1989-90 TEXAS STATE HEALTH PLAN

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STATE OF TEXAS
OFFICE OF THE GOVERNOR
AUSTIN, TEXAS 78711

WILLIAM P. CLEMENTS, JR.
GOVERNOR

October 20, 1988

Statewide Health Coordinating Council
1100 West 49th Street
Austin, Texas 78756

Dear Council Members:

I am in receipt of the proposed 1989-90 Texas State Health Plan. Your efforts in developing this document are commendable; I am sure that it will be used by our state's policymakers during the upcoming biennium.

Our current state fiscal situation mandates that we seek new ways to coordinate and integrate services so that resources are maximized. I encourage you to work closely with the Texas Health and Human Services Coordinating Council and other state agencies to ensure that a state health plan meets Texans changing needs and meets those needs in the most cost effective manner possible.

While I have concerns over possible fiscal implications, I agree that the issues raised in this document are valid concerns. I await further cost data information.

Sincerely,

W.P. Clements, Jr.

William P. Clements, Jr.
Governor

WPC:RLL/rm/lm

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Texas Statewide Health Coordinating Council

1100 West 49th Street
Austin, Texas 78756
(512) 458-7261

September 30, 1988

The Honorable William P. Clements, Jr.
Governor of Texas
State Capitol
Austin, Texas 78711

Dear Governor Clements:

On behalf of the Statewide Health Coordinating Council, I am pleased to forward to you the 1989-90 Texas State Health Plan. Your approval of this plan will culminate more than a year of work by the Council in identifying key issues in Texas health policy and proposing actions to bring about needed changes.

Every effort has been made by the Council to produce a plan that fosters a positive, concise approach and one that has the potential for implementation during the next biennium. As you know, state law requires the health-related agencies in Texas to address the plan's recommendations in their general revenue appropriations request. The challenge, as seen by the Council, has been to conceive workable recommendations which provide policy guidance but do not necessarily require additional funds.

So that implementation efforts may commence, we respectfully request your approval of this plan at your earliest convenience.

Sincerely,

Marion R. Zetzman

Marion R. Zetzman, Dr.P.H., Chairman
Statewide Health Coordinating Council

Enclosure

1989 - 90 TEXAS

STATE HEALTH PLAN

TEXAS STATEWIDE HEALTH COORDINATING COUNCIL
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BUREAU OF STATE HEALTH DATA AND POLICY ANALYSIS
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1989-90 TEXAS STATE HEALTH PLAN

TEXAS STATEWIDE HEALTH COORDINATING COUNCIL

CHAIRMAN'S STATEMENT

This is the seventh edition of the Texas State Health Plan. It is a product of a process initiated in 1974 with the enactment of the National Health Planning and Resources Development Act. Congress repealed this law in 1987, ending 40 years of federal support for health planning that began with the Hill-Burton program. In Texas, the State Health Plan will be continued on a limited basis and with greatly reduced funding and professional staff support under the authority of the 1975 Texas State Health Planning Act. This reduced effort comes at a moment in our state's economic troubles and other social travails when the continuation of the planning process is perhaps more important than ever.

In the business world, long-term planning has become obsolete and is being replaced by "strategic marketing." This is because in this arena the present and the future have very small buffer zones of time, and events move quickly. With the exception of some of the fast-paced technological and scientific advances in medicine that impact health status, change in the direction and implementation of health and social policy tends to move slowly. The person who is a realist must defer to this aspect of our pluralistic democracy. Consequently, public policy plans, such as this one, generally appear to be static and inconsequential when, quite often, they are not. Of course, no one has a monopoly on effective or efficient health problem solving; however, the rationale for achieving the optimum is lodged somewhere within the concept of planning and, perhaps, strategic marketing. Even though health planning as it exists today has not become obsolete, it has been greatly diminished because of its adversaries in the past and recent congressional action. However, it is still an urgent and relevant matter and we must continue to move forward in the right direction.

In the sense that strategic marketing shapes the direction a business should go, how it should get there and how much money should be spent, so too does this plan provide a similar approach for resolving problems of a critical nature that impact the health of most Texans. In the final analysis, it is the direction we are heading that is important—much more so than the specifics outlined in this plan—because if we are on the right path, we will eventually get there.

As Chairman of the Texas Statewide Health Coordinating Council for the past four years, I am grateful to everyone—past and present—who has taken part in the process of preparing or will take part in implementing this plan and for coming along on the trip!

Marion R. Zetzman, Dr.P.H., Chairman
Texas Statewide Health Coordinating Council
1100 West 49th Street
Austin, Texas 78756-3199

September, 1988

1989-90 TEXAS STATE HEALTH PLAN

TEXAS STATEWIDE HEALTH COORDINATING COUNCIL MEMBERSHIP

NAME/CITY	OCCUPATION
Elizabeth Ann Attel, R.N., M.S.N. Dallas	Vice-President OB-GYN Patient Care Center
Robert E. Bonham, M.D., P.A.	Medical Practice
Eugene A. Borrell Temple	Director VA Medical Center
George A. Bray Austin	State Coordinator — Citizen Rep. Program American Association of Retired Persons
The Reverend Robert Brooks Houston	Priest/Episcopal
Max Brown, Jr., Ph.D. Dallas	Business Executive
Lynda Calcote	Consumer Advocate
James L. Caldwell, Ph.D. Austin	Advisory Systems Analyst - IBM
Jack Lester Campbell Austin	President St. David's Hospital
Ms. Evelyn H. Close Perryton	Family Services Center Perryton
The Honorable Larry Thomas Craig Tyler	County Judge
Scott Moore Duncan Houston	Duncan and Associates
Ernest J. Gerlach San Antonio	Management Consultant Pulse Diversified Consultants

1989-90 TEXAS STATE HEALTH PLAN

TEXAS STATEWIDE HEALTH COORDINATING COUNCIL MEMBERSHIP

— CONTINUED —

NAME/CITY	OCCUPATION
Melinda Gonzales, R.N., B.S.N. Corpus Christi	Coordinator of Health Services Corpus Christi Independent School District
Jose L. Gonzalez, P.E. Laredo	Director Laredo-Webb County Health Department
Betty H. Himmelblau Austin	Board Chair Brackenridge Hospital
Edward A. R. Lord, Jr., M.D. Houston	Medical Practice
The Honorable Frank Madla San Antonio	State Representative
Damasco A. Oliva, M.D. San Antonio	Medical Practice
M. Madesta Smith Clarksville	Community Volunteer Advocate
Michael Cooper Waters, FACHA Abilene	President Hendrick Medical Center
Marion R. Zetzman, Dr.P.H. Dallas	Professor of Community Medicine UT Southwestern Medical Center

CONTENTS

CHAPTER I.

INTRODUCTION

PLAN PURPOSE

The Texas State Health Plan is developed biennially by the Statewide Health Coordinating Council (SHCC). It serves as a guide for Texas decision-makers in the development of health policies and programs and helps in determining the resources needed to conduct those programs. It represents a large-scale cooperative effort to provide direction for refining and implementing the essential health programs for Texas. The 1987-88 State Health Plan identified major statewide health concerns, recommended strategies to resolve these concerns, and analyzed the need for various types of health facilities and services. It also reviewed the key resources of the health service system: reimbursement for and costs of services, health manpower supply and deployment, and other related data. Its overarching goal was to assure equitable access to needed health care services—at affordable prices—for all citizens of Texas. The 1989-90 plan is smaller in size, more streamlined—but equally committed to this goal.

The acceptance and use of the 1987-88 plan in the last biennium was encouraging. However, implementation of many recommendations continues. Because of positive response to the plan, the SHCC has opted not to seek new health problem areas to address, but instead to retain the format of the 1987-88 plan and streamline and consolidate its parts. Thus, the 1989-90 plan reviews what its predecessor version recommended, updates what has or hasn't happened to those recommendations, and presents new or modified recommendations to accomplish certain goals.

Plan implementation is guided by the SHCC and the State Health Planning and Development Agency (SHPDA) of the Texas Department of Health (TDH). Of course, the ultimate responsibility for implementation continues to reside with legislators, the administrators and program managers of the various health-related agencies and—most importantly—on individual providers, professional associations and organizations in the private sector. Their cooperation, as always, is crucial to the success or failure of this plan.

LEGAL BASIS

The Texas Health Planning and Development Act (the Act), Article 4418h, V.T.C.S., establishes the health planning process for the state. Originally based on federal law, the Act was amended in 1985 to provide a health planning process which is meaningful for the state of Texas. The Statewide Health Coordinating Council, appointed by the governor, is responsible for policy development and guidance in plan development, adoption of the final State Health Plan, and plan implementation. The Texas Department of Health acts as the "state health planning and development agency", as specified in the Act, through its Bureau of State Health Data and Policy Analysis. Following a period of public comment and a review by the Texas Health and Human Services Coordinating Council, the plan as adopted by the SHCC is forwarded to the governor for his signature. State agencies which are affected by recommendations in the plan are required to determine the costs of implementing these recommendations and to report whether these costs are included in the agencies' biennial appropriations requests to the legislature.

PLAN DEVELOPMENT NETWORK

The Bureau of State Health Data and Policy Analysis, TDH, conducts the initial policy analysis and identifies priority concerns to be addressed in the plan. This preliminary analysis involves many public and private organizations which are concerned with the delivery, advocacy and reimbursement of health care in Texas. The Bureau works closely with the 16 state agencies designated by the governor to implement the parts of the plan that relate to state government. In addition,

other state, regional, and local organizations are involved by providing ideas, data, policy reviews, priority setting and implementation. To assure local participation in the process, the 24 regional councils of government in Texas have been encouraged to participate in the development of the 1989-90 plan. A series of four regional hearings (held in Arlington, Beaumont, Laredo and San Antonio) and one statewide hearing in Austin have been conducted to receive public comment, and written comments have come in from more than 15 different sources around the state.

PLAN FORMAT DIFFERENCES

The format of the 89-90 plan differs in subtle, but significant ways from its predecessor. At the outset, the SHCC decided to make this version of the plan a streamlined, updated and revised version of the 87-88 plan. Severely reduced funding and staff resources have precluded any other option. Further, many of the 87-88 plan issues remain unresolved. To ignore or not address them would be contrary to the true concept of the health planning process.

The approach, therefore, was to take each chapter of the former plan, research which recommendations had been implemented, what was still needed to be done and recommend the actions necessary to address the issues. In addition, a new chapter on the health care needs of the homeless has been included in this plan.

Finally, the 89-90 plan has been prepared with less direct regional input, since reduction or elimination of funding has been the demise of most of the states' 24 Regional Health Planning Advisory Committees (RHPACs). These once viable, active RHPACs have dwindled to a handful. Yet, the few that did participate in the production of the 89-90 plan provided valuable input. This input came in the form of an update of regional health concerns and the hosting of four local public hearings on the plan. Whether submitting input into the plan's thirteen priority issues or providing a forum for public participation into the plan development process, their efforts were—and are—crucial to the development of the State Health Plan.

CHAPTER II.

STATE CHARACTERISTICS

DEMOGRAPHICS

Age structure, racial/ethnic composition and the geographic distribution of a growing population are among demographic variables which most influence the delivery of health care services in Texas.

The rapid population growth of the 1970s and early 1980s has slowed. For the first time in more than two decades, the state experienced net outmigration. However, this outmigration of 90,000 persons was offset by a natural increase of more than 190,000. This decline in the growth rate has led to increasing uncertainty about the state's future expansion.

The slowdown in population growth during the past few years has produced patterns of change similar to those which occured in the 1960's. The state's rural counties experienced population decreases. Growth rates slowed in non-metropolitan counties adjacent to urban areas and large cities. Rates remained relatively strong in metropolitan suburban counties. Except for Central Texas, most parts of the state experienced a slowdown in population growth.

Between 1980 and 1987, the fastest growing segment of the population was the 24-44 age group, at 37.6%, while the 65 and above group grew 22.5%. The 18-24 age group experienced a 3% decline; however, Texas continues to have a population younger than that of the nation as a whole.

The hispanic population experienced a 43.6% growth between 1980-1987. In 1980, hispanics comprised 18.8% of the total population and in 1987, 22.6%. During this same period the black population remained fairly constant, while the white population declined in overall percent.

VITAL STATISTICS

Since 1973, births in Texas slowly but steadily increased each year until they peaked (at 308,027) in 1985. In 1986, the total number of births was 307,003.

The leading cause of death in Texas in 1986 was heart diseases, which accounted for 33.7% of all deaths. Malignant neoplasms was the second leading cause of death, accounting for 20.7%.

Nearly 10% of total deaths in Texas were caused by accidents, homicides and suicides. Other leading causes of death were cerebrovascular diseases; bronchitis, emphysema, athsma and allied conditions; pneumonia and influenza; diabetes mellitus; and nephritis, nephrotic syndrome and nephrosis.

ECONOMIC

High rates of unemployment and persons living in poverty increase the general dependence on public health and medical services. This places stress on health care facilities to provide more uncompensated care. The downturn in the Texas economy has resulted in a continued high unemployment rate.

Beginning in 1979 with a 4.2% unemployment rate, the unemployment figure grew each year, with the exception of 1984, until it peaked at 8.9% in 1986. During the first three months of 1988, the rates were 8.4%, 8.7% and 8.3%—not a significant difference from the 8.4% rate of 1987. At this point, however, many authorities feel that the Texas economy has now "bottomed out" and will enter a several-years-long period of recovery.

An estimated 18.3% of the Texas population live below the established federal poverty level—an estimated 25.2% of ages 0-17; 13.6% of ages 18-64; and 29.4% of persons 65 and above.

During 1985 an estimated $25.2 billion was expended on health care in Texas, an increase of nearly 400%

from 1975. More than 80% of this was spent on hospital care, physician services, and drugs and drug sundries. Out-of-pocket expenditures accounted for 42% of all health spending; private insurance, 23%; federal, 24%; state, 8%; and local government, 3%.

GENERAL TRENDS

As noted previously, economic factors have a direct impact on the provision of health care in both the public and private health care delivery systems. People who are unable to pay for the health services they need place demands on all aspects of the system, and affect not only the financial condition of facilities which serve them but also the level of service which must be provided once health care is initiated. Texas has made many strides in developing and funding health services for the indigent. The Indigent Health Care and Treatment Act of 1985, enacted by the 69th Texas Legislature, has provided innovative approaches to health-care for the poor, ranging from primary care through assignment of fiscal responsibility for health services in counties without public hospitals. Yet uncompensated care in Texas' 500 general hospitals still totalled over $1.4 billion in 1987. The Texas Medicaid program serves only about one-fourth of those living below poverty. Texas' children, our state's most valuable resource, continue to be faced with pressures related to alcohol and other drugs, teenage pregnancy, and now, AIDS.

One of the challenges Texas will face as the state moves toward economic recovery will be to continue to acknowledge the health care system, both public and private, as an integral part of the state's infrastructure.

CHAPTER III.

STATE AND REGIONAL ISSUES

Regional input into the 1989-90 State Health Plan by the ten responding councils is represented by actions taken by these councils:

Capital Area Planning Council - Continued to support the priority issues in the 1987-88 State Health Plan ('87-'88 SHP).

South Texas Development Council - Reviewed and prioritized issues in the '87-'88 SHP and gave either a high or moderate priority only.

West Central Texas Council of Governments - Retained same priorities as in the '87-'88 SHP.

Ark-Tex Council of Governments - Retained, but reprioritized issues contained in the '87-'88 SHP.

Central Texas Council of Governments - Employed a system to rank the same priority issues in the '87-'88 SHP.

South East Texas Council of Governments - Increased awareness of AIDS and all its ramifications is the thrust of this RHPAC's health concerns for the 1989-90 SHP. Gave top priority to indigent care financing.

South Plains Association of Governments - Considered the prevention of alcohol and drug abuse as its top priority.

Heart of Texas Council of Governments - Concurred with the regional priorities as stated in the '87-'88 SHP. Encouraged continued and additional funding for AIDS education to address the priority of high incidence of sexually transmitted diseases.

Panhandle Regional Planning Commission - Concluded that the issues identified in the '87-'88 SHP remain pertinent for inclusion in the 1989-90 plan. Recommended that the SHCC upgrade "continued viability of small rural hospital" issues from a referral in the '87-'88 plan to a priority issue in the plan update.

Brazos Valley Development Council - Addressed access to health care as its priority issue, with emphasis on health care costs and fragmented services.

CHAPTER IV.

ENVIRONMENTAL HEALTH

PRIORITY ISSUE:	Diversity of environmental health problems and the lack of unified direction for all environmental health issues.

RECOMMENDATIONS:

1. The Texas Legislature should renew efforts to enact H.B. 2227 from the 70th Session thereby giving the Ground Water Protection Committee statutory standing and a stronger platform for addressing future ground water quality issues.

2. All member agencies of the Toxic Substances Coordinating Committee should actively support the committee and its mandate to prepare and present a comprehensive environmental health plan to address air quality; water quality; solid, radioactive and hazardous waste disposal; and to improve communication among member agencies concerning efforts to regulate toxic substances and harmful physical agents.

BACKGROUND:

The 87-88 SHP recommended that the Texas Water Commission be the designated lead agency in coordinating and planning for ground water protection.

The following documents have been published that more clearly define the roles and responsibilities of the Texas Water Commission concerning ground water protection: a) Texas Groundwater Activities 1986, March, 1987; b) Operating Agreement, Texas Water Commission and Texas Water Development Board, Under Water Conservation Districts, November 19, 1987; and c) Texas Ground Water Protection Strategy, January, 1988.

The 87-88 SHP recommended that the Texas Water Development Board, under its ground water monitoring programs, coordinate information gathered by all agencies having groundwater monitoring functions, and also survey the extent of ground water contamination in Texas.

The Ground Water Data Committee, which was formed as an ad hoc committee of the Texas Natural Resources Information System Task Force, developed an "interface system" for accessibility and sharing of groundwater data. This committee included representatives from the Texas Water Commission (TWC), the Texas Water Development Board (TWDB), the Texas Department of Health (TDH), the Texas Department of Agriculture (TDA), and the Railroad Commission of Texas (RCT). TWDB has begun an expansion of its computerized files to include much more of the available groundwater information. The Ground Water Protection Committee (GWPC), which was formed in March, 1985, included the same membership as the Ground Water Data Committee. Funded by an Environmental Protection Agency groundwater grant, the GWPC recommended study and delineation of the extent of ground water contamination, but did not affix specific responsibility for this task.

The 87-88 SHP recommended that the legislature designate additional underground water districts where needed to protect the ground water resources of the state.

Under the provisions of the Texas Water Code, which has broad authority to protect aquifers from either contamination or over-pumping, underground water districts can be created with the consent of the voters of the proposed district. Since the 70th Legislature, six additional underground water conservation districts

have been created bringing the total to 22.

The 87-88 SHP recommended that standards for building densities be enforced, or where not established, that appropriate standards be locally developed and applied in areas where wastewater effluent and storm water runoff endanger the quality of sensitive aquifers. These standards would be developed in compliance with professional architectural and engineering levels of practice.

The GWPC has pointed out that, in most cases, local entities currently play a passive role in groundwater protection. One way that the GWPC hopes to increase local involvement in groundwater protection is through a detailed assessment of local districts, their powers and the most effective means of coordination among these districts and with state agencies. The GWPC believes that this task should be a priority for its FY 88 implementation strategy with an emphasis on groundwater districts and their focus on ground water management.

In the Texas Ground Water Protection Strategy, the GWPC has thoroughly covered the same concerns expressed in the Health Protection Chapter of the 87-88 SHP. The 70th Legislature considered, but did not pass, H.B. 2227 which would have given the GWPC statutory standing. This bill should be reintroduced in the 71st Legislature as its passage would provide the committee with a stronger platform for addressing future problems.

DISCUSSION:

The subject of environmental health has many separate issues. Among these are:

Air quality
Water quality
Solid waste management
Hazardous waste management
Radiation control
Pesticides

Many of these factors interact with one another. Pesticides can contaminate the water and air. Contaminated water can pollute the shellfish crop. Radioactive dust on the grasses consumed by dairy herds can cause radiation by-products to enter our milk supply. Other food systems can similarly be affected.

Regardless of the interrelationships of these numerous environmental factors that affect human health, several state agencies share responsibility within this sphere. For example, TDH is responsible for the following environmentally-related health programs:

Environmental Health
- General Sanitation
- Water Hygiene
- Solid Waste Management

Consumer Health Protection
- Food & Drugs
- Milk and Dairy Products
- Product Safety
- Shellfish Sanitation

Radiation Control

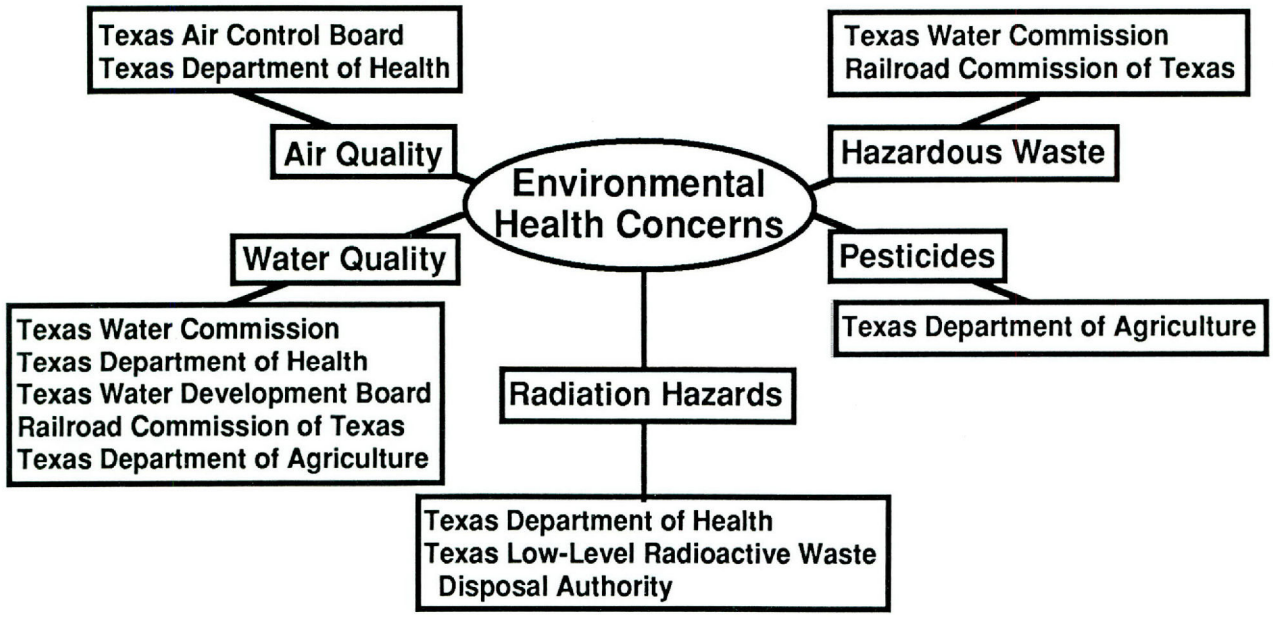
Environmental Epidemiology

In addition, the state agencies (see Figure One) have been legislated responsibilities in the illustrated areas of environmental health.

A weakness of this system is the lack of a single entity to coordinate these different programs. Within our environment, changes in one arena, e.g., air quality, have the potential to impact other areas. Some program decisions may be made unilaterally by one agency without other agencies having had the opportunity to review the impact until after implementation has occurred.

International cooperation between states and nations is also a problem in environmental health. At present there appears to be no U.S. or state agency which can resolve the U.S.-Mexico border problem of sewage and waste dumping into the Rio Grande River. In December 1987, the SHCC adopted a resolution asking the Texas Congressional delegation to urge the U.S. Congress to establish a permanent United States-Mexico Border Environmental Health Commission to assist Mexico in the planning, development, financing and implementation of environmental and other personal health programs in Mexican communities that border Texas and the United States. By August 1988, some Texas members of the U.S. Congress had expressed strong interest in the problem. Furthermore, Texas Representative Ronald Coleman has introduced

Figure 1



H.R. 4606, a bill to establish a United States-Mexico Border Regional Commission on health and human resource issues.

The SHCC recognizes the need for a comprehensive state environmental health plan which would study the impacts of individual environmental health decisions being made both internally and externally by all government agencies—international, federal, state and local—and develop procedures to coordinate and implement these decisions.

The 70th Legislature enacted S.B. 537—the Health Risk Assessment Act—which mandated the Toxic Substances Coordinating Committee composed of representatives from the Texas Department of Health, the Texas Department of Agriculture, the Texas Water Commission, the Texas Parks and Wildlife Department, the Texas Department of Public Safety, the Railroad Commission of Texas, and the Texas Air Control Board. This committee is charged with developing a plan for intergovernmental cooperation on regulation of toxic and harmful substances or agents; health risk assessment of emergency responses to accidents involving such substances; prevention and control of adverse health affects from exposure to these agents; establishing an integrated information system; and providing public education about toxic substances and harmful agents. This plan was scheduled to be presented, with recommendations on implementation, to the governor, lieutenant governor, and the speaker of the house of representatives not later than October 1, 1988.

The establishment of the Toxic Substances Coordinating Committee formalizes a previous ad hoc Environmental Hazards Working Group which was formed in 1985 following national concern about ethylene dibromide (EDB) in food products. This new committee is a major step in sharing environmental health data and developing means of planning, communication and cooperation among the participating agencies. The SHCC believes that this committee is the logical vehicle for developing a comprehensive state environmental health plan.

CHAPTER V.

SCHOOL HEALTH

PRIORITY ISSUE:	Inconsistent public policy for school health issues.

RECOMMENDATIONS:

1. Foster continued cooperation between the Texas Department of Health as the state public health authority and the Texas Education Agency as the state public education authority.

2. Foster continued cooperation between the Texas Commission on Alcohol and Drug Abuse as the state authority for drug use prevention and treatment and the Texas Education Agency as the state public education authority.

3. Support comprehensive health education as the vehicle for all health instruction including pregnancy prevention, illicit drug use (including alcohol abuse) prevention, and prevention of sexually-transmitted diseases.

4. The Texas Education Agency, along with the Texas Department of Health and its regional system, should assist all Texas schools in the implementation of "Education for Self-Responsibility" so that instruction about pregnancy prevention, alcohol and drug abuse prevention, parenting skills for both sexes, and the prevention of AIDS and other sexually transmitted diseases is taught in all public schools, is appropriate and effective for particular communities, and includes parent involvement.

5. The Texas Education Agency should develop a plan to finance and introduce a universal health record in Texas public schools.

6. The Texas Education Agency should develop a plan to enable school districts with enrollment of more than 1,000 students to employ a registered nurse and to enable other districts to provide a school health services program under the supervision of public health physicians and registered nurses.

7. The State Board of Education should strengthen sequential health instruction in schools by setting minimum time requirements for health instruction for grade six on middle school campuses and for one semester of health instruction at grade seven or eight.

8. Continue and expand the Texas School Health Project to all Education Service Center regions.

BACKGROUND:

Our children are the future of our state. From a public policy perspective, what happens to children in schools affects not only their immediate educational years, but will affect the future economic and social well-being of Texas.

The State Board of Education (SBOE) has established long-range goals for public school education that include increasing the number of students who graduate from high schools. More than 30% of Texas students drop out of school before graduation! School dropout is the final expression of school failure for students who have struggled since kindergarden. Therefore, SBOE goals emphasize continuous student progress at all grade levels as well as dropout prevention at high school.

Healthy children learn better. Persistent health problems such as dental caries, and chronic diseases such as diabetes, can distract students' attention from the learning process. Traumatic problems such as school-age pregnancy most often cause students to drop out of school. It is within the scope of responsibility of the SBOE, the Texas Education Agency (TEA), and public schools to address factors that hinder students' educational progress. The responsibility is shared by families, health care professionals, and other public agencies, such as the Texas Department of Health.

What is school health? According to the American School Health Association and TEA, schools have three areas of responsibility: health instruction, health services, and health promotion. Health instruction gives students factual information and encourages them to develop attitudes and behaviors that are conducive to developing and maintaining a healthy lifestyle. School health education is part of a total school program that focuses on instruction, which is officially expressed as a written curriculum.

SBOE rules for curriculum appear in Title 19, Chapter 75 of the Texas Administrative Code. These rules, commonly called the Essential Elements, specify health-related concepts and skills which must be taught in each grade, kindergarten through 12. They include daily health practices, safety, prevention of alcohol and drug abuse, as well as health concepts and skills that involve interaction between individuals and that affect the well-being of people collectively. These concepts and skills (e.g. self-responsibility and decision-making) are valuable since many health or social problems affecting today's school age population such as AIDS, non-medical drug use, or teen pregnancy may be addressed through these concepts. Over the long-term, a focus on comprehensive health education is more effective than a strict topical approach. Comprehensive health education emphasizes concepts and skills, with instruction centering on application of those concepts and skills to a selected set of topics that are of particular importance with respect to children's and adolescents' health.

The presence of family life education in schools—courses that typically encompass gender-role development, body image, family formation, reproduction and childbirth, and interpersonal relationships—has received considerable attention over the last several years. Several bills and resolutions were introduced during the 70th Legislative Session to require family life education in schools; these did not pass. With Texas leading the nation in births to girls under age 14, the original impetus for this legislative approach focused on the prevention of teenage pregnancies. Now, however, the grave public health concern of preventing the spread of AIDS among the school population has become a major public policy issue.

The middle school years, grades six to eight, are crucial in the development of health attitudes and behaviors among young people. The SBOE, through its rule-making authority, describes and defines a well-balanced curriculum for elementary and secondary schools. Time requirements are specified for the elementary level in health and a six-weeks life science course is required in seventh grade. Time requirements for health in grades six and eight are not specified.

State textbook adoption provides important instructional resources leading to a well-balanced curriculum. The SBOE periodically adopts health textbooks or teacher resource materials, recommended by the State Textbook Committee through a standard public process, for most grade levels. For example, Textbook Proclamation 65 in March 1988 from the SBOE called for textbooks for health, grades four through eight. The proclamation specifies textbook content. Following public hearings and SBOE adoption, school districts are required to select one or more textbooks from the adopted textbooks list.

Directly related to instruction are school health services which are staffed by school nurses. A major factor in school health services is the increasing number of medically fragile or medically complex children in schools. Because of federal laws that require special education students to receive instruction in the least restrictive environment, more children with special health needs—such as intermittent catheterization or bowel training—are attending non-residential schools and are being placed in classrooms with other students. Increasing numbers of children with AIDS are expected in the Texas public school system through the 1990s. School health services programs provide necessary services to assist students to attend school in the least restrictive environment and to provide health screening services to determine health problems which would impede learning if left undetected and uncorrected.

These factors contribute to the reasons why the responsibilities of school nurses are growing and becoming more complex. In addition to functions and duties such as mandated health screenings (e.g. vision, hearing, spinal), maintenance of immunization records, medication administration, health teaching and emergency care, professional school nurses are managing problems such as child abuse, suicide prevention, and missing children. Furthermore, school nurses serve as child health advocates, ensure confidentiality of students' health records, participate as school representatives in community health planning, and supervise other personnel. At present, school districts do not receive any direct funding to provide health services, whereas administrative funding for mandated vision and hearing screening flows directly to the Texas Department of Health.

A universal academic record is already in use in Texas schools. The development of a universal health record for use by all Texas school districts would help eliminate some of the administrative complexities in following all school-age children (and especially the medically complex child) as they move between communities and school districts. This would also allow for electronic transmission of such information between school districts and central office.

Health promotion, the third part of school health, ensures a healthy physical and social environment. A healthy school environment is clean, safe, enhances learning, and fosters students' responsibility for their own health. Examples of this important element are "no smoking on school grounds" policies; nutritious food served in school cafeterias; daily physical education with an emphasis on lifelong physical fitness; teachers serving as role models for healthy behaviors; and an expectation of and support for drug-free living.

What's currently happening with school health in Texas? The single most important recent initiative has been the adoption of the SBOE plan of action called "Education for Self-Responsibility". It is important for two reasons:

1. the concept of comprehensive health education is applied to crucial adolescent health problems, and

2. the need for cooperation among parents, schools, and community leaders is emphasized in teaching students about health.

Education for Self-Responsibility, adopted by the SBOE in 1986, called for TEA to take steps aimed at preventing school-age pregnancy. The SBOE charged TEA to work to identify students at high risk of failing to graduate because of pregnancy or parenting, to serve as a clearinghouse for information about community resources, to develop a publication focusing on self-responsibility, and to help school districts develop other resources aimed at preventing school age pregnancy. A statewide conference was held in February 1987 to provide leadership and assistance to school districts in implementing a teenage pregnancy prevention program. The Commissioner of Education has approved the expansion of Education for Self-Responsibility to include publications and conferences on illegal drug use prevention and on prevention of AIDS and other sexually-transmitted diseases.

Increasing national, state and local attention is focused on the pervasive influence of illicit drug use in schools. The School Improvement Amendments (P.L. 100-277) define "illicit drug use" to mean "the use of illegal drugs and the abuse of other drugs and alcohol." In order to combat this illicit drug use throughout schools, the Texas Commission on Alcohol and Drug Abuse and TEA jointly developed a plan for expenditure of federal funds available under the Drug-Free Schools and Communities Act of 1986. This plan has been endorsed by the Committee on Substance Abuse Treatment Delivery, which was created by the 70th Legislature.

Cooperation among families, schools, and community leaders is the single most important factor in reaching children and adolescents with health messages that result in healthy behaviors. Policy makers may introduce legislation or rules that require instruction about various topics, but unless resources are concentrated at the community level, health education will not receive the attention that is necessary for it to be effective.

An example of a successful local health promotion effort is the Texas School Health Project. This project, funded by the Texas Cancer Council, places school health specialists in 16 of 20 regional education service centers (ESC) with a program director at TEA. Each regional school health specialist collects information about the needs of the schools in the region, identifies community resources, and establishes a link between

schools and health resources by providing workshops and inservice programs and technical assistance to school district staff.

School health issues are, of course, affected by broader issues involving schools and education at the federal, state, and local level. Maintaining the state educational reforms expressed in Title 19, Chapter 75,TAC, is a continuing debate in the Texas Legislature and local communities. A major issue facing all school districts in the state concerns the allocation of state funding for school districts. A federal judge has ruled that the current allocation formula results in inequities between "poor" and "rich" school districts and statewide efforts are underway to address this issue. Another issue involves local autonomy versus state control. Historically, in Texas, the relationship between school districts and the central education agency has strongly supported local autonomy. Some see this as appropriate, especially in a vast, culturally diverse state as Texas, for local taxpayers and parents to control school policies and curriculum. Others view it as an avenue for communities to avoid locally unpopular issues such as sex education or "no pass, no play." All these broader educationally-related issues—education reform, funding of school districts, and local autonomy—affect what happens in Texas schools, including school health.

CHAPTER VI.

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

PRIORITY ISSUE:	The increasing incidence of AIDS

RECOMMENDATIONS:

1. Promote long-term planning among and between state and local health agencies to ensure future availability of adequate, appropriate services for persons with AIDS.

2. Provide adequate state appropriations to the Texas Department of Health for AIDS-related activities and programs to:

   - continue and increase grants to local agencies and organizations for education and services, with administrative funds at the state level;
   - coordinate all federal grant applications from Texas;
   - expand statewide education targeting the general public and professional counsellors, as well as persons with high risk behavior and school-aged children;
   - expand counseling and voluntary testing, with more alternate sites; and
   - provide epidemiologic staff support for surveillance activities.

3. Ensure access to vital resources, with protection against discrimination, for persons with AIDS and those at risk of infection. These resources include facilities for short and long-term care, access to insurance, and access to mental health services.

BACKGROUND:

Acquired Immunodeficiency Syndrome (AIDS) is, and will continue to be, a major public policy and public health issue in Texas. Texas currently has the fourth highest number of AIDS cases in the United States, following New York, California and Florida. As of mid-1988, more than 4,000 persons have been diagnosed with AIDS in Texas; of these, more than half have died.

AIDS is a life-threatening disease, caused by a virus, human immunodeficiency virus (HIV). HIV, transmitted by the exchange of certain body fluids (primarily blood and semen), destroys the body's immune system and its ability to fight diseases and illness. The Centers for Disease Control (CDC) has established strict criteria for defining AIDS. (See American Medical News, July 17, 1987, for CDC criteria of definitions for HIV infection in adults and pediatric AIDS.)

HIV is not easily transmitted. Transmission occurs through sexual contact; needle-sharing; from mother to child before, during, or after birth; and prior to routine blood bank screening, through blood transfusion. Casual, non-intimate contact has not been implicated in the transmission of HIV.

Those at highest risk of contracting AIDS are men who have sex with other men, intravenous drug abusers who share needles, hemophiliacs and others who have required frequent transfusion of blood or blood components prior to May 1985, sexual partners of anyone in these groups, and infants born to infected women. A disproportionate number of those with the HIV virus are indigent and black or hispanic. Even many middle-income people who have AIDS or related illnesses become impoverished as a result.

AIDS IN TEXAS

The majority of the AIDS cases in Texas have been reported in five of the seven largest metropolitan areas of the state. Harris County has the third highest number of AIDS cases for any city in the nation, with 46.4% of all the cases in Texas. Cases in Dallas, Travis, Bexar and Tarrant Counties account for the next largest percentages. However, at least 117 of Texas' 254 counties have reported residents diagnosed with AIDS.

The Texas Department of Health has estimated that there will be more than 16,200 cases of AIDS in Texas by the end of 1991, with a case fatality ratio of 68% (11,000).

To determine the extent of the spread of AIDS in Texas, the TDH has obtained federal funds for a three-month statewide, anonymous newborn HIV screening study. The results of this screening can be used to guide the allocation of program resources for AIDS prevention and services in Texas.

AIDS-related issues in Texas generally fall into one of two categories—policy or funding issues.

POLICY ISSUES

AIDS policy issues involve access to needed resources, confidentiality of medical records, and discrimination in the areas of insurance, housing or employment, and legal matters. Such policy issues generally revolve around the inherent conflict between protection against discrimination for HIV-infected persons versus the public's "right-to-know" in order to protect the public health.

Access to health insurance coverage is crucial in order to control costs of treating persons with AIDS. The Commissioner of Health's Task Force on AIDS recommended that individuals with HIV infection should be entitled to purchase medical insurance, with the costs of providing such coverage spread among all policy holders, as they are for other catastrophic diseases. An assigned-risk pool for HIV-infected individuals would be a second option for providing insurance coverage. Only if the private sector fails to provide such coverage, should the government (federal, state or local) consider becoming a co-payer of medical insurance premiums, as recommended by this task force.

The implications of assured (or not assured) confidentiality underlie many other issues related to AIDS and HIV infection. Medical records are confidential under the Texas Medical Practice Act, except for public health reporting of communicable diseases as required by law. Possible discrimination as a result of the release of HIV test results is a valid concern. Such discrimination can lead to a loss of insurance, housing or employment. Assuring confidentiality of patient test results is beneficial for at least two reasons: it is unlikely that individuals with a history of high risk behavior would come forward to be tested if this could lead, through the disclosure that they had been tested, to the loss of their job and/or health insurance; and the numbers of HIV-infected individuals would probably increase, with the virus being transmitted by asymptomatic individuals wary of being tested.

Several of these issues have been addressed statutorily or through the rule-making authority of state agencies. During the 70th Legislative Session, the Communicable Disease Prevention and Control Act was amended and updated. The act sets up reporting and maintenance of confidentiality requirements with civil penalties set forth. It provides for the detention or medical isolation of individuals who present a threat to the public health with "due process" protections specified.

The State Board of Insurance has adopted rules allowing insurance companies to require HIV antibody testing for applicants prior to obtaining insurance, as long as the tests are given on a non-discriminating basis. Insurance companies may deny coverage to applicants if their blood sample is positive for HIV on three tests.

The Legislative Task Force on AIDS, established by the 70th Legislative Session, is comprised of legislators and public members representing health, legal and insurance professionals and industries from across the state. The charge of this group is to develop recommendations for public policies needed to reduce the current and projected long-term impact of AIDS in Texas, with particular emphasis on determining the economic burden to the state and financing the cost of caring for AIDS patients. Access to health insurance is also being examined by the task force. A consensus seems to be emerging that financing the costs associated with caring for AIDS patients must be shared between public and private sectors. One option under examination by the Legislative Task Force is the creation of a high-risk pool—not AIDS-specific, but for <u>all</u> catastrophic illnesses—to be equitably financed, preferably with some mechanism other than a premium tax.

Because of the interrelationships which exist between various policy issues and state programs which are affected by AIDS, other interim legislative committees and study groups are also concerned with this issue. The Texas Commission on Health Care Reimburse-

ment Alternatives, which has been statutorily charged to recommend mechanisms to decrease the number of uninsured and underinsured in Texas, is working with the Legislative Task Force on AIDS, as is the Lieutenant Governor's Select Committee on Medicaid and Family Services.

FUNDING ISSUES

The provision of services to individuals and populations in need necessitates adequate funding. In all states, funds are needed for counseling and testing; education; surveillance and epidemiologic activities; and grants to local entities for education and services with centralized administrative support. Funding for culturally-sensitive education and prevention activities (such as initiatives targeting IV drug abusers) is imperative; prevention is cost-effective.

Funding for AIDS-related activities in Texas comes from private, federal, state, and local sources. While state appropriations are, of course, crucial for funding needed services, they also play another role, in influencing the flow of federal dollars to the state. In any federally-funded program, the continuation and expansion of federal monies is contingent upon state "maintenance of effort." In other words, a state must demonstrate its commitment to federally-funded programs with state resources and dollars. How much is Texas spending on AIDS-related programs? Is Texas getting its "fair share" of federal dollars?

The Texas Advisory Commission on Intergovernmental Relations, in its December 1987 AIDS program funding report, states that Texas in 1987-88 spent $581 in state funds on education and health-related services per diagnosed case of AIDS. This amount does not include hospital costs. Only four other states—Ohio, Georgia, Pennsylvania and Iowa—spend less on each AIDS case than Texas. On a per capita basis, Texas spends nine cents per person on AIDS education and social and health services! The U.S. average is 53 cents, and the states with the three largest populations of AIDS patients—New York, California, and New Jersey—spend $1.31 per capita.

Nearly all funds expended in Texas for AIDS are federal dollars. All the monies supporting counseling and alternate site testing, surveillance, and the educational "hotline" at the Texas Department of Health are federal funds. Requested federal funds will support the school-based AIDS educational activities being developed by the Texas Education Agency. The TDH is also administering a one-time federal allocation of approximately $2.0 million for the purchase and distribution of the drug AZT.

National research indicates that a large share of the rapidly escalating costs for treating victims of the AIDS epidemic will fall on the Medicaid program. The Texas Department of Human Services (DHS), which administers the Medicaid program, has estimated that Medicaid purchased health spending for AIDS/HIV has been over $6.0 million, as of May 1988. This does not include the monies spent on the drug AZT. The role of Medicaid in financing such care is complicated by various federal stipulations and stringent eligibility criteria, as well as its' relationship to the Social Security Disability program.

Much of the cost of AIDS is borne locally, often by public hospitals. Texas' system of public hospitals, already struggling with high levels of unreimbursed care, will be further stressed by increasing levels of uncompensated care attributable to AIDS.

During the 70th Legislative Session, state funds were appropriated in Texas for education and services grants to local agencies and organizations. Available in FY 1988 was $1.4 million, with $1.8 million appropriated for FY 1989. No administrative monies were included in these funds; they were distributed to local agencies by the Texas Department Health through a Request for Proposal process, with agencies specifying how they would use the requested funds. During the FY88 grant process, $7.5 million was requested by local entities indicating a greater need than there were funds available.

Concern has been expressed as to whether Texas receives its fair share of federal funds. With approximately 7.0% of the nation's AIDS cases, Texas should receive a comparable amount of the available federal funds. For example, the Texas Department of Health will receive $6.1 million in federal funds for an eight-month period that began May 1, 1988. The state's share amounts to 5.5% of the $109 million allocated to all 50 states. Increased coordination among state agencies and community groups is needed to bring as many federal dollars as possible to Texas through the grant application process.

CHAPTER VII.

TRAUMA AND EMERGENCY MEDICAL SERVICES

PRIORITY ISSUE:	An effective and efficient trauma care system for the state of Texas.

RECOMMENDATION:

The legislature should enact and fund a trauma center certification system with appropriations for EMS improvements and a subsidy for uncompensated and undercompensated trauma care.

BACKGROUND:

The 87-88 SHP recommended that the Texas Legislature appropriate funds based on the historical demand for EMS services, to be matched with local funds, for the purchase of EMS radio communications equipment as approved by the TDH, Bureau of Emergency Management. The 70th Legislature considered but did not pass H.B. 1106, which would have imposed surcharges on fines for certain motor vehicle violations to finance improved emergency medical services and trauma care.

The 87-88 SHP recommended that the Texas Legislature mandate 9-1-1 as a statewide emergency access telephone number for full implementation by 1995. The 70th Legislature enacted H.B. 911, which mandates that all parts of the state must be covered by 9-1-1 service by September 1, 1995.

The 87-88 SHP recommended that the Texas Legislature use the expertise of the Advisory Commission on State Emergency Communications (ACSEC) to oversee the implementation of a 9-1-1 program. In H.B. 911, the 70th Legislature created the ACSEC as a permanent body, subject to the Texas Sunset Act, to administer the implementation of statewide 9-1-1 services.

The 87-88 SHP recommended that the Texas Legislature designate TDH as the authority to identify hospitals meeting the standards for trauma centers, and to encourage emergency medical teams to transport trauma patients to the nearest hospital with such certification. In 1985 the SHCC created the Task Force on Regionalization of Specialized Medical Services to investigate the feasibility of regionalization for selected services. The task force recommended the following actions for trauma:

1. The TDH should be designated by legislation as the authority to identify trauma centers. A broad-based advisory committee to the Texas Department of Health should be established to recommend the criteria and mechanisms for selection and review of trauma centers, and

   a. The advisory committee should study the capability of hospital-based emergency rooms in Texas as supporting elements in areas of the state where trauma centers are unavailable;

   b. The committee should also initiate further study of Level II and III trauma center requirements and capabilities; and

   c. The committee should develop pediatric trauma care policies and guide-lines.

2. A simple, easy-to-use form for the collection of injury data which can be compiled and used in a trauma registry should be developed.

The 70th Texas Legislature considered but did not pass S.B. 1078 which would have given TDH authority to designate trauma centers. Without such designation, no health facility would have had the right to claim

status as a trauma center. A new bill for designation of trauma centers is being developed by a task force of the Texas Board of Health for filing in the 71st Legislature.

S.B. 1078 would also have included, "data collection requirements, including trauma incidence reporting, systems operation, and patient outcome." It is essential that any future legislation concerning trauma centers include provisions for a trauma registry. The Trauma Legislation Task Force has been carefully reviewing the difficulties incurred with S.B. 1078 during the 70th Session of the Texas Legislature. In addition, the Task Force has noted the problems encountered by participants in the California and Florida trauma systems. Three key issues have thus surfaced as major obstacles to a successful trauma system in Texas: medical liability, funding to cover uncompensated care, and coverage of "dead zones" in the vastness of the state where no trauma facilities are presently available.

The task force recognized that the increased exposure to liability from malpractice suits must be neutralized or else health care providers will be reluctant to participate. Legal remedies which were discussed included protection for trauma physicians under a Good Samaritan Law, whereby physicians could not be sued for taking any medical action deemed necessary at the time, malpractice suits which required proof of gross negligence, or if there is clear and convincing evidence of malpractice, and other legislative remedies. Additional issues included liability of nurses, EMS units and hospitals participating in trauma systems.

The California and Florida experiences also showed that trauma centers were being overloaded with indigent cases due to overt dumping by other hospitals and because trauma cases frequently reflect the lowest economic strata of society. This overloading has led to excessive burdens of uncompensated care and has caused withdrawal by many participants in the trauma systems of both states.

To ensure a successful, continuing trauma system in Texas, it would be necessary to subsidize at least a part of this uncompensated care for qualified trauma centers. Senate Bill 10 in the U.S. Congress is designed to provide federal money to develop trauma systems and pay for some portion of uncompensated care, but even if enacted, state funding would probably still be needed. The Trauma Legislation Task Force discussed additional funding measures such as levying user fees on causative factors, e.g., an alcohol tax, fire insurance, or vehicle insurance.

The third major difficulty is that the vast open spaces of Texas create many "dead zones" where EMS services are stretched thin and trauma care is non-existent. Unlike the first two, this concern is not an obstacle to building a successful trauma system, but does leave the system incomplete with many gaps.

Unfortunately, there is no easy solution for this problem. Building and maintaining trauma facilities where the population is insufficient to support these facilities would be prohibitively expensive. A rapid response, airmobile ambulance system covering the state "dead zones" might otherwise supplement the gaps in trauma services. This idea was thoroughly examined by the governor's EMS Patient Evacuation Study Committee in 1985.

Although the committee looked into helicopters for EMS transportation, they recommended only the development of "demonstration projects utilizing helicopters for transport of the critically sick and injured." Primarily, the committee recommended legislative action to 1) develop state-approved standards to certify trauma centers, 2) develop funding for local EMS improvement, 3) establish a Statewide Trauma Registry, 4) develop statewide EMS communications systems, and 5) establish EMS systems in functional geographic areas to assure access to trauma centers for all persons.

A state trauma system would be a major step towards reducing deaths and disabilities resulting from trauma. Linking the EMS system with designated trauma centers throughout Texas would provide the means for such a system. Nevertheless, the experience of other states has shown that even well-conceived trauma systems are vulnerable to the pressures of malpractice suits and uncompensated care. To meet these pressures, Texas 1) must enact medical liability laws to protect trauma and EMS providers from lawsuits except when the provider acts with reckless disregard for the health and welfare of, or to intentionally harm, the patient; and 2) Texas must subsidize accredited trauma centers for the uncompensated and undercompensated care provided to trauma victims.

CHAPTER VIII.

SHORT-TERM INSTITUTIONAL CARE

PRIORITY ISSUE:	Financial stress of Texas acute care hospitals

RECOMMENDATIONS:

1. Hospitals should continue to pursue alternative ways to provide additional revenues.

2. Medicaid eligibility should be raised to 100% of federal poverty level to provide coverage for additional indigent families and thus reduce the burden of uncompensated care provided by hospitals.

3. The 71st Legislature should give close attention to the recommendations of the Texas Commission on Health Care Reimbursement Alternatives.

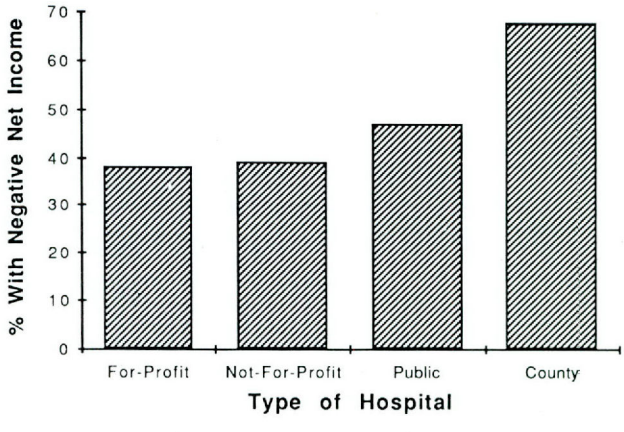
4. The 71st Legislature should uncouple the income eligibility requirements of the Indigent Health Care and Treatment Act (IHCTA) from the Aid for Families with Dependent Children Program requirements. It should also establish a higher income standard for the IHCTA eligibility requirements in order to more fully utilize county indigent health care funds.

BACKGROUND:

The need for the "development of alternative delivery methods by hospitals" was the key issue concerning short-term institutional care addressed in the 1987-88 Texas State Health Plan (87-88 SHP). Recommendations called for the Texas Department of Human Services, the insurance industry and hospitals to support and encourage participation in feasible alternative delivery methods by hospitals. Since data to document changes in the provision of alternative services are not available, it is difficult to objectively evaluate progress toward these recommendations. The recommendations presented in the 87-88 SHP should continue to be supported to provide additional revenues for hospitals.

While the provision of alternative ambulatory care services may bring hospitals additional funds to offset sagging inpatient revenues, such measures address only a portion of the greater issue of the current financial stress of acute care hospitals. The financial viability of many—especially rural—hospitals is threatened by such factors as decreasing occupancy, the third-party reimbursement systems, the necessity to provide uncompensated care, and rising costs. Also, newly evolving delivery systems, such as health maintenance organizations and freestanding ambulatory surgery centers, and the costs of new technologies effect hospital financing. Therefore, the expanded priority issue of the financial stress of Texas acute care hospitals was selected by the SHCC as the issue to be addressed in this plan.

It was reported by the American Hospital Association that the profit margin for hospitals nationwide declined to .2% in 1987. Evidence of the financial stress of acute care hospitals was provided by the TDH Hospital Data Files for 1986. Records indicate that in 1986, 42% of all hospitals licensed by the TDH showed a negative net income (expenses were greater than revenue). The percent of various types of hospitals which showed a negative net income are as follows:



From 1984 through 1987, 47 hospitals in Texas closed and did not reopen. Twenty-six of these were the only acute care provider within the community. Only five had more than 50 licensed beds. The number of licensed hospitals in the state dropped from 536 to 485, while the total licensed beds rose from 67,404 to 72,636 during 1982-1987.

Hospital utilization reflects a decline. Patient days and admissions both decreased between 1982 and 1986. The utilization rate, the ratio of patient days per 1,000 population, dropped from 1139 in 1980 to 782 in 1986. Length of stay showed a slow decline each year until 1986, when it returned to the 1984 level.

Reduced utilization naturally reduces hospital revenues. However, other factors are affecting hospitals' operating revenue. Medicare's diagnostic-related groups reimbursement system reimburses urban and rural hospitals at different rates. Private insurers are moving from paying charges as billed, to negotiated rates. Self-insuring businesses and business coalitions are becoming "prudent buyers" and negotiating contracts for delivery of services. Reduced hospital revenues have reduced hospitals' ability to shift costs among services, especially for hospitals with a large share of indigents.

One of the greater concerns of most hospitals—if not the greatest—is the unreimbursed care provided to persons unable to pay for services. In 1986, Texas hospitals reported providing over $1.4 billion in uncompensated care to patients. The burden of providing uncompensated services falls unevenly among the various types of hospitals. Some hospitals bear a disproportionate burden because of their locations and missions. Publicly-supported hospitals bear the greater portion. Hospitals in Dallas, Tarrant, Harris, Bexar, Potter, Nueces, El Paso and Travis Counties provided $582 million of uncompensated care in 1986. While these hospitals do receive public tax funds, these funds are often insufficient to cover the uncompensated care burden. Also, inappropriate shifting of uninsured patients by some hospitals places an additional burden on these public hospitals and some not-for-profit hospitals.

Many medically indigent persons are not covered by Medicaid since the state's eligibility standard remains below 100% of the federal level of poverty. In July 1988, the Texas Department of Human Services (TDHS) increased the Medicaid eligibility level for pregnant women and children services to 100%. Raising eligibility levels to 100% for all Medicaid benefits would reduce the amount of uncompensated care which must be provided by hospitals.

Some assistance to hospitals providing a heavy load of uncompensated care is provided through "disproportionate share payments" under the state Medicaid program. In addition, the Lieutenant Governor's Select Committee on Medicaid and Family Services has examined ways to "certify" local funds for Medicaid. The ability to match local funds for hospital services would enable greater numbers of people to be covered under Medicaid and would provide some reimbursement for hospital costs which are currently borne locally.

Traditionally, care for the uninsured was considered an operating cost of a facility and a component of the total cost of care for private payers, in essence a form of hidden taxation to support the care of the poor. However, the increasing number of patients unable to pay, declining utilization and rising hospital operating costs have limited this method of supporting the inpatient care of the poor, near-poor and the uninsured.

Texas counties are charged with the responsibility of providing health care services for indigent residents. Counties reported providing $10.8 million of inpatient and outpatient care in FY 1987. Under the Indigent Health Care and Treatment Act (IHCTA), income eligibility standards of the IHCTA are linked to the standards of the Aid for Families with Dependent Children Program and are considered to be restricting the number of indigents qualifying for assistance. During FY 1987, only three counties spent more than 10% of their general revenue tax levy - the threshold for receiving state matching funds under the IHCTA.

The uninsured are a source of lost revenue for hospitals. A survey by the Texas Department of Human Services reports that 2.7 million Texans, 16.9% of the total population, were uninsured in 1985. As a result, one in every six persons under age 65 who was hospitalized was uninsured. From .5% to 1% of the uninsured are considered "uninsurable" because of pre-existing conditions.

It has been reported that 85% of health insurance is employer-based group insurance; however, almost

90% of the employees without coverage work for employers who do not offer health insurance. Extending employer-based insurance to all employees and their family members would reduce the number of uninsured by 70% to 75% and provide additional revenues for hospitals. Statutory requirements to provide coverage could place undue stress on small businesses and should be studied carefully.

Several committees and task forces authorized by the 70th Legislature will provide guidance concerning uncompensated services provided by Texas hospitals. Those committees and task forces identified as having a close association with this issue include: the Texas Commission on Health Care Reimbursement Alternatives, the Special Task Force on Rural Health Care Delivery in Texas, the House Interim Study Committee on County Affairs, the Select Committee on Medicaid and Family Services, the Special Task Force on the Future of Long-Term Health Care, the House Committee on Insurance and the Legislative Task Force on AIDS. The reports of these committees and task forces will help determine how hospitals should be reimbursed for care provided to persons unable to pay, and help determine the methods Texas will employ to finance this care.

CHAPTER IX.

LONG-TERM INSTITUTIONAL CARE AND ALTERNATIVES

PRIORITY ISSUE:	The quality of care provided in long-term care facilities licensed by the Texas Department of Health.

RECOMMENDATIONS:

1. The Texas Department of Human Services should continue developing the "case-mix" reimbursement system for Medicaid with adjustments for requirements of the Omnibus Budget Reconciliation Act of 1987.

2. Licensure fees should be increased to help offset the increase in inspection program costs.

3. The Legislative Budget Board and the Governor's Budget Office should recommend appropriation levels to ensure inspection program activities meet state and federal statutory requirements.

4. The 71st Legislature should provide an adequate level of general revenue appropriations to ensure effective long-term care institution inspections.

BACKGROUND:

The SHCC selected the "quality of care provided by nursing homes" as a key concern to be addressed in the 1987-88 Texas State Health Plan (87-88 SHP). It was determined that efforts should be made to ensure the physical safety, the adequacy of care, the rights of residents, and the quality of life of residents living in nursing homes.

The method selected for the 87-88 SHP to ensure this protection was that a "case-mix" reimbursement system of Medicaid payment for nursing home care be developed and implemented. This system would pay providers according to the care actually provided to the residents, thus providing more equitable reimbursement for services with the goal to improve quality of care.

During 1987, the Texas Department of Human Services (TDHS) completed the development of a "case-mix" reimbursement system for Medicaid. This system is currently being tested using Travis and surrounding counties as the test area and McLennan and surrounding counties as the control area. TDHS anticipates that this system will be placed in statewide service in 1992.

Several actions have occurred that impact the quality of care provided by Texas nursing homes. First, the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1987, P.L. 100-203, should have a major effect on the future of the nursing home care delivery system.

OBRA will eliminate the two levels of care (skilled and intermediate care facility (ICF)) and upgrade Medicaid staffing requirements for all nursing facilities to the skilled level of staffing. Nursing facilities will be required to provide higher staffing levels by professionals, such as registered nurses and social workers, and additional training and evaluation for nurses' aides. An assessment and assurance committee must be developed and resident functional capacity assessments provided. The monthly personal needs allowance will be increased from $25 to $30 for individuals, and from $40 to $60 for couples. Implementation of OBRA will cost Texas an additional estimated $17.3 million in 1991.

The current trial use of the "case-mix" reimbursement system for Medicaid will test the patient care needs classification section of the system, but the reimbursement rates will also need to be adjusted to reflect the additional costs of implementation of OBRA. The SHCC considers the "case-mix" method an equitable method

of reimbursement. It concludes that the method should continue to be developed with adjustments for the requirements of OBRA.

Interim studies created by the 70th Legislature such as the Special Task Force on the Future of Long-Term Care, the Special Task Force on Rural Health Care Delivery, and the Joint Committee on AIDS will provide the 71st Legislature with other recommendations for dealing with these costs.

OBRA will place new requirements on the state agency responsible for inspecting nursing homes. The TDH is responsible for Medicare and Medicaid certification and licensure of nursing homes. In addition, TDH inspects and licenses personal care homes, custodial care homes, ICF-mental retardation facilities, adult day care/adult day care facilities, and maternity homes. Some state-owned and operated facilities not required to be licensed, but required to be inspected for certification are also inspected by TDH. The SHCC feels it is imperative that the state inspection program continue to meet state and federal statutory requirements. With the increased inspection requirement anticipated as a result of implementation of OBRA and other factors listed below which affect the program, it is highly questionable whether the program can perform its function under current budgeting. Should the program fail to properly inspect those long-term care institutions, the safety, quality of care, rights and quality of life of residents could be jeopardized and federal funds supporting the program could be reduced.

It is projected that the demand for nursing home care will continue to increase at a rapid rate. Between September 31, 1985 and November 1, 1987 nursing home occupancy increased from 82,639 to 87,015. Nationally, an estimated five percent of the population 65 and over will be placed in nursing homes. The elderly population is expanding rapidly, AIDS patients are placing additional demands on nursing homes, and the number of patients being released from hospitals who seek nursing home care is increasing. Therefore, a continuing rise in demand for services is projected.

Additional long-term care facilities have been built as a result of increased demands. During FY 1987, the number of licensed facilities to be inspected by TDH increased from 1395 to 1505, a growth of 7.9%. The total number of licensed beds for these facilities increased from 125,094 to 130,808.

TDH projects that the number of facilities and total licensed beds to be inspected will continue to increase and that new and expanded nursing homes will be constructed. As of February 29, 1988 there were 45 new nursing homes and 15 other long-term care facilities under construction. Twelve nursing homes and three other long-term care facilities were constructing additions to their facilities. When completed, an additional 5,622 nursing home beds and 847 other long-term care beds will require inspection. TDH projects that from 1988 through 1993 there will be an increase of 610 facilities, including nursing homes, to be inspected.

The current licensure fee for nursing homes is $50 plus $2.00 per bed to be licensed. The TDH considers this rate inadequate to cover the cost of inspection.

The SHCC has concluded that the physical safety, the adequacy of care to meet the needs of residents, and the rights and quality of life of individuals residing in licensed long-term care facilities should be ensured by the inspection program of TDH.

CHAPTER X.

DISABILITY AND REHABILITATION

PRIORITY ISSUE:	Fragmentation of the disability and rehabilitation delivery system.

RECOMMENDATIONS:

1. The 71st Legislature should require each state agency providing disability or rehabilitation services to establish a single entry point client management system.

2. The Office of the Texas Attorney General should update the "Compilation of Texas Laws Related to Persons with Disabilities." The Council on Disabilities and the Texas Planning Council for Developmental Disabilities should review these laws and provide the 72nd Legislature with recommendations concerning the coordination of services to all individuals who are disabled.

BACKGROUND:

Rehabilitation is defined as "the combined and coordinated use of medical, social, educational and vocational measures for training or retraining persons disabled by disease, injury, or other physical or mental impairment to the highest possible level of functional ability." Rehabilitation services include early intervention; physical rehabilitation; and enhancement of daily living, coping, pre-vocational, vocational and independent living skills. The final objective is to provide all persons with disabilities the ability to live their lives with dignity and as independently as possible.

Disability and rehabilitation services should be provided in a planned and coordinated manner, especially where people have multiple needs. Fragmentation of the delivery system among state and federal agencies has resulted in services gaps (particularly in rural areas), a lack of information on available services and a lack of effective referral to other agencies.

Inconsistency of eligibility requirements and benefits provided is a major problem. An individual may find that services from different agencies must be obtained at multiple locations, even within the same towns. Coordination problems are evident in services for individuals with multiple disabilities.

A disability is defined as "any limitation of physical, mental or social activity of an individual caused by illness, injury, or other physical or mental impairment as compared with other persons of similar age, sex and occupation." This frequently refers to limitation of the usual or major activities, most commonly vocational. There are varying types of disabilities: functional, vocational, learning, and mental; varying degrees: minimal, partial or total; and varying durations: temporary or permanent. The word "disability" describes the functional limitation itself, whereas "handicap" denotes the difficulty of achievement in overcoming the disability.

The Developmental Disabilities Assistance and Bill of Rights Act of 1984 (P.L. 98-527, as amended) lists limitation of life activities in self-care, self-direction, learning, language, mobility, capacity for independence and economic self-sufficiency as indicators of disability.

Disabling conditions are varied and complex. They include alcoholism, Alzheimer's Disease, arthritis, autism, blindness, cancer, cardiovascular conditions, cerebral palsy, chronic chest diseases, cystic fibrosis, and deafness and hearing impairments. Also included are Down's Syndrome, drug abuse, emotional disturbances, epilepsy, head injury, learning disabilities,

mental retardation, and multiple sclerosis. Muscular dystrophy, physical disabilities and special health problems, severe handicaps, speech and language impairments, spina bifida, spinal cord injury, and visual impairments are also included. Very frequently disabling conditions occur as multiples, which compounds the task of the service providers.

The services provided to individuals with disabilities range from prevention through early diagnosis, treatment of disease or injury, evaluation for rehabilitation, and rehabilitation training. Both public and private organizations provide services to the disabled at the state and local levels. State agencies provide certain services directly and contract with private providers for others. Federal funding supports many of these programs.

The Texas Department on Aging, the Texas Department of Community Affairs, the Texas Youth Commission, the Texas Commission for Alcohol and Drug Abuse, and the Juvenile Probation Commission provide services to groups which include persons with disabilities.

The Texas Department of Human Services provides financial and other assistance. Other state agencies deal with particular segments of disability and rehabilitation services. The Texas Rehabilitation Commission provides vocational rehabilitation for its clients, the Texas Employment Commission assists the persons with disabilities in vocational placement and the Texas Education Agency is responsible for the education of children and youth with disabilities. The Commission for the Deaf certifies interpreters who serve the deaf.

The Texas Department of Mental Health and Mental Retardation provides disability and rehabilitation services to several disability groups. The Chronically Ill and Disabled Children's Services program of the Texas Department of Health also provides care. The Texas School for the Blind, the Texas School for the Deaf, and the Texas Commission for the Blind, provide rehabilitative services for those particular disabilities.

The Texas Health and Human Services Coordinating Council and its advisory council, the Council on Disabilities, are charged with the task of coordinating services provided by this variety of state agencies. P.L. 100-146, enacted in October 1987, which amended the Developmental Disabilities Assistance and Bill of Rights Act, requires the Texas Planning Council for Developmental Disabilities to analyze services provided to the persons with developmental disabilities and report to the governor and the legislature by 1990. The Special Committee on the Organization of State Agencies will provide the 71st Legislature with recommendations concerning the functions of the multitude of state agencies. Recommendations of these councils and committees should provide the legislature with guidance for coordination of services for all persons with disabilities. In addition, the interagency memoranda of understanding required by the 70th Legislature should hopefully improve access to and coordination of services.

The plethora of separate service programs among many state and local agencies indicates a clear need for a client management system to assist persons with disabilities in gaining access to needed services. Such a system should require the agency that first receives an application for services from a client to take primary responsibility for the client until the person no longer requires services, or until this primary responsibility is transferred appropriately to another agency through mutual agreement between client and the agencies involved. The agency with primary responsibility for the client should communicate with the other pertinent parties concerning services outside its mandated authority and in cases of multiple disabilities, coordinate those service needs with other appropriate organizations. The client management systems of the various agencies should share client data to better provide a single entry for clients into the service system. Special attention should be given to the coordination of disability and rehabilitation services that prepare persons with disabilities for independent living and to the maintenance of support services such as attendant care.

CHAPTER XI.

MENTAL HEALTH AND MENTAL RETARDATION

PRIORITY ISSUE:	Aftercare and community-based mental health and mental retardation services.

RECOMMENDATION:

The SHCC supports the strategic directions of the Texas Department of Mental Health and Mental Retardation (TDMHMR), especially continuing efforts to improve and expand community-based services for discharged patients and others with similar severity of needs.

BACKGROUND:

The 87-88 SHP recommended that the legislature fund TDMHMR appropriately to meet mandated responsibilities.

The 70th Legislature funded the TDMHMR as follows:

1988-89 Biennium

Requested:	Appropriated:
$1,531.6 Million	$1,457.3 Million

Funding was 95.1 percent of request.

Services were funded as follows:

Mental Health Services	96.0%
Mental Retardation Services	92.0%
Statewide Client Services	100.0%
Central Office	81.0%
Capital Expenditures	78.4%

The 87-88 SHP also recommended that TDMHMR move quickly in making policy, budget, program, personnel, management structure and treatment mode changes to improve community-based services for discharged MHMR clients and others with the same or similar needs, and meet those standards mandated by state and federal law.

TDMHMR has made a major commitment to improving and expanding the community-based system of services. Toward this end, TDMHMR began the MH Incentive Diversion Program in September, 1987, which adjusts funding from the institutional setting to the local MHMR Center, or Authority, where the patient has relocated. This commitment to community-based services is outlined in TDMHMR's Initial Strategic Plan, 1986-1991 and in the TDMHMR FY 1988 Operating Plan.

In 1987 the 70th Legislature authorized $20 million in bonding authority for community MHMR facilities. The Legislature also appropriated $20 million from the sales of the Austin State School Annex and the Leander Rehabilitation Center for community placements if the federal court adopts the implementation plan for the settlement in the Lelsz v. Kavanagh decision. To implement the settlement of the other class-action suit, RAJ v. Miller, TDMHMR plans to ensure that staff-to-patient ratios in the state hospitals comply with the court's decision. TDMHMR may allocate funds for reduction of the state hospital populations, or for increases in direct care staff if populations do not decrease.

These two suits have provided additional acceleration to TDMHMR's programs of redirecting funding from state hospitals to community-based mental health services. Since September 1984 through the third quarter of FY88, TDMHMR has awarded more than $54 million to local mental health authorities for community-based services. This reallocation of funds has

resulted in a reduction of 1,510,269 bed-days in state hospitals. This amounts to a net reduction in the average daily census in psychiatric units of approximately 1,000 persons, a decrease of about 28% in four years.

The strategic directions of TDMHMR and the implementation plans for the settlement agreements of the class-action suits are in concert with the recommendations in the 87-88 SHP.

CHAPTER XII.

ALCOHOL AND DRUG ABUSE

PRIORITY ISSUE:	Prevention of alcohol and drug abuse through education at all school levels.

RECOMMENDATION:

The 1989-90 Texas State Health Plan supports the findings of the Committee on Substance Abuse Treatment Delivery. This effort encourages local participation in the implementation of effective school programs that emphasize drug and alcohol abuse prevention education.

BACKGROUND:

(It should be noted that the chapter on school health also addresses this priority issue). The 70th Legislature created the Committee on Substance Abuse Treatment Delivery and charged it with examining the substance abuse treatment system in the state and report its findings to the legislature. The committee report of May 1987 contained five recommendations in the area of substance abuse treatment. One of these endorses the Texas Commission on Alcoholism and Drug Abuse/ Texas Education Agency Plan for expenditure of funds under the Drug-Free School and Communities Act of 1986 (the Anti-Drug Abuse Act of 1986, P.L. 99-570). This Act authorizes funds for local programs for drug and alcohol abuse prevention, early intervention, rehabilitation, referral and education for all age groups; and training programs concerning drug abuse education and prevention for teachers, counselors, other educational personnel, parents and community leaders.

Funds are authorized for the development of educational materials to provide public information for the purpose of achieving a drug-free society, and technical assistance to help community-based organizations and educational agencies in the planning and implementation of drug abuse prevention. Funding for activities to encourage the coordination of drug abuse education and prevention programs with related community efforts and resources is also provided.

Even before the development of this and earlier state health plans, the need for a multi-faceted approach to deal with the abuse of alcohol and drugs in Texas had long been recognized by the Statewide Health Coordinating Council. It was a Council concern then, as now, that this approach must emphasize prevention as equal with intervention and treatment.

CHAPTER XIII.

HEALTH PROFESSIONS

PRIORITY ISSUE:	The uneven distribution of primary care physicians and nurses resulting in an inadequate supply in some rural and inner-city areas.

RECOMMENDATIONS:

1. The Texas Higher Education Coordinating Board should continue to monitor primary care physician shortage areas and nurse supply shortages, in association with the Texas Department of Health. This is to support considerations in the selection of sites for possible additional family practice residency program and nurse training positions.

2. The Texas Higher Education Coordinating Board, in association with the eight medical schools in the state and the Texas Medical Association, should monitor carefully the adequacy of the number of primary care graduate medical education training positions in Texas to accommodate the number of qualified Texas medical school graduates desiring to remain in the state for specialty training.

3. The Texas Legislature should support and fund a Comprehensive Health Professions Data Resource Center at the Texas Department of Health to compile and analyze statistical information on education and employment trends for the health professions in Texas. The center will report to the Texas Legislature regarding the supply and demand of specific health professions. Priority should be assigned to the professions demonstrating an acute shortage such as, for example, nursing and several other allied health categories.

4. Nursing education programs in Texas should be encouraged and funded by the Legislature to increase student recruitment efforts with particular emphasis on attracting the non-traditional and second-career students. Improvements should be made in providing opportunities for "articulation" or career-laddering within the nursing educational system, facilitating the training of nurses in as short a time as possible.

5. Increased tuition assistance should be funded by the Texas Legislature and widely publicized by the Texas Higher Education Coordinating Board and all appropriate health professions education programs. This includes the establishment of additional student loan repayment functions such as the physician program established by the 69th Legislature. Increased tuition and loan repayment assistance is necessitated by the increasing student debt resulting from the substantial tuition increases recently implemented.

BACKGROUND:

The 1987-88 Texas State Health Plan contained five recommendations concerning primary care physicians and two regarding nurses. To measure the impact of these recommendations, a brief update is presented below:

Primary Care Physicians

- Concerning the recommendation for funding of the Family Practice Residency Program (FPRP), the 1987-1988 biennium funding was set at $7.3 million which did not permit an increase in the number of resident physicians assisted through this program.

- As recommended, Primary Care Health Manpower Shortage Area (PCHMSA) designations are monitored by the FPRP in association with the Texas Department of Health (which routinely provides

updated lists) and the Texas Medical Association. The FPRP reported that 343 (41%) of the program participants are practicing in shortage areas.

- The recommendation that loan repayments be returned to the State Rural Medical Education Board (SRMEB) from the general revenue fund for redistribution as loans to medical students was not implemented. The legislature appropriated funding for the Board to only meet existing loan obligations, resulting in a continued moratorium on new SRMEB loans.

- The recommendation to re-evaluate and strengthen the loan repayment provisions of the SRMEB with the objective to increase the number of primary care physicians practicing in rural areas by reducing the default rate was not implemented by the state legislature.

- No known formal action has been taken concerning the recommendation to develop a statewide program to assist PCHMSA communities to attract and retain physicians. The establishment of the Physician Student Loan Repayment Program under the Texas Higher Education Coordinating Board by the 69th Legislature, however, provides an additional method for encouraging primary care physicians to locate or remain in rural areas experiencing a shortage of primary care physicians, or for service in one of four state agencies. Rather than requiring a medical student to meet a future service obligation, this program is targeted at physicians already in practice. Assistance in the repayment of student loans may enable a physician to continue to practice in a rural area or for a state agency. Student loan repayment programs are becoming increasingly attractive due to the rapid increase in student indebtedness, especially medical students. The recent publicity regarding this program has resulted in increased participation.

Nurses

- The first recommendation for nursing in the 1987-88 SHP was the continued evaluation of distribution problems for registered nurses in Texas. It was further recommended that the changes occurring in the health care delivery system be analyzed to determine the effects on the employment trends for nurses.

  At the time this recommendation was made, evidence was just beginning to surface concerning the impending nursing shortage. Several large hospitals in metropolitan areas were reporting critical shortages of some specialized or advanced-level nurses. There were also sporadic reports of some rural hospitals experiencing shortages of staff nurses, but at the time there was no evidence of a pervasive shortage statewide.

  By 1988, however, Texas as well as the rest of the nation was in the throes of an acute shortage of nurses. To assess the crisis, numerous study groups were established, including those appointed by the Texas Nurses Foundation, the Texas Hospital Association, and the Texas Medical Association. Extensive testimony was presented to the Special Committee on Post-Secondary Medical, Dental and Allied Health concerning the nursing shortage and its perceived impact on health care in Texas.

  At the national level, several bills have been introduced to ameliorate the shortage of nurses. These include:

  - H.B. 4599 — National Nurse Service Corps Act of 1988;
  - S. 2231, and H.B. 4833 — Nursing Shortage Reduction and Education Act of 1988; and
  - S. 2572 — Medicare Graduate Nurse Training Act of 1988.

  In Texas, it is expected that the Special Committee on Post-Secondary Medical, Dental and Allied Health Education will make specific recommendations to the Legislature, nursing schools and the Coordinating Board regarding the nursing supply in the state. The Texas Higher Education Coordinating Board has also supported the development of a Nursing Student Loan Repayment Program which would operate much like the physician program already established.

- The second recommendation regarding nurses expressed the need to continue to monitor each of the following issues relating to nursing education

and employment trends and the effect of these trends on the supply and demand for nurses.

1. Proposed changes in the educational requirements for the licensure of registered nurses (the entry-level issue).

   Proposed changes in the minimum educational requirements for licensure as a registered nurse continues to be a much debated issue; however, no changes have been made in the licensing requirements.

2. The decline in nursing school enrollments.

   The declining trend in Texas nursing school enrollments was reversed in 1987 and the volume of student applicants indicates there could be an even more substantial increase in the 1988 academic year.

3. The increased demand for specialized nurses.

   The need for specialized or advanced-level nurses continues to grow in Texas and the nation as advancements are made in medical technology and with the continued acuity of patients in hospitals and nursing homes.

CHAPTER XIV.

MATERNAL AND CHILD HEALTH

PRIORITY ISSUE:	Access to prenatal and maternity care for low-income pregnant women in Texas.

RECOMMENDATIONS:

1. The Texas Medicaid program should expand to cover pregnancy-related services for women and health services for children up to age eight, whose income fall below 185% of the federal poverty level.

2. The Texas Department of Human Services, with the assistance of the Texas Department of Health and private organizations such as the Texas Family Planning Association and others, should develop a statewide outreach and public awareness program targeting low-income pregnant women, with a particular focus on pregnant adolescents.

3. The Texas Department of Human Services should ensure that pregnant women receive expedited processing of Medicaid applications through presumptive eligibility or some other mechanism leading to immediate entry into prenatal care. Eligibility should be continuous throughout pregnancy.

4. The Texas Department of Human Services and the Texas Department of Health should develop and implement a "single point of entry" concept to facilitate client access to prenatal care. They should work closely together to ensure that all maternal and child health services are coordinated to provide optimal care.

5. The Texas Department of Human Services and the Texas Department of Health should develop common payment rates to providers across state programs (e.g. Medicaid and MIHIA), throughout the state, for similar services.

BACKGROUND:

The provision of essential health care services for pregnant women and children has received major attention at the local, state, and federal levels during the past several years. Maternal and child health issues have always been a major priority for the SHCC. The 1987-88 Texas State Plan ('87-88 SHP) focused on the prevention of teenage pregnancies.

The United States, with an infant mortality rate of 10.6 per 1,000 live births in 1985, ranks 17th among industrialized countries in infant mortality. The U.S. ranking has not improved since 1980. The Surgeon General's goal is to reduce the infant mortality rate to 9 deaths per 1,000 live births by 1990. The infant mortality rate for whites nationwide is 9.3 per 1,000 live births, but for blacks it is 19.4 per 1,000 live births.

Federal initiatives with maternal and child health Medicaid enhancement began about three years ago, as a result of a Task Force on Infant Mortality of the Southern Governors' Association. This group, concerned about problems with infant mortality in the southern states, developed a series of legislative recommendations to address the problem and successfully lobbied Congress to begin implementing needed changes. The federal Medicaid program was targeted as a vehicle to approach the problem because its programs of purchased health services are offered to large groups of low-income women of childbearing age.

Congress has incrementally expanded coverage of prenatal care under the Medicaid program during the past several years; as a result, states now have the

option of offering Medicaid coverage to pregnant women and infants with family incomes up to 185 percent of the federal poverty level. This expansion of health services may be offered to poor women and children, for the first time, without the necessity of expanding welfare benefits. Effective in 1989, states will be required to provide Medicaid coverage for pregnant women and infants with family incomes below 100% of the federal poverty level.

Texas ranks 27th nationally in infant mortality, with 9.5 deaths per 1,000 live births in 1986. As in other states, certain subpopulations in Texas have much higher infant mortality rates. The black infant mortality rate (16.0 per 1,000) is about twice the white average (8.3 per 1,000) and there are counties in Texas where the black infant mortality rate can be two, three, or more times the state average. Texas, as a whole, may still reach the 1990's objective of reducing infant mortality to no more than 9 deaths per 1,000 live births by 1990. However, the objective of reducing infant mortality to 12 deaths per 1,000 live births for all geographic and socio-economic groups will not be reached by 1990 unless specific efforts targeting the black population are effective.

In Texas, federal and state-funded health care services for low-income pregnant women and infants are provided by the following programs/funding sources:

- Medicaid (Title XIX) administered by the Texas Department of Human Services. The Texas Medicaid program provides insurance coverage and purchased health care services for low-income persons eligible under certain mandatory and optional federal coverage groups. In 1987, the Texas Medicaid program paid for approximately 44,000 births, representing those pregnant women below approximately 34% of the federal poverty level.

- Title V, the Maternal and Child Health Block grant, administered by the Texas Department of Health. Prenatal care and child health services are provided in clinics operated by local health departments or the Public Health Regions of TDH. In 1986, Title V funds provided prenatal care for 69,252 women in areas throughout the state. Title V agencies provide planning capabilities, clinical standard setting, technical assistance for health care agencies, and services for low income women, infants and children.

- The Maternal and Infant Health Improvement Act (MIHIA) program. The Texas Department of Health administers this state-funded program which builds on Title V-funded services. MIHIA delivers comprehensive maternity and infant health services to medically high-risk indigent women and infants. In 1987, MIHIA provided care and paid for approximately 11,000 births to high-risk women.

Since only "medically high-risk" women are served in the MIHIA program, a higher proportion of pregnancy complications and newborn problems can be anticipated. In general, preliminary statistics for the MIHIA program indicate that infants fared quite well compared with national figures. The proportion of low birth weight infants was not appreciably different from the statewide figures for 1986. The proportion of all Texas infants born below 2,500 grams in 1986 was 7.2%, while 10.9% of all MIHIA infants born of high-risk pregnancies were low birth weight infants. The perinatal mortality rate of Texas 1986 infants was 13.9 per 1,000 births. The MIHIA rate was 11 deaths through eight weeks of life per 1,000.

These programs, as well as other publicly funded programs for low-income women and children, have varying eligibility criteria, application forms and procedures. Many low-income women do not know they are eligible, are unsure where to go to apply for services, or do not have transportation. These factors often act as access barriers to care.

As the Southern Governors' Association has acknowledged, the Medicaid program in Texas is a logical focus for any state-initiated effort to decrease infant mortality rates by improving maternity care for poor women. The expansion of Medicaid coverage in Texas is desirable because (1) more pregnant women and young children would receive low-cost, preventive health care services, and (2) it makes good fiscal sense with the increase in federal funds that would come to Texas. The federal match rate for FY89 will be approximately 40/60; therefore, for every state dollar invested, approximately $1.50 can be provided by federal match under the Medicaid program.

Under new Medicaid expansions, Medicaid could be the purchaser of health care services for one-third of all pregnant women in Texas each year. If the goal of improving maternal and child health services is to im-

prove birth outcomes while saving costs, then it makes sense to ensure that high-quality health services are offered in the Medicaid program. It is paramount for the Title V agency (TDH), to work together with the Title XIX agency (DHS) in developing optimal clinical standards and providing technical assistance and quality assurance review for Medicaid providers. Specific protocols and guidelines to assure high quality comprehensive services, especially for high-risk pregnant women, should be a Medicaid standard. TDH should serve as the skilled MCH/public health consultants to Medicaid under contract or through interagency agreements. The same standards should apply to Title V and XIX programs and to both public and private Medicaid providers.

Interagency efforts between TDH and DHS have already begun. During the 70th Legislative Session, the MIHIA statute was amended to enable the state to better coordinate its system of maternal and infant health services. The MIHIA program had previously excluded women who were Medicaid recipients from receiving services; this exclusion was removed. TDH and DHS were directed to execute a memorandum of understanding concerning the two agencies' responsibilities in providing maternal and infant health services.

Through late 1987 and early 1988, staff from both agencies developed recommendations on Medicaid options and other areas of interagency coordination which were presented to the Commissioners of each agency. In May 1988, the Commissioners signed an interagency agreement that detailed the two agencies' plans to cooperate in the implementation of enhanced Medicaid eligibility and services. TDH agreed to transfer $12 million in MIHIA funds to the Medicaid program, thereby increasing the federal matching funds available to DHS, in order to help finance this improvement and expansion of services to pregnant women and young children.

In July 1988, the Board of Human Services approved this expansion of Medicaid services to eligible pregnant women and children to age four. The Board elected to begin this expansion of services to children up to age two, and phase-in older children up to age four. Implementation of the expansion begins in September 1988. The Legislative Budget Board directed the Department in July, 1988, to fund additional expansions in coverage of children up to age six using "local funds" (i.e., identified local public funds which can be used as a portion of the state share in obtaining federal match).

Improvements in services to pregnant women and infants are a critical investment in human capital and play a major role in reducing the need for expensive medical services in the future. A September 1987 GAO report, "Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care" found that providing poor women with prenatal care through Medicaid is cost-effective. "While expanding Medicaid eligibility in all states would increase Medicaid costs for prenatal care services," the GAO concluded, ".these costs should be offset by savings from reduced newborn intensive care and long-term institutional costs." In 1985, about $4 million in Texas Medicaid funds was spent on hospital care for approximately 17,000 normal newborns. Over $20.5 million was spent for hospital care for 7,230 newborns who were premature, experienced respiratory distress or other major problems, had to be transferred to other facilities, or who died.

Texas accounts for eight percent of all births nationally. Nearly one in every twelve infants in the nation who died in 1985 was a Texas resident. Improving birth outcomes in Texas would have a major impact in meeting the Surgeon General's goal for infant mortality rates in the United States.

The goals of any changes to the Medicaid program in Texas for pregnant women and infants are:

1) to bring more women and infants into care,

2) to improve the health services they receive in order to obtain better birth outcomes,

3) to bring more federal dollars to Texas to accomplish the first two goals, and

4) to continue to promote family planning education and services for all Medicaid recipients.

CHAPTER XV.

PROFESSIONAL AND MEDICAL LIABILITY INSURANCE

PRIORITY ISSUE:	The impact of unaffordable professional and medical liability insurance on access to health care.

RECOMMENDATIONS:

1. Insurance statutes in Texas should be revised to strengthen the authority of the State Board of Insurance (SBI) to regulate medical liability insurance rates so that affordable liability coverage is available for health care providers.

2. Encourage the use of pretrial screening panels and voluntary arbitration systems prior to the filing of a lawsuit.

3. Consider the effects of implementation of the collateral source rule to allow offsetting of plaintiff's awards by the amount of other payments for the same injury.

4. Consider the effects of implementation of caps on non-economic losses.

5. Examine the feasibility for state indemnification for Medicaid and other indigent care providers.

6. Strengthen the immunity provisions for those individuals or groups such as peer review organizations and medical boards, who report incompetent acts to the appropriate licensing board.

BACKGROUND:

Health care professionals in Texas and the U.S.A. continue to struggle with the problem of cost and availability of liability insurance. With the examination of medical liability insurance issues in the 1987-88 Texas State Health Plan, the Statewide Health Coordinating Council recommended necessary changes to the insurance regulatory system, the civil justice system, professional practices acts, and related licensure laws to ensure affordable and available liability insurance. Specific recommendations focused on insurance regulation and mandatory reporting of incompetent acts to the appropriate professional licensing board.

Since the publication of the 1987-88 SHP, the Texas Legislature made changes to the insurance and civil justice systems and two health professions licensing acts. These changes occurred during the 70th regular legislative session, as well as during the first and second called sessions.

The following changes were made during the regular session:

1. Health professions regulation: both the Medical and Nurse Practice Acts were amended. The Nurse Practice Act requires mandatory reporting of incompetent acts and establishes a peer review mechanism for RNs. Medical peer review committees, hospitals, and other health care entities are required to report to the Board of Medical Examiners the results and circumstances of various disciplinary actions taken, with immunity provided. It also provides for greater disclosure on disciplinary action taken by the Board of Medical Examiners.

2. Liability insurance related: numerous modifications were made to limit liability for volunteers and non-profit organizations, regulate "surplus lines" (unauthorized insurers), and to create the Texas Insurance Exchange to provide reinsurance for all types of insurance.

Immediately upon adjournment of the 70th session, the governor called a special session to address unresolved

"tort reform" issues. This was the first called session. Six major tort reform bills were signed by the governor. The following changes were made during this special session:

CHANGES TO THE CIVIL JUSTICE SYSTEM:

1) Sanctions for frivolous suits.

2) Comparative responsibility: Generally, in medical malpractice cases, if the percentage of responsibility for negligence is greater than 10% for the defendant, he is jointly and severally liable for damages recoverable by the claimant.

3) Limitations on liability of drug manufacturers.

4) Limitations on liabilities of cities and public officials and employees.

5) Exemplary damages (includes punitive damages): allowable only if the defendant is guilty of fraud, malice or gross negligence. Awards limited to $200,000 or four times actual damages. Prejudgement interest may not be assessed on exemplary damages.

6) Limitations on liability of charitable organizations and volunteers for such organizations.

7) Prejudgement interest: accrues from 180th day after the suit or claim is filed.

CHANGES TO THE LIABILITY INSURANCE SYSTEM:

1) Creation of the Division of Consumer Protection within the State Board of Insurance (SBI).

2) Additional claims reporting requirements to the SBI for insurance companies.

3) Risk management and loss control provisions.

4) Two-year periods for the setting of insurance rates.

5) Creation of the Texas Non-profit Organization Liability Pool.

6) Coverage allowed for punitive damages.

During the second called session, the Civil Practice and Remedies Code was amended to extend the same legal representation and indemnification offered to other state employees, to physicians under contract with any state agency, institution, or department. The State of Texas is liable for indemnification only if damages are the result of an act by the public servant in the course of their duties. The state indemnification is only $100,000 per person and $300,000 per occurrence, and the state is the payor of last resort.

In addition, a bill to limit civil liability for health care claims and a bill to establish a constitutional amendment to validate caps on medical liability were filed. These bills did not pass. However, in mid-1988, the Texas Supreme Court declared the cap on medical malpractice damages (enacted by the legislature in 1977) unconstitutional.

There is continued and increasing concern in the Texas health care community that these legislative changes will not rectify the effects of litigation on the provision of health care services, particularly to the poor and medically indigent.

While all professional health care providers are affected by this situation, a good example of limited access to care due to unavailable and unaffordable liability coverage is maternity or obstetrical care. An often cited barrier to maternity services—whether in the public or private sector—is the decreasing availability of physician providers of obstetrical care due to the fear of lawsuits, coupled with extremely high liability insurance premiums.

Physicians are actuarially classified according to the greatest risk procedure they perform. Obstetrics is considered a high-risk procedure. This is especially true with poor, pregnant women who are considered medically high-risk and statistically most likely to have poor birth outcomes. Doctors who deliver babies—including family practice physicians delivering one or two babies a year—are billed for their malpractice insurance premiums based on this obstetric risk. The Joint Committee on Liability Insurance and Tort Law (January 1987) reports that increasing numbers of physicians are, therefore, choosing to no longer deliver babies.

Two recent statewide surveys of Texas physicians corroborate this trend (LBJ School of Public affairs,

1985, and Opinion Analysts survey commissioned by TMA, 1986). Both surveys reveal that a large and growing percentage of physicians (both family doctors and OB/GYNs) are no longer delivering babies, in response to higher malpractice premiums and a greater likelihood of being sued. This is especially apparent with family physicians. Anecdotal reports indicate that this is a growing problem in rural areas of the state. Pregnant women living in rural areas thus have increasingly limited prenatal or obstetric options.

An accurate determination of the availability of obstetric services in Texas communities is necessary. TDH has compiled data showing the net change, by county, of OB-GYNs from 1984 to 1986. Information on family practice physicians who may be performing deliveries is not currently available.

Legislative reforms, in both the civil justice and insurance regulation arenas, may be needed to rectify this situation. Insurance statutes may need to be revised to strengthen the authority of the SBI to regulate professional medical liability insurance ratesetting. Immunity provisions for those individuals or groups who report incompetent acts to the appropriate licensing boards may need to be strengthened.

In addition, specific changes to the civil justice system, such as the use of voluntary arbitration systems and pretrial screening panels, implementation of the collateral source rule (to allow offsetting of a plaintiff's award by the amount of other payments for the same injury), and a cap on non-economic losses (such as pain and suffering), should be examined.

Such civil justice system changes, along with the development of a financing mechanism to subsidize liability insurance premiums for health care providers for the indigent, may indeed be needed to address the effects of litigation on the provision of health care services.

CHAPTER XVI.

THE HEALTH CARE NEEDS OF THE HOMELESS IN TEXAS

PRIORITY ISSUE:	The health and social problems of an increasing number of homeless Texans.

RECOMMENDATIONS:

1. The Texas Health and Human Services Coordinating Council, with the involvement of the Texas Department of Community Affairs, should be designated as the primary state-level coordinator for homeless issues. The Council should examine the health, social, housing and employment problems of the homeless and develop a comprehensive action plan to address these concerns.

2. State agencies should begin to respond to issues of "home" address and residency requirements as a barrier to services for the homeless.

BACKGROUND:

Not since the Great Depression "has the number of Americans without homes been so large or represented such a wide cross-section of our society as it does today" (The Faces of Homelessness, 1986). Entire families, single adults, runaway children, and illegal aliens are all a part of this continually increasing population. According to a recent Hogg Foundation for Mental Health study (Understanding the Homeless, From Research to Action, 1988), most share three characteristics—extreme poverty, poor physical and mental health, and high levels of social isolation.

On July 22, 1987, President Reagan signed the Stewart B. McKinney Homeless Assistance Act. This legislation provided $355 million in federal assistance for FY87 for programs throughout the nation to aid the homeless. Provisions of this law are administered by six different federal agencies through at least seven separate funding streams. The U.S. House of Representatives in August, 1988 approved an authorization of an emergency $642 million program to aid the homeless, including $116 million for health care services.

A portion of these federal funds have come to Texas for initiation and/or expansion of services to the homeless. These services and programs include:

- Emergency Shelter Grant Program. Funding originates with the Department of Housing and Urban Development (HUD) and is channelled to 23 emergency shelter projects sponsored by cities and counties through the Texas Department of Community Affairs (TDCA). TDCA, designated by the Governor as the administrative agency for the McKinney Act for housing programs, has completed a Comprehensive Homeless Assistance Plan.

- Supportive Housing Demonstration Program. TDCA is the administrative agency for the state portion of the Supportive Housing Demonstration Program, which consists of: 1) permanent housing for the handicapped homeless and 2) transitional housing for homeless individuals.

- "community services". TDCA is administering $1.8 million from the Department of Health and Human Services (DHHS) for the Emergency Community Services Homeless Grant Program (EHP). These funds are directed to community action agencies and migrant farmworkers organizations for the expansion of services to the homeless.

- education services. The Texas Education Agency (TEA) has applied for funding from the U.S. Department of Education to track the educational needs of homeless children and to provide services to home-

less adults (e.g., literacy skills or G.E.D) through local public education agencies.

- health services. $46 million was available to states from the Health Resources and Service Administration (HRSA), DHHS. The expected recipients were community health centers and other clinics familiar with and already serving homeless individuals. Six clinics have been funded through the Region VI, DHHS Office; they are located in Houston, Lubbock, Ft. Worth, Dallas, Amarillo, and San Antonio. Most of the funds are designated for the provision of primary health care services; however, grantees must also provide, or arrange for the provision of, mental health services including case management services.

- community mental health services. Funding originating with the Alcohol, Drug Abuse and Mental Health Administration, DHHS, was allotted to states via an urban population formula. The Governor has designated the Texas Department of Mental Health and Mental Retardation (TDMHMR) as the responsible agency for the McKinney Act for mental health programs. Reserving $300,000 off the top of a $1.9 million grant for small cities and communities, TDMHMR will distribute the majority of these federal monies to the seven largest cities in the state. The funds will expand services to the homeless at community mental health centers in Houston, Dallas, Ft. Worth, Austin, El Paso, Corpus Christi, and San Antonio.

At the state level, there are more questions than answers.

Who are the homeless in Texas?

How many are there?

How big a problem is it?

Where are they located?

What are their needs?

Who is serving them—and who pays for these services?

The answers to these questions are not readily available. In 1985, the Texas Health and Human Services Coordinating Council created an Advisory Committee on the Homeless, in response to concern expressed by the governor and the Board Chairman of TDMHMR, to explore the needs of this growing population. The Committee examined demographics and descriptions of the homeless in Texas, reasons for homelessness, access and barriers to existing resources, and recommendations for solutions. The recommendations included coordination of planning and services, case management for the homeless, examination of residence and address requirements, and continued study of homeless issues.

Few, if any, of these 1985 recommendations have been implemented. In the years since 1985, the economy in Texas has continued to change, with the downturn of the oil and gas industry, and higher unemployment rates. The homeless in Texas today appear to be a mix of the "new homeless" through recent unemployment, the mentally ill affected by deinstitutionalization, and the chronic homeless. More women and children are a part of the increasing homeless population.

The Texas Department of Human Services (DHS) recently initiated a study to examine the health care needs of the homeless. The organization under contract with DHS to conduct the study obtained additional funds from the Texas Commission on Alcohol and Drug Abuse (TCADA) in order to do a more in-depth study. The study will explore the demographic characteristics and health care needs of the homeless, barriers to health care access, and models of care for the homeless. This statewide research project has four components:

1. literature review (national and state);

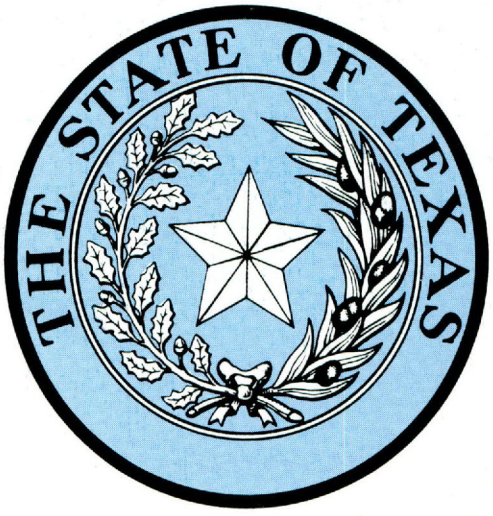
2. census count survey in shelters (on one particular night);

3. survey of health care administrators, service providers, and community leaders in 36 Texas cities, focusing on perceptions and opinions of homeless problems; and

4. site visits, focusing on access to health care services.

Private organizations and local charities (e.g., the Salvation Army and churches) have rallied in cities

across Texas to deal with the increasingly evident homeless situation. Most of these efforts are "crisis-oriented" or short-term (such as soup kitchens and overnight shelters). Few cities or communities in Texas have the resources to address any long-term remedies. Some states, however, have highly sophisticated approaches to homeless services and large state budgets to support their efforts.



Texas Statewide Health Coordinating Council