Allows athletic trainers to practice under the referral of a physician or other licensed health professional who is licensed to refer for health care services within scope of the person's license. Expands the definition of who may be treated by an athletic trainer and revises the definition of an athletic trainer.	Goal 2
SB 1288 Zaffirini	Requires the board of regents of The University of Texas System to establish and operate a campus extension of the University of Texas Health Science Center at San Antonio (UTHSCSA) in the city of Laredo. Requires UTHSCSA to act only if a public or private entity offers the board of regents sufficient land in Laredo to construct the campus extension, and public or private entities agree to provide funds necessary to construct an administrative building for the campus extension. Authorizes the extension to be used to provide undergraduate and graduate medical and dental education, and other levels of health education work in collaboration with Texas A& M International University or any component institution of the Texas A&M University System (TAMU) or the University of Texas System (UTS).	Goal 1
SB 1294 Zaffirini	Corrects conflicts in existing statues concerning billing practices by deleting language regarding overcharging or over treating a patient from several statues including the Medical Practice Act and HPC's enabling legislation and substitutes languages referencing Section 311.0025, Health and Safety Code to prohibit improper, unreasonable, or medically unnecessary billing by hospitals or health care professionals.	SHCC Vision
SB 1525 Madla	Adds the definition of "medical nutrition therapy" to the services provided by a licensed dietitian, and grants rulemaking authority to the Texas State Board of Examiners of Dietitians.	Goal 2
SB 1678 Bernsen	Set guidelines for the regulation of social workers and social work associates, provides administrative penalties for violations of the Act, and creates a whistle blower provision for licensed social workers.	Goal 2
SB 1906 Sibley	Addresses confidentiality of dental patient records with certain exceptions.	

Appendix K
Table of 1999-2004 Texas State Health Plan Recommendations

Texas Statewide Health Coordinating Council
(1999-2004) Texas State Health Plan
Ensuring a Quality Health Care Workforce for Texas

GOAL 1: Ensure that the needed number of health care professionals are educated and trained.			
OBJECTIVE 1.1: Conduct workforce supply and requirements planning for Texas (2000-2030).			
STATE STRATEGY	**ACTIONS**	**PARTIES RESPONSIBLE**	**DUE DATE/REPORT TO**
STRATEGY 1.1.1: The Statewide Health Coordinating Council appoints a Health Personnel Data Advisory Committee to work with the Health Professions Resource Center to improve coordination of data collection and statewide planning efforts	1) Coordination and Integration of data collection. 2) Standardize terminology used in health professions data. 3) Explore ways to establish electronic data sharing. 4) Guidance in data collection and analysis activities.	1) Two Statewide Health Coordinating Council Members 2) Director, Health Professions Resource Center (HPRC) 3) Texas Higher Education Coordinating Board Health Professions Staff 4) Medical Education 5) Health Professions Council 6) Health Care Information Council 7) Health care industry 8) Texas Workforce Commission	January 2000 / Statewide Health Coordinating Council
STRATEGY 1.1.2: Health Professions Resource Center to conduct ongoing assessments of workforce supply.	Will conduct assessments of workforce supply of primary care physicians, selected physician specialties, physician assistants, advanced practice nurses, nurse midwives and identify data sources on other health professions.	1) Health Professions Resource Center 2) Health Personnel Data Advisory Committee	January 2000 / Statewide Health Coordinating Council
STRATEGY 1.1.3: Statewide Health Coordinating Council in consultation with the Higher Education Coordinating Board and its relevant advisory committees make recommendations on programs and funding for health professions education in the State Health Plan Update in 2000.	Based upon workforce supply and requirements analysis, make recommendations on programs and funding for health professions education based upon workforce supply and requirements.	1) Statewide Health Coordinating Council 2) Health Professions Resource Center 3) Texas Higher Education Coordinating Board and its relevant advisory committees.	January 2000 / Statewide Health Coordinating Council

Texas Statewide Health Coordinating Council
(1999-2004) Texas State Health Plan
Ensuring a Quality Health Care Workforce for Texas

GOAL 2: Improve health professions regulation to ensure quality health care for Texans.

OBJECTIVE 2.1: Establish fair and equitable mechanisms and processes that will address health professions regulation.

STATE STRATEGY	ACTIONS	PARTIES	DUE DATE/REPORT TO
STRATEGY 2.1.1: The 76th Texas Legislature appoints a multi-disciplinary task force to review and make recommendations on issues related to health professions regulation.	1) Composition of health professions boards 2) Complaint and grievance processes 3) Disciplining of members 4) Licensing and relicensing requirements 5) Reciprocity and credentialing issues 6) Dissemination of information to consumers 7) Requirements for continuing education	Task Force composed of : 1) Health Professions Council 2) Consumers 3) Medical Policy and Ethics expert 4) Academic health centers 5) Representatives from other health professions 6) Health Professions Resource Center 7) Professional medical associations 8) Professional nursing associations	January 2000 / Statewide Health Coordinating Council
STRATEGY 2.1.2: The 76th Texas Legislature appoints or creates a body to advise them on any scope of practice or licensing changes. This body should establish criteria for evaluating any changes requested in licensing or scope of practice.	Criteria should address: 1) Data on the professional or occupational group. 2) Overall cost effectiveness and economic impact of the proposed regulation. 3) Extent to which the regulation or expansion of the profession or occupation would increase or decrease the availability of services. 4) Documentation of improved or enhanced quality of care. 5) Comparison with existing regulations and findings from other states.	Health Professions Council should include input from: 1) Health professionals 2) Academic health centers 3) State agencies 4) Health care industry 5) Consumers	January 2000 / Statewide Health Coordinating Council

Texas Statewide Health Coordinating Council
(1999-2004) Texas State Health Plan
Ensuring a Quality Health Care Workforce for Texas

GOAL 3: Address the maldistribution of health professionals.			
OBJECTIVE 3.1: Increase access to health care through technology.			
STATE STRATEGY	**ACTIONS**	**PARTIES RESPONSIBLE**	**DUE DATE/ REPORT TO**
STRATEGY 3.1.1: The Governor or 76th Texas Legislature appoints a task force to develop a Statewide Telemedicine Plan that will increase access to medical care, extend the workforce, and enhance workforce training.	1) Provide guidelines for the Telecommunications Infrastructure Fund (TIF) on grant funding for telemedicine projects. 2) Recommend telecommunications infrastructure. 3) Define roles of medical schools, teaching hospitals and public health clinics. 4) Establish priorities/criteria for the funding of telemedicine sites to serve medically underserved areas. 5) Define evaluation criteria for telemedicine projects funded by TIF. 6) Provide for the education of health professionals in community sites. 7) Make policy recommendations to ensure the quality of care and the stability of local health care systems. 8) Designate group to coordinate statewide. 9) Review and make recommendations on Interstate licensing issues relative to the use of technology.	1) Telecommunications Infrastructure Fund Telemedicine Steering Committee 2) Center for Rural Health Initiatives 3) Texas Telehealth/Education Consortium 4) Texas Telecommunications Planning Group 5) Texas Department of Health 6) Academic health centers 7) Area Health Education Centers 8) Texas Higher Education Coordinating Board and its Family Practice Advisory Committee 9) Texas Rural Health Association 10) Texas Organization of Rural and Community Hospitals 11) Texas Academy of Family Physicians	January 2000 / Statewide Health Coordinating Council, Governor and/or 77th Legislature

Texas Statewide Health Coordinating Council
(1999-2004) Texas State Health Plan
Ensuring a Quality Health Care Workforce for Texas

GOAL 3: Address the maldistribution of health professionals.			
OBJECTIVE 3.2: Increase access to health care through the coordination of recruitment and retention activities.			
STATE STRATEGY	**ACTIONS**	**PARTIES RESPONSIBLE**	**DUE DATE/ REPORT TO**
STRATEGY 3.2.1: The Statewide Health Coordinating Council establish an ad hoc committee to assess the effectiveness of current recruitment and retention efforts of health professionals in rural and underserved areas and recommend ways to improve the coordination of those programs.	1) Identify practice issues and barriers to recruiting and retaining providers in underserved areas. 2) Evaluate the effectiveness of recruitment/retention efforts. 3) Determine strategies for improving access to primary care and ways to measure performance in this activity. 4) Make recommendations for coordination of activities and/or modification to programs to increase access to medical care.	Ad Hoc Committee includes: 1) Two Statewide Health Coordinating Council members 2) Texas Department of Health, Primary Care Placement Program 3) Texas Department of Health, Health Professions Resource Center 4) Center for Rural Health Initiatives 5) Texas Higher Education Coordinating Board 6) Area Health Education Centers 7) Academic Health Centers	October 1999/ Statewide Health Coordinating Council

Texas Statewide Health Coordinating Council
(1999-2004) Texas State Health Plan
Ensuring a Quality Health Care Workforce for Texas

GOAL 4: Create a health care workforce trained and equipped to use education and prevention as the primary approach to helping Texans achieve optimal health.

OBJECTIVE 4.1: Increase the implementation of prevention activities in the health care community through the academic curriculum.

STATE STRATEGY	ACTIONS	PARTIES RESPONSIBLE	DUE DATE/ REPORT TO
STRATEGY 4.1.1: Academic health centers and other institutions training health professionals survey their health professions programs and report on the following efforts in health professions education.	1) Emphasis on prevention in health professions education. 2) Curriculum development in community and public health, epidemiology, population-based medicine, working in multi-disciplinary teams, and cultural competency. 3) Methods of evaluating or testing competency of health professionals in these areas. 4) Increasing clinic and community-based education sites to the degree practicable.	1) Academic health centers 2) Community colleges 3) Technical colleges 4) Health Professions Education Advisory Committee 5) Other institutions training health professionals	October 1999/ Statewide Health Coordinating Council

Texas Statewide Health Coordinating Council
(1999-2004) Texas State Health Plan
Ensuring a Quality Health Care Workforce for Texas

GOAL 4: Create a health care workforce trained and equipped to use education and prevention as the primary approach to helping Texans achieve optimal health.			
OBJECTIVE 4.2: Build the competencies of the public health workforce in the areas of core public health functions.			
STATE STRATEGY	**ACTIONS**	**PARTIES RESPONSIBLE**	**DUE DATE/ REPORT TO**
STRATEGY 4.2.1: The Texas Department of Health and the universities offering degrees in public health work collaboratively to enhance the education and training of the public health workforce.	1) Develop and deliver programs that will develop the skills and competencies of the public health workforce. 2) Improve public health infrastructure through training for public health practitioners. 3) Expand distance learning technologies.	1) The University of Texas School of Public Health 2) University of North Texas Health Science Center at Fort Worth 3) Texas A&M School of Rural Public Health 4) Other institutions offering degrees and/or residencies in public health 5) Texas Department of Health	November 1999/ Statewide Health Coordinating Council

Texas Statewide Health Coordinating Council
Texas State Health Plan (1999-2004)
Ensuring a Quality Health Care Workforce for Texas

GOAL 4: Create a health care workforce trained and equipped to use education and prevention as the primary approach to helping Texans achieve optimal health.			
OBJECTIVE 4.2: Build the competencies of the public health workforce in the areas of core public health functions.			
STATE STRATEGY	**ACTIONS**	**PARTIES RESPONSIBLE**	**DUE DATE/ REPORT TO**
Strategy 4.2.2: The Texas Department of Health's Health Education, Leadership and Promotion Council in collaboration with the Texas Society for Public Health Education and the centers for health promotion research and development work collaboratively to meet current and future public health education/health promotion needs.	1) Develop a system to identify current competencies and future public health. 2) Provide learning opportunities for those interested in becoming Certified Health Education Specialists (CHES). 3) Encourage the health care industry to prefer CHES as a job qualification. 4) Provide continuing education to those who practice health promotion. 5) Develop a system for recognizing quality initiatives in health promotion/education. 6) Prepare culturally competent materials and programs.	1) Texas Department of Health's Health Education, Leadership and Promotion Council 2) Texas Society for Public Health Education 3) Centers for Health Promotion Research	November 1999 / Statewide Health Coordinating Council

Texas Statewide Health Coordinating Council
(1999-2004) Texas State Health Plan
Ensuring a Quality Health Care Workforce for Texas

GOAL 4: Create a health care workforce trained and equipped to use education and prevention as the primary approach to helping Texans achieve optimal health.			
OBJECTIVE 4.3: Create incentive systems to encourage prevention activities.			
STATE STRATEGY	**ACTIONS**	**PARTIES RESPONSIBLE**	**DUE DATE/ REPORT TO**
STRATEGY 4.3.1: The Texas Department of Health, the Texas Department of Insurance, representatives from the health care industry, and health care purchasers establish incentives for prevention activities.	1) Establish or expand incentives for health professionals to provide more preventive services. 2) Establish or expand incentives for consumers to follow through with preventive activities.	1) Texas Department of Health 2) Texas Department of Insurance 3) Representatives of the health care industry 4) Health care purchasers	October 1999/ Statewide Health Coordinating Council

Texas Statewide Health Coordinating Council
(1999-2004) Texas State Health Plan
Ensuring a Quality Health Care Workforce for Texas

GOAL 4: Create a health care workforce trained and equipped to use education and prevention as the primary approach to helping Texans achieve optimal health.			
OBJECTIVE 4.4: Develop a comprehensive approach to education of children in grades K-12 to encourage healthy lifestyle choices.			
STATE STRATEGY	**ACTIONS**	**PARTIES RESPONSIBLE**	**DUE DATE/ REPORT TO**
STRATEGY 4.4.1: The Texas Education Agency, the Texas Department of Health, and the Texas Comprehensive School Health Initiative Consortium investigate and recommend strategies for implementation of a model curriculum of health education for K-12.	1) Investigate and recommend strategies for implementation of a model curriculum of health education for K-12.	1) Texas Education Agency 2) Texas Department of Health 3) Texas Comprehensive School Health Initiative Consortium	November 1999/ Statewide Health Coordinating Council

Texas Statewide Health Coordinating Council
(1999-2004) Texas State Health Plan
Ensuring a Quality Health Care Workforce for Texas

GOAL 5: Reduce disparity in health status among all population groups and enhance their access to quality health care by developing a diverse and culturally competent workforce.

OBJECTIVE 5.1: Develop a diverse and culturally competent workforce.

STATE STRATEGY	ACTIONS	PARTIES RESPONSIBLE	DUE DATE/ REPORT TO
STRATEGY 5.1.1: Statewide Health Coordinating Council appoints an ad hoc committee to address racial/ethnic health issues and their relationship to health workforce education, planning, and practice.	1) Identify socioeconomic, educational and cultural barriers to accessing health care. 2) Forecast minority health needs. 3) Develop goals and strategies for the recruitment and retention of minorities in health care professions. 4) Propose standards for culturally competent health care practice and practitioners. 5) Study and identify strategies that will reduce the disparities in minority health.	Ad Hoc Committee includes: 1) Two Statewide Health Coordinating Council members 2) Area Health Education Centers 3) Texas Department of Health, Centers for Minority Health and Cultural Competency 4) Texas Department of Health, The Office of Border Health 5) Center for Rural Health Initiatives 6) Minority special interest groups including health professionals and consumers 7) Representation from admissions committees of health professions schools	January 2000/ Statewide Health Coordinating Council

Texas Statewide Health Coordinating Council
(1999-2004) Texas State Health Plan
Ensuring a Quality Health Care Workforce for Texas

GOAL 5: Reduce disparity in health status among all population groups and enhance their access to quality health care by developing a diverse and culturally competent workforce.

OBJECTIVE 5.2: Develop a workforce equipped to meet the needs of Texas' aging populations and the population of persons with disabilities.

STATE STRATEGY	ACTIONS	PARTIES RESPONSIBLE	DUE DATE/ REPORT TO
STRATEGY 5.2.1: The Statewide Health Coordinating Council charges the Texas Department on Aging's Aging Policy Council and the Texas Department of Health to study the following aging population health issues and their relationship to health workforce education, planning and practice.	1) Identify the health needs of an aging population. 2) Forecast health professionals/ specialties that are needed to fulfill the health care needs of an aging population. 3) Study and recommend health care policies and practices that enable individuals to age successfully.	Texas Department on Aging's Aging Policy Council which consists of representation from: Texas Department of Mental Health and Mental Retardation Texas Rehabilitation Commission Texas Health and Human Services Commission Texas Department of Health	October 1999/ Statewide Health Coordinating Council
STRATEGY 5.2.2: The Statewide Health Coordinating Council charges the Texas Rehabilitation Commission to investigate the special health care needs of persons with disabilities, especially those in underserved areas, and make recommendations on the types of health professionals/specialists necessary to meet the needs of persons with disabilities.	1) Investigate the special health care needs of persons with disabilities, especially those in underserved areas. 2) Make recommendations on the types of health professionals/specialists necessary to meet the needs of persons with disabilities.	Texas Rehabilitation Commission	October 1999/ Statewide Health Coordinating Council

Texas Statewide Health Coordinating Council
(1999-2004) Texas State Health Plan
Ensuring a Quality Health Care Workforce for Texas

GOAL 6: Create a health workforce that works with communities and in partnership with federal and state governments to have the greatest positive impact on the health of citizens.

OBJECTIVE 6.1: Design systems in which local communities are empowered to plan and direct interventions that have the greatest positive impact on the health of citizens.

STATE STRATEGY	ACTIONS	PARTIES RESPONSIBLE	DUE DATE/ REPORT TO
STRATEGY 6.1.1: The Statewide Health Coordinating Council establishes an ad hoc committee to work in partnership with the Texas Department of Health and other state and community based agencies and health care delivery partners to develop a model for community health practice that defines the health professional's role as a resource and facilitator in local health.	1) Investigation of the root causes of disease at the community level. 2) Innovative ways for sharing responsibility and authority for the community's use of resources. 3) Initiatives to develop local leadership. 4) Education of community based lay care givers. 5) Methods to enhance the commitment and capacity of state agencies to participate/endorse/fund community activities.	Ad hoc committee includes: 1) Two Statewide Health Coordinating Council members 2) Texas Department of Health 3) Texas Department of Mental Health and Mental Retardation 4) Texas Association of Health Plans 5) Texas Hospital Association 6) Texas Agricultural Extension Agency 7) Individuals who represent local interests, local participation, and/or consumer groups such as: Texas Association of Counties, Texas Association of County Judges, Councils of Government, Texas Association of Business and Chambers of Commerce, Texas Association of Community Health Centers, Rural Community Health System Advisory Board, local health care professionals.	November 1999/ Statewide Health Coordinating Council

Texas Statewide Health Coordinating Council
(1999-2004) Texas State Health Plan
Ensuring a Quality Health Care Workforce for Texas

GOAL 6: Create a health workforce that works with communities and in partnership with federal and state governments to have the greatest positive impact on the health of citizens.			
OBJECTIVE 6.2: Develop the skill level of health professionals in working with communities.			
STATE STRATEGY	**ACTIONS**	**PARTIES RESPONSIBLE**	**DUE DATE/ REPORT TO**
STRATEGY 6.2.1: The Statewide Health Coordinating Council establish an ad hoc committee to work in partnership with interested parties to develop and test curricula to enhance the skills of health professionals for working more effectively with communities.	1) Identify partners to research and develop curricula and delivery methods. 2) Pilot and test curricula. 3) Evaluate outcomes. 4) Develop recommendations for adoption of the curricula in academic and/or continuing education settings.	The ad hoc committee includes: 1) Two Statewide Health Coordinating Council members 2) Texas Department of Health 3) Interested universities 4) Individuals representing communities 5) Area Health Education Centers 6) Others as appropriate	November 1999/ Statewide Health Coordinating Council

Texas Statewide Health Coordinating Council
(1999-2004) Texas State Health Plan
Ensuring a Quality Health Care Workforce for Texas

GOAL 7: Develop the health care partnership between consumers and health care professionals through increased access to health care information.			
OBJECTIVE 7.1: To enable consumers to make better health care decisions.			
STATE STRATEGY	**ACTIONS**	**PARTIES RESPONSIBLE**	**DUE DATE/ REPORT TO**
STRATEGY 7.1.1: The Statewide Health Coordinating Council appoints an ad hoc committee to develop guidelines, principles, and standards for a consumer-oriented health care partnership.	1) Survey other states' consumer information systems. 2) Investigate what kinds of information consumers should have access to in order to make informed health care decisions. 3) Explore and make recommendations on user-friendly methods for disseminating consumer information. 4) Assess current initiatives and make recommendations for needed action.	Ad hoc committee includes: 1) Two Statewide Health Coordinating Council members 2) Health Care Information Council 3) Texas Department of Insurance Office of Public Insurance 4) Health Care Industry 5) Health Professions Council 6) Citizen Advocacy Group	January 2000/ Statewide Health Coordinating Council

Appendix L
Public Comments and Responses

Public Comments on the 2001-2002 Texas State Health Plan Update during the period August 25 through September 15, 2000.

Texas Department of Health

William R. Archer III, M.D.
Commissioner of Health

Charles E. Bell, M.D.
Executive Deputy Commissioner

1100 West 49th Street
Austin, Texas 78756-3199
(512) 458-7111
http://www.tdh.state.tx.us

September 20. 2000

Ben G. Raimer, M.D., Chair
Texas Statewide Health Coordinating Council
1100 West 49th Street
Austin, Texas 78756

Dear Doctor Raimer: Ben

Thank you for the opportunity to respond to your *2001-2002 Texas State Health Plan Update*. We are all committed to improving the effectiveness of the health care workforce. The Texas Department of Health (TDH) faces similar challenges to those addressed in this plan, especially in the areas of developing a health care workforce that is well trained in up-stream prevention and in community dynamics.

TDH specifically looks forward to working with you in our shared priority areas of:

- Creating a health care workforce trained and equipped to use education and prevention as the primary approach to helping Texans achieve optimal health.
- Creating a health workforce that works with communities and in partnership with federal and state governments to have the greatest positive impact on the health of citizens.

Your 2001-2002 plan update has provided us with an appreciation of your council's strategic priorities and the common challenges that face public health in the future. We fully support your work and the new plan update.

Sincerely,

William R. Archer III, M.D.
Commissioner of Health

As always I appreciate your commitment to Texas.

TDH
TEXAS DEPARTMENT OF HEALTH

bhttp://www.tdh.state.tx.us

William R. Archer III, M.
Commissioner
(512) 458-7111

1100 West 49th Street
Austin, Texas 78756-3199

Charles Bell, M.D.
Executive Deputy Commissioner

September 15, 2000

Mr. Dennis Finuf
Office of Policy and Planning
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756

Dear Mr. Finuf:

The Bureau of Licensing and Compliance has reviewed the Texas State Health Plan Update. The following comments reflect the impact that the Plan update will have on the regulatory programs of the Bureau.

Comments on Strategy 1.1.1 regarding the implementation of the Minimum Data Set (MDS):

Lock Box Requirements: The programs use the Comptroller's Lock Box to process license renewals. This system allows the agencies to meet the state's three-day deposit requirement and generates additional state revenue by assuring immediate deposit of funds. Comptroller's requirements will not allow any increase in the size of payment coupons and will not allow for any attachments. Therefore, the Bureau would be forced to contract with a vendor to process the payments. Payments made through the TDH take three weeks on average to process.

Funding: Implementation is not possible without additional funding. The Ad Hoc Committee on Health Personnel Data recommended appropriation of funds to the Statewide Health Coordinating Committee to be used to contract with the state health licensing boards for them to collect the MDS. The Plan Update recommends that the House Regulatory sub-committee appropriate funds to cover the costs of implementing the minimum data set and raise the FTE cap for those licensing boards and the Health Professions Resource Center.

It was our understanding that funding for the MDS was to be appropriated from general revenue funds directly to the Texas Department of Health. The House Appropriations Regulatory subcommittee serves only Article VIII agencies and should not be referenced as the subcommittee to appropriate the funds. The reference should be to the Legislature.

We are concerned with the ultimate source of the funding. Member agencies are currently working on cost projections. Based on previous cost projections, it is expected that the cost will be very high. If funding for the MDS is appropriated directly to the licensing agencies, there is concern that the

appropriations for the MDS will be subject to a "contingent revenue rider" requiring agencies to assess fees to generate sufficient new revenue in excess of the Comptroller's Revenue Estimate. The effect of this rider is that any additional appropriations to a licensing board results in increased fees to the individual licensees of that board. If MDS funding were subject to this condition, full cost of implementing the MDS would be borne by the licensed health professionals. Any funding provided should be general revenue appropriated directly to the department.

Software: At least two of the licensing systems currently used are so antiquated that additional data field cannot be added to record the requested information.

Biennial license renewals: The ad hoc committee on health personnel data recommended the development of a Memorandum of Understanding between the Health Professions Resource Center and programs, which would include annual acquisition of data. Some programs have a biennial license renewal. Annual acquisition of the minimum data set would necessitate implementation of a system solely to update data at the end of the first renewal year. Attempts to collect data outside of the licensing process will create costs for additional mailing and processing and may require extensive follow up.

Sensitive Data: Programs are reluctant to collect sensitive information they do not need, such as ethnicity and place of birth, due to potential liability.

Enforcement: It will be much more difficult and costly to implement the MDS if licensees must provide all of the required data as a condition of licensure. While the strategy and actions do not address this issue, the body of the report states that provision of the MDS data will not be mandatory for licensees. We request that the Coordinating Council clarify this issue within Table 1-1.

Geocoding: The Department included expansion of geocoding activities in the Comprehensive Strategic & Operation Plan for FY 2001- 2002. National standards for database configuration should be adopted for the key address elements.

Comments on strategy 7.1.1 regarding the Texas Health Care Information Council.

The Texas Health Care Information Council is designated as the agency to clarify the roles and responsibilities of state agencies and state entities involved in consumer health information activities. We do not agree with the Council's proposed oversight role. We are unclear what is meant in the action number 1, c) evaluation and quality assurance functions. We suggest that the language of strategy 7.1.1 be revised to clarify the role of the Health Care Information Council as one of coordination rather than oversight.

Thank you for this opportunity to comment on the plan.

Sincerely,

Becky Berryhill, MPA, Chief
Bureau of Licensing and Compliance

Available Address Data Elements

This section details all information about the address data available within the Address Coding module. Each address element is listed, and the maximum length of the information returned is given in parentheses. For example, `Firm Name (40)` indicates "Firm Name" data, with a maximum length of 40 characters. If the assigned field has less than 40 characters, the Firm information may be truncated.

Address Element (size)	Explanation
*Firm Name (40)	Returns the firm name, as known by the USPS or CPC, or as entered. Will be blank if the USPS or CPC does not know what firm is at that location.
*Address Line (60)	Returns the full address line, e.g., "1920 MAIN ST W APT 12".
Address Line 2 (60)	Returns the second address line, e.g., "Suite 200".
*Last Line (60)	Returns the full last line, e.g., "BOULDER CO 80301-1234".
*City Name (28)	Returns the valid USPS city name (e.g., BOULDER).
*State Abbreviation (2) (e.g., CO).	Returns the 2-letter state (or Province) abbreviation
*Country (50)	Returns the country name.
Postal Code (10)	Returns the Canadian postal code.
ZIP Code (5)	Returns the ZIP Code (e.g., 80301).*
ZIP+4 Extension (4)	Returns the +4 code (e.g., 1234).*
ZIP9 (9)	Returns the complete ZIP+4 (e.g., 80301-1234).
ZIP10 (10)	Returns the complete ZIP+4 with hyphen (e.g., 80301-1234).
Carrier Route (4)	Returns Carrier Route ID number.
Delivery Point Barcode (2)	This two-digit field, when appended to the end of the 9-digit ZIP+4 Code, creates the Delivery Point Bar Code, which is then printed in the address section on the mailing piece to assist with automated sorting.
Check Digit (1)	Used with the DPBC to ensure that the bar code printed on the mailing piece is correct.
Urbanization (30)	Returns the urbanization code for the address. Used for Puerto Rican addresses only.
Longitude (11)	Returns the longitude coordinate in decimal degrees to 6 decimal places, e.g., 123.234234. The number will be positive or negative depending on the setting of the Negate Longitudes check box in the Options dialog box.
Latitude (11)	Returns the latitude coordinate in decimal degrees to 6 decimal places, e.g., 123.234234.
*Match Code (4)	Details which components of an address were modified if a match was successful. If a match was not successful, explains why the match could not be made. See "Match Code List" on page 127 for details.
Location Code (4)	Reports the locational accuracy of the match. See "Location Codes" on page 130 for details.

Extension separate field

TDH
TEXAS DEPARTMENT OF HEALTH

Texas Department of Health

William R. Archer III, M.D.
Commissioner of Health

http://www.tdh.state.tx.us

1100 West 49th Street
Austin, Texas 78756-3199
512/ 458-7111

Charles E. Bell, M.D.
Executive Deputy Commissioner

September 15, 2000

Ben G. Raimer, M.D., Chair
Texas Statewide Health Coordinating Council
1100 West 49th Street
Austin, TX 78756-3199

Dennis Finuf
Office of Policy and Planning
Texas Department of Health
1100 West 49th Street
Austin, TX 78756-3199

Dear Doctor Raimer and Mr. Finuf:

Thank you for the opportunity to comment on the Plan Update for the 1999-2004 Texas State Health Plan. Our office, Community Health Provider Resources (CHPR) in the Bureau of Community Oriented Public Health, is the state Primary Care Office. Our cooperative agreement with the Health Resources and Services Administration of the federal government identifies four key activities:

- Improve access to primary care providers of medical, dental and mental health services
- Recruitment and retention of primary care providers in these disciplines
- Leverage resources to improve access, and
- Build organizational capacity of communities to serve the underserved

Our partner in these activities is the Center for Rural Health Initiatives. We have a strong, positive relationship with the Center. While their focus is improving rural access and workforce development, our focus is broad— to improve access for all underserved areas in Texas.

Our recommendations would be to identify CHPR, along with the Center for Rural Health Initiatives (CRHI), as a key resource to carrying out the following strategies and actions in the State Health Plan. The strategies include: 1.1.2 Workforce studies and surveys, 3.2.1 Expanding state loan repayment programs and accessing federal matching dollars, and 3.2.2 Convening a collaborative partnership to coordinate statewide recruitment and retention of health professionals. In reference to Strategy 3.2.1, action 2) contracting out the administration of the new loan repayment programs should be a decision reached through discussions with the Texas Higher Education Coordinating Board, the CRHI and our office. These programs will use Health Professional Shortage Area designations for eligibility and those areas are statewide, not just in rural communities.

Thank you for your time and consideration of these comments. Our office is committed to 100% Access and Zero Health Disparities. If we can be of any assistance or answer any questions, please call me at (512) 458-7235.

Sincerely,

Connie Berry

Connie Berry, Program Administrator
Community Health Provider Resources

Cc: Teena Edwards, DrPH, RN

Dennis Finuf

From: Cortes,Leslie L [leslie.cortes@dhs.state.tx.us]
Sent: Tuesday, September 12, 2000 11:21 AM
To: dennis.finuf@tdh.state.tx.us
Cc: Johnson,Jackie
Subject: Comments on the Texas State Health Plan

Dear Dr. Raimer:

This note is in reply to the Texas Statewide Health coordinating Council's call for comments on the Plan Update available on the TDH Web site. I've prepared these comments at the request of Ms. Jackie Johnson, Deputy Commissioner for Long Term Care at TDHS.

In reference to SHCC Recommendations

Strategy 1.1.1 Action 2. TDHS recommends that the proposed "data collection system for health professionals" be rendered as a central (common) data repository for the health professions to better meet the needs of the state, professionals themselves, and the needs of public reporting. Such a common system should aim to address practitioner credentialing as well as the legitimate business needs of licensing and regulatory bodies.

Strategy 1.1.3c Action 2. TDHS recommends the addition of a fifth step in this action

e) To create incentives to expand the curriculum of Geriatric nurse specialists and encourage the recruitment and retention of geriatric nurse specialists.

Our concern here is primarily that Texas have a stable, well-trained cadre of nursing professionals to meet the needs of long term geriatric care.

Strategy 5.2.3 THDS recommends amending the phrase "feasibility of providing..." to "feasibility and health benefit of providing..."

Strategy 5.2.3 Actions: TDHS recommends adding a third action that will operationalize the proposed change to the wording of the strategy.

3) Provide quality review and evaluation of the impact of the pilot on Total Cost of Healthcare as an integral part of the pilot's design.

The issue in action (3) is to assure that the pilot is evaluated rigorously and that the design of that evaluation is deliberate and pre-implementation rather ad hoc and post-implementation. Our concern for rigorous evaluation stems from national level studies that demonstrate the enormous health and financial burden caused by adverse drug reactions that stem in part from inappropropriate prescribing, the vulnerability of the proposed beneficiary population, and the risks inherent in modern polypharmacy.

Thank you for the opportunity to comment.

Leslie L. Cortes, M.D.
Director - Medical Quality Assurance
Texas Department of Human Services

Dennis Finuf

From: Christy [christy@tdoa.state.tx.us]
Sent: Wednesday, September 13, 2000 2:49 PM
To: 'dennis.finuf@tdh.state.tx.us'
Cc: Mary; Mark
Subject: TSHCC State Health Plan

Thank you for the letter from Dr. Raimer regarding the Texas State Health Plan: Ensurig a Quality Health Care Workforce for Texas and the web link to it. We are thrilled to see the Interagency Aging Policy Council's report on "A Healthy Aging Texas" and its recommendations contained within the report.

Attached to Dr. Raimer's letter was a series of fiscal impact pages relating to several of the Aging Policy Council's recommendations. Since these recommendations reference and/or call on other entities or agencies to carry out the recommended task, it is very difficult for us to attach line item costs to the recommendations, without considerable research and the help of these other entities.

We'd like to talk with you further on how you can best approach your need to assess the fiscal impact of these recommendations. Please write or call me at:

Christy Fair, Policy & Planning
Tx. Dept. on Aging
email: christy@tdoa.state.tx.us
ph: 424-6850

Thanks very much, and congratulations on an excellent report. We look forward to continuing our work with the SHCC.

Texas Board of Chiropractic Examiners

333 Guadalupe, Suite 3-825
Austin, Texas 78701-3942
(512) 305-6700
Facsimile (512) 305-6705

September 14, 2000

Ben G. Raimer, M.D., Chair
Statewide Health Coordinating Council
1100 West 49th Street
Austin, Texas 78756-7261

Re: 1999-2004 Texas State Health Plan, Statewide Health Coordinating Council (SHCC)

Dear Dr. Raimer:

I have reviewed the full text of the State Health Plan Update, including Appendix A. I conducted this review with special emphasis on how this proposal would impact our agency.

The primary mission of the Texas Board of Chiropractic Examiners is to protect the public. To accomplish our mission, we are required to monitor all doctors of chiropractic, radiological technologists and owners of chiropractic clinics. Our mission must always take priority; agency work and functions must be accomplished before additional information requests can be considered.

I have the following concerns about your plan:

1) Our agency does not collect sensitive data because it is not needed to protect the public and regulate our licensees. Race/ethnicity, place of birth, high school location and licensee Social Security number should not be collected or disseminated.

www.tbce.state.tx.us
Web Address

tbce@tbce.state.tx.us
E-mail

2) Several members of the Health Profession Council use the Lock Box System, and they should not be required to change that procedure.

3) The TBCE has just completed a redesign to all agency databases, and to make substantial changes again to collect additional data that is unnecessary to accomplish our mission is counterproductive. There is also the likelihood that this extraneous data will soon have additions or revisions

4) Rather than altering numerous regulatory databases, SCHH needs to seriously consider developing its own on-line database that can be accessed directly by all of the targeted licensees. SCHH would not have to compromise its desired Minimum Data Sets, and regulatory agencies already swamped with their own work would not have to interrupt their primary missions to do this extra work for SCHH.

5) The Legislature would need to pass legislation requiring all targeted health care licensees to complete the requested information on-line. After the initial on-line survey is completed, the survey could easily be updated annually. In the long run, this method would be more efficient and the data could be processed and disseminated with greater ease. Over the years, this method would also cost less and result in more efficiency than any of the other proposed scenarios.

All members of the Health Profession Council feel the Minimum Data Set information has the potentiality to provide desirable information to the Texas Statewide Health Coordinating Council and ultimately the information would be useful.

SHCC must understand that the regulatory agencies are currently understaffed and overworked. Even if additional funding were approved for additional F.T.E.'s, our offices are so crowded that we have no room to expand for additional work stations, new staff members and additional furniture or equipment.

Sincerely,

Gary K. Cain, Ed.D.
Executive Director

P.S. On two previous occasions, September 14, 1999 and January 5, 2000, I completed and submitted two fiscal impact assessments of implementing the Minimum Data Sets into our Licensee Database to Bruce Gunn, Ph.D. I have also mailed him sample copies of our databases and mailed him a disk of the database for his perusal. I talked with Dr. Gunn yesterday and he confirmed that he has the fiscal impact information in his possession. I didn't see any reason to include the financial impact data again with this review.

Dennis Finuf

From: Priscilla Boston [Priscilla.Boston@exch.tdh.state.tx.us]
Sent: Friday, September 15, 2000 5:30 PM
To: 'dennis.finuf@tdh.state.tx.us'
Cc: 'jim.loyd@thcic.state.tx.us'
Subject: THCIC comments on SHCC update

pg. xiv: formatting inconsistency in use of the word "Goals" for #s 1, 2, and 3 vs Goals 4,5,6, and 7

Question, not comment--pg. xvi: Were consumers not mandated to be included?

pg. xix: might want to add significant progress towards release of Texas' first hospitalization data in PP that begins "In all".

pg. 283- typo, need space between words better and health under Obj. 7.1

pg. 285--mispelling on Jim's name--Jim Loyd, not Jim Lloyd

pg. 288--not sure we agree with conclusion in first PP under Background that "As the health care environment has become more complex the development of the consumer-provider partnership has become critical." We think it may have more to do with advances in health care diagnostics, the plethora and availability of conflicting information, and perhaps most importantly because of advanced analytical sophistication of the consuming public--whether it be goods or services they're purchasing.

pg. 290--might want to modify a sentence in the last PP. "Care should be designed to facilitate consumer compliance with medical recommendations, convenience and satisfaction". The medical care system also needs to apply psychosocial research on patient resistance to being compliant in order to improve that factor. We need to understand why patients do not comply and address those hurdles somehow.

pg. 291--in Changes in the HC System-- maybe the increase in collaboration is an outgrowth in broader trends of philanthrophy (collaboration required by funders, more social justice funding....)

pg. 292--in first PP you reference changes in hc info supplier roles to be to help INTERPRET info, but that isn't fully explored/defined in the recommendation for a clearinghouse. The clearinghouse recommendation seems like more of a planning task (clarify roles of existing agencies/stakeholders) rather than adding services that aid the public in interpreting info.

pg. 293--in the indented PP that begins "Before the entire online..." we are unfamiliar with the language construct "will lease the industry forward".

pg. 296--The THCIC was established in 1995, not 1993.

pg. 297--Straight Talk "contains performance data on all HMOs serving Texas BEGINNING in 1997.

pg. 302--1st PP under States Providing.....
HB 3021 needs better definition. Use of the concept "statewide clearinghouse for h.c. info" sounds more or less the same as what this group is recommending the creation of. Why recommend something that's already there? More careful review of that legislation may be in order, and you might want to clarify that it mandates TDI to do that and it's mostly to

faciliate complaints/appeals for services....

Dennis Finuf

From: Skip Langley [skip.langley@tsbme.state.tx.us]
Sent: Friday, September 15, 2000 10:40 AM
To: 'dennis.finuf@tdh.state.tx.us'
Subject: Response to State Health Plan Update

To: Texas Statewide Health Coordinating Council

We appreciate the opportunity to review the draft of the proposed 2001-2002 Texas State Health Plan Update. It is an ambitious plan and I congratulate you on the work the Coordinating Council has done in preparing it.

I will be unable to participate in the public hearing on the plan on September 21, so I wanted to submit written comments on the proposals as follows:

Strategy 1.1.1, Minimum Data Set: Collection of this data is not an issue for the Board of Medical Examiners as we currently collect most items in the data set. However, we would like to share with you the concerns recently expressed to us by our licensees about the collection and dissemination of data via electronic databases. As information once held in paper files is transferred to electronic formats, new concerns arise about its use. We, like other state agencies, have encountered increased tensions between the "right to know" and the right to privacy. We have received formal resolutions from two local medical societies about the collection or dissemination of information about ethnic origin, place of birth and date of birth. I encourage the Coordinating Council to proceed with caution in creating this new database. Also, any efforts to amend HB 692 and loosen the current protection of Social Security Numbers must be carefully considered and tightly written.

Strategy 7.1.1, Consumer Health Information: We enthusiastically support the development of a clearinghouse for consumer information. However, the plan seems to be unclear about the role that is being designated for the Texas Health Care Information Council. It was our understanding that the Ad Hoc Committee on Consumer Information had recommended that the Texas Health Care Information Council coordinate with agencies in providing consumer information. In Table 1-1, it appears that oversight authority is being created and vested in the Health Care Information Council with a responsibility for "evaluation and quality assurance functions." Conversations with Council staff confirmed the intent of the Ad Hoc Committee and we are submitting the following language to clarify this intent:

Modified Text for Chart:

1) The Texas Health Care Information Council should develop a state of Texas clearinghouse that provides one-stop access to health and insurance-related information.

2) The Texas Health Care Information Council should coordinate and organize the information available from state agencies and state entities involved in consumer health information activities. Responsibilities include:

a. Collecting and analyzing data relevant to consumer information and consumer choice;

b. Providing and disseminating data related to consumer choice of health plan, provider and treatment options; and

c. Recommending methods for organizing data relevant to consumer

information and consumer choice.

Modified Text for Plan Details:

Recommendation One: The State of Texas should develop a clearinghouse that provides one-stop access to health and insurance-related information. There is a wealth of information about health available to consumers, not only from state agencies, but also from community-based organizations, advocacy groups and the private sector. This information should be maximized and coordinated to provide seamless access to information.

Information is only of value if it gets into the hands of the people who need it, in a form that it can be used. A number of agencies and organizations in Texas compile information that could help consumers make important health care and insurance decisions. But consumers are not likely to know which agencies to contact and may be frustrated by the difficulty and amount of time involved to access it. A clearinghouse, using a variety of outreach strategies (Internet, 1-800 line, etc.) can provide one-stop, access to health and insurance-related information is needed in the state of Texas.

This clearinghouse would include an Internet website providing links to agencies and organizations that compile and publish information beneficial to consumers making health care and insurance decisions. Consumers visiting the site would access general information published by one agency, register complaints to another agency and browse through quality of care information published by yet another agency. The site would be seamless to the user. The clearinghouse's development and maintenance would be the responsibility of the Texas Health Care Information Council.

Recommendation Two: The governor, in conjunction with other state leaders, should designate the Texas Health Care Information Council as the agency to coordinate and organize the information available from state agencies and state entities involved in consumer health information activities (i.e.: Texas Health Care Information Council, Office of Public Insurance Counsel, Texas Department of Insurance, Licensing Boards, and the Texas Department of Health). The Consumer Information Ad Hoc Committee strongly urges that the Texas Health Care Information council serve as the lead agency and receive funding appropriate to carry out this role.

Responsibilities should include:

(1) collecting and analyzing data relevant to consumer information and consumer choice;

(2) providing and disseminating data related to consumer choice of health plan, provider and treatment options; and

(3) recommending methods for organizing data relevant to consumer information and consumer choice.

Should you have questions about our response, you can contact Jaime Garanflo at 305-7041 or jane McFarland at 305-7044. Again, I applaud the efforts of the Council in developing this comprehensive plan and look forward to working with you.

September 15, 2000

Dennis Finuf
Office of Policy and Planning
Texas Department of Health
1100 West 49th Street
Austin, TX 78756

Dear Mr. Finuf:

The Board of Nurse Examiners (BNE) has reviewed the Texas State Health Plan Update. The following concerns are issues for the BNE:

Comments on strategy 1.1.1 regarding the implementation of the Minimum Data Set (MDS):

Lock Box Requirements: The BNE uses the Comptroller's Lock Box to process license renewals. This system allows our agency to meet the state's three-day deposit requirement and generates additional state revenue by assuring immediate deposit of funds. Comptroller's requirements will not allow any increase in the size of payment coupons and will not allow for any attachments. Therefore, the BNE would be forced to either contract with a vendor to process the payments or hire additional staff to handle the work now done by the Comptroller.

Funding: Implementation is not possible without additional funding. The Ad Hoc Committee on Health Personnel Data recommended appropriation of funds to the Statewide Health Coordinating Committee to be used to contract with the state health licensing boards for them to collect the MDS. The Plan Update recommends that the House Regulatory sub-committee appropriate funds to cover the costs of implementing the minimum data set and raise the FTE cap for those licensing boards and the Health Professions Resource Center.

It was our understanding that SHCC was requesting that funds for the MDS be appropriated from general revenue funds directly to the Texas Department of Health. The House Appropriations Regulatory subcommittee serves only Article VIII agencies and should not be referenced as the subcommittee to appropriate the funds. The reference should be to the Legislature.

The BNE is concerned with the ultimate source of the funding. If funding for the MDS is appropriated directly to the licensing agencies, there is concern that the appropriations for the MDS will be subject to a "contingent revenue rider" requiring agencies to assess fees to generate sufficient new revenue in excess of the Comptroller's Revenue Estimate. The

effect of this rider is that any additional appropriations to a licensing board results in increased fees to the individual licensees of that board. If MDS funding were subject to this condition, full cost of implementing the MDS would be borne by the licensed health professionals, including RNs. Any funding provided should be general revenue appropriated directly to the agency in charge of implementation and could include funds already collected by the Board in excess of current appropriations.

Biennial license renewals: The Ad Hoc Committee on Health Personnel Data recommended the development of a Memorandum of Understanding between the Health Professions Resource Center and the health professions licensing boards which would include annual acquisition of data. The BNE has a biennial license renewal as a cost savings measure. Annual acquisition of the minimum data set would necessitate either a return to annual license renewals or implementation of a system solely to update data at the end of the first renewal year. Returning to annual renewal of licenses would result in an increase in workload by doubling the number of renewals processed each year. In addition, during the implementation period of reverting from a biennial to an annual license renewal, a significant decrease in revenue will occur which will negatively affect those agency's revenue projections for that period. Furthermore, the transition itself would be costly and would create confusion for licensees. The BNE does not believe that the cost and resource burdens of annual renewal are justified when weighed against the benefits of change. Attempts to collect data outside of the licensing process will also create costs for additional mailing and processing and may require extensive follow up.

Sensitive Data: Increasingly, licensees are reluctant to provide sensitive information such as ethnicity and place of birth. Although the use of social security numbers is protected by law, RNs are becoming increasingly resistant to the divulgence of their social security numbers. Their objections may lead to poor reporting or to potential liability on the part of state agencies.

Enforcement: It will be much more difficult and costly to implement the MDS if licensees must provide all of the required data as a condition of licensure. While the strategy and actions do not address this issue, the body of the report states that provision of the MDS data will not be mandatory for licensees. We request that the Coordinating Council clarify this issue within Table 1-1.

Comments on strategy 7.1.1 regarding the Texas Health Care Information Council.

The Texas Health Care Information Council is designated as the agency to clarify the roles and responsibilities of state agencies and state entities involved in consumer health information activities. It was the BNE's understanding that the Health Care Information Council was to have a coordinating role as opposed to a role of oversight. The BNE is unclear what is meant in the action number 1, c) evaluation and quality assurance functions. We suggest that the language of strategy 7.1.1 be revised to clarify the role of the Health Care Information Council as one of coordination rather than oversight.

The BNE supports the work and direction of the Statewide Health Coordinating Council's Texas State Health Plan; and, we appreciate the responsiveness of SHCC to our past concerns as reflected in this Plan Update. We have only commented on the areas that are of concern to us. We appreciate the opportunity to provide feedback to the Plan Update. Please call me at 512/305-6888 if there are any questions concerning our comments.

Sincerely,

Katherine A. Thomas, MN, RN
Executive Director
Board of Nurse Examiners

Cc: Wayne Roberts, Governor's Office of Budget and Planning
Chris Britton, Office of the Lieutenant Governor
John Keel, Legislative Budget Board
The Honorable Bill Ratliff, Senate Finance Chair
The Honorable Robert Junell, House Appropriations Chair
The Honorable Jim Pitts, Chair, Regulatory Sub-Committee, House Appropriations
Ben G, Ramier, M.D., Statewide Health Coordinating Council
David A. Valdez, M.D., Statewide Health Coordinating Council
P.J. Wright, Statewide Health Coordinating Council
Bruce Gunn, Health Professions Resource Center
Members of the Health Professions Council

TEXAS STATE BOARD OF PHARMACY

September 14, 2000

Dennis Finuf
Office of Policy and Planning
Texas Department of Health
1100 West 49th Street
Austin, TX 78756

Dear Mr. Finuf:

The following are comments on the *2001-2002 Texas State Health Plan Update* received in our office on August 30, 2000.

Goal 1, Objective 1.1, State Strategy 1.1.1

Implementation: As stated in previous correspondence to the Statewide Health Coordinating Council, the collection and maintenance of the Minimum Data Set (MDS) by the Texas State Board of Pharmacy (TSBP) is not possible without additional funding, including additional FTE's. All data fields identified are either not collected, are collected only at initial licensure, or are collected on a biennial basis only. The Fiscal Impact Assessment Instrument is enclosed.

Funding: If funding for the MDS is appropriated directly to the agency, we are concerned that the appropriations for the MDS will be subject to a "contingent revenue rider" which would require the agency to assess fees to generate sufficient new revenue in excess of the Comptroller's Revenue Estimate. Any additional appropriations under this rider would require the Board to increase fees to the individual licensees of the Board, thus the cost to implement the MDS would be borne by the licensed pharmacists.

Biennial License Renewals: The TSBP has implemented a biennial license renewal system. Annual acquisition of the MDS would necessitate either a return to annual license renewals or implementation of a system solely to update data on an annual basis. Returning to the annual renewal of licenses would result in an increase in workload by doubling the number of renewals

processed each year. The process to convert from a 1-year to 2-year phased in renewal system took 123 hours of programming time. This programming work would have to be reversed to accommodate a 1-year renewal period and it is anticipated this process would require 130 hours of programming time. In addition, during the implementation period of reverting from a biennial to an annual license renewal, a significant decrease in revenue will occur which will negatively affect the TSBP revenue projections for that period.

Lock Box Requirements: The TSBP uses the Comptroller's Lock Box to process all license renewals. This system allows the agency to meet the state's three-day deposit requirement and generates additional state revenue by assuring immediate deposit of funds. This system is primarily dependent upon a streamlined, concise renewal application form. Comptroller requirements will not allow any increase in the size of the renewal application and will not allow for attachments. If Lock Box were eliminated, the agency would be required to begin processing all cash at the agency site, which would require a minimum of 1 additional FTE. In addition, the security of cash receipts must be addressed. Bringing the cash receipts back into the agency would not only present an increased security risk, but would also delay the deposit of these monies into the State Treasury by at least 1 day.

Enforcement: It will be much more difficult and costly to implement the MDS if licensees must provide all of the required data as a condition of licensure. While the strategy and actions do not address this issue, the body of the report states that provision of the MDS data will not be mandatory for licensees. The Coordinating Council should clarify this issue within Table 1-1.

Goal 7, Objective 7.1, State Strategy 7.1.1

The Texas Health Care Information Council is designated as the agency to clarify the roles and responsibilities of state agencies and entities involved in consumer health information activities. It is our understanding that the Health Care Information Council was to coordinate activities among state agencies. It appears however, that the Council has been designated as an oversight Council with a broader role and responsibilities. The language contained in the action steps is unclear - specifically, what is the intent of the Council?

The Texas State Board of Pharmacy supports the work and direction of the Statewide Health Coordinating Council's Texas State Health Plan and we applaud the work that has gone into this Plan Update. We have only commented on the areas that are of concern to us. We believe that implementation of the Plan will serve Texas citizens to reach and maintain optimum health as well as to make health care services and facilities available to all Texans.

Sincerely,

Gay Dodson/cs

Gay Dodson, R.Ph.
Executive Director/Secretary

Enclosure

cc: Antoinette Humphrey, Analyst
Governor's Office of Budget & Planning

Ed Robertson, Analyst
Legislative Budget Board

TEXAS STATE BOARD OF EXAMINERS OF PSYCHOLOGISTS

EXECUTIVE DIRECTOR
Sherry L. Lee

September 14, 2000

Dennis Finuf
Texas Department of Health
Office of Policy & Planning
1100 West 49th Street
Austin, Texas 78756-3199

Dear Mr. Finuf:

The Statewide Health Coordinating Council asked the Texas State Board of Examiners of Psychologists to comment on the Council's drafted Texas State Health Plan Update in a letter to the Board dated August 28, 2000. The Board herein presents its response as public comment on this drafted plan update.

Please note that in addition to this letter, the Board has other concerns about the recommendations in the plan which are addressed by the joint letter sent under separate cover from the Health Professions Council of which this Board is a member.

The Board is concerned that psychologists continue to be included in the First Priority list of professions to collect the MDS, despite the fact that it was previously indicated to this Board that this profession was not in the priority list presented by the institutions of higher education of this state for information to be used for workforce analysis.

Also, contrary to the information in the drafted plan, the information to be collected for the MDS for this Board would require a total of 22-26 new fields of data to be collected and entered on the database per licensee. Hence, the high cost estimates for implementing the recommendations for this agency which will be submitted to you by your stated deadline for receiving these cost estimates of September 22, 2000.

Most importantly, this Board would recommend, as an alternative to the recommendations presented in the drafted plan, that this Minimum Data Set be a non-mandatory effort implemented like the current pilot project that was suggested by the Regulatory Subcommittee of the House Appropriations Committee. This pilot project allows selected professions to voluntarily provide this MDS information through the Department of Health website. The agencies participate by sending notices to the

licensees with their renewals stating that this information needs to be submitted for the purpose of workforce analysis via this website. It is this Board's understanding that such a project if implemented for all regulatory agencies would have only a minimal cost impact on these regulatory agencies and therefore would be by far the most economic and user friendly method of collecting this data. Also, such a voluntary project would protect the privacy rights of those licensees who take issue at some of the data that would be collected. Individual information submitted to a state agency, such as the MDS, would be subject to open records even though the purpose of collecting this information is primarily for workforce analysis such as distribution, projections, etc.

Thank you for this opportunity to share with you the Board's concerns about the proposed Texas State Health Plan Update. If additional information about the Psychology Board's views regarding the plan and its recommendations which effect this agency is needed, please feel free to contact me: 512-305-7700.

Sincerely,

Sherry L. Lee
Executive Director

Enclosures

Cc: Kim Maddox, Legislative Budget Board
Antoinette Humphrey, Governor's Budget Office
Chairman Jim Pitts, Regulatory Subcommittee,
House Appropriations Committee

BOARD OF VOCATIONAL NURSE EXAMINERS
333 GUADALUPE STREET, SUITE 3-400
AUSTIN, TEXAS 78701
512/305-8100

September 14, 2000

Ben G. Raimer, M.D.
Chair, Texas Statewide Health Coordinating Council
Office of Policy and Planning
Texas Department of Health
1100 West 49th Street Austin, TX 78756

Dear Dr. Raimer:

I appreciate the opportunity to respond to the Draft 2001-2002 State Health Plan Update. You have or will receive a letter from the Health Professions Council (HPC), of which the Board of Nurse Examiners (BVNE) is a member. We contributed to the suggested content of the letter on behalf of all HPC agencies and, therefore, support those comments.

In addition, I take this opportunity to share the BVNE perspective with you. We understand the need for a complete database by which health care workforce assessment and planning can occur, and we support the concept. However, we do have some concerns about the Draft Update, as follows:

Strategy 1.1.1, Development of a Minimum Data Set. I believe the report accurately captures our concerns about changing our licensing and renewal forms and systems to collect the Minimum Data Set (MDS) information as insufficient agency resources. Lack of necessary resources includes the fiscal impact related to the extensive revisions needed for start up, as well as the on going maintenance costs. Although the Draft Update indicates that BVNE collects all but 5 elements, in fact, those "elements" translate into 15 "field" changes of our database, as managed and supported by Northrop Grumman. Initial programming costs and monthly CPU time will be incurred. In addition, BVNE has inadequate personnel resources to do the extra work created by the MDS collection of information (pp. 25, 115).

It is not clear to me from the report who will be responsible for managing the data. On page 105, the report refers to the "data processing needed to be done by the boards" while p. 107 proposes that the "Texas Legislature appropriate funds to the HPRC to contract with the licensing boards to collect the extant data." The exact meaning of these comments should, perhaps, be clarified.

The report recommends a Memorandum of Understanding between HPRC and the licensing boards that would include annual acquisition of data. With 74,000 Licensed Vocational Nurses in Texas, this would be a monumental task! Currently, LVNs renew their licenses every two years, in odd or even years, depending on their year of birth. Therefore, we renew 'only' 36,000 licenses per year. The recommendation should allow either annual acquisition of data, or by renewal cycle, for those Boards that do not renew licenses annually (p. 109).

Interestingly, the MOU Scenario was not presented as an option in Table A-3 (p. 112), unless Scenario 1, the Board Scenario was implied to include the MOU. To more fully represent the options available, I recommend that a fourth option be included, that of HPRC and the Board working jointly through a Memorandum of Understanding.

The last item concerning this strategy relates to funding. The report references funding by the licensees on at least two separate occasions: on pages 106 and 113. BVNE is strongly opposed to raising license fees to pay for data collection. The small sub-set of health care providers should not have to carry the burden of paying for data that will potentially benefit all Texans. A compromise, perhaps, since all Boards generate more revenue than they are appropriated, is for the Boards to use funds already generated for MDS collection. While this is not the preferred method of funding, the licensees would, in effect, support the project, but an increase in fees would not be required to do so.

Strategy 7.1.1, Consumer Health Care Information. I am unclear about what SHCC is proposing with this strategy. Certainly, BVNE would cooperate in coordinating with the Texas Health Care Information Council (HCIC) in providing information that helps educate health care consumers. However, the wording implies that the HCIC would also provide an oversight and quality control function as well (pp. 44 & 307). BVNE opposes designating HCIC to provide an oversight function of regulatory Boards.

If you have any questions related to my remarks above, please feel free to contact me at 305-7652 or via email at mary.strange@bvne.state.tx.us

Sincerely,

Mary M. Strange, R.N., B.S.N.
Executive Director
cc: Charles Horton, HPC

TEXAS OPTOMETRY BOARD

333 GUADALUPE STREET, SUITE 2-420
AUSTIN, TEXAS 78701-3942
512/305-8500
FAX 512/305-8501
http://link.tsl.state.tx.us/tx/TOB/

September 15, 2000

DENNIS FINUF
OFFICE OF POLICY AND PLANNING
TEXAS DEPARTMENT OF HEALTH
1100 WEST 49TH STREET
AUSTIN TX 78756

Dear Mr. Finuf:

Our agency has been requested to review and comment on the Texas State Health Plan Update. Although it appears that several changes have been made in the draft, we continue to have concerns in the following areas:

In regard to Strategy 1.1.1, the implementation of the Minimum Data Set (MDS), funding continues to be our primary concern. It was our understanding that appropriations from General Revenue would be requested for the Statewide Health Coordinating Committee (SHCC) to be used to contract with the state health licensing boards for the required minimum data set. The Plan Update recommends that the House Regulatory Sub-committee appropriate funds to the agencies for such implementation.

Should such appropriations be granted by the Legislature to agencies, most probably the agencies will be required to assess fees to generate sufficient revenue to cover such funding request. These increased fees would have to be passed on to the individual licensees of the board. Agency budgets are not sufficient to absorb these projected costs but to further tax licensees for such data gathering is not a viable action and alternatives to funding should be sought.

Although this Board collects much of the data requested, to change renewal form applications and programs to gather additional data would be an increased cost, not to mention costs for additional mailings, as well as additional staff for collection, recording, and follow-up in regard to the MDS. The FTE cap would be a limitation currently. Additionally, much of the requested data may be sensitive, and we question the need for such information.

RECEIVED
SEP 19 2000
OFFICE OF POLICY & PLANNING

Enforcement is a concern, also. If licensees must provide all of the required data as a condition of licensure, it will be costly to implement for the reasons cited above as well as the need for enforcement hearings. While the report states that provision of the MDS data will not be mandatory, we request that SHCC clarify the issue within Table 1-1.

Concerning Strategy 7.1.1 regarding the Texas Health Care Information Council (HCIC), we have concerns that the council would be given the oversight to determine the roles and responsibilities of state agencies and state entities involved in consumer health. It was our understanding that the HCIC was to have a coordinating role as opposed to a role of oversight. We question what is meant by "evaluation and quality assurance functions" listed therein. Such language should be revised to clarify the role of the HCIC as one of coordination for consumer health information rather than oversight.

The Health Professions Council is forwarding comments on behalf of member boards, and we concur with the comments made therein. See HPC letter dated September 15, 2000, to your office.

Thank you for the opportunity to comment.

Very truly yours,

Lois Ewald

Lois Ewald
Executive Director

The Texas A&M University System Health Science Center

Office of the President and Vice Chancellor for Health Affairs
John B. Connally Building
301 Tarrow, Suite 319
College Station, Texas 77840-7896
409 458-6475 • fax 409 458-6477

18 September 00

Ben G. Raimer, M.D., Chair
Texas Statewide Health Coordinating Council
1100 West 49th Street
Austin, TX 78756-3199

Dear Dr. Raimer:

Although this is late, please see the enclosed suggestions from Dr. Jim Cole, Dean of Dentistry, concerning the Statewide Health Plan.

Sincerely,

Elvin E. Smith

Elvin E. Smith, Ph.D.
Executive Vice President

EES:tc

INTEROFFICE MEMORANDUM

Date: September 7, 2000

To: Dr. James S. Cole, Dean

From: Dr. Eric S. Solomon, Executive Director for Institutional Research

Subject: Comments on the Texas Statewide Health Coordinating Council Plan

Although the Plan contains no specific recommendations for Dentistry, there are some interesting data here. For example, the Report notes that 89 percent of general dentists are located in urban areas and that the ratio of population to dentists is almost twice as high in these urban areas. There are, however, other important disparities in the distribution of dentists. Income, for example, is a major factor in the location of dentists (Figure 1). To view the impact of income on the distribution of dentists, per Capita income was divided into four equal groups for zip codes in Texas and the ratio of population to dentists was calculated.

Figure 1 indicates the highest income area has a fourfold greater concentration of dentists than the lowest income area. The distribution of dentists has important implications for access to care and the designation of Dental Health Professional Shortage Areas.

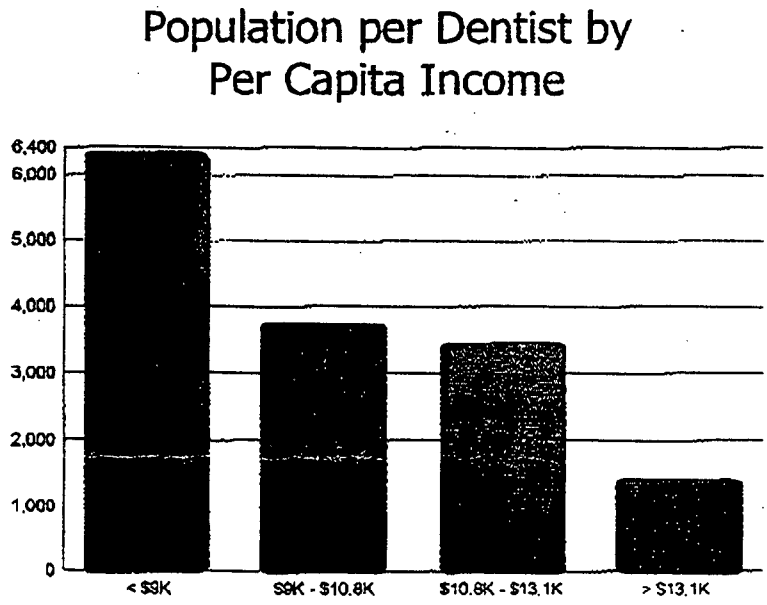


Figure 1

Dental Health Professional Shortage Areas for Texas are shown in Figure 2-12 of the Report. The near absence of Dental Health Professional Shortage Areas in the North Texas Region is evident. Wise County is the only county designated as a shortage area in our Region. In addition, there are only a handful of census blockgroups designated as shortage areas in the Metroplex – and all of them are in Dallas County (Figure 2). As a result, Dental Health Professional Shortage Areas in the Metroplex only represent a population of 108,082 while the comparable population in San Antonio (Bexar County) is 303,946. Since one of our LBB performance measures is the number of graduates who locate in Dental Health Professional Shortage Areas, the lack of these areas in our region is problematic. In fact, this disparity in number of designated areas may help to explain the College's low performance on this measure (about 1 percent of graduates).

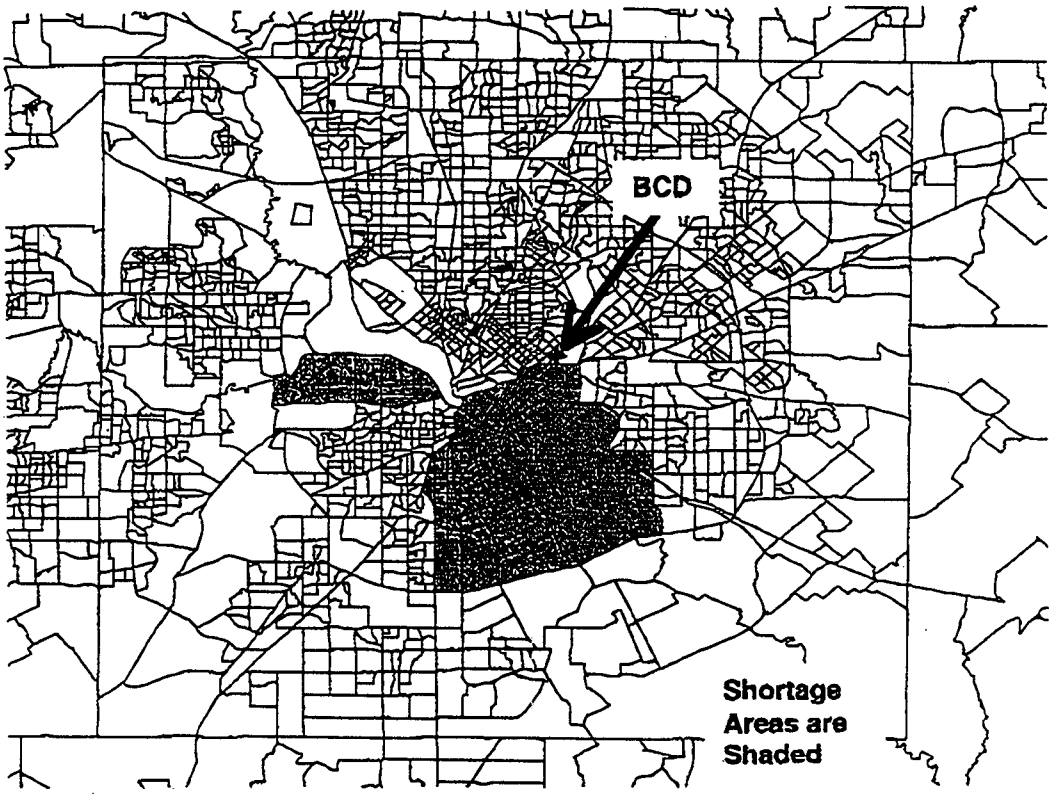


Figure 2: Dental Health Professional Shortage Areas in Dallas County

The Report also contains a series of recommendations from ad hoc committees. Most of these recommendations could be supported.

Ad Hoc Committee on Health Personnel Data – Strongly support all 5 recommendations.
Ad Hoc Committee on Community Competencies for Health Professionals – Support all 6 recommendations (this should be of particular interest to SRPH).
Texas Department on Aging – Strongly support all 10 recommendations – although not specifically mentioned, there is a role for dentistry here as well.
Ad Hoc Committee on Recruitment of Health Professionals – Support all primary and secondary recommendations – especially recommendation 3 which proposes a State-specific method for determining Health Professional Shortage Areas. Once again, dentistry could be given some specific mention in these recommendations.
Ad Hoc Committee on Minority Health – Support all 4 recommendations.
Ad Hoc Committee on Models for Community Health Practice – These recommendations are rather general in character, but probably worth supporting.
Ad Hoc Committee on Consumer Information – Both of these recommendations appear to be supportable.

Please let me know if you desire any additional information on this report.

Office of Institutional Research
Room 528
Extension 8408

UNIVERSITY of NORTH TEXAS
HEALTH SCIENCE CENTER at Fort Worth
★
Education, Research,
Patient Care and Service

Office of the President

September 13, 2000

Mr. Dennis Finuf
Office of Policy and Planning
Texas Department of Health
1100 West 49th Street
Austin, TX 78756

Dear Mr. Finuf:

Thank you for the opportunity to review the *2001-2002 Texas State Health Plan Update.* The *Plan Update* offers a variety of especially interesting information on the health care workforce in Texas. In reading through the draft, we found two apparent errors.

1. Definition of Primary Care Specialties on Page 59 and subsequent data in Table 2-1 Primary Care Physicians by Location of Training, Texas, 1999, Page 62

   Osteopathic General Practice should be included as a Primary Care specialty. Some physicians who characterize themselves as Osteopathic General Practice actually have completed Family Practice residencies. Many older General Practitioners practice in underserved urban and rural areas and deliver important needed primary health care services. They should be recognized.

   In Table 2-1, the number of UNT Health Science Center graduates practicing in Primary Care in Texas appears low relative to our own recent assessment of the Texas State Board of Medical Examiners' database. It appears that physicians who characterized themselves as practicing Osteopathic General Practice were excluded from this assessment. In our most recent assessment in August, 2000, there were 172 physicians who characterized themselves as Osteopathic General Practice and 774 total graduates in active practice in Primary Care in Texas. For 1999 data, Table 2-1 lists only 562 UNT Health Science Center graduates in active practice in primary care. Please include our graduates in Osteopathic General Practice in the data in Table 2-1.

2. Exhibit 2-1 Texas Population by Type of Health Insurance 1999, Page 93

   The Total for Location, Rural, People appears to be in error because it does not represent the total of all items in that column. As a result, the Rural percentages are in error. The Total and percentages should be corrected. When you correct these, some interesting comparisons pop out. For example, there is a much higher percentage of Uninsured People in Rural areas than in Urban areas.

Once again, thank you for the opportunity to comment on the *2001-2002 Texas State Health Plan Update*. This is a very interesting piece of work. If you would like to discuss our comments, please contact Susan Motheral, Ph.D. at 817-735-0450 or smothera@hsc.unt.edu.

Sincerely,

Ronald R. Blanck

Ronald R. Blanck, D.O.
President

RRB:gc

Dennis Finuf

From: Rumaldo Z. Juarez [rj05@swt.edu]
Sent: Friday, September 01, 2000 3:46 PM
To: dennis.finuf@tdh.state.tx.us
Subject: Texas State Health Plan

Hi Dennis:

Thanks for guiding me through the report this afternoon.

I have two comments regarding the plan:

1. The Plan is still greatly dificient in addressing the allied health workforce. For the most part, it is focused on the professions that are easy to get data, such as physicians, physician assistants, dentists, etc. We are still not able to get a handle on many of the other allied health professions that make up the complete healthcare team.

2. I noticed in Plan that it has information about the various Health Science Center programs and completely neglects the role that institutions such as ours play in producing healthcare professionals for the state. Until institutions like Southwest Texas State University, U.T. Pan American, U.T. El Paso and other community colleges that offer health programs are also included in these analyses, we will never get a true picture of the supply side.

Thanks!

********** ********** **********
If you are feeling down--go out and help someone!
********** ********** **********
Rumaldo Z. Juarez, Ph.D.
Dean and Professor
College of Health Professions
601 University Drive
Southwest Texas State University
San Marcos, Texas 78666-4616
Phone: (512) 245-3300
Fax: (512) 245-3791
E-mail: RJ05@swt.edu

TexasMedical Association

September 13, 2000

Ben G. Raimer, MD, Chair
Statewide Health Coordinating Council
Texas Department of Health
1100 W. 49th Street
Austin, Texas 78756

Dear Dr. Raimer:

We appreciate the opportunity to review the draft recommendations contained in the "2001-2004 Texas State Health Plan Update" and offer only brief comments regarding Strategy 2.1.1. Scope of practice issues are often highly charged, emotional issues that potentially can affect access, cost and quality of care. Accordingly, TMA is willing to explore a process for evaluating scope of practice recommendations. Our association feels it is appropriate to propose a legislative study during the 2001/2002 interim period to focus on processes for addressing scope of practice issues.

TMA remains committed to resolving scope of practice issues and appreciates the opportunity to provide input to the Texas State Health Plan.

Sincerely,

Louis J. Goodman

Louis J. Goodman, PhD, CAE
Executive Vice President/CEO

TNA
TEXAS NURSES ASSOCIATION
7600 Burnet Road, Suite 440
Austin, Texas 78757-1292
Telephone 512/452-0645
Fax 512/452-0648
Internet http://www.texasnurses.org

Testimony to the Texas Statewide Health Coordinating Council On The The Texas State Health Plan: Update September 21, 2000

Dr. Rainer and members of the State Health Coordinating Council: thank you for allowing me to have time to speak to the Health Plan Update. My name is Nancy Ackley MRC, MTS, RN. I am Director of the Texas Nurses Foundation and I am here representing the Texas Nurses Foundation and the Texas Nurses Association.
Before I make comments directly related to the Health Plan Update, I believe that it is important that I establish the context within which these comments are to be made.

We have a crisis in the making. National and state experts are finding that the current and developing nursing shortage is uniquely serious. This is not the typical, cyclical nursing shortage. It is becoming clear that this is both a supply and a demand shortage that encompasses interwoven and complex issues. For example:

- Throughout Texas there are reports of serious shortages of Registered Nurses. This is particularly true of experienced nurses in critical care, emergency care, labor and delivery and operative services.
- The ratio of RNs per 100,000 population in Texas is well below the national average. Only 5 other states had RN/population ratios lower than that of Texas. In 1998, to meet the national average, Texas would have needed almost 39,000 more nurses.
- Hispanic nurses are a greatly under represented segment of the Texas nursing workforce. Although 29% of the current population is Hispanic, only about 6% of employed RNs are Hispanic.
- The average age of Texas RNs is more than 44 years with only 10.5 % of the RNs in Texas being under age 30. Nursing is aging at a faster rate than any occupation in the US. 50% of Texas nurses will be at retirement age within 15 years.
- Faculty shortages, faculty aging (close to 50 years of age in Texas and 56 years if age in some of our communities), low faculty salaries and indications of a dampening interest in graduate nursing education are widely reported.
- From 1994 to 1998, Texas nursing education programs received 37% fewer applicants, enrollments dropped 17% and the number of graduates decreased by 14%.
- Current nursing education programs have significant capacity restrictions driven in large part by formula funding issues.
- Nurse salaries are flat.

- Talented women no longer have limited career options. Nursing as a primarily female profession (94% female), is experiencing the effects of these increased opportunities. Decreasing applicants is likely a primary result of this societal change.
- More and more nurses report they are working harder than ever; work satisfaction, and morale are low, and the quality of patient care has deteriorated over the past few years.
- Inadequate staffing, lack of control over an increasingly difficult and a stressful work environment are contributing to fewer applicants and RNs leaving the healthcare work environment.

We have a large and serious problem that will not be resolved quickly, easily or without information, ingenuity and resolve. Therefore, I respectfully offer the following comments:

Comments Regarding the Health Plan Update

Strategy 1.1.1: Nursing acknowledges and supports the importance of a minimum data set to improve health professions' workforce planning and allocation of educational resources. However, given Texas' critical need to ably manage the supply and demand of the nursing workforce during the next five to ten years, we are very concerned that **Strategy 1.1.2,** as proposed will be insufficient and problematic.

The lack of Texas data and information on nurse supply and demand and the absence of an effective and operational supply and demand model for nursing in Texas, prevented educators, employers, policy and decision-makers from predicting and minimizing our current complex nursing shortage.

States such as North Carolina, that have a Nursing Data Center, and have built a data base of information as well as a workforce prediction system, have been able to be more proactive and strategic in their efforts to address the shortage in a timely and targeted way. Texas is already several years behind in addressing this shortage due to our lack of data and information.

The absence of data and information was the stimulus for the Texas Nurses Foundation, the Texas Institute for Health Policy Research and the Center for Health Economics and Policy to initiate the Nurse Workforce Data System Project. (An update on this project is attached.)

Because of the seriousness and complexity of this nursing shortage, we believe that Texas needs a dedicated Nursing Data Center that will work to assure that our state has the nursing resources necessary to meet the healthcare needs of our citizens.

All indications are that it is imperative that Texas has a dynamic statewide system for projecting nurse workforce demand. Texas must insure an adequate nursing workforce in terms of numbers, ethnic diversity, educational mix and geographic distribution. This will not occur if nursing workforce studies and planning are not a priority. For the next five years at least, activities related to the nursing shortage must be intense, targeted, timely and systematic. Nursing feels so strongly about this that we propose to fund at least 50% or more of the cost of such a center with RN and LVN licensing fees. An additional portion of the cost could be funded through a nominal surcharge on hospitals and other healthcare facilities.

We are particularly concerned about the suggested use of the Integrated Requirements Model to predict nurse supply and demand. This is the model that the

Texas Medical Association (TMA) has used to evaluate the status of physician supply and demand. A primary assumption of the model is that a person's age, gender, geographic location (urban vs. rural) and health insurance status can reasonable be used as predictors of a person's health status and corresponding willingness and ability to access **physician** services. The Integrated Requirements Model is inappropriate and inadequate to project supply and demand data for professional nurses. Our inquiries with national and state experts substantiate this view. While there are a variety of approaches currently being used by other states to estimate demand, there is not currently a state level supply and demand model for nursing that is thought to be predictably sufficient or ideal.

(As a point of information: The Texas Nurses Foundation and the Nurse Workforce Data System Project team believe that the development of an effective model is crucial to managing the supply and demand of Texas' nursing workforce. Therefore, we are bringing together six of the most knowledgeable national experts on nurse workforce and modeling to work with the members of the Project team for one and one-half days in October. Part of our work will be to begin the work of envisioning a predictive model for nurse workforce supply and demand.)

The role of most nurses is not episodic. Nurses provide continuity of care services 24 hours a day, 7 days a week, 365 days a year. Nurses, whether RN, LVN or Nursing Assistants, are more likely to be employees not independent practitioners. They work in many locations including hospitals, home health, long term care and the community. Nurse workforce data collection, analysis and supply and demand projections must have a multi-leveled focus, analyzing all nursing roles – RN, LVN and Nursing Assistants. The shear numbers for Texas, close to 250,000 tell us that this is a big and complex job.

While nursing recognizes and appreciates the work of the Health Professions Resource Center, given limited resources and time, it can not possibly give nursing the attention it must receive. The proposed increase in funds and resources for the Center would challenge the Center to conduct studies and surveys needed by all of the health-related professions found on page 25 of the Update, much less meet the unique and critically pressing needs of nursing. Development of the proposed details of the structure, funding, administrative oversight and scope of a Nursing Data Center for Texas are still being discussed. So I cannot yet share with you an explicit description of what and how a Nursing Data Center might look. What I am able to state, however, is the following.

We believe that Texas needs a dedicated state supported nursing workforce data center; a center that will prioritize nursing; a center that will cooperatively gather data with other state agencies; a center that will not duplicate efforts but will work cooperatively and collaboratively to integrate data, analysis and information. We believe that it is only through such a dedicated, state-designated nursing workforce data center that decision and policy makers, nurse educators and employers will be able to be proactive and respond quickly. And, we believe that having access to information and data that is readily available, timely, targeted, reliable and pertinent is critical if Texas is to effectively meet the challenges of this nursing shortage and effectively manage the supply and demand of our nursing workforce.

Strategy 1.1.3: Nursing believes that formula funding ratios and the access of funds distribution to the schools of nursing should be reviewed. We are particularly concerned about the biennial-funding lag that limits nursing education's ability to respond rapidly and appropriately to changing market demands.

Strategy 1.1.3a: Nursing supports Action steps 3, 4, 5, 6, and 7. We believe that it is particularly important that the state increase financial support of nursing programs (See Action 3) if Texas is to meet the workforce needs of our healthcare system and the health needs of Texans. Because of the severity of the nursing shortage, we believe that the collection and analysis of information about nursing education should have the highest priority (Action 4).

Strategy 1.1.3b: It has been noted that 5 or 6 schools of nursing in Texas have instituted a formal, for-credit internship for nursing students. We recommend the following: That the Board of Nurse Examiners and the Texas Higher Education Coordinating Board explore nursing internships in terms of need, best practices, outcomes and effectiveness.

Nursing also asks that the recommendation to the Texas Higher Education Coordinating Board to establish a formal recognition process to identify the most successful outreach and recruiting programs should be extended to nursing.

Strategy 1.1.3c: Nursing strongly and enthusiastically supports this strategy and accompanying actions.

Strategy 2.1.1: Nursing favors a fair and equitable process for addressing changes in scope of practice for health professionals.

Strategy 3.1.1: We are in support of plans to address the maldistribution of healthcare professionals and increase access to rural and underserved populations through funded programs that expand the use of telehealth/distance technology. However, we believe that it is critical that professional nurses be included in telehealth reimbursement opportunities. Registered Nurses are frequently the healthcare professional who presents the patient to the physician (i.e. school nurses). Additionally, this strategy will be an important resource toward preparing enough nurse faculty for our rural and underserved areas. (Note: Nurse Midwives <u>are</u> advanced practice nurses. Advanced Practice Nurses includes: Nurse Practitioners, Nurse Anesthetists, Nurse Midwives and Clinical Nurse Specialists.)

Strategy 3.2.1: While we support the recruitment and retention of health professionals into Health Professional shortage Areas, we believe that loan repayment programs may not be sufficiently attractive options. We believe that scholarships and loan forgiveness programs have much greater appeal to advanced practice nurses. (Note: We are not familiar with a Psychiatric Nurse Specialist designation. Perhaps you mean a Nurse Practitioner. Adding the category of ' other registered nurses', may better describe the intent.)

Strategy 3.2.2: We suggest that Action 4 read: "Expand current physician recruitment programs to include other health care professionals."

Strategy 4.1.1: Nurses have long been proponents of emphasizing prevention in nursing education through our curricula and the use of community-based training sites. We strongly endorse this focus and emphasis.

Strategy 4.2.1: We believe nursing is critical to the public health workforce. We also believe that collaborative efforts to enhance the education and training of the public health workforce must include nursing education endeavors. Therefore, we suggest that Strategy 4.2.1 should read: ".... the public health and nursing workforce."

Strategy 5.1.1: See 1.1.3b. We enthusiastically support the strategies and actions for increasing the number of minorities in the health professions. However, we believe it is prudent and wise to identify 'best practices' and explore which strategies and approaches are most successful in recruiting and retaining minorities. These are the programs that should be funded.

Strategy 5.2.1: Nurses currently provide a significant portion of the health care provided to the elderly. We therefore recommend that both the Texas Nurses Association and the Nursing Education Policy Coalition be added to the list of responsible parties.

Respectfully submitted,

9/20/00

Nancy L. Ackley MRC, MTS, RN

Health Professions Council

333 Guadalupe Street, Suite 2-220
Austin, Texas 78701-3942

September 15, 2000

Dennis Finuf
Office of Policy and Planning
Texas Department of Health
1100 West 49th Street
Austin, TX 78756

Dear Mr. Finuf:

The Health Professions Council has reviewed the Texas State Health Plan Update. The following comments reflect the impact that the Plan Update will have on the member agencies of the Health Professions Council. While many of our concerns have been resolved as we expressed them throughout the planning process, the following concerns continue to be an issue for us.

Comments on strategy 1.1.1 regarding the implementation of the Minimum Data Set (MDS):

Lock Box Requirements: Four of the independent boards and 12 of the TDH boards use the Comptroller's Lock Box to process license renewals. This system allows the agencies to meet the state's three-day deposit requirement and generates additional state revenue by assuring immediate deposit of funds. Comptroller's requirements will not allow any increase in the size of payment coupons and will not allow for any attachments. Therefore, agencies would be forced to either contract with a vendor to process the payments or hire additional staff to handle the work now done by the Comptroller.

Funding: Implementation is not possible without additional funding. The Ad Hoc Committee on Health Personnel Data recommended appropriation of funds to the Statewide Health Coordinating Committee to be used to contract with the state health licensing boards for them to collect the MDS. The Plan Update recommends that the House Regulatory sub-committee appropriate funds to cover the costs of implementing the minimum data set and raise the FTE cap for those licensing boards and the Health Professions Resource Center.

It was our understanding that funding for the MDS was to be appropriated from general revenue funds directly to the Texas Department of Health. The House Appropriations Regulatory subcommittee serves only Article VIII agencies and should not be referenced as the subcommittee to appropriate the funds. The reference should be to the Legislature.

The Health Professions Council is concerned with the ultimate source of the funding. Member agencies are currently working on cost projections. Based on previous cost projections, it is expected that the cost to some agencies will be very high. If funding for the MDS is appropriated directly to the licensing agencies, there is concern that the appropriations for the MDS will be subject to a "contingent revenue rider" requiring agencies to assess fees to generate sufficient new revenue in excess of the Comptroller's Revenue Estimate. The effect of this rider is that any additional appropriations to a licensing board results in increased fees to the individual licensees of that board. If MDS funding were subject to this condition, full cost of implementing the MDS would be borne by the licensed health care professionals. Further, since the projected cost to collect the data is greater in some agencies than in others, recovering the costs by charging the licensees in some cases is simply not practical. Any funding provided should be general revenue appropriated directly to the agency in charge of implementation.

Biennial license renewals: The Ad Hoc Committee on Health Personnel Data recommended the development of a Memorandum of Understanding between the Health Professions Resource Center and the health professions licensing boards which would include annual acquisition of data. Some member agencies have changed to a biennial license renewal as a cost savings measure. Annual acquisition of the minimum data set would necessitate either a return to annual license renewals or implementation of a system solely to update data at the end of the first renewal year. Returning to annual renewal of licenses would result in an increase in workload by doubling the number of renewals processed each year. In addition, during the implementation period of reverting from a biennial to an annual license renewal, a significant decrease in revenue will occur which will negatively affect those agencies' revenue projections for that period. Furthermore, the transition itself would be costly and would create confusion for licensees. Attempts to collect data outside of the licensing process will also create costs for additional staff, mailing and processing, and may require extensive follow up.

Sensitive Data: Agencies are reluctant to collect sensitive information they do not need, such as ethnicity and place of birth, due to potential liability.

Enforcement: It will be much more difficult and costly to implement the MDS if licensees must provide all of the required data as a condition of licensure. While the strategy and actions do not address this issue, the body of the report states that provision of the MDS data will not be mandatory for licensees. We request that the Coordinating Council clarify this issue within Table 1-1.

Comments on strategy 7.1.1 regarding the Texas Health Care Information Council:

The Texas Health Care Information Council is designated as the agency to clarify the roles and responsibilities of state agencies and state entities involved in consumer health information activities. The Health Professions Council had the understanding that the Health Care Information Council was to have a coordinating role as opposed to a role of oversight. The Health Professions Council is unclear what is meant in the action number 1, c) evaluation and quality assurance functions. We suggest that the language of strategy 7.1.1 be revised to clarify the role of the Health Care Information Council as one of coordination rather than oversight.

The Health Professions Council supports the work and direction of the Statewide Health Coordinating Council's Texas State Health Plan; and, we appreciate the work that has gone into this Plan Update. We have only commented on the areas that are of concern to us. We appreciate the opportunity to provide input to the Plan Update. Please call if there are any questions regarding our feedback.

Sincerely,

Katherine A. Thomas, MN, RN
Executive Director
Board of Nurse Examiners
Chair, Health Professions Council

cc: Wayne Roberts, Governor's Office of Budget and Planning
Chris Britton, Office of the Lieutenant Governor
John Keel, Legislative Budget Board
The Honorable Bill Ratliff, Senate Finance Chair
The Honorable Robert Junell, House Appropriations Chair
The Honorable Jim Pitts, Chair, Regulatory Sub-Committee, House Appropriations
Ben G. Raimer, M.D., Statewide Health Coordinating Council
David A. Valdez, M.D., Statewide Health Coordinating Council
P.J. Wright, Statewide Health Coordinating Council
Bruce Gunn, Health Professions Resource Center
Members of the Health Professions Council

September 19, 2000

Mr. Dennis Finuf
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756

Dear Mr. Finuf:

The Coalition for Nurses in Advanced Practice (CNAP) appreciates the hard work of the Statewide Health Coordinating Council and staff in developing the draft of the Texas State Health Plan biennial update for 2001-2002. As the primary organization representing advanced practice nurses in Texas, we certainly support the recommendations included in the draft report. We do wish to comment on a few points of particular importance to our profession.

On page 16, under "Scope of Practice" on lines 1 and 5, the report refers to scope of practice being defined in "medical practice acts." This is confusing since there is only one Medical Practice Act and it regulates physicians, physician assistants and acupuncturists. Other health care professions have their own practice acts. For instance, authority for advanced practice nurses (APNs) is found in the Nurse Practice Act. Therefore on lines 1 and 5, CNAP recommends changing, "the medical practice acts" to "professional practice acts."

Pages 16 through 18 continue to discuss scope of practice issues and suggest a sunrise process before the Legislature considers such legislation. Since CNAP has participated in a negotiation process with Texas Medical Association to develop scope of practice legislation since 1995, we certainly appreciate the importance of developing a fair process to resolve these issues. While CNAP supports such a process, we are concerned that sunrise and arbitration processes might be enacted without adequate funding for staff. If this were the case, such a data-driven process would rely largely on the information brought by associations. Because of the difference in resources that physician associations have versus other health care professional associations, the process could be inherently unfair. We understand that such issues would be brought to light during the interim study suggested in Strategy 2.1.1, and that the Council partially addressed this issue in Action # (1)(b). However, CNAP suggests that the report address this issue specifically by adding an additional action, (1)(c), to read as follows: "Consider variations in financial and staffing capacities among professional organizations in developing a fair and equitable process."

CNAP also supports Strategy 3.1.1. Telemedicine is an important strategy to address maldistribution of health care providers. Obviously, we appreciate that the SHCC recommends reimbursement for telehealth services provided by APNs. However, CNAP also strongly recommends that the report specifically identify registered nurses as providers who should be reimbursed for presenting patients. RNs are educated in

physical assessment and may be the most appropriate presenters in some remote areas of Texas or in some school-based clinics. Action # 1 certainly includes the possibility of reimbursing RNs for this service by including "other health care providers" in the listing of health care professionals that the state should consider for reimbursement. However, CNAP asks that the SHCC specifically include RNs in that list.

Action # 7 in Strategy 3.2.2 recommends development of a plan for a physician relief service for rural physicians. CNAP strongly recommends that APNs and physician assistants (PAs) also are included in a plan for relief services. Some APNs and PAs are already providing essential services in remote areas, just as physicians do. For example, according to a 1998 study using 1997 Texas data, certified registered nurse anesthetists (CRNAs) work in 78 counties in which no anesthesiologist resides. If the SHCC's recommendations are implemented, there may be an increasing number of rural APNs and PAs who need occasional relief. Therefore CNAP recommends that Action # 7 read as follows: "Develop a plan for a relief service for rural physicians, advanced practice nurses, and physician assistants."

The substitution grid for physicians and non-physician providers on pages 94 and 95 contains some errors. On page 95, under psychiatrists, clinical nurse specialists are listed twice and the two listings have different substitution factors. Under the category of anesthesiology, physician assistants, who are not trained to deliver anesthesia in their educational programs, are listed twice with two different substitution ratios, but CRNAs, who deliver 65% of all the anesthetics in this country, are not listed at all. In addition, the grid shows that PAs work in otolaryngology, urology and other specialty practices, but does not show the fact that nurse practitioners (NPs) also work in many of these specialties.

In addition, the draft report contains very little information on how the substitution model should be interpreted and its limitations. If the reader takes the information in the table at face value, erroneous conclusions may be drawn. For instance, all published estimates indicate that a family nurse practitioner can properly evaluate and treat from 60 to 90% of the patients seen by a family physician. Therefore, even if the model accounts for the fact that NPs spend a longer amount of time with each patient, a substitution rate of .38 seems very low. Even the concept of a substitution rate is flawed. As the report indicates on page 68 in the discussion of "Non-Physician Primary Care Providers," nurse practitioners and physicians generally work in teams, and always in collaboration. No number of NPs can totally substitute for what a physician can do because there are always tasks that are beyond the scope of an NP's practice.

Dr. Bruce Gunn is certainly aware of the limitations of the substitution model, and the fact that additional development work is needed. In the meantime, CNAP suggests the substitution model that appears on pages 94 and 95 be deleted from the report, or at a minimum, it should be corrected and should appear with a strong caution about its reliability and applicability to policy decisions.

The remaining two suggestions are editorial. Page 21 refers to a definition of primary health care in 42 US Code 254b. Since most readers do not have ready access to the US Code, it would be helpful if the content of this citation were included in the report. On page 74, "(Apns)" should be written "(APNs)."

Thank you for allowing the Coalition for Nurses in Advanced Practice to delay submission of its comments on the draft of the Texas State Health Plan until members of the SHCC staff were able to answer our questions. You and Dr. Gunn have been very helpful. If you have any questions, please contact me by phone, (979) 345-5974, fax, (979) 345-3496, or pager (800) 344-3208 Pin #3249. You may also contact CNAP's governmental affairs consultant, Kathy Hutto, in Austin at 236-2018.

Sincerely,
Lynda Woolbert, MSN, RN, CPNP
Director of Public Policy
Coalition for Nurses in Advanced Practice

NURSING EDUCATION POLICY COALITION

Deans and Directors
Texas League for Nursing
Texas Nurses Association
The Texas Organization for Associate Degree Nursing
The Texas Organization for Baccalaureate & Graduate Nursing Education

September 15, 2000

Dennis Finuf
Office of Policy and Planning
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756

Dear Mr. Finuf:

This letter is in response to the Statewide Health Coordinating Council's 2001-2002 Texas State Health Plan Update. As nurse educators representing all professional nursing education groups in Texas, the Nursing Education Policy Coalition (NEPC) would like to make the following points regarding the update.

- Strategy 1.1.2: We are in support of conducting work force project studies and surveys that will encourage work force and education policy development. However, we are concerned that the Integrated Requirements Model is not adequate to project supply and demand data for professional nurses. Although this model does appear to be accurate in projecting requirements for physicians and mid-level providers, we would not recommend relying on it for projections regarding professional nurses. This leads us to believe that a parallel entity would be necessary to accurately project complementary nursing workforce data.

- Strategy 1.1.3: We are in support of the concept of reexamination of formula funding, particularly as it relates to the biennial funding lag that hampers nursing's ability to respond rapidly to changing market demands.

- Strategy 1.1.3a (3): We believe it is crucial that the state increase financial support of nursing programs to help allay the current and ever worsening nursing shortage.

- Strategy 1.1.3a(4): Although we support the establishment of automated data collection systems, because of the severity of the nursing shortage, we believe that collection of information about nursing should have the highest priority. Through our collaborative efforts among the nursing groups we know that nurses are willing to support a Nursing Data Collection Center funded through increases in licensing fees.

- Strategy 1.1.3c: We enthusiastically support this recommendation and believe it provides the best strategies for addressing the nursing workforce needs.

- Strategy 2.1.1 we are in support the creation of a fair and equitable process for addressing changes in scope of practice for health professionals.

- Strategy 3.1.1 (1): We are in support of plans to address the maldistribution of health care professionals while increasing access to rural and underserved population through funded programs that expand the use of telehealth/distance technology. However, we believe that it is critical that professional nurses be included in telehealth reimbursement opportunities. This is especially important to increase access to health care in rural and underserved populations.

- Strategy 4.1.1: Nurses have long been proponents of emphasizing prevention in nursing education through our curricula and the use of community-based training sites.

- Strategy 4.2.1: We believe nursing is critical to the public health workforce; therefore, collaborative efforts to enhance the education and training of the public health workforce must include nursing education endeavors.

- Strategy 5.1.1: We enthusiastically support the strategies for increasing the number of minorities in the health professions.

- Strategy 5.2.1: Since nurses currently provide a significant portion of the health care to the elderly, it would be remiss of the Council to exclude nursing as a responsible party in the study of the needs of the elderly. We recommend that the Texas Nurses Association and the Nursing Education Policy Coalition be identified as responsible parties for implementing this strategy.

Thank you for this opportunity to respond to the Texas State Health Plan Update. We look forward to working with you to implement these strategies.

Sincerely

Alexia Green

Alexia Green, RN, Ph.D.
Chair, Nursing Education Policy Coalition

Dennis Finuf

From: The Ratliff's [midwife@i4f.net]
Sent: Wednesday, August 30, 2000 10:27 AM
To: dennis.finuf@tdh.state.tx.us
Subject: Re: Draft Proposed 2001-2002 Texas State Health Plan Update: Ensuring a Quality Health Care Workforce for Texas

Mr. Finuf,

In the proposed document about Community Care, there is no mention made of including midwives. Midwives provide quality, affordable, safe well woman and maternity care. We are accessible even to the poorest segments of our communities, and to those who fall in the gap between Medicaid and Insurance. These are the most 'at risk' groups in our state. Please consider this when you are putting together the final Texas State Health Plan, leaving the midwives out of the plan would be a grievous error.

Allison Ratliff
documented midwife #00010

Responses to Public Comments

State Agencies

Archer / Texas Department of Health (TDH)

Favorable. No comment.

Berryhill / TDH

See responses to the Health Professions Council

Berry / TDH

Language in the Table 1-1 was changed in Strategy 1.1.2 to include the Community Health Provider Resources Program.
Language in Strategy 3.2.1 was changed to be less restrictive.
The convener in Strategy 3.2.2. was changed to the SHCC rather than the Center for Rural Health Initiatives.

Cortes / Texas Department of Human Services

The SHCC changed the language in Strategy 5.2.3. per the recommendation.

Fair /Texas Department on Aging

Favorable comments.

Cain / Texas Board of Chiropractic Examiners

See responses to the Health Professions Council

Boston / Center for Rural Health Initiatives

p. xix: **No change recommended. This comment is not germane the subject of the paragraph.**

p. 288: **Wording changed to read: "The health care environment has become more complex. Advances in health care diagnostics added to the availability of often conflicting information, and because of the increasing analytical sophistication of health consumers a new paradigm needs to be developed in the relationship between health care consumers and providers. The need for development of the consumer-provider partnership has become critical."**

p. 290: **No changes recommended. While this is an important factor in the provider-patient relationship it is outside of the scope of the SHCC charge.**

p. 291: **No changes recommended. While this is an important factor in the provider-patient relationship it is outside of the scope of the SHCC charge.**

p. 292: **Change in wording of recommendation addresses the issues in this comment. Change word "lease" to "move".**

p. 302: **Change in wording of recommendation addresses the issues in this comment.**

Professional Licensing Boards

Langley / Texas State Board of Medical Examiners

See responses to the Health Professions Council

Thomas / Board of Nurse Examiners

See responses to the Health Professions Council

Dodson / Texas State Board of Pharmacy

See responses to the Health Professions Council

Lee / Texas State Board of Examiners of Psychologists

See responses to the Health Professions Council

Strange / Board of Vocational Nurse Examiners

See responses to the Health Professions Council

Psychologists will continue to be included in the First Priority List for implementing the MDS.

Ewald / Texas Optometry Board

See responses to the Health Professions Council

Academic Health Centers

Smith / Texas A&M University System Health Science Center

Comments were all favorable.

Blanck / University of North Texas Health Science Center at Fort Worth

Changes were made to Table 2-1 and Exhibit 2-1.

Juarez / Southwest Texas State University

Recommend no change. The SHCC will consider this as an item of priority for the next SHP update.

Professional Associations

Goodman / Texas Medical Association

Favorable comments.

Ackley / Texas Nurses Association

See responses to the Health Professions Council

Language change using "all health care professionals" in lieu of listing various professions, or referring to "non -physician practitioners."

Thomas / Health Professions Council

Lock Box Requirements: No change required, the problem with implementing the Minimum Data Set (MDS) was addressed in the State Health Plan. The SHCC intends for the lock box procedures to continue as is.

Funding: TABLE 1-1 (GOAL 1, OBJECTIVE 1.1, ACTION 3) was amended to read, "The legislature should appropriate funds to the Texas Department of Health to cover the costs of contracting to implement the minimum data set. The legislature should raise the FTE cap for those licensing boards and the Health Professions Resource Center which are required to implement and maintain the collection of that data."

Biennial License Renewals: TABLE 1-1 (GOAL 1, OBJECTIVE 1, ACTION 3) was amended to read, "3) The Licensing Boards for those professions named should change their licensing and renewal forms and data systems to include the collection of the minimum data set on an annual or biennial basis."

Sensitive Data: No change required, the problem with implementing the MDS was addressed in the State Health Plan. See Recommendation Four.

Enforcement: Table 1-1 (Goal 1, Objective 1.1, Strategy 1.1.1) was amended to state, "The reporting of health personnel data is non-mandatory for health

professionals except for those data elements required for board administrative and regulatory purposes."

Responses to Additional Comments from Various Boards:

Many of the variables that were used with each data element or field in earlier versions of the MDS have now been designated as "board specific" and will be defined as each board determines. This difference between earlier versions of the MDS and the latest version (in which no variables were provided) accounts for most of the discrepancies between the boards and the SHCC.

As mentioned in the plan, the boards will manage the data, the HPRC will contract with the boards to collect the data and the data will be shared with the HPRC through a memorandum of understanding.

The results of workforce surveys conducted in other states and Texas indicate that poor response rates are typical when licensees are asked to respond to surveys that are not mandatory, as will be the MDS. Thus, the usefulness of collecting data by an on-line survey system is questionable. The results from the pilot system that is currently being tested by the HPRC will help to answer this question later this year.

A file layout for the MDS was developed by the SHCC Health Personnel Data Subcommittee, but a recommended list of variables for each data field was not identified in the State Health Plan. This allows the boards to have flexibility in designing the MDS to suit their particular board when funding becomes available. Flexibility is important because some data fields and variables are not appropriate to some boards. Substituting the "zip code" field for a "zip code plus four" field would accommodate some geocoding requirements.

The Health Personnel Data Advisory Committee chose 37 data elements out of 60+ elements as being the minimum number required for workforce analyses. This does not preclude boards from adding additional elements for their own internal purposes.

The State Health Plan indicates that the Integrated Requirements Model should not be the sole determinant for estimating the requirements for health professionals in Texas. See Chapter 2, Introduction, Workforce Models Used in this Report.

Woolbert / Coalition for Nurses in Advanced Practice

See responses to the Health Professions Council

Green / Nursing Education Policy Coalition

See responses to the Health Professions Council

Ratliff / Midwife

No change. This plan update could not address the allied health professions in depth

Texas Statewide Health Coordinating Council
1100 West 49th Street
Austin, Texas 78756-3199
512 458-7261
11/00
Publication #25-10898