Senate Committee on Health and Human Services

Report to the 78th Legislature

November 15, 2002

Please direct questions and comments to:

Senator Mike Moncrief, Chairman
Senate Committee on Health and Human Services
P.O. Box 12068
Austin, Texas 78711
512/463-0360

Interim Report prepared by:

Patricia A. Becker	Committee Director/General Counsel
Karen Hilton	Policy Analyst
Jennifer Sims	Policy Analyst
Lisa Barton	Policy Analyst
David Quin	Policy Analyst
Scott Caffey	Committee Clerk

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P.O. BOX 12068
AUSTIN, TEXAS 78711
PHONE: 512/463-0360
FAX: 512/463-9889
TDD: 1-800-735-2989

SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES
77TH LEGISLATURE

November 15, 2002

The Honorable Bill Ratliff
Lieutenant Governor of Texas
P.O. Box 12068
Austin, TX 78711

Dear Governor Ratliff:

The Senate Committee on Health and Human Services respectfully submits this report on the assigned and considered interim studies. Five public hearings were held where public testimony was received on the issues. At one, or more, of the hearings testimony was received on mental health and mental retardation organization and structure, welfare related issues, the Social Security Disability determination system, the misuse and diversion of prescription painkillers, our state's public health preparedness, organ donation and allocation, childhood immunizations, and on restraints and seclusion.

The recommendations contained within this report are derived from the extensive public testimony, stakeholder meetings, and suggestions from state agencies, organizations and other interested persons. In making these recommendations to the Seventy-Eighth Texas Legislature, this committee is aware of the anticipated fiscal implications attached to some of the recommendations. Acknowledging that the State's budget will be of paramount importance during the next legislative session, the committee respectfully submits the recommendations as options for consideration by the Seventy-Eighth Texas Legislature.

The committee sincerely appreciates the leadership and foresight you have exhibited by providing this committee the opportunity to address these important issues and propose options for consideration. The committee's primary focus throughout the interim has been to improve the health, safety, and welfare of all Texans.

Respectfully submitted,

Senator Mike Moncrief
Chairman

Senator John Carona
Vice Chairman

Senator Chris Harris

Senator Jane Nelson

Senator Frank Madla

Senator Mario Gallegos

Senator Eliot Shapleigh

Senator David Bernsen

Senator Kip Averitt

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Texas Commission on Alcohol and Drug Abuse
Texas Council on Offenders with Mental Illness
Texas Department on Aging
Texas Education Agency
Texas Juvenile Probation Commission
Texas Youth Commission
Texas State Board of Dental Examiners
Texas State Board of Medical Examiners
Texas State Board of Nurse Examiners
Texas State Board of Pharmacy
Texas State Board of Pediatric Medical Examiners
Texas State Board of Veterinary Medical Examiners

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Executive Summary

At the beginning of the 77th Legislative Session, Lieutenant Governor Bill Ratliff combined the Senate Committee on Health with the Senate Committee on Human Services naming Senator Mike Moncrief as Chair. The breadth of issues within the jurisdiction of the combined committee, the Senate Committee on Health and Human Services (committee), touches Texans from birth through death, from programs and services that assist the frail elderly, disabled, and those in poverty to health programs affecting the individual person as well as health protection for Texas as a whole.

On September 13, 2001 and February 13, 2002, Lieutenant Governor Ratliff issued interim charges to the committee to study mental health, Welfare, Supplemental Security Income, and prescription painkillers. Appendix A. Senator Moncrief asked the committee to study additional issues within the committee's jurisdiction focusing on public health preparedness, immunizations, organ donation and allocation, and restraints and seclusion.

During the interim five public hearings were held where public testimony was received on the charges and additional issues. Further, many stakeholder meetings, where state agencies, organizations, other interested persons and members' staff were invited to participate, were held where the issues were discussed and recommendations formulated. The recommendations to the committee are the priority recommendations as determined during the numerous stakeholder meetings. In developing these recommendations, the fiscal state of Texas was considered at all times. The Legislative Budget Board reviewed the final recommendations and provided an estimated fiscal impact. Appendix N. In light of the anticipated challenges facing the 78th Legislature, the recommendations adopted by the committee are options for consideration and guidance during the next legislative session.

Summarized below are the issues studied by the committee and contained in this interim report.

Mental Health

Across the United States, approximately 20 percent of the adult and child populations have a mental health disorder, as a result, this issue is one in which Texas must make informed and systematic decisions. The charge to this committee was to review the availability and adequacy of mental health services for children, to review the current status of the community mental health services delivery structure, and to review the mental health and mental retardation allocation formulas for distributing funds to local communities.

State funded mental health services maybe provided to children through one of ten state agencies. Those services may be a direct function of the agency or a byproduct of the

agency's mission. This fractured method of providing services could be enhanced through the use of a "system of care" approach. In order to effectively address children's mental health, the state must take a multidirectional approach, including prevention, program and service coordination efforts.

The current community mental health services delivery structure evolved over more than one hundred years. Recent history has brought a variety of program innovations and pilot programs that serve as a foundation from which to make decisions about the future structure of the Texas mental health system. Funding allocation and equity issues have been discussed for the last twenty years. Texas should either resolve the equity issue or determine that equity cannot be achieved within the state's resources and adapt the system accordingly.

Welfare Reauthorization

Texas faces several challenges with the Temporary Aid to Need Families (TANF) reauthorization in 2002. Members of Congress are considering significant changes to the welfare system. These include TANF funding issues, work related requirements, child care issues, reauthorization of the Social Services Block Grant, marriage and child support provisions, immigrant provisions, and other provisions that will impact the state. The committee was charged with reviewing, evaluating and making recommendations to improve the effectiveness of TANF, Child Care, and other related programs directed at moving families from poverty to self-sufficiency. Additionally, the committee was directed to monitor federal reauthorization activities.

Five years into the implementation of welfare reform, a more comprehensive welfare system is evolving with a greater focus on services rather than cash assistance. It will be important for Texas to develop an overall strategy for TANF spending and make strategic use of TANF to combat poverty in Texas. Child care plays a crucial role in helping families enter and maintain employment by ensuring the safety and well-being of children while parents work. During welfare reform, Congress recognized the need to address accessibility, affordability, and quality of child care as a necessary support in workforce participation and child well being. Congress is expected to reauthorize the Child Care and Development Block Grant in late 2002.

In May 2002, President Bush signed into law the Farm Security and Rural Investment Act of 2002 (Farm Bill), that includes provisions for reauthorizing and strengthening the Food Stamp Program. Certain provisions in the nutrition title of the Farm Bill are mandatory changes states must implement, while others are optional. States now have an array of new choices to simplify the program and make it easier for families to obtain and retain benefits, in particular, working families. By simplifying program rules, states will be able to deliver benefits more effectively to eligible households, thereby, decreasing and improving payment accuracy and program integrity.

Supplemental Security Income

The Texas Health and Human Services Commission reports approximately four million Texans live with at least one type of disability. Of those, two million may have serious limitations in performing activities of daily living. The Social Security Administration operates two programs that provide direct income assistance and healthcare benefits to persons with severe disabilities, Social Security Disability Insurance (SSDI) and the Supplemental Security Income (SSI). Although eligibility criteria for these two programs are the same across all states, the denial rates are inconsistent. Over the past several years, questions have surfaced concerning the high initial denial rates in Texas.

Nationally and in Texas, there are many barriers and system issues that have an impact on applications for disability services. This committee has attempted to review the internal operation of the state program to identify areas in need of improvement, and to support initiatives currently underway within the Texas Rehabilitation Commission Disability Determination Service. Problem areas that appear to be federal issues have been identified and changes recommended.

Prescription Painkillers

Prescription drugs hold an important place in health care and in society as a whole. Although most people who take prescription medications do so responsibly, the nonmedical use or abuse of prescription drugs is a serious public health concern. One of the drugs subject to nonmedical use or abuse is hydrocodone. This drug is used frequently by health care providers to achieve pain control. For those who use this drug nonmedically it may elicit a feeling of euphoria. The report reviews the nature of the drug, the Controlled Substances Act, the frequency of use and misuse in Texas and makes recommendations that consider ensuring availability and adequate pain management for individuals with chronic pain which is an equally important public health objective.

Public Health Preparedness

The events of September 11, 2001 and subsequent anthrax crisis changed not only the landscape of America but also the nation's sense of security, especially in the area of public health. This forced America, as well as, the State of Texas to examine its public health preparedness infrastructure. Although authorization of federal funding to assist states in building and maintaining their infrastructure remedied immediate fiscal concerns, in order to be fully prepared modification of states' public health laws was necessary to meet the challenges of the 21st Century. The report addresses Texas' public health infrastructure and proposes recommendations to update the existing state laws.

Organ Donation and Allocation

Medical advances in organ and tissue transplants over the last two decades have enabled many people suffering from life-threatening diseases to lead productive lives. However, one of the tragedies in the United States is the number of people who do not receive a donor organ or tissue because it is unavailable. No simple solution to the problem of organ donation and allocation exists in Texas. The issues must be addressed on a variety of fronts including raising public awareness, collection of vital data, developing a more equitable allocation system, and educating our medical professionals and families on the importance of donating.

Increasing Childhood Immunization Rates

Immunizations are one of the 20th Century's greatest achievements in public health. Immunizations serve as a barrier to disease and protect both the individual who receives the vaccination and those around them who are not immunized. Texas remains near the bottom of national rankings for immunization rates. No single method will increase these rates. The problem must be addressed on a variety of fronts including raising parental awareness, improving information and data collection, increasing provider education, and developing ready access to immunization services.

Restraints and Seclusion

Texas has attempted, for several legislative sessions, to bring consistency across different facility types providing patients with the same protections regardless of where they received services and to clarify the procedures agencies are required to follow when developing rules on restraints, seclusion and emergency medications. This report studies the various agencies within Texas that license and/or regulate facilities or programs that utilize restraints or seclusion. It proffers recommendations bringing consistency to definitions in these behavioral management techniques, reduces the use of restraints, improves reporting, and increases training on the use of restraints and seclusion.

INTERIM CHARGE 1

Mental Health

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Mental Health

Interim Charge 1

Review, evaluate, and make recommendations on the following mental health and mental retardation issues:

a. *Availability and adequacy of mental health services for children and adolescents and their families, including services funded through the mental health system, Medicaid, the Children's Health Insurance Program, and other funding sources the Committee considers relevant.*

b. *Community mental health services delivery structure, including evaluating the efficacy of continuation or expansion of the NorthStar managed care pilot and the role of local community MHMR centers as mental health authorities.*

c. *Texas Department of Mental Health and Mental Retardation's allocation formulas for distributing mental health and mental retardation funds to local communities.*

Mental Health

The United States Congress declared the 1990s, the *Decade of the Brain*, in an effort to organize and facilitate research regarding the workings of the brain.[1] Over the course of the last century, and specifically the last decade, research has provided great insight into these functions. Consequently, society has a better understand of the complex processes of the brain and how those processes may be manifested in the form of mental illness.

In 1999 the first Surgeon General's Report on Mental Health was published.[2] This report brought attention to an often ignored public health issue and represented the culmination of the *Decade of the Brain*. The report recognized the relationship between mental and physical health and well-being, and discussed mental health throughout the life span. Further, it suggested that although considerable progress has been made since the days

of “insane asylums,” more is known about how to treat mental illness than is known about the causes of and methods to prevent mental illness.

Mental Health and Children

Background

According to the Surgeon General’s report, the United States is facing a crisis in mental health for young children, children and adolescents. Unfortunately, it also suggested that the United States is not prepared to address this crisis. These children and their families often suffer as a result of missed opportunities for prevention and early intervention, poorly coordinated treatment systems and a lack of the resources necessary to respond to their unique needs. In addition, the stigma associated with mental illness often hampers efforts to address mental health issues.[3]

> ***The burden of suffering experienced by children with mental health needs and their families has created a health crisis in this country.***
>
> Dr. David Satcher, Former Surgeon General

One of the primary topics discussed in the Surgeon General’s report is children’s mental health. The report discusses normal development, risk factors and prevention, mental disorders in children, service intervention, delivery and service systems, and financing.[4] In September 2000, the Surgeon General held the *Children’s Mental Health: Developing a National Action Agenda* conference. The goal of the conference was to create specific recommendations for national action related to this issue.[5]

In a speech given at the conference, former Surgeon General David Satcher indicated five areas of agreement which emerged during the conference. They were:

- the need for a broad system to improve the identification, diagnosis, and treatment of children with potential mental health problems. In addition, it is important to remember that many people—parents, primary care providers, and teachers—may play a role in identifying a problem;
- the need to create a simple set of warning signs indicating potential problems with children. This information needs to be distributed widely to parents, the general public, and professional groups;
- the need to focus on social and emotional issues as well as academic skills. Teachers need information about behavioral and emotional issues and how to help children in trouble;
- the need to encourage primary care medical providers to develop primers for their offices that tell both parents and providers what to ask; and
- the need for additional spending on children's mental health services. Money should follow the need, not limit and dictate services that are unresponsive to children's needs.[6]

Definitions

When defining mental health, it is helpful to note that mental health and mental illness are points along a continuum and not unrelated cognitive states. There is a strong relationship between an individual's mental status and physical health. The following are the definitions of mental health and mental illness used in the Surgeon General's report.

> **Mental health -** the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental

health is the spring board of thinking and communication skills, learning, emotional growth, resilience, and self-esteem.[7]

Mental illness - the term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.[8]

While these definitions hold true for both children and adults, it is important to note that children are not small adults and their developmental milestones play a key role in determining mental health issues. According to the chapter on children's mental health, "mental health in childhood and adolescence is defined by the achievement of expected developmental, cognitive, social and emotional milestones and by secure attachments, satisfying social relationships and coping skills. Mentally healthy children and adolescents enjoy a positive quality of life; function well at home, in school and in their communities; and are free of disabling symptoms of psychopathology." [9] Further the report stresses that it is particularly important that children be seen in the context of their social environments including, family, peer groups, and their larger physical and cultural surroundings.

Prevalence

National prevalence rates for mental disorders in children vary based on the child's developmental status and level of impairment. The Methodology for Epidemiology of Mental Disorders in Children and Adolescents (MECA) estimates that almost 21 percent of the children in United States ages nine to 17 had a diagnosable mental or addictive disorder associated with minimum impairment.[10] That translates to one in five children experiencing signs or symptoms in the course of a year. However, when the numbers were limited to children with a significant functional impairment, the estimate dropped to 11 percent.[11] That number represents four million youth suffering from a major mental illness limiting their ability to participate in home life, school and with peers. Finally, when the term "extreme functional impairment" is applied, the estimates dropped to 5 percent or

one in 20 children.[12] According to the Texas Department of Mental Health and Mental Retardation (TDMHMR), prevalence estimates for FY 02 indicate that 662,114 children in Texas have a mental health disorder.[13]

The symptoms of mental health disorders are often most evident in non-mental health measures, for example:

- Suicide is the second leading cause of death for Texas males between the ages of 15 and 24 and the fifth leading cause for youth between 1- 14 years of age. [14]
- In 2001 there were 42,818 unduplicated confirmed cases of child abuse or neglect[15] and 22,169 children received foster care services in the state of Texas.[16]
- More than 79,207 juveniles were involved with the juvenile probation system in FY 2000.[17]

Risk Factors

Mental disorders and problems are not unique to any particular social class or background. These disorders occur across all socio-economic and racial groupings. However, some children are at greater risk based on a variety of factors. "There is strong evidence that both biological factors and adverse psychosocial experiences during childhood influence, but not necessarily cause, childhood mental disorders."[18] Risk factors for developing a mental disorder or experiencing problems in social-emotional development include: prenatal damage from exposure to alcohol, illegal drugs or tobacco; low birth weight; difficult temperament or an inherited predisposition to a mental disorder; external risk factors such as: poverty, deprivation, abuse and neglect; unsatisfactory relationships; parental mental health disorders; or exposure to traumatic events. Current trends suggest movement from the traditional focus on individual risk factors toward one of identifying

measurable risk factors and possible combinations which can be used in developing prevention models.[19]

Prevention

The goal of identifying risk factors is to devise treatment tools and methods to prevent mental illnesses or disorders. Prevention plays a critical role in addressing children's mental illness for several reasons: first, children are most likely to respond to early intervention and second, because many adult mental disorders have their roots in problems during childhood and thus the effects may be minimized. There is growing recognition that prevention works and is cost effective.[20] For example, improving parenting skills through training, can substantially reduce antisocial behavior in children. Research in the field of prevention has lead practitioners to the point where "reduction of risk, prevention of onset and early intervention are realistic possibilities."[21] Positive examples of prevention models with proven track records include early intervention/early childhood mental health and school-based services.

> ***Science paints a picture of both hope and caution. It tells us that young children are resilient, that problems may be transitory, that children respond to environmental support and changes. But it also tells us that the risk and potential lost opportunities are real. It underscores the importance of focusing on prevention and early intervention, rather than simply referring young children for treatment or assuming that children will outgrow problems.*** [22]

Early intervention

As discussed earlier, development plays an integral role in children's mental health issues. Growing evidence and research on brain development, especially infant brain development, demonstrates the first years of life serve as the foundation of future mental health and well-being. Specifically, developmental research tells us that early childhood

mental health depends largely on the well-being of the child's family unit. According to Dr. Jane Knitzer, of the National Center for Children in Poverty, mental health problems for young children occur when child developmental knowledge and strategies fail.[23] Thus the goal of addressing early childhood mental health is to enhance the social and emotional well-being of young children and their families by strengthening relationships with caregivers and to encourage age appropriate social and emotional skills.[24]

Further, Dr. Knitzer suggests there are three reasons to focus prevention efforts on early childhood mental health: first, the concerns expressed by teachers, caregivers, and mental health providers regarding the growing number of very young children demonstrating emotional distress; second, research suggesting the long term effects of early disruption in emotional development and caregiving relationships; finally, the potential importance of an early childhood mental health perspective in achieving widely accepted social goals such as school readiness.[25]

> ***Young children and their caregivers need developmentally appropriate interventions that will prevent more serious emotional and behavioral problems, repair problematic relationships, and help young children develop the emotional skills they need to succeed in school.*** [26]
>
> ***Dr. Jane Knitzer***

Because the emotional development of infants and young children occurs within the context of their families and other primary care relationships, it is important that infant/early childhood mental health services are provided within that same context. Services must be provided in a collaborative manner which includes parents and ultimately strengthens the relationship between the child and parent. These services should include a variety of methods to support the family as a unit, including emotional support for the parent and child, concrete resources, developmental guidance and support network identification.[27]

School-Based Mental Health Programs

There is growing recognition among educators, parents and the community that truly effective schools must do more than teach children to read and write; they must also attend to children's social and emotional learning. The deliberate teaching of behaviors such as sharing, helping, initiating relationships, requesting help from others and empathy, give children the tools they need to optimize their life skills and competencies. In addition, the use of medication to treat behavior and psychiatric problems places schools directly in the role of interventionist.

Prevention and intervention programs help reduce classroom disruption and decrease school violence. Mental health professionals, school psychologists, school counselors, and school social workers, are often the first and best equipped to identify children struggling with mental health problems. They are able to provide consultation and support to teachers and other school staff regarding children experiencing difficulty in the classroom. The success of a school-based mental health program can be affected by the ratio of school based mental health professionals to student. Programs with a ratio of 1:1,000 have reduced discipline problems and other barriers to learning.[28] However, in programs with higher ratios (e.g. 1:2,500), the ability to intervene early is greatly impaired.[29]

The role of schools in the provision of mental health services is critical:

- Only 16 percent of all children receive any mental health services. Of those receiving care, 70 to 80 percent receive that care in a school setting. [30]
- More than 83 percent of schools report providing case management for students with behavioral or social problems. [31]
- Nearly half of all schools contract or make other arrangements with a community-based organization to provide mental health or social services to students.[32]

- About 60 percent of the nation's 1,500 school-based health centers have a mental health professional on staff. With support from primary care providers, nearly 80 percent of centers provide crisis intervention services.[33]

Texas Children's Mental Health Services

Texas children who require mental health assistance may receive services or funding for those services from one of ten state agencies. Although TDMHMR may be the agency most directly responsible for providing mental health services, other state agencies are drawn into the provision of these services as a function of their mission. In some cases these agencies may be the most effective means of providing mental health services, however, their intervention is often due to a prescribed funding stream which allows for the provision of mental health services. The following section of this report identifies those agencies and their roles in providing mental health services in this state.

The Department of Mental Health and Mental Retardation

History

- FY 1990-91: TDMHMR received the first children's mental health appropriation of $2 million for community mental health services. Prior to this, services for children were largely provided at state hospitals and the Waco Center for Youth.
- FY 1992 - 93: The Texas Children's Mental Health Plan (the Plan) was created to establish a coordinated community-based system of services for children with serious emotional disturbances. The Plan included prevention and early intervention with an emphasis on intensive mental health treatment for youth in the juvenile justice system. An appropriation of $22.1 million was provided to implement the Plan.
- FY 1996 - 97: The 74th Legislature directed TDMHMR to develop a plan to address parental relinquishment of custody of children to the TDPRS as a method of accessing state funded mental health services. The resulting

report, *Wraparound Services and Residential Options,* recommended $20 million to implement the plan. The funds were not appropriated.

- TDMHMR has not received new funding for children's mental health services since FY 1996-97.
- FY 2001: The 77th Legislature reduced the children's mental health budget by $2.3 million for FY 2002 and $3.5 million for FY 2003 in anticipation of a shift of service delivery from TDMHMR to the Children's Health Insurance Program (CHIP).[34]

Prevalence Rates vs. Services Provided

In FY 2001, prevalence estimates for Texas indicate 662,114 children have a mental health disorder; of those, 150,481 would meet the criteria for serious emotional disturbance and require publicly funded services. However, in FY 2001, TDMHMR served 39,951 children and families, an estimated 26 percent of the need. As a result, more than 110,000 Texas children who may have qualified for publicly funded mental health services may have been untreated.[35] Projections indicate that in more than one-third of Texas counties between 1-100 seriously emotionally disturbed children did not receive services in FY 2001. In approximately half of Texas counties, as many as 500 seriously emotionally disturbed children were unserved.[36]

Program Services

TDMHMR provides children's mental health services through contracts with 40 local mental health authorities and NorthSTAR pilot (which is discussed in detail later in this report). The following list of services is required to be available in each service area: crisis hotline, screening, eligibility assessments, service coordination, treatment planing, skills training, family training, medication related services, respite, crisis stabilization beds, and inpatient services. In addition, the following services may be available as resources permit: wraparound planning, counseling, family-focused services, flexible community supports, in-home crisis intervention, day treatment, therapeutic foster care, and other residential

services. Inpatient care for children and adolescents is available at eight state mental health facilities, Austin State Hospital, Big Spring State Hospital, El Paso Psychiatric Center, Kerrville State Hospital, North Texas State Hospital, Rusk State Hospital, San Antonio State Hospital, Terrell State Hospital, and Waco Center for Youth.[37] Residential treatment is available through the Waco Center for Youth for children 13 to 17 years of age, but the wait list for services at the Center is generally six months.[38] In providing these services TDMHMR is required to:

- ensure the development of programs and the expansion of services at the community level for children with mental illnesses and their families;
- prepare and review budgets for services for children;
- develop departmental policies relating to children's programs and service delivery; and
- increase interagency coordination activities to enhance the provision of services for children.[39]

Priority population

As noted above, there are many children and adolescents who may be identified as having a mental health disorder, however, TDMHMR provides services to a subset of that group, the designated "priority population." State law requires TDMHMR to identify this subset and the minimum range of services necessary to address the needs of these children. Further, the department is directed to offer services to the children most in need and to use state funds only for those in the "priority population."[40] This group is defined as children and adolescents under the age of 18 with a diagnosis of mental illness who exhibit severe emotional, behavioral or mental disorders and who:

- have a serous functional impairment; or

- are at risk of disruption of preferred living or child care environment due to psychiatric symptoms; or
- are enrolled in a school system's special education program because of a severe emotional disturbance.[41]

According to TDMHMR statistics, the three most prevalent diagnoses for children receiving services from the department are:

- **Attention Deficit Hyperactivity Disorder (ADHD):** a disorder characterized by inattention, hyperactivity, and impulsiveness, lasting more than six months.
  - Total Served FY 2001 = 13, 468
- **Depression/Bipolar Depression:** depression is characterized by symptoms such as feeling sad, anxious or hopeless most of the time, no longer caring about favorite activities, lasting at least two weeks. Bipolar disorder causes extreme mood swings, alternating cycles of depression and mania.
  - Total Served FY 2001 = 5,478
- **Conduct Disorder:** characterized by a repetitive and persistent pattern of behavior that violates the basic rights of others and of society, including stealing, fighting, constantly lying, and actively defying rules.
  - Total Served FY 2001 = 4,587 [42]

Funding

The funds used to provide these services come from a variety of sources including general revenue (GR), the federal *Mental Health Block Grant (MHBG)*, *Temporary Assistance for Needy Families* (TANF), Title XX, tobacco settlement funds (in the form of a GR swap from previous biennia), local match, and projected Medicaid earnings. For FY 2001, TDMHMR

received $64,929,269 in appropriations specifically for children's mental health services. During the same fiscal year, TDMHMR expended $115,100,000 for the provision of these services. The difference between the two figures is the cost associated with the services provided at state hospitals and through NorthSTAR. Estimates indicate approximately 48 percent of the children served are enrolled in Medicaid and an additional 10 percent are enrolled in CHIP.[43]

Health and Human Services Commission

The Health and Human Services Commission (HHSC) provides direction and oversight for the eleven Texas health and human services agencies. The agency goal is to encourage innovation, and to use research and experience to maintain an efficient and effective health and human services system for the state. In addition, HHSC administers certain health and human services programs including the Texas Medicaid Program and CHIP. The agency also conducts Medicaid waste, fraud, and abuse investigations.

Although HHSC does not provide direct mental health services, they administer two of the key funding mechanisms for these services, Medicaid and CHIP. Both programs have a well defined mental health benefit which enables enrollees to access care. These programs will be discussed in greater detail later in this chapter.[44]

In addition to Medicaid and CHIP, HHSC operates two additional programs which will also be discussed: the Community Resource Coordination Groups (CRCG) and the Texas Integrated Funding Initiative (TIFI). These programs seek to foster interagency and community-based communication with the goal of enhancing services and improving treatment outcomes for their defined population.

Protective and Regulatory Services

The mission of the TDPRS is to protect the unprotected - - children, elderly, and people with disabilities -- from abuse, neglect, and exploitation. The agency administers child

protective services, childcare licensing, adult protective services, and community-based prevention programs.

While TDPRS has no direct statutory duty to provide mental health services, these services and prevention efforts are provided through two of the agency's divisions. As the entity authorized to protect children from abuse and neglect, Child Protective Services (CPS) is responsible for the provision of any needed service or treatment for children under their care. These services often include mental health treatment, to address the effects of abuse and neglect or other generalized mental health problems and are primarily funded through Medicaid. Although the majority of the children in PRS care require services due to abuse or neglect, a subset of these children enter TDPRS custody because their parents refuse to accept parental responsibility, commonly referred to as relinquishment of custody. There are several reasons for this behavior, but the most common is to access mental health services for their children.[45] This phenomenon will be discussed in greater detail later in this report.

A second program division at TDPRS which strives to address problems facing children and families is the Prevention and Early Intervention Division (PEI). While none of the PEI programs has the specific goal of decreasing or preventing mental health problems, many of them have the potential to do so. Early intervention programs often focus on self esteem building, social skills development, problem solving skills, and support system identification.[46] Although program outcome goals are not directly related to mental health issues, the development of these skills clearly has an impact on a child's mental health.

Texas Juvenile Probation Commission

The Texas Juvenile Probation Commission (TJPC) works in partnership with local juvenile boards and juvenile probation departments to support and enhance juvenile probation services throughout the state by providing funding, technical assistance, and training; establishing and enforcing standards; collecting, analyzing and disseminating information;

and facilitating communication between state and local entities. TJPC provides services within a network of 254 counties, 164 juvenile probation departments, and 172 Juvenile boards and serves 100 percent of the population of juvenile offenders in the state of Texas.[47]

Although TJPC has no direct mandate to provide mental health services to children, services are often provided by local probation departments as an component of probation services. Local probation departments estimate 14,005 youth were identified as in need of mental health services and 8,331 of these youth actually received mental health services.[48] Juveniles in need of mental health services enter the juvenile probation system for several reasons; one, parents seeking assistance for a child with mental problems; two, the youth has committed an offense that leads to a legitimate referral; or three, the youth has behavior problems at school and is viewed as defiant. Juvenile probation departments may refer youth to community-based services, pay for the services, or if problems are severe enough and no other resources are available, the youth may be referred to the Texas Youth Commission.[49]

Texas Youth Commission

The mission of the Texas Youth Commission (TYC) involves four main areas, protection, productivity, rehabilitation, and prevention.[50] According to the TYC, all youth committed to their agency are provided basic levels of mental health services as a function of the agency mission to rehabilitate these youth. The objective is to stabilize their mental health condition and enable the youth to participate in resocialization programs. As a result, all TYC facilities have both onsite and contract mental health services including, evaluations, crisis counseling, short term psychotherapy, and medication treatment.[51] TYC estimates approximately 450 youth received either residential or aftercare mental health services in FY 2001 and nearly 21 percent of the total TYC institutional population receives psychotropic medications.[52] When mental health problems go beyond the general scope of the correctional environment, referrals or services are provided at the TYC Corsicana

Stabilization Unit for those with acute psychiatric distress and who are a danger to themselves or others. For those in need of a strict treatment milieu, referrals may also be made to the TYC Corsicana Residential Treatment Center or private psychiatric hospitals in rare cases. Finally, referrals are made to local mental health authorities upon transition to parole.[53] Although provision of mental health services is not TYC's primary mission, youthful offenders often come to TYC with mental health issues which must be addressed.

Texas Council on Offenders with Mental Impairments

The Texas Council on Offenders with Mental Impairments (TCOMI) is another state agency involved in the provision of mental health services for the Texas youth. The mission of TCOMI is to provide a formal structure for criminal justice, health and human services, and other affected organizations to communicate and coordinate on policy, legislative, and programmatic issues affecting offenders with special needs. "Special needs" includes offenders with serious mental illnesses, mental retardation, terminal or serious medical conditions, physical disabilities and those who are elderly.[54] During FY 2002-2003 TCOMI provided services to 830 juvenile probationers and 415 offenders released from the TYC thus serving a total of 1245.[55]

During the 77th Legislative Session, TCOMI and TJPC were allocated funds (TCOMI $10 million and TJPC $4 million) to increase the availability of mental health services to juvenile offenders. These agencies are working to implement pilot programs to prevent the removal of children with mental health needs from their homes and to prevent further involvement with the juvenile justice system.[56] Under the proposed model, teams of staff from local juvenile probation departments and local mental health centers work jointly to provide intensive community-based case management services and treatment to identified youth and their families. A report on the success of the project will be made available to the 78th Legislature with recommendations for the future of the project.

Early Childhood Intervention

The mission of Early Childhood Intervention (ECI) is to assure that families with young children with developmental delays have the resources and supports they need. ECI is a system of services designed in accordance with federal education laws and funded through the Individuals with Disabilities Education Act (IDEA).[57] ECI contracts with 63 local programs throughout Texas to help children during the first three years of life.[58] Each program must have a full array of services for which the state reimburses program costs based on a cost per child reimbursement formula.[59]

The array of services include the provision of psychological services to infants and toddlers, as appropriate, to meet their individual needs. Mental health services for infants and toddlers generally are relational and delivered in the context of care giver/baby interactions.[60] Due to the team approach of the ECI model an ECI Social Worker, early intervention specialist, speech therapist, or licensed counselor, may be the professional treating the mental health issue in conjunction with other services. The challenge of training professionals to provide early mental health services and interventions is a growing issue for ECI.

In recognition of the growing number of young children in need of mental health services and the importance of providing that service by trained professionals trained, ECI and TDMHMR have crafted a memorandum of understanding (MOU).[61] The MOU assigns children with mental health needs under the age of three to ECI and children three and older to TDMHMR. The MOU was drafted with the understanding that ECI is an entitlement program and TDMHMR services are available only as resources permit. If, at the age of three, the child's mental health difficulty continues, TDMHMR will transition the child to their program. Ideally the MOU will aid in the development of a continuum of care for these young children.

Texas Education Agency

The Texas Education Agency (TEA) is responsible for the provision of public education services and with that responsibility comes the need to provide mental health services as a means of removing barriers to learning. The TEA's mission is to build the capacity for excellence in the Texas public education system and to hold the system accountable for providing all students with a quality education that enables them to achieve their full potential.[62]

While many students may be affected by mental illness, a smaller set of students is identified as emotionally disturbed. During FY 2000 - 2001, school districts served 35,451 emotionally disturbed children through special education programs. This represents approximately seven percent of the total special education program. A smaller group of children require higher levels of service. When a student's educational needs cannot be met in a traditional setting due to their emotional disturbance, school districts provide funding for residential placements. Thirty-three emotionally disturbed students were placed in private residential treatment facilities during FY 2000 - 2001 at an estimated cost of $3.5 million.[63] Clearly, schools are being called on to provide a wide variety of services to children and families, including mental health services. Unfortunately, education professionals face behavioral problems in the classroom each day due to a stressed mental health system that is unable to meet the needs of all children with serious emotional disturbances.

Texas Commission on Alcohol and Drug Abuse

The Texas Commission on Alcohol and Drug Abuse (TCADA) provides leadership and resources to prevent children from using drugs, to help addicted individuals recover, and to protect families and communities from the dangers of drug abuse. TCADA's goals are to provide for the delivery of substance abuse prevention, intervention and treatment services based on need throughout the state, and to ensure the value, safety and accountability of those services. To meet these goals, TCADA contracts with close to 200

public and private agencies to provide prevention and treatment programs, and related services to more than 700,000 Texans each year.[64]

TCADA provided substance abuse services to 4,435 children ages 13 -17, meeting approximately four percent of the need among indigent children.[65] While substance abuse is TCADA's primary focus, mental health problems (i.e., dual diagnosis) are common with youthful substance abusers. Common co-occurring diagnoses include: depression, conduct disorder, and attention deficit disorder.[66]

In addition to providing treatment services, TCADA actively seeks to prevent substance abuse through prevention and early intervention programs. Prevention efforts are a cost effective and research-based strategy that can reduce the use of alcohol, tobacco, or other drugs and, ultimately, reduce the need for treatment services.[67]

Texas Department of Health

The Texas Department of Health (TDH) provides services to Texans under two major categories of programs, essential public health services and as the health care safety net. The health care safety net focuses on providing medical services to individuals, especially those individuals without health insurance or individuals with special health care needs.

One program in this category that specifically provides mental health services to children is Children with Special Health Care Needs (CSHCN).[68] This program contains a limited behavioral health component as a recent addition (July 2001) to its benefit package. It is important to note that a child with a mental health condition as a primary diagnosis would not qualify for the CSHCN program unless the child has an accompanying chronic physical or developmental condition which makes them eligible. Since behavioral health services are a new addition to the CHSCN program, data on the use of the benefit is limited at this time.[69]

Symptoms of System Weakness

Relinquishment of Custody

The choice between obtaining mental health services for a child and retaining legal custody of the child is not one a parent should have to make. However, across the country, parents are facing that decision each day. In more than half of the states, approximately one in four families seeking mental health care are asked to make this choice.[70] Parents face this dilemma due to limits in private health plans, a lack of insurance coverage or unenforced entitlements in public programs.[71] "Requiring families to surrender custody of their children penalizes them for the state's failure to develop adequate services and supports."[72]

Accessing mental health services is not an issue if a child becomes part of the child welfare or juvenile justice systems. Once a child becomes part of these systems, the child typically qualifies to receive publicly funded mental health services. Unfortunately, as parents seek any avenue to mental health services for their child, they may turn to the child welfare system as a last resort. Afterward, they are viewed as neglectful or unfit parents and their ability to participate in their child's life is strictly limited.[73]

Requiring families to surrender custody of their children penalizes them for the state's failure to develop adequate services and supports.

No federal or state law currently guarantees mental health services to all children thus families must access care for their children from a range of uncoordinated and underfunded programs. These programs include: Medicaid, special education, and state funded public mental health. According to the Bazelon Center for Mental Health Law, "erroneous interpretation of the federal Foster Care and Adoption Assistance Program (Title IV-E) creates a fiscal incentive for custody relinquishment."[74] This program partially reimburses states for the cost of caring for children when they are removed from their parents' homes. As a result, parents and other child advocates seek assistance from child welfare programs in order to access this funding stream.

The consequences of custody relinquishment are extremely detrimental.[75] Parents who have made the choice to seek mental health assistance through the child welfare system must go to court and file neglect charges against themselves or claim that their child is "unmanageable." The bond between the parent and child is broken, and parents have little or no involvement in decisions affecting their child's mental health, health, and education. In addition, the child welfare system is unduly burdened with the care of children for whom a loving and caring family exist except for the lack of access to mental health services. This places a strain on child welfare systems and decreases necessary resources for children suffering from abuse, neglect or exploitation. Finally, when families relinquish custody of children with serious emotional disturbances, they often require the highest level of intervention, expensive residential placements.[76]

This is not a recently identified problem, and despite more than twenty years of effort the problem continues. In 1978, Jane Knitzer first recognized this problem in her study entitled, *Children Without Homes: An Examination of Public Responsibility to Children in Out of Home Care*.[77] In 1995, Texas began to identify possible solutions, in Phase II of the *Texas Children's Mental Health Plan,* including a proposal to allow parents to "voluntarily" relinquish custody to TDPRS to qualify a child for state funded services.[78] This concept has been adopted by several other states, including Oregon. It was not implemented in Texas.

According to TDPRS, in Texas the relinquishment of custody in order to obtain services is labeled "Refusal to Assume Parental Responsibility" or more commonly call "RAPR." These refusals often involve one of the following circumstances:

- upon release from a psychiatric hospital or residential treatment center;
- when an informal relative placement dissolves and the relative attempts to return the child to the parent;

- when a runaway attempts to return home and the parents refuse to permit their return; or
- upon release from a juvenile detention facility.[79]

For TDPRS to become involved, the parent must knowingly refuse responsibility for the child. If parents will not assume responsibility for the child, TDPRS will petition the court for conservatorship and place the child in an appropriate setting. These children are most often in need of services, not protection. In 2001, TDPRS had 720 confirmed cases identified as RAPR, although it is difficult to clearly identify the number of children whose parents refused to accept responsibility in an effort to obtain mental health resources.[80] In some Texas communities, prevention programs serve families in an effort to avoid RAPR situations.[81]

Case Example of RAPR - John

John is a nine-year-old boy from TDPRS Region 11, with a diagnosis of Biopolar Disorder with severe psychotic features, oppositional defiant disorder and conduct disorder. After his release from a psychiatric facility, his mother refused to take him home out of fear for her other children. John no longer needed acute care but his physicians recommended he be placed in a long term treatment facility. Medicaid would not pay for this type of care. John has been in counseling and on medications since he was three. He has been a witness to domestic violence and may have been abused by his father. His behavior has grown progressively worse and he was kicked out of numerous preschool programs. During his short life, he has received respite care from the local MHMR center for brief periods of time, however, due to his out of control behavior caretakers often refused to work with him.[82]

Juvenile Justice

A second symptom of weakness in the mental health system is the number of children and youth who receive services through the juvenile justice system. As detailed earlier in this report, juvenile justice agencies (TJPC, TYC and TCOMI) face growing demands for mental health services for the youth under their supervision. This demand can be traced to one of two factors, either the youth demonstrates unlawful behavior and coincidentally has a mental health disorder, or the youth has a mental health disorder which leads them to commit an offense.[83] Due to the absence of mental health services, some desperate families come to believe their best course of action to obtain help for an emotionally disturbed youth is to turn to the juvenile courts.

According to the Coalition for Juvenile Justice, "the juvenile justice system has largely become a warehouse for children suffering from mental illness."[84] National estimates suggest between 50 and 75 percent of incarcerated youth have a diagnosable mental health disorder. In addition, more than half of those have a substance abuse problem, which maybe a form of self medication. Further, nine to 13 percent of youth confined in juvenile facilities across the nation suffer with a serious emotional disturbance. Nationally, more than 28,000 boys and girls demonstrate suicidal behavior while incarcerated in youth facilities.[85]

The juvenile justice system has largely become a warehouse for children suffering from mental illness.

Texas statistics indicate that from 15 to 22 percent of the youth involved with the juvenile justice system suffer from diagnosable mental health disorder. Of those classified as having "high need" for services, 31 percent were Anglo, 21 percent African American, 17 percent Hispanic.[86] The juvenile justice system struggles to meet the needs of these youth with limited resources. Research suggest that youth who receive specialized treatment

have a significantly decreased rate of recidivism for up to three years after discharge from the treatment program.[87]

Promising Practices

System of Care

As outlined earlier in this report, more than ten state agencies provide or participate in the children's mental health system in Texas. Systems of care can be a positive step toward improved mental health care because many state and community organizations fail to communicate and coordinate services for children with serious emotional disturbances.

For the last fifteen years, research in the field of children's mental health and treatment practices has demonstrated that the most promising practice is the concept and philosophy of "system of care." The concept has provided a framework and foundation for recent reforms in children's mental health.[88] A "system of care" is defined as:

> a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families.[89]

While the system of care concept was developed to meet the needs of children with serious emotional disturbances, the concept clearly has applicability to other populations. This concept recognizes that children and families have needs in many domains and is based on a holistic approach where all factors are taken into consideration rather than mental health as an isolated service.[90]

Clearly, mental health issues are stressed but in the context of other overlapping dimensions which each express an area of need for the child or family. In this framework, the child and family remain at the center of the process. The key areas include; mental health services, social services, educational services, health services, substance abuse services, vocational services, recreational services, and operational services. In addition,

the definition of mental health services must be expanded to include support services such as, respite care, school-based mental health services, mental health consultation, behavioral aide services, and case management. [91]

Experience has shown that these dimensions are interrelated and each has an effect on the other. This interrelationship further demonstrates the need for a coordinated system rather than assuming a single service model. Finding a balance between these dimensions, services and funding, aids in the development of a system of care. It is important to remember that systems of care are a range of treatment services and supports guided by a philosophy and supported by an infrastructure. Elements of the system of care include service coordination, interagency collaboration, family involvement and cultural competence, but none of these elements are the primary focus of the system.[92]

Systems of care involve developing individualized "wraparound" teams which are unique to each child and who are responsible for the coordination of services for a specific child. The concept presupposes that young people with emotional and behavioral problems respond most favorably when they are allowed to remain in their families and communities while receiving treatment. Unlike more traditional approaches that focus mainly on treating the child, wraparound gives both the child and family an active role in devising a treatment plan. The membership of the team is determined by the family of the child being served, and includes persons important in the immediate life of the child, such as family members, friends, service providers and the care coordinator/case manager. Wraparound is a strengths based process, where the strengths of the child and family are the driving force behind a treatment plan not a service model.

System of Care Values and Principles

Core Values

1. The system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community based, with the focus of services as well as management and decision making responsibility resting at the community level.
3. The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

Guiding Principles

1. Children with emotional disturbances should have access to a comprehensive array of services that address their physical, emotional, social, and educational needs.
2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.
3. Children with emotional disturbances should receive services with the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of planning and delivery of services.
5. Children with emotional disturbances should receive services that are integrated, with linkages between child serving agencies and program and mechanisms for planing, development, and coordinating services.
6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Children with emotional disturbances should be ensured smooth transitions to the adult service system as the reach maturity.
9. The rights of children with emotional disturbances should be protected, and effective advocacy efforts for children and adolescents with emotional disturbances should be promoted.
10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

Source: Substance Abuse and Mental Health Services Administration. *Issue brief - A framework for system reform in children's mental health.*

System of Care in Other States

Several other communities and/or states have implemented this concept and are beginning to evaluate the results of their efforts.

- **Wraparound Milwaukee**

The Wraparound Milwaukee program began in 1994 with a federal grant to serve children in the state's mental health system using the wraparound approach. The effectiveness of wraparound was fully recognized during a 1996 pilot program for 25 children that focused on youth in the child welfare or juvenile justice systems. These children were living in residential treatment centers with no impending discharge scheduled. Wraparound Milwaukee's aim was to return them to either their own homes or to community-based foster care. Within a few months, 24 of the 25 children had been returned to their families or successfully placed in foster care at a savings to the state of $18 million per year.[93]

The *2000 Annual Report* lists other successes, including the fact that national test scores showed families and youth enrolled in the program functioning better in school, at home, and in the community.[94] The school attendance of enrollees improved by 60 percent and fewer children required hospitalization in psychiatric inpatient facilities and residential treatment centers.

- **New Jersey Children's System of Care Initiative**

New Jersey began the Children's System of Care Initiative (CSOC) in 2001 to address the need for fundamental structural reform in children's mental health care.[95] CSOC builds on the strengths of existing services and develops a more effective system of care responsive to the objective of supporting children and adolescents in achieving their highest potentials while living in a safe and permanent home and attending local schools. New Jersey officials recognized that each child serving system had difficultly accessing services from the others and the CSOC was developed, in part, in response to this problem. The goal

is for children and families to receive coordinated and unduplicated services through individualized service plans.

CSOC is designed to integrate and promote family and professional partnerships, the system of care core values and practices, and key managed care principles. This is accomplished through partnerships between state government and the community by using non-traditional contracts with service providers. It creates three new organizations: Care Management Organizations(CMO), Family Support Organizations(FSO), and a Contracted System Administrator(CSA). The Care Management Organizations are contracted with to coordinate and manage services under a single, cross-system individualized service plan. FSO organize families for peer-to-peer support within the community for high-risk children and families. Finally, a CSA handles information management issues, quality management and service coordination and utilization management for non-CMO children and families.[96]

- Other states using the system of care concept include: California, Michigan, Connecticut, North Carolina and Virginia.

Texas Coordination Efforts

Community Resource Coordination Groups

In 1987, the Legislature recognized the importance of coordinating services between state agencies and programs, as a result CRCG was created. "CRCG's are local interagency groups composed of public and private agencies that develop service plans for children and adolescents whose needs can only be met through interagency coordination and cooperation."[97] The establishing Legislation directed the state agencies serving children to create a community-based service model, in an effort to increase coordination and facilitate improved outcomes. Based on the success of the CRCG's model across the state, the CRCG model was expanded to include adults during the 77th Legislature.[98]

CRCG services are not restricted to a single population group. As a result, children with mental health needs, juvenile justice issues, educational needs or special health care needs may be served. This program is available in all 254 Texas counties and provides a mechanism that enables public and private agencies, organizations and families to work in collaboration to meet the needs of children. Some CRCG's include a parent representative of a child with disabilities as a regular member. Members in CRCG include the following:

- Texas Commission for the Blind;
- Texas Commission on Alcohol and Drug Abuse;
- Texas Department of Health;
- Texas Department of Mental Health and Mental Retardation;
- Texas Department of Human Services;
- Texas Department of Protective and Regulatory Services;
- Texas Education Agency (or local school district);
- Texas Interagency Council on Early Childhood Intervention;
- Texas Juvenile Probation Commission (or local juvenile probation department);
- Texas Rehabilitation Commission;
- Texas Youth Commission; and
- Local representatives from private-sector services providers.[99]

CRCG members meet in partnership with the family to plan for needed services. For example, a child receiving services through his or her local school district may also be receiving supplemental services from the community mental health center, or be involved with juvenile probation. As a result of failure to coordinate services, a family may be experience gaps in or barriers to necessary services; so the service plan a local CRCG implements can lead to enhanced outcomes for the child and family.

Each CRCG operates in a sightly different manner but utilizes the same general model and guiding principles. Some CRCG's operate in a very structured model; others use a more informal method of operation. Most CRCG's meet on a monthly basis and allow for emergency responses. Each local group has a Chairperson who has volunteered to lead and facilitate the process. In addition, several CRCG's have Service Coordinator or Case Manager positions, either voluntary, in kind or paid, whose duties are prescribed by the local CRCG.[100]

Children and families are referred to CRCG's through one of a variety of state or community agencies which are providing services to the child. Once a referral is made, families are asked to give consent and to participate in the planning process. That plan includes identifying the strengths and needs of the child, and prioritizing the areas of greatest need. A plan is developed based on this information and a lead agency or person is identified to ensure that the plan is followed. In subsequent weeks and months, the CRCG meets to discuss the progress made on the plan.[101]

The success of CRCG in serving families across the state, is a strong example of how the coordination of services and the collaborative efforts of community leaders can greatly improve and influence the life of a child in need. This model establishes a foundation on which a statewide system of care could be built.

Texas Integrated Funding Initiative

As discussed above, the challenge of serving children and families whose needs encompass many systems is one that Texas has attempted to address through CRCG's and other collaborative efforts. While these efforts have significantly increased information sharing and streamlined processes, they have not sought to combine or integrate funding resources. In response to this fragmentation, the 76th Legislature established TIFI specifically to address the needs of children with serious emotional disturbances through

the system of care philosophy. TIFI was designed as a pilot project to be implemented at the local level.[102]

The Legislature directed HHSC to form a consortium with representation from the following state agencies, including a person from the agency and a family representative:

- Texas Education Agency;
- Texas Department of Protective and Regulatory Services;
- Texas Youth Commission;
- Texas Juvenile Probation Commission;
- Texas Department of Mental Health and Mental Retardation;
- Texas Commission on Alcohol and Drug Abuse;
- Texas Council for Developmental Disabilities;
- Texas Department of Health;
- State Office of CRCG's; and
- Two youth representatives.

The TIFI Consortium is responsible for several activities. These include the development of a blueprint for providing mental health services which takes advantage of national best practices, the dissemination of technical assistance and training resources, the identification of funds to finance services within the initiative, the expansion TIFI in up to six communities, and the evaluation of the pilot sites.[103]

The objective of TIFI is to restructure and enhance funding processes for children with serious emotional disturbances through a collaborative approach. TIFI does not create or pay for direct services, but attempts to maximize existing funding and services through collaborative efforts.[104]

Goals of TIFI

- To acknowledge families as important and necessary partners in the development and implementation of an integrated service delivery system;
- To foster and maintain local control to allow for better decision-making and to enhance community development; and
- To support communities in managing funds and providers through a single local entity to produce better outcomes.[105]

Four original pilots were instituted in Travis, Brown, and Tarrant counties and the Riceland region (south of Houston). Each community brought special benefits and challenges and served as varied examples of how this concept could be implemented. The current pilot sites and home agencies, are:

- The Children's Partnership - Austin Travis County MHMR;
- Brown County TIFI Project - Central Texas MHMR;
- Harris County TIFI Project - Mental Health Association of Greater Houston;
- Rural Initiative Project, STAND Intervention Program - Lamb County Juvenile Probation Department;
- Tarrant County Mental Health Connection - Lena Pope Home; and
- Tri-County MHMR - Conroe, Texas.

As other communities across the state have recognized the benefit of instituting a process to integrate funding for children's mental health, they have begun to incorporate the system of care concept. The Hogg Foundation for Mental Health recently awarded funding to the Center for Health Care Services in San Antonio to support current wraparound efforts.

Additional Mental Health Funding Streams

Across the county, states are facing difficult funding decisions due to budget shortfalls. Some states have reduced funding for children's mental health thus shifting the responsibility for financing treatment to local communities.[106] In a recent survey conducted by the Maternal and Child Health Policy Research Center, 19 of the 33 states who responded to the survey, report budget cuts for children's mental health services.[107] It appears the majority of the responding states are making these decisions by targeting administrative spending, enhancing efforts to reduce inpatient or residential services and by focusing on community-based programs.

Major Funding Sources for Mental Health Services

- Mental Health Block Grant
- Temporary Assistance for Needy Families -TANF
- Medicaid
- CHIP
- Title XX
- Tobacco Funds
- Substance Abuse Prevention Treatment Block Grant

Source: HHSC, *Funding Mental Health Services for Children*

As detailed earlier, several state agencies fund children's mental health services, some as a primary function of their mission and other as a secondary means of achieving their mission. However, mental health treatment is also funded through public and private insurance programs, including Medicaid, CHIP and commercial insurance products.

Medicaid

Title XIX of the Social Security Act, otherwise known as Medicaid, is a Federal/State insurance program for certain low-income individuals and families.[108] The program was created in 1965 as a jointly funded cooperative venture between the Federal and State governments in an effort to assist states with the provision of basic medical services to needy persons. The primary populations served by Medicaid are children, pregnant women, the elderly and the disabled.

Under Medicaid, eligible children are able to access behavioral health services through predetermined benefits. Those benefits are defined as services to treat a mental, emotional or chemical dependency disorder. In Texas, the services available to children include:

- therapy by psychiatrists, psychologists, licensed professional counselors, licensed marriage and family therapists and master's level social workers;
- inpatient care in a general acute hospital;
- inpatient care in a psychiatric hospital;
- outpatient adolescent chemical dependency counseling by TCADA licensed facilities;
- prescription medications;
- rehabilitative and targeted case management services for children with severe emotional disturbances;
- ancillary services required to diagnose or treat behavioral health conditions; and
- care and treatment of behavioral health conditions by primary care physicians.[109]

Covered services for children in the Medicaid program are unlimited; Medicaid does not include coverage for residential treatment.

HHSC is conducting a *Behavioral Health Comparative Review* which will be completed in the fall of 2002. This comprehensive review will provide additional information about mental health benefits in the Medicaid program and specific detail relating to Medicaid managed care.[110]

Medicaid/CHIP - FY 2001 Estimated Children Receiving Mental Health Services			
	Total Enrolled	**Children Served**	**Expenditure**
Medicaid	1.1 million	67,000	$116 million
CHIP	444,599	18,304	$7 million

Source: Health and Human Services Commission. *Health and Human Services Current Funding Issues and Funding for Mental Health Services for Children.*

Children's Health Insurance Program

CHIP is a national program designed for families who earn too much money to qualify for Medicaid, yet cannot afford commercial insurance. The State of Texas developed the TexCare Partnership to raise awareness of new children's health insurance options and to help Texas families obtain affordable coverage for their uninsured children (ages 0-19).[111] TexCare Partnership offers a comprehensive benefits package with a full range of coverage, including: regular checkups, immunizations, prescription drugs, eyeglasses, lab tests, X-rays, hospital visits, dental care and mental health care; from a broad choice of providers.

One component of the CHIP program is a mental health benefit. During the creation of CHIP, special attention was given to the issue of children's mental health. The resulting mental health benefit is designed to provide a full array of mental health services. These benefits include three areas of service: inpatient mental health services; out patient mental health services; and inpatient residential and outpatient substance abuse treatment services.

Inpatient Mental Health Services: Medically necessary services furnished in a freestanding psychiatric unit of a general acute care hospital or a state-operated mental hospital. Inpatient services are limited to:

- 45 days annual inpatient limit per 12 month period;

- 25 days of the inpatient benefit can be converted to residential treatment, therapeutic foster care or other 24-hour therapeutically planned and structured services or subacute out patient (partial hospitalization) mental health services; and
- 20 of the impatient days must be held in reserve for inpatient use only.[112]

Outpatient Mental Health Services: Medically necessary services include, but are not limited to, mental health services provided on an outpatient basis. Medication management visits do not count against the outpatient visit limit. Outpatient mental health services are limited to:

- 60 days annual limit per 12 month period for rehabilitative day treatment;
- 60 outpatient visits annual limit per 12 month period for crisis stabilization, evaluation and treatment, including school, home-based and outpatient hospital services; and
- 60 rehabilitative day treatment days can be converted to outpatient visits on the basis of financial equivalence against the day treatment per diem cost.[113]

Inpatient/Residential and Outpatient Substance Abuse Treatment Services: Medically necessary services include residential rehabilitation and outpatient substance abuse treatment services. These services include, but are not limited to, prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorder, hospital inpatient/residential services. Substance abuse treatment services are limited to:

- 14 days annual limit detox/crisis stabilization;
- 24-hour residential rehabilitation program up to 60 days per episode. Thirty days must be held in reserve but 30 days may be converted to

60 days of partial hospitalization, 90 days intensive outpatient rehabilitation or 90 days of outpatient services;

- maximum of three inpatient and/or residential episodes per plan lifetime;
- intensive outpatient program (up to 12 weeks per episode);
- outpatient services (up to six months per episode);
- maximum of three outpatient episodes per plan lifetime; and
- aftercare for chemical dependency services such as, but not limited to, Alcoholics Anonymous, support groups and other services focused on preventing relapses.[114]

During the 77th Legislative Session, the TDMHMR children's mental health appropriation was reduced by $5.8 million for FY 2002-2004. This reduction was made under the assumption that children previously receiving services through the public mental health system would now receive mental health services through CHIP.[115]

Similar to Medicaid, HHSC and TDMHMR are in the process of reviewing utilization and penetration rates, provider capacity and other mental health related measures within the CHIP program. Because CHIP is a fairly new program, this data analysis will assist HHSC and TDMHMR in ensuring that mental health services are accessible and available through CHIP. The results of these studies are not yet available.

Commercial Insurance

Yet another method of funding children's mental health services is through commercial insurance. Many private insurance policies do not provide coverage for a child's mental illness that is comparable to the coverage provided for a physical illness.[116] This can result in a mental illness in a child not being treated or discovered until the mental illness causes a physical ailment. Because of the limitations placed on mental health care

reimbursements by insurers and a family's inability to pay the high cost of intensive private care, some children are forced into the public health care system.

Parity

A practical solution to this dilemma is parity. Parity is defined as a system where "health insurance companies must provide the same degrees and types of coverage for mental illness and substance-abuse treatment that they provide for physical conditions."[117] In the US, many health plans place lifetime caps on the mental health benefits a child or adult can access. Because current Texas parity legislation requires mental health coverage for biologically based illnesses and most biologically based mental illnesses are not diagnosed until adolescence, children experiencing serious emotional disturbances are excluded from this protection.[118]

Experts agree that if a child with a serious emotional disturbance receives appropriate treatment, the clinical outcomes for the child improve greatly. However, the reverse is also true if an emotional disturbance is untreated or under treated the potential for long term mental health problems increase significantly. These children and youth are more likely to develop a mental illness and/or to become involved with the child welfare or juvenile justice system.[119]

The cost of parity is often raised as a stumbling block to its implementation. However, studies have demonstrated that parity has no apparent impact on premium cost and has not caused companies to drop employees' policies or switch to self-insured plans to avoid the mandate. In the Mathematica Policy Research, Inc. study of the effects of the 1999 California parity law, findings suggest that while the cost did not prove a barrier to implementation of parity, some minor transition challenges for consumers emerged as employers moved to managed behavioral health care organizations, such as locating new providers.[120]

Conclusion

Children are estimated to represent 28 percent of the population. They account for about 14 percent of the health care expenditures but only account for 7 percent of mental health expenditures.[121] Sadly, one in five children has a diagnosable mental health disorder. Of those, 70 percent receive the treatment they need.[122] Serious emotional disturbances and mental health disorders are problems Texas pays for, either through the programs and mechanisms directly established to meet these needs or through indirect and often inefficient programs or services. Mental health difficulties do not go away if left untreated, they only grow more complicated and difficult to treat. In order to effectively address children's mental health, the state must take a multi-directional approach, including prevention, program and service coordination efforts such as the system of care concept.

Recommendations

1. **The Legislature shall require the statewide expansion of the Systems of Care model and integrated funding efforts at the Health and Human Services Commission through a graduated process by 2009.**

   Rationale: Current research indicates the most effective method of intervention involves a model of service called “Systems of Care.” This model has been utilized across the country and has been found to be a sound investment in terms of treatment outcomes and cost effectiveness. In a well defined "system of care," schools, community mental health centers, psychiatric treatment programs, social service organizations, juvenile justice programs, and primary health care organizations coordinate services to address the needs of children while allowing them to remain in their community.

   Over the course of the last fifteen years, Texas has taken steps to create a coordinated response across state agencies to address the needs of children with serious emotional disturbances through CRCG and ,later, TIFI. While these programs have been successful, the state should take advantage of the most recent research and modify these programs to create a unified program which best meets the needs of this special population of children.

2. **The Legislature shall direct the Health and Human Services Commission to review and evaluate all funding streams and spending at local, state and federal levels for children’s mental health and make recommendations about future funding needs and opportunities for inter agency coordination. HHSC shall report their findings to the 79th Legislature.**

Rationale: In order to maximize dollars meet the growing need for services and supports in a fiscally responsible manner, the coordination of all publicly funded children's mental health programs is critical. Texas must appropriately address the needs of children with serious emotional disorders. Funding availability to allow appropriate services, prior to "crisis level" of intervention is needed to keep service cost low. Currently, the state spends millions dollars each year to provide mental health services to children in the juvenile justice system or through Child Protective Services because these children are unable to access care in a more appropriate setting. It would be beneficial to determine where and how Texas funds are being spent and if there are more effective methods of financing treatment for seriously emotionally disturbed children.

3. **The Legislature should require the Texas Education Agency in conjunction with the Texas Department of Mental Health and Mental Retardation, the Texas Department of Health and the Texas Commission on Alcohol and Drug Abuse to assess current programs relating to school based mental health and substance abuse programs, and make recommendations about further development of this type of program.**

Rationale: School-based mental health programs are proven to reduce the risk of mental illness through population-based approaches. This approach recognizes individuals at increased risk and provides treatment to those who are developing problems. When appropriate, these programs should incorporate substance abuse and mental health prevention

education and services into their programing to enhance prevention and increase access to services.

4. **The Legislature shall mandate that all state regulated health insurance policies provide coverage for mental, emotional and behavioral disorders in children equal to coverage provided for other medical conditions, without discrimination against the category of illness.**

Rationale: Currently, many private insurance policies do not provide coverage for a child's mental illness that is comparable to the coverage provided for a physical illness. To address this problem the following areas must be addressed:

- Coverage must be provided for disorders listed in the American Psychiatric Association's Diagnostic and Statistical Manual, without exclusions;
- Prohibit lesser thresholds for annual or lifetime spending caps, annual or lifetime physician visit limits, or annual or lifetime inpatient hospital day limits;
- Prohibit discrimination in the form of higher cost-sharing-payment requirements for mental, emotional or behavioral disorders, such as higher co-payments or deductibles; and,
- The Texas Department of Insurance should be authorized to require that mental health services be a recognized and billable treatment by primary care physicians and other appropriate providers. While the scientific literature clearly supports the role of the

primary care physician in identifying and managing disorders such as ADHD and depression in children, many health plans do not allow or do not recognize billings by primary care physicians for such services.

5. The Legislature shall direct the Health and Human Services Commission to:

a. Assure that Medicaid/CHIP are appropriately meeting the mental health and substance abuse needs of enrollees by examining the sub-capitation arrangements between Health Maintenance Organizations and Behavioral Health Organizations, studying penetration and utilization rates, provider networks and reimbursement rates.

b. Explore options to expand the range of mental health and substance abuse services and supports to Medicaid enrollees through various waivers.

Rationale: Given the increased reliance on Medicaid and CHIP to provide access and funding for children's mental health services, it is important that there is confidence that those programs are meeting the mental health needs of their enrollees. The level of funding that TDMHMR receives allows the agency to serve 27 percent of children projected to be in its priority population. Adequate Medicaid and CHIP services permit TDMHMR to address the needs of children who are not eligible for public insurance and to augment all Medicaid programs(manage care, fee for service and EPSDT) and CHIP services as indicated. This expansion would allow the state to maximize all funding and services allowable under Medicaid.

6. **The Legislature shall direct the Texas Department of Mental Health and Mental Retardation and the Interagency Council for Early Childhood Intervention to develop a continuum of care for young children under the age of seven with mental health disorders and a plan to develop expertise with this age group among service providers, if funding is available.**

   Rationale: Research indicates that the earlier are reached children with emotional disturbances the better the outcome and the less money spent on costly services. TDMHMR and the Interagency Council for Early Childhood Intervention are working together to develop a continuum of care for preschool age children with early signs of emotional, behavioral or mental problems. TDMHMR estimates that the priority population ages 3-6 equals 32,545 children/families. In FY 2001, the agency served 3,623 children/families in this age group, using funding specifically appropriated for this purpose during the 75th Legislative Session. Services include treatment and support services, parent training, parental clinical treatment for those who do not meet the adult priority population definition, and training of child care providers. In addition, expertise in the field of infant and toddler mental health is rare. Each agency tackling these issues has challenges in preparing service providers to appropriately address mental health issues. The creation of a plan to develop this level of expertise will further the goal of reaching children early before their illness become severe.

7. **The Legislature should direct the Texas Department of Mental Health and Mental Retardation to continuously develop, implement and disseminate**

treatment algorithms for children's mental health, including the Children's Medication Algorithm Project and to facilitate continuing education for primary care physicians regarding children's mental health through state agencies.

Rationale: Many times, scientific results from studies conducted at the National Institutes of Health and elsewhere are slow to make their way into the hands of practitioners. As has been done for adult populations, TDMHMR should work with psychiatric specialists to develop and effectively disseminate state-of-the-science clinical treatment algorithms for child and adolescent mental health. The Children's Medication Algorithm Project (CMAP) is a collaborative venture involving TXMHMR, The University of Texas at Austin College of Pharmacy, The University of Texas Southwestern Medical Center - Dallas, The University of Texas Health Science Center - San Antonio, parent and family representatives, and representatives from various mental health advocacy groups (NAMI-Texas, Texas Federation of Families for Children's Mental Health, Texas MH Consumers, and the Mental Health Association in Texas). The project involves developing and testing specific medication treatment guidelines, or "algorithms," for attention deficit/hyperactivity disorder (ADHD) and major depressive disorder (MDD) in children and adolescents. There is a pressing need to bring together the most current knowledge of academicians, experienced clinicians, parents and policymakers to develop recommendations for reasoned and feasible clinical practice. The ultimate goal of the project is to develop children's medication algorithms that will reduce the

immediate and long-term emotional, physical and financial burdens of mental disorders for children, their families, and their health care systems. Although costs are not a direct consideration in the development of the algorithms, the underlying assumption is that better clinical outcomes will lead to the containment of long-term costs. Primary care physicians need to know how to identify mental illness, such as what to do early on, what resources and disciplines are available for referral, and the latest information about medicines.

8. **The Legislature shall direct and fund TDMHMR to develop the statewide capacity for therapeutic foster care and intensive community treatment and supports for children and families to avoid parental relinquishment of custody to TDPRS.**

   Rationale: During FY 2001, parents of hundreds of children relinquished custody to TDPRS, many in order to access residential treatment (Refusal to Accept Parental Responsibility). Unfortunately, the Waco Center for Youth is almost always full and has a six-month waiting list. It is commonly believed that many such children could be maintained in the community if therapeutic foster care and intensive treatment and supports were available either to prevent the residential placement or to shorten the length of stay. This recommendation will increase the capacity of therapeutic foster care over a two-year period.

9. **The Legislature shall require insurance plans, including but not limited to, Health Maintenance Organization's Preferred Provider Organization's and Point of Service, to update their web based behavioral health provider lists on a quarterly basis.**

Rationale: A health plan's directory often list many more providers than are actually taking new patients, creating the appearance that more providers are available than is actually the case. Patients need continuous access to a medical home which has access to a variety of psychiatric, neurologic and other specialists for referral to services within the community. Currently, HMO's are required to update their provider list on a quarterly basis, but they are not required to do this through their web-based provider list. Currently, PPO's are only required to update their list on an annual basis.

10. The Legislature should allow state agencies to honor the psychological assessments done by other state agencies to lessen the amount of time it takes for a child or youth to be served.

Rationale: This would allow state agencies to honor and utilize psychological assessments conducted by other state agencies rather than paying for additional assessments.

Mental Health Delivery System

Background

Since the mid 1880s, Texas has operated a system of institutions to care for individuals with mental illness and mental retardation.[123] This system began as a method of "warehousing" mentally ill or retarded individuals and has become the primary means through which treatment and services are provided to these groups. Through the years TDMHMR has utilized a variety of service models in order to accomplish their mission:

> To improve the quality and efficiency of public and private services and supports for Texans with mental illnesses and with mental retardation so that they can increase their opportunities and abilities to lead lives of dignity and independence.[124]

The TDMHMR system offers both community and campus-based services. The majority of the mental health services TDMHMR provides are available in local communities through 42 community MHMR centers. TDMHMR funds and oversees performance contracts with Centers to ensure access to and the quality of treatment services.[125] TDMHMR provides inpatient services through 21 campus-based facilities, eight states hospitals, eleven state schools, two state centers and the Waco Center for Youth.[126]

Texas Mental Health History

1965 The Legislature created TDMHMR, giving it broad responsibilities as both a provider of and an authority for the purchase of the state's institutional community services for mental health and mental retardation. The Legislature also authorized local governmental entities to establish community MHMR centers to provide local services.[127]

1991 Senate Bill 112 clarified the relationships between MHMR centers and their local appointing boards and between centers and the state. The bill clarified

the centers dual role as local authorities and providers of services and the way in which the state pays community centers to provide local services.[128]

1995 The Legislature passed HB 2377, authorizing pilots to demonstrate the concept of separating provider and authority functions. The Legislature and private providers of services were concerned that a conflict of interest existed when a community center that provides direct services also acts as the purchaser (or "authority") of those services. Specifically, they were concerned that the center would have an incentive to select itself as the provider rather than selecting the best available provider in the community. The pilot sites developed procedures to separate authority and provider functions and to use methods for provider selection that are open, provide for public input, and represent "best value".[129]

1995 SB 10 established Medicaid managed care pilots, and SCR 55 created a pilot to demonstrate integrated mental health and physical health care. As Medicaid managed care (known as the STAR program) rolled out in Texas, each Managed Care Organization (MCO) in turn subcontracted with a Behavioral Health Care organization (BHO) to provide mental health and chemical dependency services. The BHO then assembled a network of providers, including the community centers.[130]

1998 The NorthSTAR pilot was rolled out in the Dallas region. This pilot differed significantly from previous pilots, due to concerns that the conventional Medicaid managed care model did not do enough to ensure that clients had access to care and that indigent clients were experiencing unreasonable waiting list for services. Instead of having each managed care plan subcontract to its own BHO, in NorthSTAR the state contracts separately with a BHO. Additionally, NorthSTAR combines funding streams for Medicaid, TDMHMR and TCADA general revenue. The community centers

have a defined role as "speciality providers" in each network, but in NorthSTAR all services (to indigent clients as well as Medicaid clients) are under contract with a BHO.[131]

1997-98 The Legislature passed HB1734, allowing organizations other than a community MHMR center to be a local authority. A task force is formed and a report is issued in 1998, defining guidelines for TDMHMR to use in selecting an authority. The TDMHMR board accepts the report and transmitted it to the Legislature.[132]

2001 The Mental Health Service System Task Force is created by the TDMHMR board. The task force is charged with making recommendations regarding "the fundamental structure and functions of the major components of a model by which TDMHMR will purchase community mental health services throughout the state." In April 2002, the TDMHMR Board accepted the proposed recommendations and directed the management staff of TDMHMR to develop an implementation plan. [133]

Current Structure of the Mental Health System

Prevalence vs. Priority Population

Current estimates indicate about 21 percent of the United States adult population is affected by a mental disorder in a given year. This translates into more than 44 million Americans with a diagnosable mental health disorder.[134] In Texas, one in seven or 2.5 million Texans struggle with some form of mental illness.[135]

Clearly, it is unrealistic to assume TDMHMR can meet the needs of 2.5 million citizens. Therefore, the department is required to offer services first to those most in need. This policy is implemented through what is deemed the "priority population". The goal is to focus services on those individuals in most need of mental health services and those most affected by mental illness.[136] The priority population is defined as:

adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders that require crisis resolution or ongoing and long-term support and treatment.[137]

Of the 2.5 million Texans with mental health issues, approximately 403,016 or 16 percent meet the criteria for priority population.[138] Services are provided on a funding available basis, therefore in FY 2001 approximately 139,383 were served.[139]

Community Based Services

When the Legislature established TDMHMR in 1965, it gave the department the authority to establish community mental health and mental retardation centers. These centers are created locally and have an appointing and oversight board of trustees. Centers contract with the state to ensure the provision of mental health and mental retardation services within a given catchment area. The staff of the community centers are local employees rather than state employees. Currently, 42 community centers provide services through annual performance contracts with TDMHMR and often provide services in several counties.[140]

TDMHMR Snapshot

FY 2002 Operating Budget	$2.0 Billion
By Service Type	
Mental Health	38%
Mental Retardation	62%
FY 2002 Full Time Equivalent Cap	19,717.7
FY 2002 Number Served	
Community Services	
Mental Health	167,828
Mental Retardation (includes private ICR/MRs)	39,545
Campus Based Services	
Mental Health	15,805
Average Daily Census	2,283
Mental Retardation	5,479
Average Daily Enrollment	5,133
Community MHMR Centers	42
Mental Health Authorities	40
Mental Retardation Authorities	42

Source: Texas Department of Mental Health and Mental Retardation

As components of the MHMR delivery system, community centers are political subdivisions of the state of Texas. HB 1734, passed in 1997, allows entities other than community centers to become local authorities. However, in 247 counties (all areas of the state except the NorthSTAR region), TDMHMR designates a community center as the local mental health authority as a means of ensuring the provision and continuity of services for the priority population.[141] The one exception is the NorthSTAR region, which will be discussed at a later point in this section. The authority/center receives prior funding from TDMHMR, in return for a commitment to provide services to a specific number of consumers. The authority/center can provide the services directly or subcontract with other local providers. If demand exceeds available program capacity, waiting lists are established.

A county, municipality, hospital district, school district or a combination of these may establish a community center; the majority are established by counties and approved by the TDMHMR board. The establishing entity appoints a Board of Trustees who sets policy for the center and hires an Executive Director to manage daily operations.[142]

Across the state, community centers vary by annual budget and number of clients served. TDMHMR is the primary funding source for centers, however, centers contribute a local match and may seek additional funding sources. State and local matching funds may only be used to meet the performance contract agreement and to serve the priority population. Any additional funding sources may be used to provide services to individuals outside the scope of the priority population.[143]

Although community centers primarily serve individuals within the priority population, they also work in concert with other state agencies and local entities and may be a provider of services for the clients of other agencies. Examples include TCADA, ECI, the Texas Rehabilitation Commission, local jails and state criminal justice facilities.

State Operated Facilities

Until the 1960's, public mental health services were exclusively provided through state hospitals. While community-based treatment is generally viewed as cost effective and least restrictive, the need for campus based treatment services remains an integral piece of the continuum of care. In Texas, these facilities now serve individuals with specialized needs for whom service in the community is not available.

Inpatient services are provided to individuals with severe mental illness who need intensive treatment, short and long term, in seven regional mental health facilities. Two additional facilities serve the entire state; the North Texas State Hospital in Vernon and the Waco Center for Youth. The Vernon unit serves as the state's forensic maximum security hospital for individuals who are incompetent to stand trial, not guilty by reason of insanity and/or manifestly dangerous. Additionally, the unit provides inpatient services to adolescents involved with the juvenile justice system.[144] The Waco Center is the only state residential treatment facility for youth and can serve up to 81 emotionally disturbed youth between the ages of 13 and 17.[145]

Each year approximately 16,000 admissions are made to the state mental health facilities.[146] Generally those admissions are short term, lasting only a

Cultural Competency

One topic which is becoming increasingly important for the Texas Mental Health System to consider is culturally competency. In an increasingly diverse state, efforts to meet consumers needs can either be enhanced or impaired by cultural competency. This is defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables them to work effectively in cross cultural situations. It is also the acceptance and respect for difference, a continuous self-assessment regarding culture, an attention to the dynamics of difference, the ongoing development of cultural knowledge, and the resources and flexibility within service models to meet the needs of minority populations". Examples of issues to understand include, folkways, traditions, customs, and rituals.

One of the most critical factors in accessibility of services may be cultural competency, as culturally sensitive practices can reduce barriers to treatment and improve outcomes. Although ultimate responsibility for competency falls to the mental health professional, a effective mental health system seeks to provide opportunities to expand employees knowledge, skills and attributes thus creating a culturally competent atmosphere.

Source: The Hogg Foundation for Mental Health, Cultural Competency: A Practice Guide for Mental Health Service Providers

few weeks. However, there is a small group of consumers whose needs are severe and who require long term inpatient treatment. State hospitals are serving two distinct populations: first, a group with acute short term needs; and, second, a group of chronically and seriously mentally ill individuals whose symptoms require long term care.[147] In pursuit of a seamless and coordinated treatment approach, state hospitals and community centers work in conjunction to develop a service array specific to the needs of the community served.

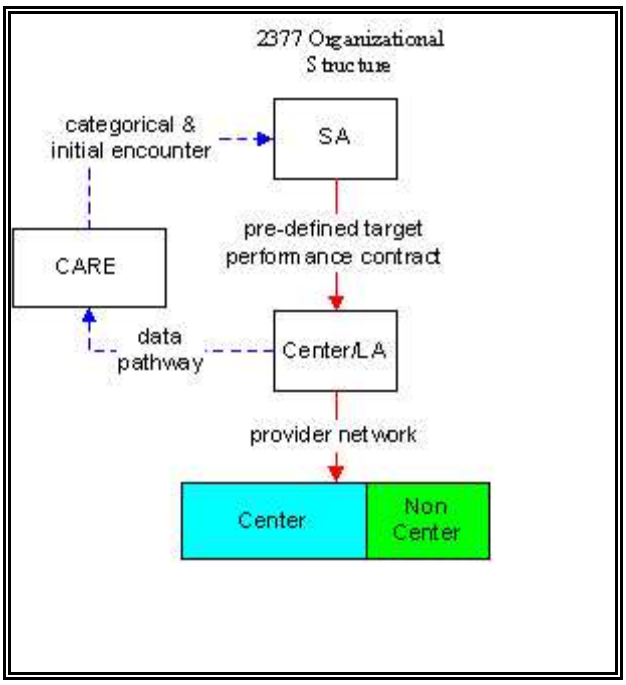
Within the continuum of care, state mental health facilities play a key role. They are in place to aid local authorities in meeting the needs of mental health consumers who can not be served in the community.[148] To that end, it is essential to determine and operate an adequate number of facilities and to balance limited resources across the state.

Related Pilots and Studies

House Bill 2377

HB 2377 (74th Regular Session, 1995), attempted to increase the mental health system's efficiency and accountability and address potential conflicts of interest. This conflict could arise when a local authority is allowed to be both provider and local authority, thus purchasing services from itself. The bill led to the creation of three pilots, called "2377 pilots", in: Tarrant, Lubbock and Travis counties. The goal of the pilots was to put safeguards in place to minimize potential conflicts of interest and to ensure consumer choice. In these pilots, the authority created internal divisions, between its authority and provider functions, including separate budgets for each functional area.[149]

Ultimately, the objective of HB 2377 was to create a clear definition of authority and provider responsibilities. The bill directed community centers, as local authorities, to "consider public input, ultimate cost benefit, and client care issues to ensure consumer choice and best use of public money in assembling a network of service providers and



determining whether to become a provider of service or to contract that service to another organization."[150]

The authority establishes a network of community providers of which its "provider division" is an equal member. The network providers submit claims to the authority, usually on a fee-for-service basis, much like a private managed care situation. The pilots all use a "network advisory committee" to ensure public and consumer input regarding the adequacy of consumer choice of providers and to ensure that the public is getting the "best value" for its money. Many of the strategies developed in the 2377 pilots have been expanded statewide, through inclusion in the state's performance contracts with the local centers.[151]

In addition to outlining local authority responsibilities, HB 2377, defined the key functions of the state authority (TDMHMR) including: planning, policy development, resource development and allocation, and oversight of mental health and mental retardation services in the state.[152] Further, the bill gives TDMHMR the authority to delegate some or all of these functions to a local authority.

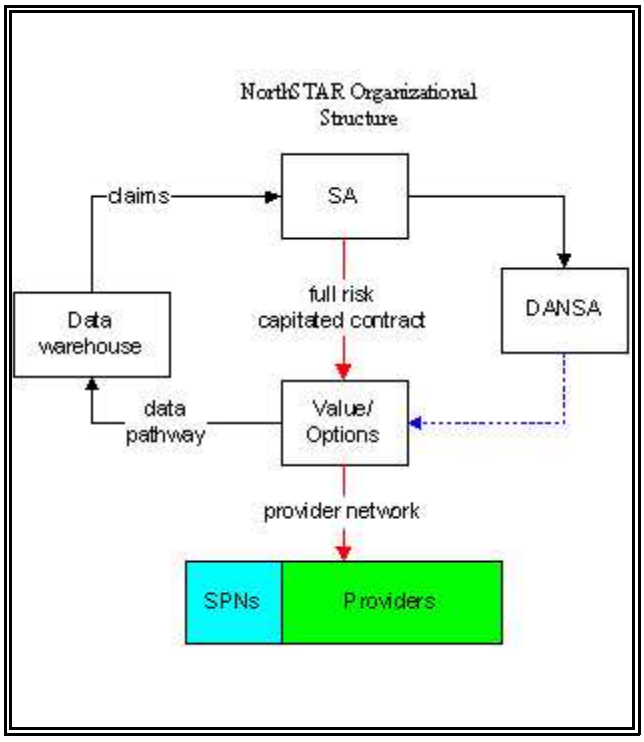
Advocates and consumer groups have been pleased with the 2377 pilots. Supporters believe that, properly implemented, the 2377 safeguards protect the public from conflicts of interest and maintain a "level playing field" for all providers in the community.[153] However, there has been some criticism of the 2377 model that has focused on the conflict of interest issue.

House Bill 1734

HB 1734 (75th Regular Session,1997), removes the statutory preference given to community mental health centers when TDMHMR is designating a local authority. The bill allows for organizations other than community centers to become the local mental health authority and directed TDMHMR to establish a committee to develop a plan setting the number of local authorities, the functions that are delegated from the state to local authority, and the method by which a local authority would be selected. This committee completed their work in the fall of 1998 and submitted their recommendations to the TDMHMR board.[154] The report included guiding principals, responsibilities of the state and local authority, criteria for the selection of a local authority, a method of determining the specific number of local authorities needed and an implementation plan. At that time, the board accepted the report but to date has not taken steps to implement the plan.[155] The Mental Health Service System Task Force, to be discussed later in this section, utilized the recommendations of the 1734 Committee as the starting point for its discussions.

NorthSTAR

As managed care models began to be considered for the Texas Medicaid program, HHSC was asked by the Legislature to evaluate managed behavioral health care and make recommendations for possible implementation. As a result, NorthSTAR became the first carve out model for behavioral health care for Medicaid managed care in Texas.[156]



The NorthSTAR pilot pools funds from Medicaid, indigent services (pure GR)

and substance abuse services into single stream. The pilot was developed by HHSC, TDMHMR and TCADA as an effort to increase consumer access to services through greater efficiencies by using a private managed care model. The pilot covers seven counties (Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall) and provides services to both Medicaid and indigent consumers under a unified service model for both mental health and substance abuse services.[157]

The goal is to pool state funds and contract on a capitated basis with specialized mental health managed care companies or BHOs, to provide a single unified set of benefits to eligible clients. Community centers and other providers in the region then contract on a fee-for-service basis as network providers with the BHOs. A local Dallas Area NorthSTAR Authority (DANSA), appointed by local elected officials, serves as a vehicle for community input and oversight for the pilot. Under the NorthSTAR contract, all eligible clients are to receive benefits; no waiting lists for services are allowed.[158]

In its first two years of operation, NorthSTAR significantly overused its state hospital resources, increasing overall costs.[159] During the last year, however, the program greatly reduced hospitalization rates by setting up a "front-door" function at Green Oaks Hospital in Dallas, enabling it to assess and stabilize patients and avoid sending them to the state hospital unnecessarily. To further control program costs, the state added an eligibility restriction for indigent clients, limiting eligibility to those under 200 percent of the federal poverty level.[160]

In 2001, the NorthSTAR BHO, indicated that they would not renew their contract unless the capitation rate was increased.[161] The resulting increase was drawn from a transfer from the state hospital budget to the NorthSTAR budget, new appropriations, and various other sources including new contracts with county governments and other state agencies (TJPC, TCOMI).[162] The issue of financial viability of the program should be monitored closely over the course of the next biennium to ensure the stability of the program.

NorthSTAR has proven immensely popular with mental health consumer groups in the Dallas area.[163] Consumer groups favorably compare access to services and consumer choice under NorthSTAR to what they experienced under the old system. They suggest that the concept of a "safety net" should be defined as guaranteeing appropriate services to those who need them, not simply guaranteeing the financial viability of traditional providers.[164] They also report that:

- waiting lists for mental health services have been largely eliminated;
- consumers can choose from a range of providers offering various specialty services; and
- the wait for new appointments is only a few days, rather than weeks or months under the old system.[165]

In addition, non-center providers generally report high satisfaction with the program. They suggest their programs are much leaner than traditional MHMR centers, with less overhead and mid-level management, enabling them to operate efficiently even at lower reimbursement levels.[166]

Conversely, criticism of NorthSTAR has largely come from the community mental health centers, those that are part of the 7-county region and those outside of the region, who are concerned that NorthSTAR might be expanded to cover them.[167] They and others make the following points:

- NorthSTAR removes local governmental control of mental health services, since the contract is between the state and a private company, not a locally-appointed board, and since the DANSA authority has no real control over the system;
- The BHO has gone too far in its efforts to reduce unnecessary hospitalization and discharges clients too rapidly; and

- NorthSTAR has created major financial losses among public and private traditional providers, including the closure of good providers.[168]

Mental Health System Task Force

In September 2001, the TDMHMR board appointed a task force of advocates, providers, community centers and TDMHMR staff to examine the community mental health system in Texas. They were asked to make recommendations for the future direction of the system, in light of the state's experience with the NorthSTAR and the 2377 provider-authority pilots.[169] The task force chair, a TDMHMR board member, directed the task force to combine the best elements of both models as they completed their task. The central charge to this task force was to make recommendations to the TDMHMR board about the fundamental structure and functions of the major components of a model by which TDMHMR will purchase community mental health services throughout the state.[170]

In addition, the charge directed that the recommended model be clearly articulated and systematic in how its components interact, and that it:

- be congruent with the guiding values stated below;
- define the roles of the state authority, local authorities, centers, and other organizational entities, including state hospitals, identified as being critical to the functioning of the model developed by the task force; and
- identify a timeline for full implementation that considered any need for phase-in, and implement at least parts of the model in the FY2003 contract year.[171]

In addressing its charge, the task force adhered to the following values:

- commitment to local community involvement and empowerment, as realized in the presence of the local authority;

- commitment to consumer choice, as realized through the right of the consumer to choose from more than one provider for each service in the benefit package when multiple providers are available;
- commitment to efficiency as reflected in two major ways:
  - all services purchased by TDMHMR are identified in a pre-defined benefit package and associated price schedule; and
  - identifies the most cost efficient way to purchase the business functions necessary to ensure the operation of an effective and efficient service system; and
- commitment to accountability as realized by a service system that functions at the local and state levels in a way that objectively demonstrates its responsiveness to public need as it provides quality services to as many Texans as possible.[172]

The task force met from September 2001 to March 2002. In the deliberations, the task force discussed in depth the problems of the mental health service system. It was systemic in its efforts to develop recommendations capable of making a difference in the lives of Texans in need of mental health services. Further, they believe the proposed system will increase efficiency in funding and service delivery and will increase the department's ability to provide services.[173]

The task force was in general agreement regarding the need to clarify the role of local mental authorities and ensure against conflicts of interest when a community center is both a provider and an authority. During the process, discussion occurred about the possibility of a complete separation between provider and authority, but members acknowledged that,

in reality, this would be difficult to accomplish in areas where there are few providers to choose from.

Recommendations of the task force were divided into the five following key areas.[174]

- Structure and Function

  Major Functions of the State Authority and Local Authority

  - The State Authority (SA) will develop performance criteria, standards and cost parameters which define quality and efficiency for the Local Authorities (LA) performance of the business functions.
  - LAs will determine whether they are able to perform the authority functions as described by the SA criteria. If not, they can contract with an Administrative Service Organization (ASO) type entity, but will retain responsibility.

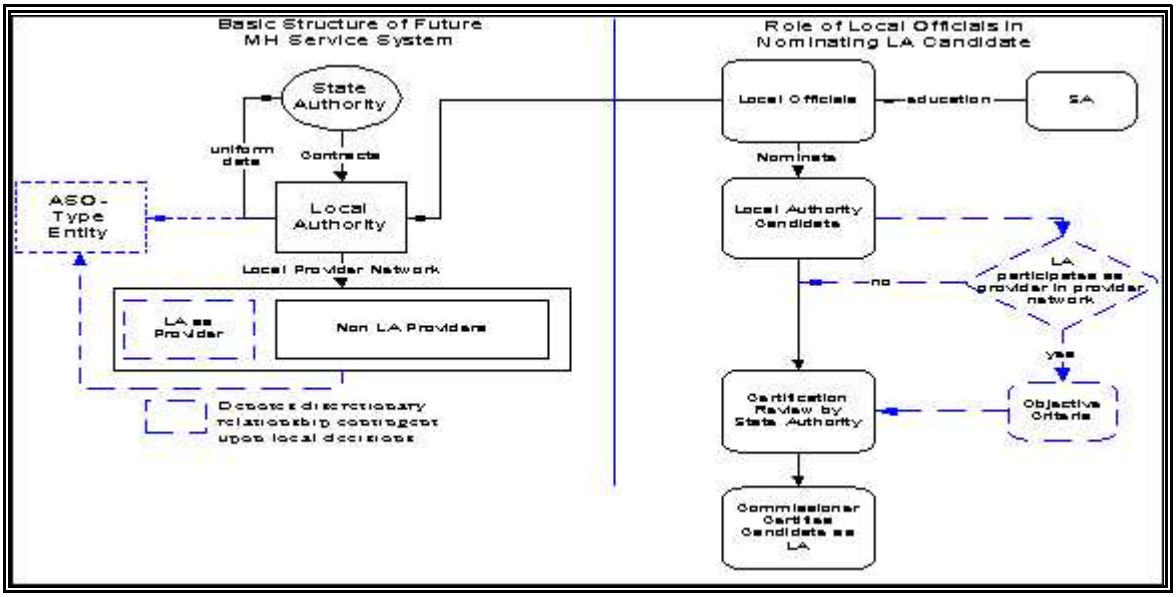
  Local Authority as Provider

  - The LA can be one of the providers in the network it assembles and manages if the local community determines that this is what it wants.
  - If the LA is to be a provider, then objectivity criteria defined by the SA must be met and verified by the SA's certification review.

  Objectivity Criteria

  - Separate LA budget;
  - Independent ombudsman;
  - Network Advisory Committee;
  - Provider Advisory Committee;
  - Provider relations office;
  - Consumer relations office; and
  - Separate staff for ASO type functions.

Basic Structure and Function of the Mental Health System



- State Hospital System's Relationship to the Community Service System
  - LAs plan their need for inpatient beds.
  - Local plans become the basis for developing a regional plan (state hospital region), to include:
    - the need for beds, including speciality beds;
    - local alternatives to hospitalization; and
    - the impact on economics if state hospital funds are moved to the community.
  - SA evaluates feasibility of implementing regional plans, to include, risk and statewide need for beds.
- Culturally Competent Service System
  - *State Authority*
    - TDMHMR Board defines cultural competency and pursues deployment throughout the system.
    - TDMHMR Board identifies a champion.
    - Conducts a self-assessment.

- Conducts state level planning to bench mark population demographics and monitor services to eliminate disparities in access.
- The Office of Multicultural Services develops training models and best practices and works as a consultant to the LA's and coordinates strategic plan development.

- *Local Authorities*
  - LA identifies a champion.
  - Conducts a self-assessment.
  - Conducts local level planning to include:
    - identifying demographics and needs of diverse populations and strategies for addressing needs;
    - monitoring services to eliminate disparities in access; and
    - integration of cultural competence in provider networks.
  - Develops strategies for developing interpreter resources.
  - Educates the local community about the mental health system to increase minority participation.

- Collaboration with State Agencies
  - For state agencies, conduct a feasibility study to develop a uniform data base for mental health services across agencies.
  - TDMHMR will develop and deploy, in collaboration with other state agencies, standards of care, best practices and outcomes for expenditure of mental health funds across state agencies.
  - For HHSC agencies, develop and implement the concept of behavioral health covered life for the medically indigent.
- Implementation
  - TDMHMR will appoint a Guidance Team to advise the Commissioner on implementation of the recommendations contained in this report with a subset of the Team composed of Task Force members.[175]

In response to the Task Force report, the Board has appointed a Guidance Team (TDMHMR staff and key advocates) and charged them to track the progress of the implementation process and to assist TDMHMR in bringing this project to fruition. In addition, the Guidance Team will ensure that the scope of the implementation process will not be expanded to new topics or policy considerations outside the recommendations made by the Task Force. The Guidance Team has created a timeline and plan to implement the recommendations from the report.[176]

Public Mental Health Systems in Other States

- **Michigan**

Much like Texas, Michigan's current mental health system has evolved over the course of the last 30 years. At the core of that evolution was the principle that the least restrictive setting for persons with mental illness, developmental disabilities and addictive disorders is the best setting. In the early 1970s, Michigan began to move away from segregating the mentally ill into state institutions and developed a more community-based approach to service delivery.[177]

Initially, each of the 83 counties in Michigan established a community mental health board. Since that time, some of the boards have consolidated and currently 49 boards provide services throughout the state. The community mental health boards, Community Mental Health Service Programs (CMHSPs), are primarily responsible for delivering specialty mental health services. However, program, policy and funding fragmentation continued to hamper the system. In 1998, the state obtained permission from the federal Centers for Medicare and Medicaid Services (CMS) to implement a Medicaid managed care program specifically for public mental health.[178]

In order to implement this new managed care model, the Michigan Department of Community Health carved out specialty mental health services from the general Medicaid program and placed these services into specialty care Prepaid Health Plan (PHP). After

making an effort to have open competition for managed care contracts, Michigan requested approval from CMS to contract on a preferential basis with the state's 49 CMHSPs to operate the PHPs for mental health, substance abuse, and developmental disabilities.[179]

Under the CMS approved plan, CMHSPs may be both a provider of services and function as the managed care entity. However, the entity must delineate how these functions will be performed and specify the responsibilities of each function, i.e. provider and manager. Funding for the program is managed in a unified manner and pools Medicaid capitation payments, state general fund appropriations, and federal block grant dollars into a blended funding stream.[180]

- **Arizona**

Arizona also follows a managed care model for provision of its mental health services. The Arizona Department of Health Services manages the public mental health system and provides mental health and substance abuse services to adults and children. These services are provided through one of six Regional Behavioral Health Authorities (RBHA), using a managed care model. All decisions about service delivery are made by RBHAs at the local level within a range of services set by the state. RBHAs may deliver services directly or they may subcontract with providers to delivery services. [181]

For persons eligible for publicly funded mental health services, RBHAs are funded through the state Medicaid office. The RBHAs are responsible for management of non-Medicaid funding sources that are used to serve persons not eligible for Medicaid. These services are prioritized using the following indicators: serious mental illness, risk, acuity, level of functioning, capacity to benefit, and according to block grant requirements.[182]

Indigent Mental Health and Benefit Design

A recent report by TDMHMR, *Rider 64 Indigent Mental Health Services*, highlights one of the gravest issues facing the public mental health system, namely that Medicaid clients receive a much richer and broader set of services than do people who are medically indigent.[183] In recent years, community mental health centers have increased the amount of services they bill to Medicaid, thereby bringing additional federal dollars into the Texas public mental health system.[184] However, as more Medicaid clients are served, a greater percentage of general revenue funds must be designated as Medicaid matching funds. This need for state Medicaid match has reduced the amount of general revenue available to serve the medically indigent population. Fewer general revenue funds translate into fewer services for the medically indigent.[185]

The impact of this disparity on the system is significant. Recent analysis by TDMHMR indicates that as the medically indigent receive fewer mental health services, they are more likely to have involvement with the criminal justice system and have higher rates of substance abuse.[186] Both criminal justice involvement and substance abuse may suggest the state's overall costs of treating these individuals will be higher than what would have been the case if they had been adequately treated in the mental health system initially.[187]

Rider 64 of the Appropriations bill from the 77th Legislative Session mandated that TDMHMR study trends in services to mentally ill indigent citizens and make recommendations.[188] When the report was released it indicated that 60 percent of adult and 38 percent child MHMR clients are indigent.[189]

60 percent of adult and 38 percent of child MHMR clients are indigent.

The dilemma is that the state has a finite amount of general revenue (GR) to fund mental health services. It uses that GR for two purposes, first, as the state match for Medicaid services and second, for direct payment for indigent services. Over the last several years, the Legislature has directed TDMHMR to maximize use of Medicaid. As more GR has been used for Medicaid match, less is available for indigent services. The indigent are less likely to access services due to long waiting lists and, if they are fortunate enough to receive services, they receive less of the service than a Medicaid-eligible client would, with poorer outcomes.[190]

In an effort to address this issue, TDMHMR established the benefit design initiative to redesign the way public mental health services are delivered. The primary goal of the project is to reduce the inequality between TDMHMR consumers who have third party insurance and those who do not. Other project goals include:

- establishing who is eligible to receive services (financially and clinically);
- developing ways to manage the use of services;
- measuring clinical outcomes; and
- determining how much the services should cost.[191]

The project plan has been approved by the TDMHMR board and will begin at four implementation sites in the Hill Country, Lubbock, Panhandle and Tarrant County local authorities. Workgroups have been established to address specific topics. Those groups are: case rate content, utilization management, case rate cost, data reporting and other local authority functions. The current plan calls for the project to work through any implementation issues in the fall and spring, and to fully implement the plan in the pilot sites in the summer of 2003.[192]

Conclusion

The mental health system is an evolving process and not a static system. As a result, new models and methods of providing services and supports must be considered and if deemed appropriate, piloted or fully implemented. Texas has the opportunity to move the mental health system into the current century, however, that progress can only be achieved through knowledge and experience. The following recommendations are meant to provide a foundation and to facilitate future discussions and decisions about the mental health system in Texas.

Recommendations

11. The Legislature should direct the Texas Department of Mental Health and Mental Retardation to implement the plan and recommendations of the Mental Health Service System Task Force.

Rationale: The TDMHMR Board appointed a task force composed of 20 major stakeholders from across the state to recommend the fundamental structure and functions of the major components of a model by which TDMHMR would purchase community mental health services throughout the state. The resulting report and plan of action should be fully implemented with Legislative support.

12. The Legislature shall direct TDMHMR to expand efforts to reduce the growing disparity in funding between the medically indigent and those with Medicaid through a benefit design process that defines appropriate types and amounts of services, payment methods that encourage evidenced-based practices, and accountability measures which track services provided and outcomes achieved.

Rationale: TDMHMR is currently involved in a benefit design process to address the disparity between Medicaid and indigent consumers. The "benefit design" project is an effort to redesign the way public mental health services are delivered to adults with severe and persistent mental illness and children with severe emotional disturbance. One primary goal is to reduce the inequality between TDMHMR consumers who have third-party insurance and those who do not. Establishing a well-

defined benefit package will provide local authorities with direction about who will get what, for how long, how much that service should cost, and what outcomes services should produce.

13. **The Legislature shall direct the Texas Health and Human Services Commission to conduct an evaluation of the inpatient mental health needs of the state, and an analysis of how the state can most effectively meet those needs and report to the 79th Legislature.**

Rationale: While inpatient hospitalization will be a necessity for some individuals with mental illnesses, effective and adequate services in the community can prevent deterioration in an individual's mental health status that causes the need for inpatient care. Inpatient services are an essential component of a complete continuum of mental health care. The study will build on, rather than replicate, existing analysis of how to best meet the state's need for publicly funded inpatient mental health services. Such an analysis must consider that inpatient care does not necessarily need to be provided in the state's mental health facilities.

14. **The Legislature shall direct the Health and Human Services Commission to review and evaluate all funding streams and spending at local, state, and federal levels which are used to provide public mental health services and make recommendations about future funding needs and opportunities for coordination. HHSC shall report their findings to the 79th Legislature.**

Rationale: Currently, many of the funds used for public mental health services are "siloed," meaning that they are earmarked only for certain populations or can only be used to purchase certain types of services. While TDMHMR is the main payor of public mental health services, state funds are also provided to the Texas Rehabilitation Commission, the Texas Criminal Justice System, the Texas Department of Housing and Community Affairs, and other state agencies. In light of the state's financial situation, agencies charged with providing mental health services must coordinate the delivery of their services in a way that places the needs of the consumer at the center and which is cost effective. State level mechanisms should be implemented so that both local and state planning efforts regarding public mental health can be improved. While funds for mental health services in Texas are severely limited, improved coordination of existing state funds can help stretch public dollars and therefore services. Specifically, joint planning can help to better meet the needs of specific populations, particularly those with past histories of criminal justice involvement, multiple hospitalizations or homelessness.

15. **The Legislature should direct the Texas Department of Mental Health and Mental Retardation to continue the NorthSTAR initiative in Dallas and the surrounding counties. However, expansion of the program should be contingent upon Legislative approval and a thorough evaluation of the programs treatment and cost effectiveness**.

Rationale: NorthSTAR is a behavioral health (mental health and chemical dependency) managed care program that combines funds from TCADA, TDMHMR, Medicaid, and other sources to operate a single system of behavioral healthcare for residents of Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall counties. This recommendation allows the current program to continue and would only allow for expansion if TDMHMR demonstrates that the program has improved client treatment outcomes and is cost effective.

16. The Legislature shall direct the Texas Department of Mental Health and Mental Retardation to develop and implement a series of productivity measures to increase system wide efficiency.

Rationale: TDMHMR is currently developing new tools necessary to more effectively manage the costs of providing services. With the development of these management tools, they will be able to identify and manage the productivity of professional staff as this pertains to the number of services provided to consumers in a specified time period. The identification and implementation of these productivity ratios for professional staff in community MHMR centers will enable TDMHMR to substantially increase the fiscal efficiency with which services are provided. These measures will also help TDMHMR to target the services that it wants to purchase, helping to ensure that clinically appropriate services are provided to consumers.

Allocation Formula

Background

Across the state thousands of citizens are on waiting lists for mental health and mental retardation services and projections indicate many more are ready to add their names if it appears services maybe available.[193] In Texas, disparity exists in the funding levels allocated to local authorities to provide mental health and mental retardation services. This disparity in the per capita funding is detailed below.

- **Mental Health:** In FY 2002 funding levels among local Mental Health Authorities (MHA) ranged from $28.27 per person to $11.15, with a mean of $14.62.[194]

- **Mental Retardation:** In FY 2002 funding levels among local Mental Retardation Authorities (MRA) ranged from $109.97 per person to $26.12 per person, with a mean of $41.22.[195]

According to the Task Force on Equity of Resource Allocation, the combination of a large number of uninsured, an expanding population, and an increase in indemnification and awareness of needs has resulted in a growing demand for mental health and mental retardation services across the country, particularly in Texas.[196] TDMHMR is now serving less than one-third of the estimated priority population for these services.[197]

Equity Illustration on a Per Capita Basis			
Mental Health FY2002 Top and Bottom Five		**Mental Retardation FY 2002** Top and Bottom Five	
1. Heart of Texas	**$28.27**	1. Central Texas MHMR Center	**$109.97**
2. Anderson/Cherokee County	**$27.76**	2. Betty Hardwick Center	**$100.27**
3. West Texas Center	**$26.77**	3. Concho Valley	**$99.74**
4. Coastal Plains	**$25.13**	4. Lubbock	**$78.44**
5. Helen Farabee Center	**$25.98**	5. Anderson/Cherokee County	**$73.95**
State Average	***$14.61***	***State Average***	***$41.22***
36. Johnson-Ellis-Navarro Co.	**$12.48**	38. Tri-County MHMR Services	**$28.87**
37. Center for Health Care Services	**$12.04**	39. Border Region MHMR Community Center	**$27.10**
38. Harris County	**$11.65**	40. Life Management Center for MHMR	**$26.50**
39. Sabine Valley	**$11.47**	41. Tropical Texas Center for MHMR	**$26.12**
40. Denton County	**$11.15**	42. LifePath Systems	**$20.59**

Source: Texas Department of Mental Health and Mental Retardation
Appendix B - Complete List of Mental Health Authority Funding Levels
Appendix C - Complete List of Mental Retardation Authority Funding Levels

Service Waiting List

It is clear that current funding levels for all local authorities does not allow them to fully serve the priority population. Although TDMHMR calculates waiting list numbers on a quarterly basis; this documentation may not fully demonstrate the unmet demand for services. The lists; reflect only those individuals who choose to submit their names, does

not reflect individuals who require services but who make the decision not to add their name to a long waiting list. Other data sources suggest that for every 5,000 on the waiting list, the unmet need may be as high as 50,000.[198]

Waiting List for Mental Health Services as of May 31, 2002	
Unduplicated Total of person waiting for mental health services	**5,990**
Persons waiting for services and receiving no services currently	
Adults	2,805
Children	377
Total	**3,182**
Persons waiting for some services and also receiving some service	
Adults	2,656
Children	152
Total	**2,808**

Source: Texas Department of Mental Health and Mental Retardation. *Waiting List Reports as of May 31, 2002.*

Waiting List for Mental Retardation Services as of May 31, 2002	
Unduplicated Total of persons waiting for mental retardation services	**20,259**
Persons waiting for services and receiving no services currently	
Adults	5,964
Children	3,953
Total	**9,917**
Persons waiting for some service and also receiving some service	
Adults	7,061
Children	3,281
Total	**10,342**

Source: Texas Department of Mental Health and Mental Retardation. *Waiting List Reports as of May 31, 2002.*

Previous Efforts to Resolve This Issue

In December 1999, the challenge of re-examine equity was given to the TDMHMR Task Force on Equity of Resource Allocation. The task force was charged to make recommendations to the TDMHMR Commissioner so that a plan could be submitted to the 77th Legislature by January 1, 2001, on strategies to improve the distribution of funds in a more equitable manner.[199]

TDMHMR convened workgroups in 1987 and again in 1994 to examine the issues surrounding equity.[200] However, the basic quandary remained: without an adequate infusion of new dollars, equity could only be achieved by removing people from services and supports in one place and adding them in another. In 1987 and 1994, it was recommended that those areas above average per capita allocation should not be penalized by cuts to current service levels, but rather to apply any new funding to those local authorities below the per capita average.[201] Since 1994, resources have been primarily distributed in that manner. Despite this shift, little progress has been made toward equity and great disparities remain.[202]

The 1999 task force built on the work of these previous efforts, examined the allocation process and made recommendations on how to allocate per capita formulas and how to distribute funds.[203] The task force made four recommendations to the Commissioner:

- To seek a legislative appropriation which would bring all local authorities to the national average per capita expenditure over the course of three biennia. They suggest the first step would be to bring all local authorities up to the state average.
- To direct the majority of new funds to communities that are funded below the state average and then to all communities below the national average.

- Allocation to local authorities should not be reduced for the purpose of achieving equity, except as a last resort, if substantial new funding is not received.

- To continue current formula methodologies to calculate per capita funding, one for mental health and one for mental retardation, but the mental retardation formula should be adjusted to take into account all mental retardation related resources in a community.[204]

The 1999 task force recommended the continued use of separate formulas for mental health and mental retardation.[205] The formula endorsed by the task force for mental health continues to use population with an adjustment for poverty to bring poorer areas closer to the average per capita. This is due to research which shows a correlation between poverty and mental health. The formula endorsed for mental retardation uses population solely, but adds previously not included federal funding streams as part of the resource base as far as the calculation of the equity.[206]

The task force concurred with past workgroups that a redistribution of resources would be the least desirable approach to achieving equity. However, they conceded that unless a viable alternative involving new resources presents itself, this option may need to be evaluated.[207] During the last several legislative sessions, a rider has been placed on the appropriations bill to explicitly forbid transferring funds from one community to another in order to achieve equity.

Conclusion

It appears Texas is at a crossroads in terms of mental health and mental retardation funding. Either the state resolves the equity issue or equity is identified as unachievable within the state's resources and the system adapts accordingly leaving major gaps in the provision of mental health services in Texas. There are three issues to consider in terms

of equity: first, no one wants to decrease services in a given community; second, many communities in the Texas are funded below the state and national average; and, finally, new resources to alleviate the inequities maybe unrealistic. While redistributing funds may lead to a decrease in services in those communities with higher-than-average funding, the reality is basic services are not provided to many consumers in communities with below average funding. Given the state's current budget forecast, it seems unlikely that TDMHMR will receive substantial new allocations to resolve the equity issue. In light of the many complicated issues related to equity, the following recommendation is presented with the assumption that over the course of the next seven years the issue must finally be resolved.

Recommendation

17. The Legislature shall direct the Texas Department of Mental Health and Mental Retardation to develop and implement a plan to achieve equity among Texas communities by 2009 using existing resources and new funds and for mental health and mental retardation.

Rationale: State funding disparities in mental health and mental retardation services across Texas severely restrict access to necessary care and cost-effective treatment. Due to state and local population changes (both growth and losses), and new TDMHMR funding being targeted toward specific uses, movement toward a resolution of this problem for certain residents has been minimal. Recognizing that Texas is almost last in the nation in funding, the fair distribution of funds becomes essential.

Acronyms

ADHD	Attention Deficit Hyperactivity Disorder
ASO	Administrative Service Organization
BHO	Behavioral Health Organization
CHIP	Children's Health Insurance Program
CMHSP	Community Mental Health Service Program
CMO	Care Management Organization
CMS	Centers for Medicare and Medicaid
CPS	Child Protective Services
CRCG	Community Resource Coordination Group
CSHCN	Children with Special Health Care Needs
CSOC	Children's System of Care Initiative
DANSA	Dallas Area NorthSTAR Authority
ECI	Early Childhood Intervention
GR	General Revenue
HHSC	Health and Human Services Commission
IDEA	Individuals with Disabilities Education Act
LA	Local Authority
MCO	Managed Care Organization

MECA	Methodology for Epidemiology of Mental Disorders in Children and Adolescents
MHA	Mental Health Authority
MOU	Memorandum of Understanding
MRA	Mental Retardation Authority
PEI	Prevention and Early Intervention
PHP	Prepaid Health Plan
RAPR	Refusal to Accept Parental Responsibility
RBHA	Regional Behavioral Health Authority
SA	State Authority
TANF	Temporary Assistance to Need Assistance
TCOMI	Texas Commission on Offenders with Mental Impairments
TCADA	Texas Commission on Alcohol and Drug Abuse
TDH	Texas Department of Health
TDMHMR	Texas Department of Mental Health and Mental Retardation
TDPRS	Texas Department of Protective and Regulatory Services
TEA	Texas Education Agency
TIFI	Texas Integrated Funding Initiative
TJPC	Texas Juvenile Probation Commission
TYC	Texas Youth Commission

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INTERIM COMMITTEE CHARGE 2

Welfare Reauthorization

Welfare Reauthorization
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Welfare Reauthorization

Interim Charge 2

Review, evaluate, and make recommendations to improve the effectiveness of the state's Temporary Assistance for Needy Families (TANF), Welfare-to-Work, Child Care and related programs in moving families out of poverty to self-sufficiency, with special focus on expiration of the state's federal waiver in FY 2002. Monitor federal reauthorization activities on these programs.

Welfare Reform

Background

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), was passed by the U.S. Congress as a comprehensive welfare reform plan intended to change the nation's welfare system. This legislation ended welfare as an entitlement program and instead promoted a philosophy of work and responsibility. Temporary Assistance for Needy Families (TANF), a block grant to states, was created to replace the Aid to Families with Dependent Children (AFDC) program. The intent of the federal legislation was to provide states with greater flexibility and local control in designing and implementing systems tailored to meet their specific needs.[1]

States can use TANF funds to operate programs that are designed to meet any one of the four purposes mandated by federal law, as follows:

- provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives;
- end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage;
- prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and

- encourage the formation and maintenance of two-parent families.[2]

States have used TANF funds in a variety of ways, including: cash assistance, wage supplements, child care, education, job training, transportation, and other services to help families make the transition to work.[3]

The law creating the TANF block grant expires at the end of FFY 2002 (September 30, 2002).[4] Congress will consider legislation this year to reauthorize the program. Congress is also likely to consider making some modifications to the rules and funding of the TANF block grant based on the experiences of the last five years.

Eligibility

States have broad discretion in determining who will be eligible for various TANF-funded benefits and services. The main federal requirement is that states use the funds to serve families with children.[5]

The Texas Department of Human Services (DHS) is the state agency responsible for determining eligibility for TANF cash assistance. DHS determines a household's financial eligibility based on a figure that represents 100 percent of the estimated cost necessary to meet basic needs for one month according to household size. DHS determines benefits based on a figure that equals 25 percent of the budgetary needs amount and pays a maximum grant amount.[6]

The TANF grant amounts are indexed to the Federal Poverty Level (FPL). During the 76th Legislative Session the Texas Legislature instructed DHS to adjust the TANF grant amount each year to ensure the maximum monthly grant for a family of three is at least 17 percent of the FPL. Currently, the FPL for a family of three is $15,020 annually. In Texas the maximum TANF grant for a family of three, is $213 monthly.[7]

Federal Poverty Level for 2002	
One Person	$8,860
Two Persons	$11,940
Three Persons	$15,020
Four Persons	$18,100
Five Persons	$21,180
Six Persons	$24,260

Source: http://www.aspe.hhs.gov/poverty/02poverty.htm

An exception to the broad flexibility that states have in establishing TANF eligibility is the federal law barring states from using federal TANF dollars to assist most legal immigrants until they have been in the U.S. for at least five years.[8]

Texas Eligibility Workers

DHS' Texas Works staffing levels have been reduced by approximately 2,680 full time employees (FTEs) since FY 1997 as a result of caseload declines and Medicaid simplification. In field visits, caseworkers cite increased workload as a major issue. Due to decreased funding for staff, the workload has significantly increased. From FY 2000 to FY 2003 case equivalents per worker in Texas Works have increased by 24 percent. Without additional funding for staffing, the estimated workload per worker in FY 2005 will be 36 percent higher than the FY 2000 level.[9] Taking advantage of any option to reduce workload will help DHS address staff shortages and manage increased caseloads.

TIERS Implementation

The 76th Texas Legislature (1999) appropriated $54.8 million to DHS to begin implementing the Texas Integrated Eligibility Redesign System (TIERS) project. TIERS will provide DHS eligibility workers with a single, integrated system that will be used in delivering food, cash assistance, medical, and aged and disabled services to Texans in need. The TIERS project launched an Internet-based screener, STARS, that allows the public to find out what types of health and human services assistance they may be eligible for.[10]

The implementation of TIERS will involve a staggered statewide rollout over a period from March 2003 through August 2004. The TIERS system will be piloted beginning in November 2002, and then implemented in one DHS region at a time. Due to the complexity of the eligibility rules, the size of the state, the critical nature of benefits issued, and the number of clients impacted, this staggered approach to implementing the TIERS system was determined to minimize the risk to the state and the clients served. In addition, this staggered approach to roll out allows DHS the opportunity to make any adjustments and provide additional staff training, as necessary.[11]

During the roll out phase, both the current SAVERR system and the TIERS system will be in use. Federal or state mandated policy changes which result in changes to these automated system will have to be made to two separate systems. To ensure that clients' cases are appropriately handled, and the benefits are issued accurately and timely, it will be critical to keep TIERS and SAVERR synchronized while operating in a dual-system environment.[12]

Work Requirements

Federal law requires that half of all families receiving assistance under TANF must be engaged in some type of work-related activity at least 30 hours per week.[13] Of the 45,578 average monthly clients served in the Choices Program in FY 2002, 24,745 (54 percent)

are participating in work activities. In FY 2003, the Texas Workforce Commission (TWC) projects the local workforce development boards (LWDBs) will serve an average of 55,352 clients monthly in the Choices Program, with 30,720 participating in work activities.[14] Almost 56 percent of all clients, in 2003, are expected to participate in the Choices Program based on the above figures.

Characteristics of TANF Clients

The most common TANF caretaker:

- is a Black or Hispanic female;
- is approximately 30 years old;
- has one or two children under the age of 11;
- is unemployed and has no other income;
- receives a TANF grant of $213 or less; and
- receives TANF for less than 12 continuous months

The educational level of this typical mother is between the 8th and 11th grades and she has had no job training. When she attempts to enter the labor market she will have these obstacles:

- She is a minority female without a high school education and without job training;
- she has young children who must have affordable, competent day care; and
- she does not have reliable transportation.

Source: www.dhs.state.tx.us/programs/TexasWorks/TANF.html

As with all states, Texas receives a Caseload Reduction Credit which reduces a state's participation rate requirement by a percentage point for every percent that their caseload

has declined since 1995. This credit currently allows Texas to meet the work participation rate without penalties.

TANF Funding

TANF was established by Congress as a mandatory block grant to the states totaling $16.5 billion per year, for six years. This is a flat dollar amount, not adjusted for inflation. Fiscal year 2002 is the last year for which the basic block grant is currently authorized.[15]

Texas' federal TANF block grant for 1997 through 2002 is $486.3 million, based on the state's historical expenditures for the former Aid to Families with Dependent Children (AFDC) program.[16]

In an effort to maintain the shared federal-state responsibility built into the AFDC program, states must spend an amount equal to 80 percent of the amount spent on AFDC programs in FFY 1994. This Maintenance of Effort (MOE) requirement, for all states' totals approximately $10.5 billion. If the state meets targeted work participation rates, the MOE requirement is reduced to 75 percent. Texas' TANF MOE requirement for the 2001-2002 biennium is $251.4 million based on the 80 percent requirement.[17]

Currently, Texas uses a portion of its MOE funds to operate a separate state program for two parent TANF families. This program is essentially identical to that funded by TANF dollars. Texas chose to implement this state program to allow more flexibility in meeting the work requirement for two parent families which the federal government set at 90 percent.

The 1996 law also established supplemental grants to address disparities in TANF funding among states, as well as a contingency fund to help states weather a recession. The supplemental fund was targeted at certain states with high population growth or low block grant allocations relative to their needy population. An annual 2.5 percent increase to

block grants was authorized for states that qualified.[18] Texas met the criteria for receiving supplemental funds and received a supplemental grant of $57.2 million in 2001.[19]

PRWORA authorized $200 million per year (1999-2003) for annual bonuses to states for meeting employment-related goals like job entry, job retention, and wage progression. Texas earned $16.3 million in FY 1999, $24. 3 million in FY 2000 and FY 2001, totaling $64.9 million in High Performance Bonuses.[20] For 2001 bonuses, new categories were added to address family formation and enrollment in Medicaid, Children's Health Insurance Program, and Food Stamps.

PRWORA authorized $100 million per year (1999-2002) for annual bonuses to five states with the largest reduction in the proportion of out-of-wedlock births.[21] Texas will receive$19.8 million for FY 2002.

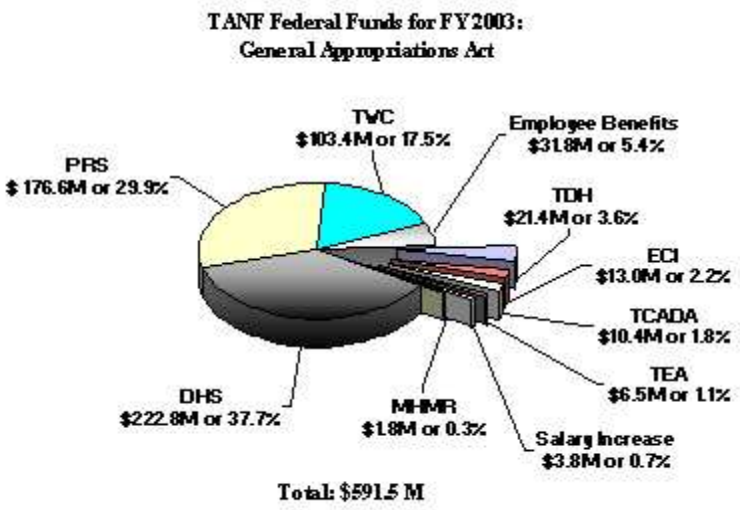
The 1996 Act established a $2 billion contingency fund available to states with high unemployment or significant increases in their food stamp caseload. To access the funds, states had to increase their own spending to 100 percent of MOE and provide matching funds at the Federal Medical Assistance Percentage.[22]

Funding in Texas

Block grants were based on state and federal AFDC spending in 1994, and because Texas was a low grant state in relation to other states, Texas received a lower per capita block grant amount. Despite Texas' low block grant amount, because caseloads declined dramatically since 1995, large surpluses built up over time. In 1997, the Legislature began the session with projected TANF surpluses of nearly $400 million. Even with allocations made during that session, surpluses continued to build, and by 1999 the 76th Legislature had nearly $600 million in TANF surplus funds. Further expenditures were authorized and spread among several state agencies and the surplus began to be spent down. The

appropriations levels set in 1997 and 1999 will be unsustainable without increases in state or federal TANF funding. [23]

Texas primarily extends TANF funds to four major agencies: Texas Department of Human Services, Texas Department of Protective and Regulatory Services, Texas Workforce Commission, and the Texas Department of Health. In looking at current agency requests for the FY 2004-2005 biennium the total TANF requested at these four agencies is $760 million by 2005. Texas' base and supplemental TANF grants account for $539 million per year under current law. If Texas factors in the remaining unspent TANF balance and potential performance bonuses, Texas will still be unable to cover the base request of all these agencies for TANF federal funds submitted in 2004.[24]



Source: Legislative Budget Board Committee Testimony

Federal Welfare Reauthorization Activities

The TANF block grant expires September 30, 2002. The House has passed a bill to reauthorize TANF; and a reauthorization bill approved by the Senate Finance Committee, in July 2002, is expected to be taken up by the full Senate later this year.[25] In recent developments, Congress extended the TANF block grant and related program through December 31, 2002. The extension also provides another quarter's funding for TANF supplemental grants, contingency grants, and high performance bonuses, as well as, child care entitlements, abstinence education, and transitional Medicaid. However, current TANF waivers set to expire, the 10-percent TANF transfer into social services block grants, and child welfare demonstration projects were not extended.[26] There are some discussions regarding extending the program one to three additional years. The following is a description of provisions within the bills currently being debated.

Work-Related Requirements

Both congressional bills increase work participation rates that states must meet. Currently, the 2002 "all-families" rate is 50 percent. With implementation of either bill, work participation rates would increase to 55 percent in 2004, 60 percent in 2005, 65 percent in 2006 and 70 percent in 2007. Both bills eliminate the separate two-parent work participation rate. The Senate Finance bill maintains the 30 hours work week and allows for partial credit for recipients who participate in work activities for at least half of the required hours.[27] It also allows states to provide a range of welfare-to-work activities and rewards state when families find jobs. The House bill requires recipients to participate in activities for 40 hours each week in order to count toward participation rates, limits access to education and vocational training programs, and gives states credit toward their work rates for reducing caseloads, regardless of whether families were employed or not.[28]

The Senate Finance bill allows states to operate welfare-to-work programs that combine work focus with education and training opportunities. The House bill would require states

to scale back on existing education and training efforts and work toward large-scale workfare programs.[29]

The Senate Finance bill funds two new approaches to increasing employment and earnings of recipients. First it funds transitional jobs programs that provide short-term, subsidized jobs and support services to recipients with barriers to employment. Second, the bill funds a "business-link" program designed to provide low-wage workers with work-based training and advancement opportunities. The House bill does not provide any funding for similar initiatives.[30]

The Senate Finance bill allows states to make reasonable allowances for families caring for children who are ill or have disabilities. Under this bill, states could exempt, from work participation requirements, a limited number of parents who are unable to meet the requirements because of the need to care for a child. Additionally, states would get partial credit for those parents who are able to participate in welfare-to-work activities for some number of hours. The House bill does not have a similar provision.[31]

The Senate Finance bill adds a provision that limits sanctioning of families with barriers to employment who are not able to meet program requirements. States would retain the ability to reduce or terminate assistance if a family fails to comply with requirements; however, a review of the family's welfare-to-work plan could be conducted before the sanction is imposed. The House bill would require states to terminate, completely, all assistance for noncompliant families. In the House bill, the state plan must describe strategies the state may take to address "services to struggling and noncompliant families and for clients with special problems."[32]

Supporting Working Families

Under the Senate Finance bill, mandatory child care funding would increase by $5.5 billion. The bill would also extend the Transitional Medical Assistance (TMA) program, which

provides short-term Medicaid coverage for low-income working families, including families that leave TANF, for five years and include new state options allowing states to simplify the program. The House bill increases mandatory child care funding by $1 billion and extends TMA for one year, but does not include state options to simplify. Additionally, the Senate Finance bill would allow States to provide supplemental housing benefits to low-income working families without triggering welfare requirements such as time limits and data reporting rules. The House bill does not include this provision.

Marriage and Child Support Provisions

The Senate Finance bill precludes states from discriminating against two-parent families in their TANF program and provides $1 billion overall for an array of marriage-related initiatives. The bill promotes family formation by emphasizing both marriage education programs and programs that address underlying factors that contribute to marital instability, including domestic violence and economic stress.[33] The House bill would more narrowly focus funding on marriage education programs.

The Senate Finance bill provides states with new flexibility to change child support rules, so that, when a non-custodial parent pays support it is passed to the children rather than being retained by the state or federal government. The House bill also contains some child support provisions, however, it places more limits on state flexibility and passes through less support to the children.[34]

Additional Reauthorization Provisions

The Senate Finance bill includes a contingency fund directing additional TANF resources to states facing a rising number of families that need assistance, due to the recession, for example. The House bill includes the current law contingency fund with some minor changes.[35]

The Senate Finance bill gives states the option to provide Medicaid and SCHIP coverage to low-income immigrant children and pregnant women who have been in the country for less than five years, and TANF benefits to legal immigrant families that have been in the country for less than five years.[36] The House bill does not include this provision.

The House bill includes a "superwaiver" allowing the Executive Branch to override a wide array of program rules and regulations, at a governor's request, with no Congressional input. This provision affects a variety of programs governed by federal law.

Despite the significant differences between the bills, there are some areas of commonality. There is general agreement in both the House and Senate that: the block grant structure should be maintained; TANF funding should not be cut below current levels; states should engage more adults in welfare-to-work programs; states should have more flexibility to direct child support to children; and more resources should be devoted to efforts to promote and encourage marriage and strengthen families.

Barriers to Self Sufficiency

Hardest to Serve

Texas, like many states across the nation, has succeeded in moving significant portions of the welfare caseload into the labor market. As an increasing number of job-ready welfare recipients become employed and leave welfare, the individuals who remain are likely to have barriers to work. The most common barriers include: mental and physical impairments; substance abuse; domestic violence; low literacy or skill levels; learning disabilities; having a child with a disability; and problems with housing, child care, or transportation.[37]

TANF recipients with learning disabilities, mental health problems or addictions to alcohol or drugs typically require a combination of specialized and coordinated services, treatment, or workplace accommodations, to make a successful transition to employment. Similarly,

persons who speak little or no English tend to require services that increase their employability by improving their language skills, and helping them to understand and cope with job requirement and cultural differences.[38]

Nationwide, almost 50 percent of TANF recipients report facing multiple barriers to employment.[39] One of the strongest predictors of work nonparticipation is the presence of multiple barriers. An Urban Institute study found almost one third of current welfare recipients are at high risk of remaining on welfare and losing benefits when time limits expire unless state programs can assist them overcome their multiple work obstacles.[40]

The barriers making a person hard to serve do not necessarily make participation or employment impossible. Many recipients may be able to participate in employment or training programs without special intervention, while others may need extra support. Programs involving participants in activities that build job readiness and simultaneously addressing a barrier may create a better environment in which the person can succeed.[41]

Housing

Lack of stable housing is a barrier to employment. While different in nature from a physical or mental impairment that impedes a recipient's ability to secure employment, unstable, inadequate, unsafe or unaffordable housing also render it difficult for a parent to retain employment. These housing conditions lead to frequent moves which can disrupt job attendance and performance and children's school attendance and performance.[42]

Sanctions

A growing body of evidence demonstrates that many families that are being sanctioned face serious barriers to employment impeding their ability to meet program requirements.[43] Under TANF, many states, although not including Texas, have adopted full-family sanctions that terminate assistance to the entire family when an adult recipient does not meet work requirements. Some states that have imposed full-family sanctions have also

included provisions to help improve compliance such as, case review, outreach and assistance to families in correcting the noncompliance prior to implementing sanctions.

At the time Texas designed its 1995 welfare reform legislation (HB 1863, 74th Legislature), policy makers chose to focus sanction policies on adults by removing their portion of assistance for specific infractions while leaving in place assistance for the children in the family. The rationale supporting this policy was that children should not be penalized for the actions of their parents.[44]

In recent years there has been some debate among policy makers about whether the current sanction structure is effective in enforcing compliance, particularly regarding work requirements. A number of local workforce boards are experimenting with home visits and incentives for participation, to improve compliance. If Texas chooses to implement full family sanctions, it will be necessary to balance compliance with work requirements and outreach efforts in order to assist families in maintaining compliance and avoiding unnecessary sanctions.

Job Retention and Employment Advancement

TANF recipients that find jobs generally earn low wages and often remain poor. In a review of families who left welfare and are working, the Urban Institute found that working former recipients tend to earn between $6.00 and $7.15 per hour.[45] In addition, many families who left welfare do not receive two key income supports, Medicaid and food stamps, despite remaining eligible for these benefits. This occurred in some cases because states did not have procedures in place to ensure that families continued to receive these important benefits.

Additionally, placing recipients in good jobs with higher wages and providing post-employment mentoring increases the likelihood of steady employment and wage growth

over time.[46] In Texas, TWC and DHS are currently experimenting with a job retention and advancement project which is showing some promise. See the following text box.

Immigrants

Prior to the passage of PRWORA, legal immigrants were generally eligible for public benefits on the same basis as citizens. PRWORA restricted benefits to those who had entered the United States prior to the enactment of the law. The restriction applies not only to cash assistance, but also to TANF-funded work supports and services such as child care, transportation, and job training.[47] Texas joined many other states in maintaining

Employment Retention and Advancement Project

ERA is a pilot project designed to facilitate employment retention and job advancement of TANF recipients. The project is designed to increase job stability and wages among former welfare recipients. It is also expected to reduce reliance on cash assistance in Texas, lower the TANF recidivism rate, and produce strategies that can be replicated in other Texas communities. ERA provides:

- up front linking of DHS eligibility services with workforce activities;
- long-term career planning;
- on-going assessment and support; and
- a post employment stipend.

ERA is a model for collaboration and coordination among multiple agencies at the state and local level. The pilot is operating in four locations Corpus Christi, Houston, Abilene and Arlington. This project is currently part of a national evaluation being conducted in fifteen sites in eight states. The first report is scheduled to be complete in the summer of 2003 and the final report is scheduled to be complete in 2007. If the strategies used in the ERA pilot are found to be effective, Texas should consider expansion of these strategies.

Source: Texas Department of Human Services. *Employment Retention and Advancement Project - A New ERA in Welfare*

TANF and Medicaid eligibility for immigrants already in the country before enactment of PRWORA. However, Texas is one of five states that has yet to choose to extend TANF and Medicaid assistance to legal immigrants after the five-year residency requirement has been met.

There has been much debate in Congress, as well as, the rest of the nation regarding the immigrant restrictions. In 1997, Congress restored SSI to most immigrants who were already in the United States when the welfare law was enacted and, in 1998, Congress restored food stamp eligibility for immigrant children, and for elderly and disabled persons who where in the United States before August 1996.[48] Congress, recently reauthorized the Food Stamp Program, extending food stamp benefits to qualified legal immigrants that have lived in the US for five years and to all qualified immigrant children.[49]

Reconsideration of the welfare law immigrant provisions is timely given the growing demographic importance of immigrant populations in the United States.[50] A significant percentage of poor children have non-citizen parents who are ineligible for TANF benefits and services.[51]

Conclusion

Texas faces several challenges with TANF reauthorization in 2002. Members of Congress are considering significant changes to the welfare system, including TANF funding issues, work related requirements, funding and quality of child care issues, reauthorization of the Social Services Block Grant (SSBG), marriage and child support provisions, immigrant provisions, and other provisions that will impact the state. Five years into the implementation of welfare reform, a more comprehensive welfare system is evolving, one with a greater focus on services instead of cash assistance. It will be important for Texas to develop an overall strategy for TANF spending and make strategic use of TANF to combat poverty in Texas.

Recommendations

1. The Legislature should take advantage of the federal option to provide TANF and Medicaid assistance to legal immigrants after the five-year bar.

Rationale: Most legal immigrants arriving after enactment of PRWORA are barred from TANF for their first five years in the United States. Currently, states can only fund services for these legal immigrants with state funds. Federal TANF funds may only be spent on them after the five-year bar has passed. This five-year bar applies not only to cash assistance but also to other services funded with federal TANF dollars such as employment assistance, child care, transportation, and other "non-cash" benefits.

Texas joined most other states in maintaining TANF and Medicaid eligibility for immigrants already in the country before enactment of the new welfare law. Texas is one of five states that has yet to choose to extend TANF and Medicaid assistance to legal immigrants after the five-year bar. Legal immigrants pay taxes that fund these services. Extending benefits to legal immigrants after the five-year bar would allow these immigrants to access services in times of need. Accessing services could help them achieve self-sufficiency and shift the burden from local communities with limited resources. Roll out of the TIERS system at DHS will need to be considered in determining the implementation date of this recommendation.

2. The Legislature should take advantage of current or future state options to offer TANF benefits to legal immigrants or consider, at minimum, extending services separate from cash assistance.

Rationale: Currently, Congress allows states to implement state-funded programs for any qualified immigrants who entered the United States after August 22, 1996, who are subject to the five-year bar on federal assistance. Other legislation has been filed which would allow states to use federal TANF funds to provide assistance and benefits to legal immigrants not withstanding the five-year bar. This proposal would take advantage of current rules or future state options, and seeks to provide legal immigrants access to TANF-funded "support services" as opposed to "assistance," if full restorations do not occur. TANF regulations currently contain a differentiation between the concept of assistance, cash and cash-like benefits, and services, such as employment assistance, ESL and adult literacy classes, transportation, work supports, etc. TANF-funded services for legal immigrants, separate from cash assistance, could foster a number of creative efforts to assist legal immigrants with the skills and supports they need to become employed or improve their skills and work opportunities. Roll out of the TIERS system at DHS will need to be considered in determining the implementation date of this recommendation.

3. The Legislature should explore the option of using a separate state program, to the extent federal rules allow, for selected groups that may require more intensive or customized services than is easily accomplished under the restrictions on federal TANF funds.

Rationale: Under currently proposed federal legislation, Texas would continue to have the option to implement a state TANF program for select groups. Texas would not be spending any additional new dollars; the method of finance would involve using MOE funds instead of federal dollars.

The eligible group would be comprised of individuals who are less able to meet the work requirement contained in the House-passed TANF Reauthorization bill, such as elderly grandparents caring for a child or an adult who is caring for a disabled child or spouse. Taking advantage of this option would decrease the number of individuals counted in our work participation rate, in turn, decreasing the potential for a penalty for failing to meet our federal work participation requirements. It would also allow the state more flexibility for designing programs for families facing uniquely difficult situations. Roll out of the TIERS system at DHS will need to be considered in determining the implementation date of this recommendation.

4. The Legislature should explore federal options regarding child support pass-through and matching funds. Build upon current changes within the child support system that recognize the difference between unwilling fathers and

fathers with low income and explore modifying the child support guidelines for determining support orders for low-income fathers.

Rationale: The State and Federal Governments generally retain child support collected on behalf of families that receive TANF. However, almost half of the states give TANF families some of the support collected on their behalf. Texas currently pays TANF families, for whom child support is being collected, a Supplemental Payment of $50. Pending federal legislation proposes federal matching for states to provide up to the greater of $100 per month or $50 over the current state pass-through to families that receive TANF. This support would also be disregarded for purposes of calculating a family's amount of TANF assistance.

The role of the child support program has shifted from a focus on cost-recovery to an emphasis on supporting family self-sufficiency. Allowing for the greater federally matched pass-through to low-income families would assist these families in better meeting the needs of their children. It would also have the potential of helping these families achieve self sufficiency more quickly.

The Office of Attorney General (OAG) estimates a total of $9.3 million to retain our current system of providing a supplemental child support payment to TANF parents. If Texas replaces the supplemental payment with the $100 federal pass-through option, it would cost $5.4 million ($3.9 million less than current

system). However, a larger portion of the funds passed through would come from retained collections at the OAG's office. If the state replaces the supplemental payment with a pass-through of $75 to current TANF parents, the total cost would be $4 million with virtually no additional costs to retained collections.

5. **The Legislature shall direct the Texas Workforce Commission and the Local Workforce Development Boards to identify housing barriers to employment and to work in partnership with local housing authorities to address these barriers.**

Rationale: According to national studies, a lack of housing is one of the leading barriers to employment. In Texas, initial steps have been taken to build a collaborative model, however, a portion of the TANF population continues to face housing barriers which need to be addressed for these individuals to participate fully in the workforce. Additional efforts to develop collaborative programs between the workforce and housing community will ultimately lead to improved work participation as individuals are able to maintain housing thus increased stability and self sufficiency.

6. **The Legislature should stop the state time clock when clients are working a defined number of hours. If federal Reauthorization allows states the option of stopping the federal clock, Texas should consider this option.**

Rationale: TANF recipients who become employed are able to access an earned income disregard for four months in a twelve-month period. Ninety percent of TANF recipients earnings are disregarded during the 4-month period, after subtracting the standard work-related expenses. However, during the four-month period, the federal and state time limits are still running. This initiative would not count the four months in which the earned income disregard was being applied against state time limits for temporary cash benefits. Stopping the clock for this short period of time, while the clients are transitioning to self-sufficiency, would act as an incentive for work and reward clients who are meeting all programs expectations. It would also allow them to save valuable assistance for any future crises. Roll out of the TIERS system at DHS will need to be considered in determining the implementation date of this recommendation.

7. The Legislature should extend the vehicle limit currently allowed for two-parent families to include all families.

Rationale: Currently, in Texas, when two parent families apply for TANF assistance they are allowed to exclude one vehicle worth up to $15,000. This option has allowed families to obtain reliable transportation that supports their ability to locate and retain work. Applying this vehicle limit to all families would allow single parent families the same opportunities to receive needed assistance while enabling the family to have reliable transportation. This would decrease a key barrier to work.

Roll out of the TIERS system at DHS will need to be considered in determining the implementation date of this recommendation.

8. **Recommend the Legislature explore options to draw down federal transportation funds and direct TWC to address transportation barriers and expand other transportation initiatives.**

Rationale: According to national studies, a lack of transportation is one of the leading barriers to employment. A large portion of the TANF population faces transportation barriers which need to be addressed for these individuals to participate fully in the workforce. Texas should attempt to draw down all available federal funds to address this need. One option Texas could implement would be to assist people in funding work vehicle purchases and repairs. This effort will ultimately lead to improved work participation, stability and self-sufficiency as individuals are able to reach work sites.

9. **The Legislature should review sanction policies to ensure safeguards are in place to assist families in addressing barriers to compliance. Additionally, explore option of graduated incremental steps prior to consideration or implementation of full family sanctions.**

Rationale: The partial sanction process in HB 1863 was designed to send a clear message to TANF recipients about the importance of complying with program requirements. In Texas, where the benefits are low, the legislature made the decision to keep the

children's portion of the grant, in those families being sanctioned, to ensure children receive adequate support. Partial sanctions were part of a balanced package emphasizing personal responsibility through time limits and work requirements with adequate exemptions and appropriate penalties. If Congress mandates a full family sanction policy, Texas should take steps to ensure sanctions are appropriately applied and where needed, address barriers to help families obtain and maintain compliance. Roll out of the TIERS system at DHS will need to be considered in determining the implementation date of this recommendation.

10. **The Legislature should direct the Office of Attorney General and the Texas Workforce Commission (TWC) to improve child support linkages to workforce development services and other critical support services for non-custodial fathers to encourage family involvement and support. TWC should set fathers with children who receive or have received public assistance as a statewide targeted group for workforce services.**

Rationale: The Office of Attorney General in Texas is the primary contact for many low-income, non-custodial fathers who owe child support. As these fathers enter the system, they should be better linked to other systems that can help them increase their life skills and earning power. Helping fathers engage in workforce activities increases the likelihood of them paying more child support over time. Current efforts, like the Non-Custodial Parent Referral Project between the OAG and TWC,

have led to an increase in the sharing of information about low-income fathers between those two agencies.

However, there is little incentive for local workforce development boards to work with the non-custodial parents that the OAG refers and there is inadequate follow-up for those that do receive services. Targeting fathers of children who receive or have received public assistance as a priority group for workforce services at the state level would help improve follow-up and collaboration among these agencies and provide an incentive to local workforce boards to work with this population.

11. The Legislature shall direct the Health and Human Services Commission, the Texas Workforce Commission, and the Office of Attorney General to integrate the importance of working with fathers into existing staff training programs for agency case workers.

Rationale: Fathers are important for the support of the emotional, physical, and financial needs of their children. Public agency caseworkers for low-income families often have stereo types about low-income fathers. While caseworkers are generally willing to serve fathers, there is, at times, an expectation that fathers should take the initiative. Some fathers are able to take that initiative while others struggle to request needed assistance. Fathers must be better engaged by public agencies working with low-income families. Part of this

outreach to fathers includes training agency caseworkers on the importance of fathers in their children's lives.

12. **The Legislature shall direct the Texas Workforce Commission to develop guidelines for job retention and wage advancement strategies and require that employment plans for all TANF recipients include specific post employment strategies to ensure a transition to stable employment at a family supporting wage.**

Rationale: Currently, strategies for job placement are disconnected from post-employment strategies. If clients are placed in a low wage job without a specific plan that connects them to additional education and training opportunities, they will have little realistic opportunity to advance successfully. Caseworkers should build into their employment plans for clients specific post employment strategies. This includes targeting placements to employers to explicitly offering on-the-job training and advancement opportunities. It also requires considering the work schedules of certain jobs, and whether or not they allow for adequate time and scheduling for clients to pursue education and training opportunities.

13. **Implement a strong employability plan for TANF clients at the Texas Workforce Commission (TWC) and the local workforce development boards. Direct TWC and the local workforce development boards to develop a referral plan using community based organizations that provide specific services for the hardest-to-serve clients. Encourage local workforce development boards**

to provide post-employment case management and mentoring for the hardest-to-serve clients.

Rationale: Placing clients in good jobs with higher wages and providing post-employment mentoring increases the likelihood of steady employment and wage growth over time. Local workforce development boards and one-stop centers could use federal funds to coordinate and develop local partnerships and contracts with community-based organizations that provide up front and post employment services to the hardest-to-serve clients.

Child Care

Every day, 13 million preschoolers, including 6 million infants and toddlers are in child care.

Source: National Center for Education Statistics

Background

Child care plays a crucial role in helping families enter and maintain employment by ensuring the safety and well-being of children while parents work. Additionally, child care is often the principal early education program for young children.[52]

Later this year, the US Congress will reauthorize the Child Care and Development Fund (CCDF) and the TANF block grants. Both of these federal block grants were established during welfare reform through the passage of PRWORA.[53] Federal law permits states to transfer up to 30 percent of their TANF block grant to child care. However, in 2002-2003, Texas chose not to transfer TANF funds to child care.

During welfare reform, Congress recognized the need to address accessibility, affordability, and quality of child care as a necessary support in workforce participation and child well being. In addition to making broad changes in the welfare system, Congress altered the funding and policy structure by consolidating several low-income child care subsidy programs into the CCDF and allowing states to transfer TANF funds for child care purposes.[54]

Child Care and early education are critical to the success of two national priorities: helping families work, and ensuring that every child enters school ready to succeed.

Source: Children's Defense Fund: www.childrensdefense.org/cc_facts.htm

Texas Child Care System

Texas has paralleled federal welfare reform over the past five years. Child care policies, funding, and programming have all experienced significant and far-reaching modifications.[55] Both funding levels and the number of children in subsidized care have increased dramatically.[56] While child care funds almost tripled, approximately three-quarters of the increase is due to federal spending.[57] System-wide changes in the management and oversight of child care programs have resulted in a decentralized and locally controlled infrastructure.[58]

The Texas Workforce Commission (TWC) is the state agency responsible for administering the child care program in Texas. The child care system is operated through TWC's network of 28 local workforce development boards (LWDBs).[59] The Texas Legislature sets overall policy but gives LWDBs flexibility in setting eligibility levels, parent co-payment requirements, and provider reimbursement rates.[60] In addition, Texas' LWDBs are required to raise local match dollars to draw down federal child care matching funds.

The transfer of control of the State's child care system to Texas communities has had both positive and negative implications for families and their children. Some well-funded LWDBs have developed innovative programs to address quality and access issues for parents. In other areas, where LWDBs have had limited finances or lack strong leadership, less has been done to improve available child care. Advocates have expressed concern that the local match requirement negatively impacts rural and border communities.

However, TWC states that less than one half of one percent of funds had to be reallocated in FY 2002 as a result of boards not meeting their local match requirement.

Funding for Child Care

When Congress passed PRWORA in 1996, it made more federal dollars available for child care through increased funding for CCDF and by allowing states to use TANF dollars for child care. Since 1996, combined federal and state funding for child care under the CCDF and TANF has more than doubled. The majority of growth in spending has been attributed to federal funds, with most of those funds becoming available through TANF as state welfare caseloads fell.[61]

The additional funding to child care made it possible for many states to increase numbers of children served, raise eligibility levels, reduce parental co-payment requirements, increase provider reimbursement rates, and expand initiatives to improve the quality of care.[62] While these steps are substantial, states may still be forced to make difficult trade-offs, notably the choice between the quality and the quantity of care provided, due to limited resources.[63]

States receive $16.5 billion a year in basic TANF funding. States are permitted to use these funds for child care in two ways: through transfers or direct spending. States may transfer up to 30 percent of their current year TANF funds to CCDF, and as much as 10 percent to the Social Services Block Grant (SSBG), provided the total amount transferred does not exceed 30 percent. Congress also permitted states the option of using the funds they spent on child care to meet their MOE requirements for TANF.[64] Texas does not currently transfer any TANF or SSBG funds to child care, nor does it spend TANF funds directly on child care.

Between FFY 1997 and FFY 2000, CCDF federal dollars available to states increased from $1.9 to $3.5 billion.[65] In FFY 2001, Congress appropriated an additional $817 million in

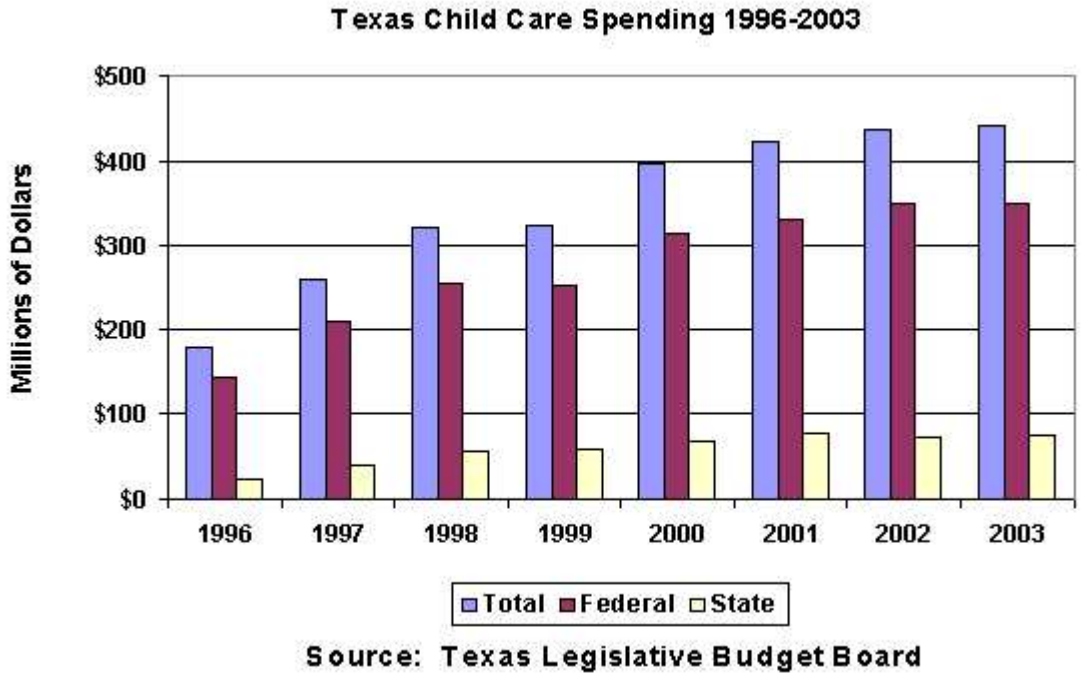
CCDF discretionary funding. However, commencing in 2001, most states began experiencing economic downturns. As a result, many states, including Texas, are facing difficult decisions regarding budgets.[66]

Child care costs can vary widely and are higher for infants, toddlers, and children who spend long hours in care.

Source: National Health Policy Forum

In 1996, child care subsidy spending in Texas totaled $179.9 million, with state funds accounting for $22.6 million of that total. By 2000, total child care spending had grown to $398.4 million, with state funds accounting for $68.4 million of the total cost. By 2003, total child care spending is projected to increase to $441.4 million with $75 million in state funds.[67]

Up to the current biennium, Texas committed all the funds necessary to draw down federal matching dollars. Limited state revenue, however, has resulted in inadequate appropriations for FY 2002-2003, and Texas chose not to draw down all available federal funds. Texas was eventually able to access these funds through a local match, primarily generated by urban communities.[68]



As part of Texas' child care decentralization process, LWDBs are asked to come up with local matching funds, and the state, in turn, uses the funds to draw down federal match. These funds are then distributed to the LWDBs according to the amount of local match that was raised by each board. LWDBs are also eligible to attempt to drawn down federal funds not matched by state appropriations.

Texas advocates fear that the state's local match expectation has the potential to increase existing disparities across the state by advantaging LWDBs with greater access to resources. Local workforce development boards in rural and border areas have limited local capacity to generate match and may benefit less from increased child care allocations.[69] Continued local capacity to generate matching funds and the effects on local communities caused by increased state expectations, occurring alongside dropping local tax revenues, and, increasing demands on local charitable donors, raises additional concerns.

Eligibility Criteria

Despite the progress in increasing the number of families receiving assistance, the majority of potentially eligible families do not receive child care assistance.[70] The US Department Health and Human Services (DHHS) estimated in FFY 1999 almost 15 million children met federal CCDF eligibility guidelines. Therefore, the 1.8 million children receiving child care funded subsidies constitutes only 12 percent of potentially eligible children in FFY 1999.[71]

Texas currently extends child care services to 109,000 children out of a potentially eligible population of 1.2 million.[72] Texas is serving approximately nine percent of the total potentially eligible population.

In Texas, child care eligibility criteria are established by the LWDBs up to the federal limit of 85 percent of State Median Income (SMI). For a family of three this would equate to income between $21,948 - $38,052 in FY 2002. Income eligibility among the LWDBs ranges from 49 percent to 85 percent of 2002 SMI. This equates to a range of 150 to 260 percent of the 2001 poverty guidelines. Child care is not guaranteed to all working-poor families who are eligible.[73]

Child Care Access

Nationally, between 1996 and 1999, the average monthly number of children receiving child care subsidies grew from one million to 1.8 million. DHHS estimates that the number of federally eligible children grew by approximately one million from October 1997 to October 1999.[74] Many factors have contributed to this increase.

First, welfare caseloads have dropped by 1.8 million families from 1996 to 1999.[75] Studies found that the majority of these families are employed, but typically in low-wage jobs. According to data from the National Survey of America's Families (NSAF), median wages for recent families leaving TANF in 1999 were $7.15 an hour.[76] A study in Texas showed that 46 percent of respondents reported receiving hourly wages averaging $7.20, slightly

above the national average.[77] The share of families working or participating in work-related activities while receiving TANF has also grown significantly due to changes in welfare reform. Lastly, there was a large increase in labor force participation by low-income single parents. The Administration reported that after a decade in which the annual employment rate for single mothers remained at 58 percent, the rate had increased every year, reaching over 73 percent of mothers heading families in 2000.[78] Over this period, both the number of families needing child care and the number of families receiving child care assistance grew sharply.[79]

While employment for low-income parents has surged, much of that employment has been in low-wage jobs. A family with both parents working full-time at minimum wage earns only $21,400 a year. Sustaining and increasing work rates for these populations depends heavily on the ability of families to find affordable and reliable child care. More than one quarter of families with young children have incomes less than $25,000 per year.[80] Even though some child care subsidies are available for low-income families, funds are severely limited. Currently, no state serves all families eligible for assistance under federal guidelines.[81]

Despite the doubling of federal child care spending on low-income families since 1997, researchers estimate that only about one in seven eligible children, and only one-third of workers leaving welfare, receive any federal child care support.[82]

By 2003, TWC projects that it will provide child care to 107,195 Texas children. This is a significant increase from the 1996 total of slightly more than 63,000 children. TWC has set the maximum income eligibility for child care at the federal maximum of 85 percent of SMI. While 85 percent SMI represents the state maximum, nearly all LWDBs have set operational limits at much lower income levels.[83]

Texas also operates an extensive pre-kindergarten program through its public school system, serving three- and four-year olds who have limited English proficiency, are educationally disadvantaged, or are homeless.[84] While, these programs are typically not full-day or full-year and are not available in all school districts, they provide a significant complement to the state's subsidized child care system.

Increases in the number of children receiving subsidized child care in Texas are related to additional funding and to an increased demand for services. Texas guarantees child care to TANF recipients. Additionally, Transitional Child Care (TCC) services are available to families for twelve to eighteen months as long as the families' employment income does not exceed the income guidelines.[85]

While Texas' TANF caseloads have dropped significantly since 1996, the percentage of recipients required to participate in work activities has increased. When the 1996 federal welfare law was passed, the work exemption pertained only to families with a child under the age of one. Texas, however, had a waiver allowing families with children five and under to be exempted. Texas stair-stepped the age of exemption over a three-year period from six down to one, to accommodate the expiration of the waiver and the need to conform to federal law. This change has resulted in a significant increase in TANF recipients who need child care assistance.[86]

The increase in TANF recipient child care is anticipated to have a direct impact on resources available for "at-risk" or working-poor recipients. The 2001 General Appropriations Act projected the number of TANF Choices participants to increase from 8,150 in FY 2000 to almost 20,000 by FY 2003.[87] The economic downturn and revised projections will likely increase this number.[88] In 1996, Texas served 10,996 children of Choices participants in the child care program and it is expected that number will increase to almost 28,000 in 2003.[89]

Quality Child Care

The body of research linking quality child care to good child development outcomes has grown considerably since 1996.[90] Quality child care has a lasting impact on children's well-being and ability to learn. Children in poor quality child care have shown delays in language and reading skills, and display more aggression toward other children and adults.[91] Children in higher quality child care demonstrated greater mathematical ability, greater thinking and attention skills, and exhibited fewer behavioral problems than children in lower quality care.[92] These research results were true for children from a variety of family backgrounds, with particularly significant effects for low-income children.[93]

Attending formal child care programs of at least adequate quality enhances school-age children's academic performance. Children attending such programs have been found to have better work habits and relationships with peers, and to be better adjusted and more social than children who spend their out-of-school hours alone, in front of the television, or informally supervised by other adults.[94]

Child development researchers have described the current supply of child care for families of all incomes as mediocre.[95] Staff salaries are low, training is inadequate, and in many cases group size and child-to-staff ratios are high.[96]

Child care helps shape children's futures and is key to school readiness.
Source: Children's Defense Fund: www.childrensdefense.org/cc_facts.htm

Providing families with high quality, developmentally appropriate child care is a priority of TWC and the 28 LWDB's. However, limited resources can severely impair LWDBs' ability to maintain and improve quality of child care in their communities.

Beginning in FY 2002, LWDBs are no longer mandated to spend four percent of their child care funds on quality improvement initiatives. Prior to this fiscal year, spending by LWDBs on quality initiatives was part of the state calculation in meeting the federal requirement that four percent of CCDF dollars be spent on quality and/or licensing activities. Due to funding constraints, Texas uses existing funding for child care regulatory and licensing activities to meet the four percent federal quality spending requirement.[97] LWDBs can continue spending a portion of their child care allocations on quality initiatives, but at the risk of not meeting state expectations for child care slots available.

Texas' LWDBs have used quality funds for a variety of purposes including:

- designated vendor [Texas Rising Star] and national accreditation incentives;
- caregiver training on a range of relevant topics;
- creative efforts to increase school-age and infant and toddler capacities;
- early childhood education development, including funding for innovative lending libraries and technology projects;
- parent education; and
- technical assistance[98]

In addition to local quality improvement initiatives through the LWDBs, TWC is responsible for statewide quality activities, including:

- publication and distribution of *Child Care Quarterly* magazine;
- *Train Our Teachers* education scholarship program (currently funded with $1 million in CCDF discretionary funds);
- development and implementation of 19 Employer Dependent Care Coalitions;
- development of *Child Care Texas*, a resource and referral service expected to operate statewide by 2006; and
- publication and distribution of 80,000 *I Am Your Child* developmental calenders to self-arranged care providers and others in 2001.[99]

Despite promising programs, state quality initiatives to date are small in scale. Texas would benefit from expanded resources to reach more providers and children to ensure that all children have access to early learning opportunities and to ensure that gains made locally are not lost due to funding contractions.

Child Care Reauthorization

Pending reauthorization of the TANF and child care block grants brings considerable uncertainty to the current TWC budget process due to the profound impact that decisions made in the US Congress will have upon Texas' workforce development system. Currently, reauthorization is in the US Senate with the possibility that it will be pushed back until next year with funding levels remaining constant until the issue is debated and signed into law.[100]

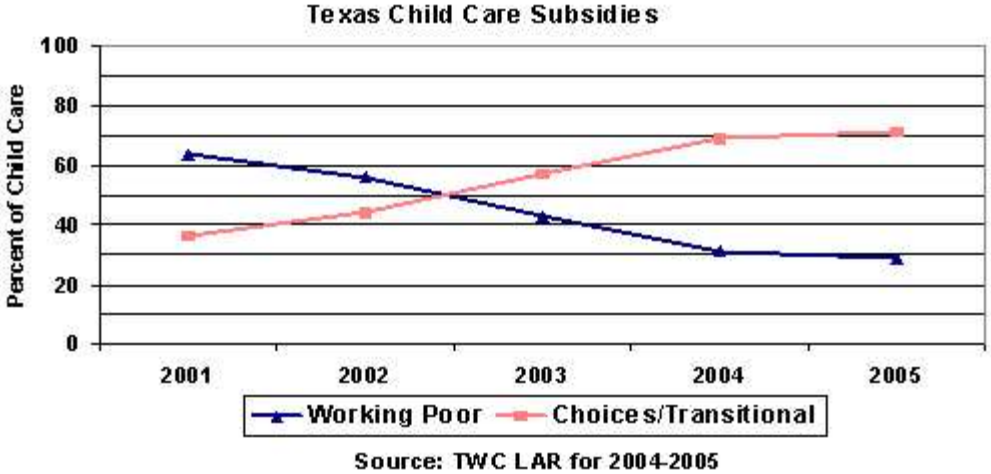
Proposed increases in TANF work participation rates and hours, having bipartisan support in both the House and Senate, have significant cost implications to Texas. If Texas must comply with the full 70 percent participation rate requirement advocates estimate a one-year cost of $108 million in related child care costs.[101] Unless Texas is able to absorb the cost of 10,000 to 30,000 children from working-poor families, these families may lose child care, depending on Congress' final decision regarding work participation rates.[102]

Choices and Transitional Child Care slots represented 36 percent of the state's child care subsidy program in 2001. However, by 2005 this figure is expected to increase to 71 percent of the state's child care subsidy program. Working families will have fewer child care slots as the number of welfare recipients accessing the state's limited slots increases. Families that are currently receiving child care subsidies and those needing assistance paying for child care will have more difficulty retaining or receiving a child care subsidy.[103] These percentages are based upon the assumption that TWC receives its request for $176 million in TANF for the biennium. Several state agencies have requested TANF funding in their LARs which exceeds the amount of TANF funds available. If TWC does not

receive the requested TANF funds, the number of At-Risk families helped will be significantly lower.

Though necessary and required by Texas law, prioritizing TANF recipients and leavers for child care subsidy eligibility in times of limited resources can hurt non-TANF families. TWC projects an estimated 6,000 fewer children per day from non-TANF families will have access to child care subsidies in 2003, as LWDBs transfer available resources to the children of prioritized Choices participants and former participants receiving TCC.[104] The reduction is expected due to funding limitations. Additionally, the state will be required to serve more than 5,000 additional children of TANF recipients who are guaranteed child care services, largely due to changes in exemption policies for parents with young children. As a result, the state may be required to reduce the number of openings available to non-TANF families.[105]

Low-income working parents removed from the child care subsidy program may have to choose between putting their children in questionable circumstances while they work or potentially losing their jobs due to lack of child care. Because parents participating in the Choices program are prioritized for child care subsidies, many parents may lose child care and may return to welfare or apply for public assistance for the first time.[106]



Texas Workforce Commission's 2004-2005 Legislative Appropriations Request (LAR), requests additional federal child care funds totaling $74.6 million and $74.9 million, respectively, in an attempt to offset some cuts in subsidies to working-poor families. As stated previously, Texas' current funding levels support only nine percent of the potentially eligible population. Texas is dependent on federal dollars to fund its child care subsidy system, with state funds currently accounting for only 17 percent of the total funds expended. Texas should consider additional funding in order to address the state's unmet need for child care subsidies.[107]

Conclusion

Texas must review its current spending on child care subsidies and invest in improvements to the child care programs' capacity and quality. Many families who could benefit from child care assistance remain unserved and thousands of working-poor families face service cuts. Moreover, much remains to be done to improve the quality of child care and to assure that low-income children are provided with early education opportunities. Additional federal funding is essential to make continued progress in expanding access to child care for low-income working families, improving the quality of child care, and ensuring early education opportunities for all children.

Recommendations

14. The Legislature shall direct the Texas Workforce Commission to develop a protocol to evaluate the success of the child care subsidy system through examination of participant and programmatic outcomes and report to the Legislature.

Rationale: Texas spends approximately $425 million annually on child care subsidies. If Texans are to be assured that the child care program is effectively helping families transition from public assistance or poverty to self-sufficiency, the effectiveness of the child care subsidy system must be evaluated on its ability to: increase parents' earnings; to improve the training of child care professionals; to facilitate collaboration with Head Start, Texas Education Agency, Texas Protective and Regulatory Services and the Health and Human Services Commission; and other measures deemed appropriate for study.

15. The Legislature shall develop a program based on the TEACH model and require that a portion of any additional Federal Child Care Development Fund (CCDF) quality earmark set-a-sides be allocated for the education and compensation support of child care providers as outlined by this model.

Rationale: Originating in North Carolina in 1990, the T.E.A.C.H.(Teacher Education And Compensation Helps) Early Childhood Project supports scholarships, education, compensation, and retention of child care teachers. The program has significantly improved the quality of care children received in North Carolina. With North Carolina's statewide universal availability of

scholarships, the state now requires in its licensing standards that lead teachers and directors in licensed child care centers have college courses as a requisite for their positions.

SB 1294 passed in the 77th Legislature established the T.E.A.C.H. Early Childhood Project as a pilot program in Texas. Texas should move toward statewide implementation of a model, based on that program. The Texas Workforce Commission (TWC) is in discussion with Texas A&M to implement a similar model. TWC is currently developing plans to provide scholarships, create a training registry and develop an endowment to pay teacher bonuses with the ultimate goal to enhance teacher education and retention.

16. **The Legislature shall direct the Health and Human Services Commission in conjunction with the Texas Workforce Commission and the Texas Department of Protective and Regulatory Services to develop a comprehensive report of statewide and local initiatives, publicly and privately funded, targeted at enhancing the quality of child care. The report will establish statewide benchmarks and will include a description of the program's activity, its success factors, the amount and source of funding and programmatic best practices for statewide use.**

Rationale: While the majority of initiatives targeted for enhancing quality of child care are provided through TWC and the local workforce development boards, there are a number of initiatives funded through other public - federal, state, and local-funds, as well as privately funded initiatives. The report

will provide valuable information on the success of the programs, as well as the possibilities of the funding source to be used to leverage additional funds. Additionally, the report may provide models that could be replicated statewide. Ideally, this effort would be coordinated with the work of the Office of Early Childhood Coordination and the development of the statewide strategic plan for services to children under the age of six.

17. **The Legislature shall direct the Texas Workforce Commission to provide technical assistance to board areas on employer driven child care resources by September 1, 2003 by: assisting working-poor subsidy recipients in establishing "dependent care accounts," pre-tax payroll deductions for child care costs; and encouraging employers to provide increased child care benefits to low-wage employees including marketing tax incentives as well as research-demonstrated productivity increases. Direct the LWDBs to give a 30-day notice to families prior to termination of child care services.**

Rationale: Texas must do more to assist working parents of all incomes pay for child care. It is particularly important to begin planning for steep declines in access to child care subsidies for the working-poor. The $1 billion increase to the Child Care and Development Block Grant will merely allow local authorities to increase vendor reimbursement rates in order to keep pace with inflation. Furthermore, the increased work participation and work hour requirements included in the House bill will place an increased demand on available child care funds, and a much larger portion of child care funds will be "mandatory,"

or reserved for TANF clients, not the working-poor. Texas may be unable to redirect TANF funds into child care in order to prevent reductions in "discretionary" child care funds for the working-poor because current TANF funding patterns will lead to projected deficits during the next biennium due to competing agency requests. It will be important to take advantage of the existing infrastructure the Texas Association of Child Care Resource and Referral Agencies has developed to assist families to find alternative child care and to decrease the chance of a job loss due to a lack of child care. The Texas Workforce Commission and LWDBs must begin planning for possible terminations of child care subsidies for the working-poor. Having LWDBs give families sufficient notice prior to discontinuing their service will assist these families in finding alternative care and decrease the chances of job loss due to lack of child care.

18. **The Legislature shall direct TWC to assist LWDBs in collaborating with other child care resources - Head Start, Pre-Kindergarten, and locally funded after school programs to: identify children in state funded child care who may qualify for the above programs, and assist board areas in developing collaboration agreements with these programs in order to facilitate program transfers when appropriate and desired by parent. Direct the Texas Education Agency to develop a plan for a joint-funded program (Pre-K and CCDF Dollars) that will allow pre-kindergarten programs to be established within the child care industry.**

Rationale: As subsidized child care resources become more difficult for the working-poor to access and, in an effort to facilitate the transition of families receiving subsidized child care to other child care resources, it will be critical for LWDBs to work closely with other community and state programs serving young children. Texas should implement a single portal of entry for child care, pre-kindergarten, and Head Start services to ensure maximum use of scarce state and federal funds. The Texas Association of Child Care Resource and Referral Agencies will be vital to the success of any collaborative effort because they can disseminate the information across their network.

19. The Legislature shall direct the Texas Workforce Commission to assist LWDBs in developing measurable targets in quality improvement. One measure should be a focus on sustained improvements at the provider level by assisting them to achieve Rising Star status, or accreditation through the National Association for the Education of Young Children.

Rationale: During the last legislative session, the federally mandated quality improvement obligation was effectively fulfilled through existing programs within Child Care Licensing. LWDBs are no longer required to spend four percent to improve child care quality with CCDF dollars. It is important to return control of quality spending to local boards, child care contractors, local organizations and providers.

The other side of the issue involves the quantity of child care resources. As Texas is faced with the task of providing services to an increasing number of families, the issue of spending resources on quality is often questioned. However, providing poor quality child care decreases the likelihood that children will be prepared to learn.

20. The Legislature should set aside any CCDF earmarked funds above the current 4 percent requirement to be restricted to quality activities and initiatives, and not be allowed for direct care slots. These funds should be under the direction of local workforce development boards.

Rationale: The Texas Workforce Commission is designed as the lead agency for subsidized child care in Texas. According to federal regulations, at least four percent of these funds must be used to enhance child care quality on a state level. Pending federal legislation expands the CCDF funds set aside for quality activities from the current 4 percent to anywhere from six to 12 percent. Requiring additional earmarked funds to be set aside provides direction to the agency to designate a portion of those funds for quality activities. Currently, the specific earmarks include: infant and toddler; school age; and capacity building. However, these funds could also be used for other quality initiatives.

Food Stamps

Background

The Food Stamp Program (FSP) is the largest federally-funded food assistance program in the United States serving an average of 17.3 million individuals per month in 2001 at a cost of $15.5 billion.[108] In FFY 2001, Texas served an average of 1.394 million participants and issued over $1.24 billion in Food Stamp benefits.[109] In FFY 2002 the monthly average of Food Stamp participants exceeded 1.5 million reaching a total of $1.48 billion in benefits.[110]

The goal of the FSP is to provide crucial support to low-income families to assist them in purchasing nutritious meals at a low cost. Food stamps are available to most low-income households with few resources, to supplement their food purchase and help them maintain a healthy diet. The program also provides assistance to those making the transition from welfare to work.[111]

The US Department of Agriculture's Food and Nutrition Service (FNS) administers the FSP at the federal level. State agencies administer the program at the State and local levels, including determination of eligibility and allotments, and distribution of benefits.[112] The Texas Department of Human Services (DHS) is the state agency responsible for administering the FSP in Texas.[113]

The federal government funds the total cost of food stamp benefits issued to participating households and contributes 50 percent of the state's cost in administering the program. To be eligible for the program, families must have limited assets, gross income less than 130 percent of the FPL, and countable income after allowable deductions must be less than 100 percent of the FPL.[114] There is no limit on the length of time families with children may receive food stamps. Able-bodied adults *without* children can also qualify for Food Stamps but face time limits on benefits. The level of benefits that each household receives

is determined by income and family size.[115] Currently, the average per person benefit in Texas is $78.32. Food Stamp benefits for a family of four averages $308.96 per month.[116]

Nationally, according to the FNS, in FY 2001, nearly 54 percent of all food stamp benefits went to households with children.[117] Of these households, over two-thirds (67.4 percent) were single-parent households. Households containing elderly individuals represented 20.4 percent of the food stamp population; and over one-quarter of food stamp households contained an individual with a disability.[118]

In Texas, the average size of a food stamp household is 2.7 persons with female-headed households accounting for slightly more than 83 percent of the food stamp cases. Of households with income, 14.7 percent of heads of household work full- or part-time and approximately 87 percent have some income, of which 34 percent have earned income. Only 19 percent of Food Stamp recipients receive TANF cash assistance.[119]

The FSP has played an important role in reducing hunger in the United States. Moreover, Food Stamps serve as an important work support by assisting low-wage workers to make ends meet. However, it is estimated that the FSP nationally reaches only 57 percent of those eligible for the program.[120] It is estimated that Texas is currently reaching approximately 46 percent of the potentially eligible population.[121]

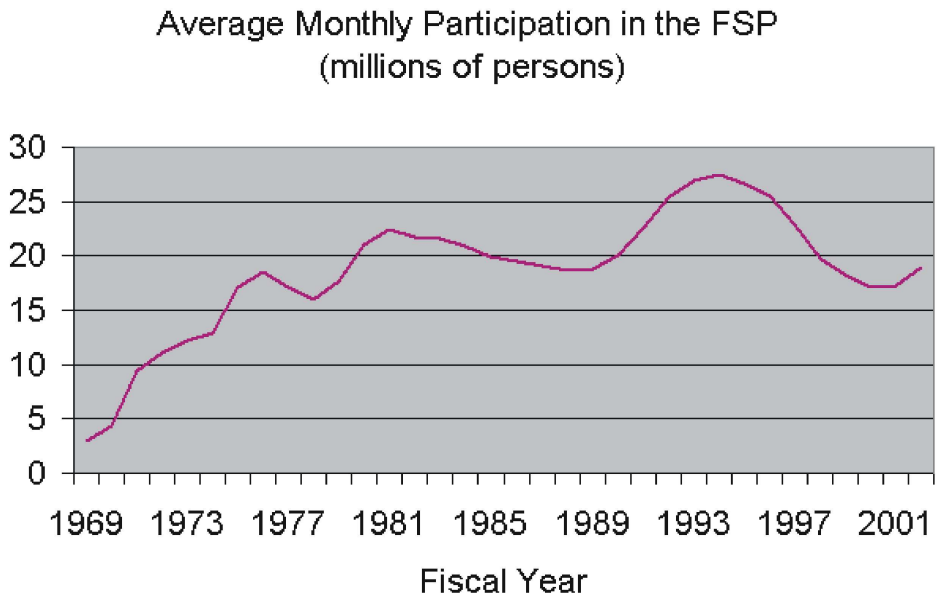
Following the PRWORA, food stamp caseloads dropped significantly. In Texas, as of June 2002, only 1.6 million persons received food stamps as opposed to 2.7 million in July of 1994.[122] While a booming economy and changes in food stamp eligibility, such as the exclusion of legal immigrants, certainly contributed to this decline, other factors also played a role. For example, more time-consuming and complex administrative enrollment requirements may have contributed to a smaller percentage of eligible families participating in the program.[123]

While participation rates for the elderly and disabled have remained fairly constant, participation rates among households with children have declined significantly. In 1995 approximately 6.5 million households with children, in the United States were receiving food stamps compared to four million households in 2000. From 1995 to 1999, the participation of eligible families with children declined from 85 percent to 67 percent. It is estimated that more than half the decline in food stamp cases occurred because fewer eligible individuals participated.[124]

Research shows that food stamps can lift low-income families out of poverty and help them to make ends meet.[125] The decline in food stamp participation in Texas not only means that low-income families may not be receiving adequate nutrition, but also that Texas is foregoing millions of federally funded food assistance each year. In 2002, based on census data, 3.2 million Texans potentially eligible for food stamps, were not enrolled in the program. Additionally, it is estimated that from 1996 to 2001, Texas lost almost $3.9 billion in federal food stamp revenue as a result of the decline in enrollment.[126]

Food Stamp Caseloads

Food stamp caseloads typically mirror changes in the economy. During periods of high unemployment they increase, they decline when the economy improves. Despite these fluctuations, nationwide food stamp caseloads have increased steadily over the years, reaching a peak of nearly 28 million participants per month in FY 1994. However, in 1994, food stamp caseloads began to decline more rapidly than unemployment and did not start to grow again until recently. Nationwide caseloads declined by 38 percent to just over 17 million participants per month between FY 1994 and FY 2001.[127]



Source: Making Wages Work http://makingwageswork.org/foodstamps.htm

Research findings point to three primary reasons for these steep declines. These factors include a strong economy during the 1990s, welfare reform, and a tightening of eligibility requirements.[128] In addition, pressure on states from the federal government to improve payment accuracy in the program led states to put in place more stringent enrollment and recertification requirements in the 1990s which may have unintentionally discouraged participation.[129]

In 1996, Congress tightened eligibility requirements for food stamp participants. Federal legislation established work-requirements and time limits for able-bodied adults with no dependants and disqualified most legal immigrants. The 1996 changes also reduced food stamp benefits from an average of 80 cents, per person per meal, to an average of 75 cents.[130] These reductions in benefits likely reduced the incentive for some households to participate in the program.

From 1994 to 1999, USDA estimates that eight percent of the national decline in food stamp participation can be attributed to the direct effect of welfare reform's changes to Food Stamp eligibility rules, which restricted eligibility for non-citizens and imposed time limits on able-bodied adults without dependents.[131] In Texas, the federal changes designed to limit participation by legal immigrants also played a role in the Food Stamp decline. In 1996, 168,000 legal immigrants received Food Stamps in Texas. By November of 1999, that number had fallen to 52,629. When compared to the total food stamp decline over the same time period, the drop in participation by legal immigrants accounts for 12 percent of the overall drop in food stamp enrollment.[132]

A strong economy and changes in eligibility rules can account for some of the declines in food stamp participation, but not all. Food stamps remain an entitlement and, except for the changes in eligibility mentioned above, the welfare reform legislation was not intended to affect food stamp or Medicaid recipients.[133] However, research shows that welfare reform inadvertently created barriers to participation in both Medicaid and the FSP.[134]

Most families leaving TANF cash assistance programs have low incomes and remain eligible for food stamps when they go to work.[135] However, several reports have found evidence that clients who left welfare left the FSP at significantly higher rates than those who had not been on welfare, even though both of these groups still qualified for food stamps based on their income.[136] Research by both the U.S. Department of Health and Human Services and the Urban Institute has shown that fewer than half of the individuals who leave TANF cash assistance continue to participate in the FSP despite earning low wages and, in most cases, remaining eligible for food stamp benefits.[137] These findings suggest that many people leaving welfare due to increased earnings or time limits may have falsely assumed the more stringent welfare rules also applied to food stamps.[138]

Extensive paperwork requirements have also created barriers to participation and may be among the recent declines. For example the FSP has historically required that clients

report changes in their household's circumstances within 10 days of the change occurring.[139] This requirement is particularly challenging for working families, whose income and expenses are more likely to fluctuate than those of non-working families. While large numbers of food stamp households have moved from welfare to work in recent years, many have dropped out of the FSP, finding it too cumbersome to keep up with the program's extensive paperwork requirements.[140]

USDA's emphasis on minimizing payment errors and reducing fraud, known as Quality Control (QC) may also have inadvertently contributed to a decline in participation among eligible families. Under the QC system, USDA evaluates states according to the accuracy of food stamp benefits issued and imposes fiscal sanctions on states with error rates above the national average.[141] As a result, during the mid 1990s, many states increased paperwork requirements, face-to-face visits, and required families to reapply for food stamps more frequently in an effort to monitor households more closely in order to reduce errors and avoid sanctions. Research suggest that these changes contributed to many working families leaving the program.[142] States requiring working families to reapply for food stamps every three months experience much higher caseload declines among working families with children than did other states.[143]

Under the QC system, states are also eligible to receive substantial monetary rewards for successful efforts to improve payment accuracy, which creates another incentive for states to lower their error rates. Texas has been a leader in this area for the past several years. Since 1999, Texas has received $106 million in enhanced federal funding for program administration (above the 50 percent share already paid by the federal government) and is estimated to receive over $30 million more by 2003, before the QC reforms in the 2002 Farm Bill discussed below take effect. The following chart illustrates actual and projected enhanced funding award amounts by fiscal year through FY 2003.[144]

Texas Enhanced Funding Awards (in millions)				
FY 1999	FY 2000	FY 2001	FY 2002	FY 2003 est.
$19.7	$27.9	$28.6	$29.8	$30.0

Source: Legislative Budget Board

The FY 2002-2003 General Appropriations Act earmarks up to $2 million of these funds for operation of nutrition education and outreach programs and, $5 million for bonuses to employees responsible for attaining enhanced funding or improving client access to food stamps. The balance of these funds are designated for the Texas Integrated Eligibility Redesign System (TIERS).[145] Additionally, portion of the outreach funds are being used to pay for a food stamp outreach campaign operated by DHS.

Since 1999, DHS has operated a food stamp education and outreach campaign to raise awareness about the FSP in low-income communities with high percentages of potentially eligible residents and low participation rates. DHS contracts with the Texas Association of Community Action Agencies to conduct the outreach at the local level. In addition, DHS has recently started airing radio spots to publicize the FSP. This outreach has played an important role in educating low-income individuals about the availability of nutrition assistance. Current outreach efforts are focused on assisting applicants with the enrollment process.

Current Caseload Increases

Nationally participation in the FSP has recently started to increase, most likely as a result of the poor economy, as well as, changes in eligibility and enrollment requirements mandated by new federal and state laws. In April of 2002, 19.1 million people participated in the FSP nationwide.[146] From March 1994 to July 2000, food stamp participation decreased by 11 million participants, a 40 percent decline.[147] In contrast participation has increased by 2.3 million people since July 2000.[148]

It is difficult to determine what caused the increase in participation, but research indicates it is likely that the majority of the increase can be attributed to the recent economic downturn.[149] Unemployment rates increased throughout 2001 and remained high in 2002.[150] Rising unemployment during this same period is accountable for some of the caseload increase as more families became eligible for food stamps.[151] Additionally, rules targeted at improving program access may also have helped encourage program participants. While some of the increase can be attributed to a greater share of eligible families participating in the program, this effect is believed to have been smaller than the impact of the economic downturn.[152]

Food Stamp Reauthorization

In May of 2002, President Bush signed into law, the Farm Security and Rural Investment Act of 2002, (Farm Bill), that includes provisions for reauthorizing and strengthening the FSP. Certain provisions in the nutrition title of the Farm Bill are mandatory changes states must implement, while others are options states may choose to exercise.[153]

The nutrition title of the 2002 Farm Bill makes significant changes in the FSP. These changes are intended to simplify enrollment in the FSP, increase benefits for larger families, restore benefits to many legal immigrants, and reform the Quality Control system that evaluates state performance.[154]

Additionally, states have been given several new options to help them deliver benefits more efficiently to households, especially working households. Adopting the new options will make the FSP easier for states to administer and simpler for families to access. The Quality Control system has been revised to focus on states with consistently high error rates, making it less likely that states will face penalties. The reward system has also been reformed to include new areas in which state performance will be measured, such as the timely provision of benefits to households.[155] Some of the other options include extending transitional benefits to families when they leave welfare, semi-annual reporting of

household changes, simplified treatment of child support, and the easing of restrictions in the Food Stamp Employment and Training Program.[156]

Mandated Changes to the Food Stamp Program

Partial Restoration of Benefits to Immigrants

Under the new law, qualified immigrants will become eligible for the FSP after they have lived in the US for five years, although "sponsor deeming" of income will remain a requirement.[157] Sponsor deeming refers to counting the income and resources of the immigrant's sponsor when determining food stamp eligibility and benefit amounts.[158] However, federal regulations issued in November of 2000 exempt most immigrants applying for Food Stamps from the deeming provisions.[159] This provision is effective April 1, 2003.[160]

The new law also extends eligibility to legal immigrants who receive a disability benefit, regardless of date of entry into the U.S. (current law requires them to have been in the country on or before August 22, 1996). However, because legal immigrants who arrived after August 22, 1996 are not eligible for federal disability benefits, the only disability benefits available in Texas, this change will have no effect in Texas. Certain states provide state-funded disability benefits to legal immigrants who arrived after August 22, 1996, which under the new law means these immigrants will now be eligible for Food Stamps as well.[161] This restoration takes effect October 1, 2002. Additionally, all qualified immigrant children will become eligible for food stamps effective October 1, 2003 (current law restricts eligibility to children who were in the country prior to August 22, 1996). The provision also eliminates the deeming requirements for immigrant children.[162]

Restructured Standard Deduction

When calculating food stamp benefits, households are permitted to deduct, from their income a "standard deduction" to reflect the basic costs of housing, utilities, and other household expenses. Under prior law the standard deduction of $134 was the same for

all household sizes. The new deduction will vary by household size and will increase with inflation. The deduction is set at 8.31 percent of the federal poverty level for each household size, but no less than the current $134.[163] The standard deduction for households of five persons will be $147 and for households of six or more persons will be $168. Households of fewer than five will continue to receive the $134 standard deduction until increases in the cost of living raise the Federal Poverty Level to the point that 8.31 percent of FPL for their household size exceeds $134. This provision is effective October 1, 2002.[164]

The USDA's implementation memo to States includes a table with the new standard deduction amounts for FFY 2003 that starts on October 1, 2002. See chart below.

Household Size	Standard Deduction
1 person	$134
2 people	$134
3 people	$134
4 people	$134
5 people	$147
6+ people	$168

Resource Limit for Persons With Disabilities

This provision raises the asset limit for households with a member who is disabled to $3000, making it the same as the asset limit for households with an elderly member.[165] This provision will not affect Texas, where under state regulations all households may have resources up to $5000.

Quality Control Reform

The Farm Bill includes a major reform of the food stamp Quality Control system, under which the federal government oversees the accuracy of state agencies' food stamp payments. It modifies the current feature, whereby states face annual fiscal sanctions if their payment error rate exceeds the national average. In addition, the current system of enhanced funding (which states are now eligible to receive when they lower their error rate below the national average) will be replaced with $48 million per year in new performance bonuses to states. Bonuses will be provided to states with the best or most improved performance in several areas that are yet to be determined, although the law prescribes a process for establishing the new criteria.[166]

Under the new system, starting October 1, 2002, a state may only be penalized if there is a 95 percent statistical probability that its error rate has been above 105 percent of the national average for two consecutive years. In addition, USDA has informed states that they will not be penalized for errors incurred within 120 days of implementing the new law provisions.[167] This reform eases the threat of fiscal sanctions dramatically allowing states to consider program changes previously rejected out of concern they might increase error rates.

State Options to Simplify Food Stamps

Improved Transitional Food Stamps

Under previous food stamp regulations, states may adopt a Transitional Benefit Alternative (TBA) and grant up to three months of food stamps to households that leave welfare (TANF) for work or other reasons, without requiring these households to submit new information or recertify for food stamp benefits. Texas has opted not to offer a three-month transitional benefit. The new provision allows states to provide up to five months of transitional food stamps to families that leave welfare without requiring the family to reapply or submit any additional paperwork.[168]

During this transition period the household's food stamp benefit level is frozen at the amount it received prior to leaving TANF, with adjustments made for the loss of TANF income.[169] Two exceptions to this rule include: 1) a household may reapply in order to have its benefits adjusted; and 2) the state may opt to adjust benefits based on information it receives from another program in which the household participates, such as, the state's child care subsidy system. This option also makes the program easier for states to administer by allowing recertification to be postponed until the end of the transition period.[170]

All families leaving TANF would be eligible for transitional food stamps except those sanctioned under the state's TANF program, those ineligible to receive food stamps due to an intentional program violation such as a work sanction, and any other population at the state's discretion.[171]

Transitional food stamps help working households understand that food stamp benefits are not dependent upon TANF enrollment. They also ease the burden that extensive paperwork and multiple office visits place on families and state agencies during the transition period.[172] This option will go into effect when a state elects to enact the provision.

Determination of Amount of Deductions

Under current policy, Food Stamp recipients receive deductions for certain expenses, such as child care, when their benefits are calculated. Clients are currently required to report changes that would affect these deductions within 10 days of the change in their circumstances. This option gives states the ability to freeze most deductions between certifications, which means both that clients no longer have to report certain changes, and the state agency is not required to act on these changes even if the client elects to report them. Exceptions to the provision include changes in earnings and changes in residence, which clients must continue to report. Under both of these circumstances, deductions will

be adjusted to reflect the change.[173] Implementing this option has the potential to reduce reporting requirements for food stamp recipients and potentially reduce the chances for an error on the part of clients and eligibility workers, which will improve payment accuracy in the FSP.[174]

Congress has given states the option to freeze deductions between certification periods in an attempt to reduce the paperwork burden for clients and caseworkers. As the FSP's rules have grown more complicated over the years, and more emphasis has been placed on QC, the workload of eligibility workers has increased. Freezing deduction between certifications is one way states can now ease the workload of their caseworkers.

Improved Semi-Annual Reporting Option

The current requirement that households report all changes in their circumstances to the food stamp office, can present an obstacle for clients, particularly working families who may experience frequent changes in their circumstances. Many working families are unable to keep up with these reporting demands, and consequently lose or forego food stamps for which they are eligible.[175] To ease these requirements, since early 2001, USDA permits states to collect information from working households every six months via a written report.[176] Effective October 1, 2001, states are allowed to extend this semi-annual reporting option beyond households with earnings to almost all food stamp households.[177]

Under a semi-annual reporting option, the family's food stamp benefit level is frozen during the six-month period, and the family will only be required to report if its monthly income rises above the eligibility limit (130 percent of the FPL). In most cases, during the six-month period, states are not required to act on reported changes that *decrease* a client's benefit, but are required to adjust the benefits should the family report a change that increases its allotment, for example if the household lost income or gained new members in the interim. In addition to easing the burdens on clients, semi-annual reporting reduces the workload of state caseworkers.[178]

Simplified Treatment of Child Support

Currently, individuals applying for food stamp assistance are required to supply the food stamp agency with the necessary proof of payment of child support. Any child support paid is then treated as an expense that is deducted from the household's income when calculating its benefit level. The Farm Bill simplifies treatment of individuals paying child support in two ways. First, it gives states the option to replace the current child support deduction with an *income exclusion* in the same amount, which means that the child support paid would be deducted up front prior to calculating the client's gross income. Second, this provision permits states to use information from their child support enforcement agencies to determine the amount of child support paid, even if that information is several months old.[179]

Employment and Training Expense Reimbursements

The employment and training provision grants states new flexibility to design and operate their employment and training programs. The provision also reduces federal funding for these programs.

The Food Stamp Employment and Training (FSET) program was established to provide recipients with employment and training opportunities that will lead to paid employment. As part of the PRWORA, Congress established a three-month time limit for Able Bodied Adults Without Dependents (ABAWDs), who are not working more than 20 hours per week or participating in an approved work activity.[180]

The Farm Bill made several changes to the FSET authorizing, for each of fiscal years 2002 through 2007, $90 million in unrestricted funding and up to $20 million in additional funding for states that pledge to offer work slots to every unemployed, childless adults. The provision also:

- eliminates the requirement that 80 percent of unmatched funds be used for able-bodied adults with dependents;

- eliminates the requirement that States maintain their 1996 E&T funding levels to access additional funds;
- eliminates the limit on the amount that USDA will reimburse States for work activities;
- rescinds unspent funds from fiscal year 2001 and prior years; and
- lifts the $25 cap on the federal reimbursement for FSET participants' work-related expenses, such as transportation. States will now receive a 50 percent match for reimbursing these expenses.[181]

Other Food Stamp Options

Additional food stamp options in the Farm Bill available to States include aligning income and resource rules with TANF or Medicaid; new grants to improve Food Stamp Program access; an improved homeless shelter deduction; and the option to simplify the Standard Utility Allowance (SUA) provided that the state elects to use the SUA for all households rather than allowing households the choice of calculating actual utility expenses.[182]

Conclusion

The food stamp provisions within the Farm Bill make positive changes that will improve access to the FSP for low-income households across the nation. States now have an array of new options to simplify the program and make it easier for families to get and retain benefits, particularly working families. By simplifying program rules, states will be able to deliver benefits more effectively to eligible households, thereby decreasing and improving payment accuracy and program integrity.

Recommendations

21. The Legislature shall direct the Department of Human Services to implement the option allowed under Section 4101, Title IV of the Farm Bill that permits states to use child support information from the Attorney General's office to determine the amount of child support paid by an applicant.

Rationale: Under current policy, the applicant must provide information regarding the child support they pay to the agency. Requiring this information to come directly from the Office of the Attorney General will reduce paperwork, simplify the verification process for caseworkers, and ensure the accuracy of the information. Implementation of this option will require coordination between the OAG's office and DHS and may have automation costs that should be reviewed. If DHS determines the implementation of this option is cost effective and will have an overall positive impact on the program they should proceed by adopting by rule. In determining whether implementation would have a positive impact, DHS should consider client access, eligibility staff workload and impact on the accurate delivery of benefits. Roll out of the TIERS system at DHS will need to be considered in determining the implementation date of this recommendation.

22. The Legislature shall direct DHS to implement the option allowed under Section 4106, Title IV of the Farm Bill that permits states to freeze the income deductions claimed by Food Stamp recipients between scheduled certifications of a household's eligibility for benefits.

Rationale: Under current policy, Food Stamp recipients must report within 10 days any change in their circumstances that would affect their deductions. This new option gives states the ability to freeze most deductions between certifications. Exceptions include adjusting the earned income deduction for reported changes in earnings and recalculating the shelter deduction when a household reports that it moved. Implementing this option will reduce reporting requirements for food stamp recipients and decrease the likelihood for error on the part of both client and eligibility worker, which will improve payment accuracy in the Food Stamp Program.

As Texas continues to receive further federal guidance and reviews other states, DHS will continue to explore the impact on Texas. If DHS determines the implementation of this option will have a positive overall impact on the program they should proceed by adopting by rule. In determining whether implementation would have a positive impact, DHS should consider client access, eligibility staff workload and impact on the accurate delivery of benefits. Roll out of the TIERS system at DHS will need to be considered in determining the implementation date of this recommendation.

23. The Legislature shall direct DHS to implement the option allowed under Section 4115, Title IV of the Farm Bill that permits states to provide a frozen Food Stamp benefit for five months to families leaving TANF without additional paperwork or certification requirements. States can elect to adjust a household's benefits during this five-month period based on information

received from another program about the household, and households may reapply to have their benefits adjusted if their income goes down or their family situation changes.

Rationale: As families transition from welfare to work the first few months are critical to stabilizing the family and connecting them to the workforce. Under current policy, families leaving TANF can continue to receive Food Stamp benefits provided they comply with all of the recertification and documentation requirements of the Food Stamp Program. In most cases, this means they are required to recertify for Food Stamps one or two months after leaving TANF. Allowing families leaving TANF to receive a fixed benefit for five months will ensure that all those who remain eligible for Food Stamps still receive them, which will assist families as they move toward self-sufficiency. This option makes it easier for states to administer the program by allowing recertification to be postponed until the end of the transition period.

As Texas continues to receive further federal guidance and reviews other states, DHS will continue to explore the impact on Texas. If DHS determines the implementation of this option will have a positive overall impact on the program they should proceed by adopting by rule. In determining whether implementation would have a positive impact, DHS should consider client access, eligibility staff workload and impact on the accurate delivery of benefits. Roll out of the TIERS

system at DHS will need to be considered in determining the implementation date of this recommendation.

Acronyms

ABAWDs	Able Bodied Adults Without Dependents
AFDC	Aid to Families with Dependent Children
CCDBG	Child Care and Development Fund Block Grant
CCDF	Child Care and Development Fund
CSS	Client Self Support
DDHS	US Department of Health and Human Services
DHS	Texas Department of Human Services
ESL	English as a Second Language
FFY	Federal Fiscal Year
FNS	Food and Nutrition Service
FPL	Federal Poverty Level
FSP	Food Stamp Program
FSET	Food Stamp Employment and Training
LWDBs	Local Workforce Development Boards
MOE	Maintenance of Effort
NSAF	National Survey of America's Families
OAG	Office of the Attorney General
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
SMI	State Median Income
SSBG	Social Service Block Grant
TANF	Temporary Assistance for Needy Families
TBA	Transitional Benefit Alternative
T.E.A.C.H.	Teacher Education and Compensation Helps
TIERS	Texas Integrated Eligibility Redesign System
TMA	Transitional Medical Assistance
TWC	Texas Workforce Commission

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INTERIM CHARGE 3

Supplemental Security Income Disability Determination Procedures

Supplemental Security Income Disability Determination
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Supplemental Security Income Disability Determination

Interim Charge 3

Review, evaluate and make recommendations to improve Texas' Supplemental Security Income disability determination procedures. The Committee should compare Texas' denial rate with other state's rates, analyze any changes in Texas' rate, and examine the impact of Texas' system on Medicaid coverage for the uninsured.

Background

The Texas Health and Human Services Commission reports approximately four million Texans live with at least one type of disability. Of those, about two million may have serious limitations in performing activities of daily living. The Social Security Administration (SSA) operates two programs that provide direct income assistance and healthcare benefits to persons with severe disabilities. Although eligibility criteria for these two programs are the same across all states, the denial rates are inconsistent. Over the past several years, questions have surfaced concerning the high initial denial rates of Texans.[1]

A 1998 review by the Sunset Commission identified a disparity of Texas' denial rates.[2] Texas Rehabilitation Commission Disability Determination Service (TRC DDS) attempted to respond to all recommendations made in the Sunset review; however, denial rates in Texas remained comparatively high until the fall of 2000. Since that time, Texas has steadily reduced its denial rate, dropping below the national average for denials in May 2002.[3]

Unique Charge

This charge to the Senate Committee on Health and Human Services is unique because disability determination policy is established by the federal Social Security Administration and the state cannot make policy decisions about a federal program. Nevertheless, the Committee responded to the charge through testimony and research, identifying several

areas contributing to delays in the determination process. The Committee will relay any findings determined to be within federal jurisdiction to the Texas Congressional Delegation and the Social Security Administration through a resolution to Congress.

Program Overview

The two federal SSA programs "that provide benefits based on disability are the Social Security Disability Insurance (SSDI) program within Title II of the Social Security Act and the Supplemental Security Income (SSI) program in Title XVI of the Social Security Act."[4] DI benefits are financed through employer and employee payroll taxes.[5]

> The two federal SSA programs that provide benefits based on disability are the Social Security Disability Insurance (SSDI) program (Title II of the Social Security Act (the Act) and the Supplemental Security Income (SSI) program

Social Security Disability Insurance

SSDI provides cash benefits to severely disabled workers and their dependents. To be eligible for this program, applicants, called 'claimants,' must have paid into the Social Security system. Types of claims include disabled individual benefit, disabled widow/widower benefit, and disabled adult benefit. Claimants must wait five months from the onset of the disability before receiving their first benefit payment. In addition, they must wait 24 months after receiving the first benefit payment before Medicare coverage begins. The average disabled individual benefit payment in Texas is $780.[6]

Supplemental Security Income

SSI provides cash assistance to disabled persons who do not have enough Social Security payroll deductions to qualify for SSDI and whose income and resources fall below a certain

level. Types of claims include disabled/blind individual; disabled/blind spouse; disabled/blind child (under age 18). There is no waiting period for benefits to begin, and Medicaid coverage begins with the first payment of benefits. The national average SSI benefit claim is approximately $400.[7] The program is financed through general tax revenues.[8]

Percentage of SSDI vs. SSI Clients (Texas)				
	Initial Cases	Number Cleared	Percent of Applicants	Allowance Rate
FFY 1999	SSDI only	35,248	26.6%	31.9%
	SSI only	61,642	46.5%	31.7%
	SSDI & SSI	35,605	26.9%	24.4%
FFY 2000	SSDI only	34,692	27.1%	30.9%
	SSI only	58,790	46.0%	31.5%
	SSDI & SSI	34,439	26.9%	22.8%
FFY2001	SSDI only	36,802	27.9%	40.4%
	SSI only	58,498	44.4%	39.9%
	SSDI & SSI	36,430	27.7%	30.5%

Source: Social Security Administration, Texas Rehabilitation Commission Disability Determination Service

Definition of Disability/Eligibility

The rules for determining if an individual is considered disabled are prescribed by the Social Security Act and SSA's regulations implementing the act. It is important to note that SSA's criteria for disability determination is not necessarily the same as criteria applied in other government and private disability programs.[9] However, the definition of disability is the same for individuals applying for SSDI benefits and for adults applying for SSI. Disability, is defined under SSA as "the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted, or can be expected to last, for a continuous period of not less than 12 months."[10]

About 25 to 30 percent of today's 20-year-olds will become disabled before retirement.

A child under age 18 will be considered disabled under SSI, if they have a "medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations and that can be expected to cause death or that has lasted, or can be expected to last, for a continuous period of not less than 12 months."[11]

The SSA defines a medically determinable physical or mental impairment as "an impairment that results from anatomical, physiological or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques."[12] Determinations "must be established by medical evidence consisting of signs, symptoms and laboratory findings."[13]

Texas Rehabilitation Commission

Under federal law, each state has a Disability Determination Services agency to determine eligibility for SSI and SSDI. In Texas, the Disability Determination Service is a division of the Texas Rehabilitation Commission known as the TRC DDS. The TRC DDS is the single largest facility in the nation.[14] Both California and New York, each have higher caseloads than Texas (Texas is third in total caseloads nationwide) but have decentralized disability determination service offices.[15] Each disability determination service agency is directly overseen by one of ten regional Social Security Offices. Texas is part of Region 6 along with Arkansas, Oklahoma, New Mexico, and Louisiana. Employees in the TRC DDS are state employees receiving state benefits; however, their salaries and all costs associated with operating the SSDI and SSI programs are paid for with federal dollars.[16] In essence, Texas Rehabilitation Commission acts as a funnel for federal funds and provides administration to the Disability Determination Service department. According to TRC DDS, this arrangement is in accordance with the Social Security Act, the Code of Federal

Regulations, federal court mandated Social Security Rulings, and policies developed by the SSA. As a national program, with the exception of federal circuit court rulings, it is administered substantially in a standard manner throughout the United States.

Social Security Field Offices

Social Security field offices (or Social Security "District Offices") are a network of offices located throughout each state that administer the SSI and SSDI programs. In Texas, there are 68 field offices. Field office staff receive applications for disability benefits either in person or by telephone or mail. The field offices are responsible for verifying all non-medical information, including eligibility requirements, age, employment, and marital status. The case is then sent to a disability determination service for evaluation of the actual medical disability.[17]

Application Process

A person filing for both SSDI and SSI benefits must complete five separate federal forms totaling 40 pages, consisting of approximately 211 questions, many with multiple sub-parts.

The federally-mandated application, created by the SSA, and related forms require a description of the claimant's impairment(s), information regarding the treating health care providers, and other information that relates to the alleged disability. The person requesting disability benefit is called the claimant. SSI and SSDI may also be filed and processed concurrently. Both applications are sent to the disability determination service as one case. However, a separate determination is prepared for each application (SSDI and SSI). A person filing for both SSDI and SSI benefits currently must complete five separate federal forms totaling 40 pages, consisting of approximately 211 questions, many with multiple sub-parts.[18] Since the two forms are processed concurrently, there is no significant difference in the

processing time. According to TRC DDS, in the vast majority of determinations, the decision is the same for both claims.

Determination Process

A Disability Examiner at the disability determination service office is responsible for developing medical evidence and rendering the initial determination of blind or disabled as defined by federal law. Disability examiners obtain evidence from several sources including the claimant's own medical providers and consultative examinations, if necessary. According to the SSA, the claimant's treating source is the preferred source of information and can be used for a consultative examination.[19] However, the disability determination service may also obtain the necessary consultative examination from an independent medical contractor.[20] The disability determination service may also render a determination regarding the claimant's potential eligibility for vocational rehabilitation and will if appropriate, make a referral to the state's vocational rehabilitation agency.[21]

After completing the initial case development, the disability determination service makes a disability determination. The determination is made by a two-person adjudicative team composed of a medical or a psychological consultant, state agency medical consultants and a disability examiner.[22] All state agency medical consultants are licensed physicians or psychologists under contract to TRC DDS. If the adjudicative team finds that additional evidence is still required for the determination, the consultant or examiner may contact a medical source(s) and request supplemental information.[23]

After the initial disability determination, disability determination service returns the case to the SSA field office for appropriate action. If the disability determination service finds the claimant disabled, SSA will complete any outstanding non-disability claims, compute the benefit amount, and commence paying benefits. A claimant awarded benefits is now

referred to as a "beneficiary." If the claimant is found not disabled, the file is retained in the SSA field office pending any appeal that may be instituted by the claimant.[24]

Once the claimant has been awarded disability benefits, they must undergo a periodic Continuing Disability Review to determine if medical improvement has occurred. The reviews occur between one and seven years depending upon the initial reason for the allowance. If a beneficiary returns to work, an immediate investigation may be triggered. There are separate regulations that permit beneficiaries to regain payment status if the work experience proves unsuccessful.[25]

Accuracy Review

There are essentially three levels of review: federal, TRC DDS Quality Appraisal, and TRC DDS supervisor end-of-line review. Additionally, there are targeted reviews depending upon program emphasis and enhanced reviews for new disability examiners. The accuracy level with which a disability determination service adjudicates disability cases is determined through the Federal Quality Assurance process. Federal quality assurance accuracy is important because it is one of the standards by which SSA measures performance of a disability determination service.[26] The results of the quality reviews performed at all levels are also used to determine training needs. For federal fiscal year (FFY) 2001, TRC DDS reports an accuracy rate of 95 percent compared to the national average of 93.9. percent.[27]

Texas Rehabilitation Commission Disability Determination Service Initial Case Review and Prioritizing

The TRC DDS office conducts a daily systematic review of all newly received claims for disability benefits to identify prioritization of the case based on the severity of the condition and financial need. The initial case review process is a joint venture conducted by Disability Hearing Officers from the Austin Office of Disability Hearings and staff from the

Disability Determination Service Program Operations. Upon review, cases are identified for priority assignment if any of the following exists:

- evidence or allegation of terminal illness;
- evidence or allegation of dire need;
- evidence or allegation of AIDS/HIV;
- a favorable decision is likely based on the alleged medical conditions alone or in consideration of both medical and vocational factors; and
- all medical evidence is in the case file, and a decision can be rendered immediately or with minimal development.[28]

In addition to reviewing the new case receipts, medical evidence belonging to previously received cases (not identified for priority assignment) is also reviewed daily. If the evidence suggests that one of the above criteria are met, that case is pulled for priority assignment. During FFY 2001, approximately 30,000 cases were identified for immediate assignment.[29] The remainders of the daily case receipts are placed in "staged pending," and are assigned on a "first-in, first-out" basis.

Presumptive Disability

Long-standing SSA instructions permit "presumptive disability" determinations by either the SSA field offices or the TRC DDS.[30] The criteria used in both SSA Field Offices for presumptive disability and disability determination service units are separate, but the criterion for each is promulgated by the SSA and governs the activities of all SSA field offices and disability determination service units nationwide. Presumptive disability can only be applied to SSI claims. If the disability determination service makes a presumptive disability decision, SSA is notified and conducts an investigation to make sure the claimant's income and resources are low enough to qualify for SSI. If the income and resources are low enough, the claimant is put into a payment status for up to six months

during which time they may also receive Medicaid.[31] These decisions are encouraged by SSA and TRC DDS administration for disability examiner determinations and can be made at any time during the development of the case.[32]

Case Assignment

Cases are assigned according to priority and complexity. Assignments are made through an automated process after data either is entered into the computer system, or are assigned by intake case reviewers. Dire need cases, terminal illness cases, HIV cases and other cases identified by the case intake review team for priority handling are the first cases to be assigned each day.

- For FY 2001, TRC DDS processed 20,307 cases per month with a total of 232,465 annually.
- For FY 2002, TRC DDS received an average of 999 cases per day or 30,000 cases a month.

Source: Social Security Administration, Texas Rehabilitation Commission Disability Determination Service

All other cases are assigned by type of case, which is considered the most effective indicator of complexity available at the time of case assignment. HIV and continuing disability review cases tend to be more complex and are assigned to a special team of experienced disability examiners. Reconsideration cases, the first level of appellate review, are assigned to disability examiners with the most experience adjudicating initial cases. Assignments are made through an automated process. The types of cases to be assigned and the number of assignments each day/week is controlled by Program Operations Directors. This assures more complex cases requiring higher skill levels such

as continuing disability reviews and HIV cases are assigned to more experienced examiners.

Process of Appeal

Following the initial determination of a disability claim, subsequent appeals of unfavorable determination may be decided in the disability Determination service or by administrative law judges in the SSA Office of hearings and appeals. If the claimant files an appeal of an initial unfavorable determination, the appeal is subject to the same adjudicative process as the initial determination. However, the disability determination is made by a different adjudicative team than the team that handled the original case.[33] TRC DDS reports the "reconsideration phase" usually adds approximately 94 days to the initial determination, approxamately114 days, or about 208 days total. Approximately 18 percent of cases initially denied are approved during the reconsideration phase.[34]

Claimants dissatisfied with the first appeal, may file a subsequent appeal with the Hearing Office within SSA's Office of Hearings and Appeals.[35] Further medical development of the claim occurs during the appeal process by the administrative law judges and is frequently conducted through the Disability Determination Service. Since both SSDI and SSI are federally funded programs, the appeals are determined by federal judges and not the Texas State Office of Administrative Hearings. These judges have more latitude when interpreting the regulations and may use circuit court decisions to guide their judgements when adjudicating cases. Should the ruling remain adverse, the claimant may request an Appeals Council Review which is a second level appeal. If still denied, the applicant may institute a civil action in a United States District Court.[36]

Reasons for differences in allowance rates vary per state and per region

SSA Office of Hearings and Appeals		
	ALJ Allowance Rate	**Number**
Texas	57.3 %	16,313
Region VI	57.5%	34,819
United States	58.2%	259,136

*Data from Office of Hearings and Appeals is cumulative and is available approximately three months after the end of each quarter. This data reflects cumulative totals for FFY 2001 (October 2000 - September 2001). Source: Social Security Administration, Texas Rehabilitation Commission Disability Determination Service

Reasons for differences in allowance rates vary per state and per region. TRC DDS addresses these differences in the following ways:

- General level of education of people in the state.
- Proportion of males in the workforce.
- Proportion of state's population living in urban areas.
- Unemployment rate in the state.

"Since the characteristics of the individual filing for disability benefits may vary among states, it is reasonable to expect allowance rates also to vary. Therefore, the different allowance rates do not necessarily suggest inconsistent or inaccurate application of policy."[37]

Federal Court Decisions Impacting Specific States

SSA's Program Operations Manual System lists 54 federal court rulings, 2 federal court settlements and 8 acquiescence rulings each of which pertain to specific states within federal district court jurisdictions.

There have ". . .been many court decisions that have affected the way decisions are made leading to changes in decision making over time, differences in decision making among different regions of the country, and differences in decision making between administrative law judges and disability determination service."[38]

"Adjudicative Climate" Differences Due to Influences of the Federal Disability Quality Branch

"Each SSA has its own disability quality branch that is charged with measuring the accuracy of the disability determination service within the region. Accuracy is a major factor SSA uses in evaluating the performance of a disability determination service. Thus, there is enormous pressure on each disability determination service to comply with the SSA disability policies as interpreted by the disability quality branch. Anecdotal evidence suggests there is inconsistency in policy interpretations between regional disability quality branches."[39]

Federal Funding Process

TRC DDS is 100 percent federally funded. Prior to each federal fiscal year, TRC DDS submits an annual budget plan to the SSA Regional Office for review. The plan is then submitted to the SSA central office for final approval pending passage of a federal budget by Congress. When Congress passes a budget, the SSA adjusts the submitted budget plans from the disability determination services and releases a budget authorization. Texas Rehabilitation Commission reports their total budget cost for FFY 2001 was $83.4 million.[40]

Major Issues

Case Backlogs

For FFY 2001, TRC DDS adjudicated 232,465 cases and 19,363 cases were in pending status.[41] For FFY 2002, TRC DDS is currently processing an average of 20,307 cases

each month.[42] At the end of state FY 2001, there were 55,358 cases waiting decisions, of which 10,781 had not been assigned to an examiner.[43] TRC DDS reports backlog increases due in part to increased applications received.[44] SSA under funding and an increased workload in FFY 2000 also contributed to the backlog.[45] During 2000, Texas received 253,000 disability cases, but SSA provided funded for only 237,000 cases.[46] Much of that year, the TRC DDS was under a federally-mandated hiring freeze.[47] As disability examiners were lost through attrition, TRC DDS was not able to replace the workers. By the end of FFY 2000, the pending cases had grown to more than 22,000.[48] During FFY 2001, SSA provided additional funding to increase TRC DDS staff which helped to reduce the backlog.[49] Continued efforts through FFY 2002, resulted in pending cases being reduced to approximately 11,830 cases.[50]

Yearly Comparison of TRC DDS Backlogged Cases				
1998	1999	2000	2001	2002
4,999	6,093	10,582	24,085	11,785

Source: Social Security Administration, Texas Rehabilitation Commission Disability Determination Service

The Houston Chronicle Allegations

During 2001, The *Houston Chronicle,* published a series of articles criticizing the SSI disability determination process in Texas charging that a higher-than-average denial rate existed within the state, including regional disparities in determination decisions involving fictitious examiners.[51] [52] The *Houston Chronicle* also criticized the high number of backlogged cases.[53] The TRC DDS acknowledged the backlog of cases. They reported that by at the end of FFY 01, 55,358 cases awaited decisions; of those, 10,781 had not been assigned to an examiner.

Texas Denial Rates

On May 3, 2001, the *Houston Chronicle* criticized Texas for a higher-than-average denial rate alleging that other states process claims in 60 to 90 days while, Texas has an average processing time of 108 days.[54] At the end of FY 2000, TRC DDS reports Texas' Allowance Rate was 29 percent compared to the national average of 38.2 percent.[55] As of June 7, 2002, TRC DDS reports year-to-date approval rates for FFY 2002 at 39.1 percent compared to the national average of 38.7 percent.[56]

Fictitious Examiners

The *Houston Chronicle* also charged that TRC DDS "invented" 24 disability examiners, all of whom had the first initial "W."[57] According to the agency, the disability examiners were not fictitious but employees whose first names were replaced with the initial "W" as an internal code to signify these workers were performing authorized overtime duties.[58] The SSA indicated these procedures were acceptable as they are used in other disability determination services and field offices as an internal workload control mechanism.[59] TRC DDS stated that the overtime activity enabled the department to process 12,000 more cases than would have been possible otherwise.[60] To avoid a misleading appearance, the agency subsequently changed the coding system.[61]

Houston/Harris County

The *Houston Chronicle* focused on an issue particularly problematic to the Houston area charging that claimants who appealed their cases in Houston "waited longer than the national average and faced tougher odds at winning their appeal" than claimants within the state and across the nation.[62] The March 11, 2001 article reported that claimants in the Houston area received a lower-than-average approval rate through Houston administrative law judges at the appeal stage.[63] The article also alleged there was a "culture of skepticism" among the judges and a prevailing philosophy opposed to individuals receiving government benefits. The article acknowledged several possible

theories as to why the Houston-area cases may have unfavorable outcomes including a high number of physical laborers who may not understand that some injuries do not quality for disability.[64] The news article quoted the *January 2001, Social Security Advisory Board* publication stating "*gaping differences across the country and state agencies are troubling—and for now, beyond a single explanation."*[65] In response to concerns highlighted by the *Houston Chronicle,* area congressional representatives sought and received two additional judges to help with backlogged cases in the Harris County area.[66]

National Concerns and Efforts

Current delays in final determinations are not limited to Texas. An *Associated Press* article, from May 2002, reported 200,000 cases in a backlog across the nation.[67] Growing caseloads, new guidelines for mental illness, children and musculoskeletal conditions are all cited as contributing factors to the increase.[68] The nation's baby boomers reaching the age where there is an increased likelihood of disability is considered to be the most significant factor.[69] Between now and 2010, SSA actuaries' project the number of SSDI beneficiaries will increase by nearly 50 percent and SSI beneficiaries by 15 percent.[70]

The Social Security Advisory Board's February 2001 Report, *"Agenda for Social Security: Challenges for the New Congress and the New Administration,*" states:

> In recent decades, disability policy has come to resemble a mosaic, pieced together in response to court decisions and other external pressures, rather than the result of a well-thought out concept of how the programs should be operating. There are substantial data that show striking differences in decisional outcomes over time, among state agencies and between levels of adjudication, raising the question of whether disability determinations are being made in a uniform and consistent manner.[71]

A 2001 SSA publication, *Managing Social Security Disability Programs: Meeting the Challenge,* again emphasized the issue. The report notes:

> The consistency issue is usually defined in terms of the variation in allowance rates at different levels of adjudication (vertical consistency) or at the same level of adjudication (horizontal consistency). Such variations are often cited as indicating a lack of uniformity in the application of disability policy. Concern about vertical consistency arises largely because of high appeal allowance rates after the claimant has been denied during the initial process. Concern about horizontal consistency arises because of variation in such indicators as filing rates and allowance rates across states. State allowance rates have varied since the SSDI program began, and as early as 1959, the issue was the subject of congressional hearings. Many efforts have been made to enhance consistency, including legislative changes, which require the agency to review a percentage of favorable determinations. In response to these concerns, SSA has undertaken process changes to improve vertical consistency and is undertaking further analysis to better understand the extent to which horizontal equity is actually a problem.[72]

The 2001 report noted SSA's intent to achieve greater consistency through process unification.[73] SSA has undertaken a number of initiatives to ensure that all reviewers at all levels of the adjudication process use the same approach in evaluating claims through the consistent application of policy.[74] In addition, SSA is attempting to clarify various agency rulings and to assure that all adjudications at all levels hear the same information at the same time from expert instructors.[75]

Texas Denial Rate Comparison		
FY 2001 Denial Rates		
	Initial	Reconsideration
National	60.1	83.3
Region VI	63.9	83.0
Non-Prototype DDSs		
Arkansas	67.4	84.4
Louisiana	65.8	66.5
Oklahoma	64.5	87.3
New Mexico	59.2	78.8
Texas *	62.7	82.3
Florida *	61.3	81.1
Illinois *	59.9	83.4
Ohio *	65.8	85.2
Prototype DDSs		
New York *	57.1	88.2
California *	54.6	80.3
Michigan *	59.6	71.0
Pennsylvania *	49.2	67.9

Source: Texas Rehabilitation Commission, *State Agency Operations Report*
*Considered the "Big Eight" (states with largest number of claims).

SSA has been testing several process changes over the past few years that are meant to speed claim decisions, increase accuracy and reduce appeals of denied claims. For approximately two years, the SSA has piloted a prototype disability process in ten states.[76] The key elements of the prototype pilot are the elimination of the reconsideration step, the addition of a claimant conference, an expanded decision rationale, and a single decision maker. The results of the pilot are currently being evaluated by the SSA. The pilot will continue in the initial ten states.[77] TRC DDS reports that SSA plans to publish regulations

during 2002 to expand the revised prototype model to all states for implementation in early 2003.[78]

State Concerns

Texas Rehabilitation Commission Disability Determination Service Staffing Factors

TRC DDS faces significant personnel issues, especially disability examiners who are charged with the hands-on responsibility for case adjudication actions. As of September 30, 2002, there are 376 disability examiners with 21 vacancies.[79] The average caseload is 120 cases, and disability examiners are assigned 15-17 new cases per week. Each week, 700 continuing disability review cases are assigned to senior disability examiners.[80] TRC DDS has five Special Assignment Units, one of which includes a unit dedicated to processing HIV/AIDS cases.[81]

Many tenured TRC DDS employees are now eligible for retirement. As a result, experienced disability examiners are replacing retiring managers or leaving for better-paying jobs in other state agencies. Recruiting and maintaining qualified staff in a highly competitive job market is problematic for TRC DDS. TRC DDS reports that the experience level of the disability examiner staff has declined; only 20 percent of the authorized disability examiners have 10 or more years of service. As of January 2, 2001, the average experience level of authorized disability examiners was just more than six years; more than half of the disability examiners have an average tenure of less than 18 months.[82] A disability examiner is considered "fully qualified" 24 months after beginning employment.[83]

Experienced DE's are replacing retiring managers or leaving for better-paying jobs in other state agencies or the local economy.

As noted earlier, in FFY 2001 the SSA recognized a shortfall in both budget and staffing in Texas. The issue was addressed by the SSAs approval of overtime and the creation of additional disability examiner positions in 2001.[84] The overtime approval led to a decrease in the backlog. The additional disability examiner positions will likely increase the number of claims adjudicated thereby increasing the number of eligible claimants. In addition, the TRC DDS has adopted the SSA process unification principles which are designed to increase the number of eligible claimants at the initial determination level.[85] A lack of resources to process case receipts has lead to significant delays in processing time, a problem that will only worsen with an ever-increasing amount of work both in volume and complexity. This limits the disability determination service's ability to deliver timely services for those seeking assistance.[86]

Staffing Levels vs. Caseload		
Year	**Employees**	**Case Receipts**
1998	847	236,594 (actual)
1999	820	242,971 (actual)
2000	797	252,385 (actual)
2001	792 - 874	233,996 (actual)
2002	874	254,556 (projected)

Source: Texas Rehabilitation Commission Disability Determination Service

Increased Number of Applicants

The SSA projects the number of SSDI beneficiaries will increase by nearly fifty percent by 2010 and SSI beneficiaries by fifteen percent.

Economic factors and population characteristics influence the number of applications for disability benefits. Downturns in the economy and the aging "baby boom" population affect the number of claims filed. SSA projects significant increases in the disability workload

for the future.[87] As baby boomers age, the growth in both SSI and SSDI will accelerate. The SSA projects the number of SSDI beneficiaries will increase by nearly 50 percent by 2010 and SSI beneficiaries by 15 percent.[88] "This projected growth in the number of disability claimants threatens to overwhelm a policy and administrative infrastructure that are already inadequate to meet the needs of the public."[89]

Yearly Increases in New Applications				
FFY 1998	FFY 1999	FFY 2000	FFY 2001	FFY 2002*
123,814	134,702	139,240	141,193	114,548

*Data as of June 21, 2002
Source: Social Security Administration, Texas Rehabilitation Commission Disability Determination Service

Funding vs. Caseloads

Maintaining an increasing pending caseload level is problematic. For example, during FFY 2000, the budgeted clearance rate was 237,606 cases; however, 252,385 individuals applied for benefits.[90] FFY 2000 ended with more than 23,000 cases in the assignment process which delays, by weeks, the case going to a disability examiner.[91] Additionally, while these cases are waiting for assignment to a disability examiner, staff must be diverted from regular duties to handle client contacts regarding these cases.[92]

Since TRC DDS does not know the actual funding for the fiscal year at the beginning of a fiscal year, it is common for the agency to revise budgets and workload targets throughout the year. This makes it difficult to plan for hiring of staff and management of workloads. TRC reports 13 budget revisions during FFY 2000 and, in FFY 2001, 21 continuing resolutions and 16 budget revisions.[93]

Agency Efforts

In response to growing legislative concerns and media attention, TRC DDS reviewed its internal processes to identify areas of improvement. The agency identified three primary areas: training, mentoring and outreach.

- **Training**

TRC DDS provided intensive training to adjudicative staff, including disability examiners and state agency medical consultants, in the revised mental health regulations that went into effect at the beginning of FFY 2001.[94] In addition, Quality Appraisal staff shares, on a monthly basis, "lessons learned" and helpful hints with all staff as a result of their case reviews.[95] Case staffings are held on a weekly basis with all trainee disability examiners to assure they are acting consistently within established policies regarding the various types of cases.[96]

- **Mentoring**

TRC DDS uses state agency medical consultants and experienced disability examiners to mentor other staff and less experienced staff in the nuances of the adjudicative process. Senior managers have worked directly with these consultants and disability examiners to assure consistency in determinations.[97]

- **Outreach**

In addition, TRC DDS works closely with medical providers to insure that evidence submitted meets SSA standards of disability evidentiary requirements. TRC DDS employees work to educate provider groups such as Mental Health Mental Retardation community centers, and state and local medical associations. In addition, TRC DDS medical relations officers work closely with the medical community throughout the state to develop efficiencies that lead to quicker and more accurate determinations.[98]

Legislative Issues

Rider 7, SB 1, 77th Legislature

Rider 7 required the Texas Rehabilitation Commission to submit a written report quarterly to the Legislative Budget Board and Governor that compare the Commission's rate and the numbers of denials for initial claims for SSDI and SSI to regional and national rates of denials. The Commission is also required to report the rate and numbers of initial denials overturned upon appeal compared to regional and national rates.[99]

Texas Council on Offenders with Mental Impairments

In October 2000, the SSA, Texas Department of Criminal Justice and Texas Council on Offenders with Mental Impairments entered into an interagency agreement to implement a pre-release application pilot project for offenders with special needs who are being released from incarceration. The target population includes individuals with mental illness, physical disabilities and terminal illness. This project allows Social Security and other federal entitlement programs to be applied for 90 days prior to release from custody. Texas Department of Criminal Justice provided Texas Council on Offenders with Mental Impairments with additional funds to contract for benefit eligibility specialists who prepare and submit all entitlement applications on behalf of inmates. By establishing eligibility for benefits prior to release, reimbursement for medical or psychiatric service is automatic upon the inmates' release. Texas Council on Offenders with Mental Impairments reported an approval rate of 38 percent for FY 2000 for those individuals meeting qualifications prescribed by SSA. At the conclusion of FY 2001, the approval rate increased to 55 percent; for FY 2002, the approval rate is 67 percent.[100]

Rider 8, SB 1, 77th Legislature

Rider 8 requires the Texas Rehabilitation Commission and the Texas Department of Mental Health and Mental Retardation to develop a memorandum of understanding for the purpose of having Texas Rehabilitation Commission staff conduct SSDI and SSI

eligibility reviews on-site at Community Centers for persons referred by the centers to determine eligibility for services.[101]

Program Changes Impact on the Texas Rate

- **New Guidelines for Mental Impairments**

In September, 2000, revised regulations went into effect for the evaluation of mental impairments. These redefined the evaluation criteria in the medical listings, added new criteria to three listings and placed more emphasis on functional limitations that affect ability to work. The impact has been to increase the allowance rate for mental impairments.[102]

- **New Guidelines for Children's Conditions**

In January, 2001, final childhood regulations were published. These simplified and clarified the interim childhood regulations. The new regulations emphasized the whole child to determine what the child can and cannot do compared to other children of the same age. The impact has been to simplify the disability adjudication process for children.[103]

- **New Guidelines for Musculoskeletal Impairments**

In February, 2002, revised regulations went into effect for the evaluation of musculoskeletal impairments. More evaluation of functional limitations will be required and the medical listings criterion has been expanded for the evaluation of back impairments. The impact will be to make the evaluation easier for allowances.[104]

TRC DDS has initiated the following to address current legislative concerns:

- Ongoing dialogue with SSA regarding the allowance rate issue, as well as, staffing and funding issues that support the disability program in Texas.
- Work with service providers such as the Consumer Benefits Consortium and the Texas Council on Offenders with Mental Impairments establishing methods and partnerships to better serve those seeking assistance from the Social Security Disability Program.
- Work with Texas Department of Mental Health and Mental Retardation to implement Rider #8, SB 1, 77th Legislature, a joint endeavor to facilitate

services for the population served by the Texas Department of Mental Health and Mental Retardation local authorities across the state.

- Submit quarterly updates to the Legislative Budget Board as well as the Senate Committee on Health and Human Services detailing current, initial, and reconsideration case allowance and denial rates as well as the SSA Office of Hearing Appeals case reversal rates pursuant to Rider #7, SB 1, 77th Legislature.
- Provide ongoing updates to the Texas Rehabilitation Commission Board on the disability program including current status on the allowance rates, staffing, and funding profiles.
- Work with stakeholders to improve the DDS service delivery model.[105]

Medicaid Issues

TRC DDS anticipates the number of individuals eligible for SSI to increase. Individuals who receive SSI are also eligible for Medicaid. Therefore, changes in the number of SSI eligible individuals have a direct impact on the state Medicaid system. There may also be a state fiscal impact with those SSI applicants who remain uninsured.

The Actuarial Analysis Department of the Health and Human Services Commission reports that once Texas Rehabilitation Commission returns the disability case to the SSA for final approval and payment of SSI benefits, SSI clients are eligible for Medicaid under the Disabled and Blind Risk group.[106] Health and Human Services Commission reports that TRC allowance rates have increased significantly causing Medicaid acute care costs to increase.[107] Medicaid acute care services include physician, hospital, drugs and transportation. Several agencies share the acute care Medicaid cost for SSI clients including Health and Human Services Commission, Texas Department of Health, Texas Department of Human Services and Texas Department of Mental Health and Mental Retardation. Health and Human Services Commission assumes the new clients have an

average cost similar to existing clients. The average cost of Medicaid acute care services per Disabled and Blind client is approximately $1000 per month. Medicaid costs for the Disabled and Blind tend to increase about 10 percent per year.[108]

Health and Human Services Commission assumes 5,299 clients are cleared each month for SSI and 3,518 clients for SSI/SSDI concurrent clients.[109] Increasing the Texas Rehabilitation Commission allowance rate by one percent would cause the Medicaid caseload to increase steadily, adding 53 new clients each month for SSI and 35 each month for SSI/SSDI concurrent.[110] In addition, Health and Human Services Commission assumes that an increase of one percent in the TRC allowance rate for SSI would add to Medicaid acute care costs by about $4.1 million in the first 12 months. The cost for the second 12 months is almost $13 million. An increase of one percent in the TRC allowance rate for SSI/SSDI concurrent clients would add to Medicaid acute care costs by about $11.3 million over a two-year period. After two years as SSI/SSDI, many of the clients become eligible for Medicare which would pay approximately 75 percent of their acute care costs.

The former Commissioner of Social Security, Ken Apfel, summarized the crucial role of SSDI in protecting families:

> For most Disability Insurance (or SSDI) beneficiaries, the program provides a crucial safety net. Without disability insurance, millions of Americans would be without any form of insurance should they become disabled, a risk that is greater than many people realize. About 25 to 30 percent of today's 20 year olds will become disabled before retirement.
>
> The disability insurance program gives the average worker with two children

According to the Department of Labor, only one-third of all employees have an employer-provided, long-term disability policy.

the equivalent of a disability insurance policy worth about $230,000. It is the only national government disability insurance program. According to the Department of Labor, only one-third of all employees have an employer-provided, long-term disability policy. Although private insurance provides additional financial protection to the minority of the workforce it covers, it does not offer the type of affordable, universal and comprehensive protection that disability insurance provides to virtually all workers and their families.[111]

Worker Buy-In

Recent changes in federal law have created new opportunities for people to access Medicaid. Worker Buy-In programs allow people to return to work without jeopardizing their health insurance. The current system creates a dilemma for people with disabilities. If they recover enough to return to work, they may lose their health insurance coverage. Worker Buy-In programs allow people who would lose their Medicaid due to earnings an opportunity to purchase Medicaid at an affordable rate. This type of program removes a substantial barrier to employment faced by individuals with disabilities.[112]

The Texas Project

Texas has received a grant to participate in a federal demonstration project that will provide Medicaid coverage to people earlier in the course of their disabilities.[113] The grant targets individuals with schizophrenia, bipolar disorder and major depression and is being conducted primarily for research and evaluation purposes. The intent of this project is to test the cost-effectiveness of providing Medicaid to working people with potentially severe disabilities before they become too disabled to work.[114] Study participants will be drawn from consumers already receiving services at Harris and Tarrant County Mental Health and Mental Retardation Centers. By providing Medicaid-covered services earlier on, the debilitation that currently qualifies the person for Medicaid (in conjunction with SSI) may be prevented. This grant was awarded to the Health and Human Services Commission

State Medicaid Office, but the proposed project is within the Texas Department of Mental Health and Mental Retardation system.[115]

Conclusion

Many problems plaguing SSI nationally are also apparent in Texas. This committee has attempted to review the internal workings of the state program, to identify areas in need of improvement and to support initiatives currently underway within TRC DDS. Problem areas that appear to be federal issues have been identified and changes recommended.

Recommendations

1. The Legislature shall pass a Resolution to the United States Congress, requesting the Social Security Administration (SSA) considers the following recommendations from the Senate Committee on Health and Human Services Interim Study:

a. Simplify initial application forms for SSI and SSDI, including:

Rationale: Many of the same records are needed for the SSI and SSDI programs, and individuals may be eligible for both programs. Applicants may not know how to request both applications or, if denied under one, may not realize they might be eligible under the other. Considerable time is spent re-filing for the second program. While waiting the individual remains uninsured and often their health deteriorates to the degree they may be admitted to a facility. Facilities often expect expects the individual's application to be approved to cover the cost of care retroactively. In addition, if errors occur during the process, providers are unable to recoup payment for services already rendered.

b. Field Office staff should record claimant observations at the initial application whether in person or if contacted by telephone.

Rationale: Since disability examiners do not see or hear claimants at the initial application, they must rely on field office staff to provide observations about the claimant. Recorded details of face-to-face contact (as well as telephone impressions) could

enhance the decision-making process and disability examiners could better tailor case development.

c. Field office staff, at the time of initial application, should ensure that all forms are accurately and thoroughly completed including allegations of disability, medical sources, addresses, treatment dates and details, and/or work history.

Rationale: The most common reason for denial is lack of documentation. When forms are inaccurate or incomplete, case development by the disability examiner is delayed. Often, vital information is missing or poorly documented: length of treatment, number of hospitals stays, or charts of the treating physician.

d. Field office staff should resolve inconsistencies between work activity and alleged onset of disability.

Rationale: Disability is not determined by diagnosis but by inability to work and/or earn a set monthly income (substantial gainful activity). Proving that a person cannot engage in substantial gainful activity although they have worked within the past 12 months is difficult as the work activity may be in conflict with the statutory definition of disability. Work activity that occurs after the alleged disability onset date should be investigated and resolved at the field office level prior to sending the case to the disability determination service.

e. Ensure that field office staff inform claimants at the initial application phase of the possible need for someone to act on their behalf through representation.

Rationale: The individual and their families may not have adequately considered how difficult appropriately responding to future and various requests for additional documentation might be for persons with disabilities. Additional efforts to explain this option at the initial application phase can help claimants, family members and others better understand how the assistance of a representative might be beneficial. As the recipient's condition may deteriorate during the course of program participation, there may also be a need for more effective contact regarding representation at periodic reviews.

f. Establish and publicize a "Help Desk" for common questions and a referral list for local assistance.

Rationale: Claimants are often confused by the forms and often may not understand the intent behind the questions. Various local or state volunteer groups and agency benefits counselors provide assistance with application forms, but claimants may not be aware of their existence. Publications on available local assistance programs or telephone access to common questions could expedite the process and help to eliminate confusion.

g. Field office staff should secure prior disability case folders, if available, before transmitting a current folder to disability determination service.

Rationale: During the course of case development, the disability examiner may become aware the claimant has previously filed a claim which was denied. Medical and vocational information documented in the previous folder is needed and if field staff forwarded the prior folder, processing time could be saved.

h. Expedite plans for a technology-enhanced service delivery model that incorporates an electronic disability folder, allowing transfer of claim data, medical records and final case clearance files.

Rationale: This would reduce the time delay of mail transactions between field and state offices, make files instantly accessible to employees and provide efficiencies in case processing. The current system requires prior folders to be retrieved from federal record centers which can take months.

I. Improve telephone accessibility for the public.

Rationale: Repeated testimony cited frustration in trying to access assistance from SSA staff due to the continual busy signal at the toll-free number or difficulty navigating the maze of voice mail. For persons with disabilities, completing an application in person may not be practical, and the frustration of trying to access services by phone is discouraging.

j. Make field office staff more accessible to disability examiners, to facilitate case development and determination through additional and dedicated, priority telephone lines.

Rationale: Contact with a claims representative in a SSA field office is often critical for the disability examiner to clarify information or expedite final determination. Because of constant busy signals (same number as the public toll-free line) and a complex voice mail network, it is usual for a disability claim to be delayed because a disability examiner had to wait several days in order to make verbal contact with field office staff. Lack of direct and adequate phone access to SSA staff from disability examiners unnecessarily delays determination and wastes valuable time which could be better used developing cases.

k. Incorporate a "face to face" meeting with the claimant at the State disability determination service reconsideration stage.

Rationale: An in-person interview at this stage for a person with physical or mental disabilities, rather than waiting until the hearing with the administrative law judge, could expedite the determination. This process often takes more than a year and, many times, requires the hiring of an attorney. Usual attorney fees are 25% of retroactive benefits.

l. Provide disability determination service with requested funding to support the program in Texas that includes the impact of newly

expanded guidelines for children, mental health, and musculoskeletal claims.

Rationale: Additional funding is needed to continue to develop cases in the face of rising medical costs and to maintain or increase staffing costs to keep up with workloads sent by SSA (including impact of new guidelines). In May 2002, TRC DDS requested $101.7 million to process 244,679 cases for FFY 2002. SSA countered, asking TRC DDS to process 247,289 cases with $98.5 million, which leaves staffing at current levels. Federal report findings indicate at least one-third of the delays could be reduced by new technology and process improvements.

m. Contract with former employees.

Rationale: The SSA Regional Commissioner indicated to TRC DDS that it may be possible to obtain special funding separate and apart from the normal disability determination service budget process for contracting with former disability examiners to perform case-related functions. This is being explored to determine specific duties they could perform and the feasibility of contracting with them.

n. Conclude and report on SSA's evaluation of the 'prototype' case adjudication process and implement design features that will increase effectiveness of the program.

Rationale: Presently, SSA is testing a case processing 'prototype' model in ten states (not including Texas). Features of this model include the single decision maker, a claimant conference at the initial level, use of an expanded case decision rationale and the elimination of the reconsideration step.

o. The Legislature shall request SSA and the TRC DDS to work together to improve common problems of process: accuracy, consistency and communication.

Rationale: The most common factors causing processing delays are basic human errors, misplaced files, information and documentation not placed in case folders.

p. The Legislature shall request SSA/TRC DDS and state agencies to improve communication and publicity concerning existing work options to remove the stigma and misunderstanding about program participation and work opportunities.

Rationale: Many individuals fail to apply for disability assistance, erroneously believing it will impact their future ability to obtain employment. Those already receiving benefits are sometimes fearful of obtaining employment to supplement their disability income and improve their quality of life believing that, by becoming employed in any capacity, they might jeopardize their benefits. Better publicizing the work option under Section 1619 of the Act and helping claimants to understand their employment options at the initial application stage will

encourage more individuals to apply for assistance without fear of its impact on their future employment.

q. The Legislature shall request SSA/TRC DDS to develop an educational training 'tool,' or document/brochure, for healthcare professionals, including physicians, on functional description necessary for claimants with special needs such as mental illness. Explore ways of ensuring that healthcare workers and state agencies are familiar with factors necessary to document a disability according to SSA standards.

Rationale: Denial is often a result of a lack of accurate documentation of the disability by treating physicians. Medical reports alone do not reflect an accurate picture of the person with mental illness. Healthcare professionals (especially for mental health claimants) relay chart documentation which focuses on what patients can do rather than what they cannot do. Under SSA requirements, documentation must also include details that portray the claimant's inability to function in daily activities and that precludes a successful work experience.

2. The Legislature shall request TRC DDS and SSA work together to improve common problems of process: accuracy, consistency and communication.

Rationale: The most common factors causing delays are the basic human errors of misplaced files, information and documentation not placed in case folders.

3. **The Legislature shall request SSA/TRC DDS and state agencies to improve communication and publicity concerning existing work options to remove the stigma and misunderstanding about program participation and work opportunities.**

   Rationale: Many individuals apply for disability assistance, believing it will impact their future ability to obtain employment. Those already receiving benefits are sometimes fearful of obtaining employment to supplement their disability income and improve their quality of life believing that, by becoming employed in any capacity, they might jeopardize their benefits. Better publicizing the work option under Section 1619 of the Act and helping claimants to understand their employment options at the initial application stage will encourage more individuals to apply for assistance without fear of its impact on their future employment.

4. **The Legislature shall instruct health and human service agencies to improve communication with agency/facility staff and to provide recipient/family members with information (and telephone number) on SSA requirements regarding notification of admission to a facility. Explore options to automatically contact SSA on behalf of the recipient at the appropriate time.**

   Rationale: When an SSI/SSDI recipient goes into a state facility, Medicaid-contracted facility or private hospital, after a pre-set length of time, they become ineligible for benefits and are required to notify SSA. However, due to their disability or illness, notification often may not occur. At discharge, the

error is discovered and recipients may have to reimburse SSA for overpayments.

5. The Legislature shall instruct health and human services agencies, including TRC DDS, Texas Council on Offenders with Mental Impairments, and affiliated agencies, to explore outreach initiatives to inform and assist persons with mental disabilities, who are not currently served by the system, regarding SSI/SSDI programs and application process.

Rationale: At least one-half of the individuals with a mental disability are not in the public mental health system. Many potential beneficiaries access the healthcare system intermittently. Individuals entitled to, but not receiving, SSI/SSDI may remain uninsured and their quality of life and healthcare may suffer. When care is needed, it is often sought at the local level, resulting in expenditures of local dollars rather than utilizing services to which the individual may be entitled through matched or federal dollars (Medicaid and Medicare). A focused outreach program and publications could provide opportunities to reach this unserved population.

a. Encourage the TRC DDS to collaborate with advocacy groups to disseminate information on available assistance programs at the initial application stage and make reference to these services. TRC DDS should assist in training identified groups to assure compliance with SSA standards and emphasize the importance of assisting the claimant through application completion.

Rationale: Many individuals apply for assistance at their local field office; however, there is little assistance given to those individuals or their family members regarding the application process. Further, potential beneficiaries, because of their disability or other factors (such as illiteracy), may be incapable of maintaining the necessary contact with SSA, Texas Department of Mental Health and Mental Retardation, Texas Rehabilitation Commission or the person assigned to complete the application for benefits or, if denied, to understand and negotiate the appeal process. The disability determination service routinely works with and provides training to the medical community, Texas Department of Mental Health and Mental Retardation, Texas Council on Offenders with Mental Impairments, and state, county and local authorities to improve the quality of applications.

Acronyms

SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
TRC DDS	Texas Rehabilitation Commission Disability Determination Service

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INTERIM CHARGE 4

Prescription Painkillers

Prescription Painkillers
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Prescription Painkillers

Interim Charge 4

Examine the problem of abuse of prescription painkillers, especially Schedule III drugs containing hydrocodone, and make recommendations on ways to reduce diversion and misuse of these drugs. (Keep Sen. Armbrister apprised of committee's deliberations on this issue.)

Background

Prescription drugs hold an important place in health care and in society as a whole. They make surgery possible, relieve pain for millions of people, and provide individuals with chronic medical conditions the ability to control their symptoms enabling them to lead productive lives. "Most people who take prescription medications take them responsibly; however, the nonmedical use or abuse of prescription drugs remains a serious public health concern."[1] According to the 2000 National Household Survey on Drug Abuse (NHSDA), an estimated 3.8 million Americans were using psychotherapeutics nonmedically (during the past month).[2] "This represents 1.7 percent of the population aged 12 and older, about the same rate as in 1999 (1.8 percent)."[3] Psychotherapeutics include four categories of prescription-type drugs: pain relievers (2.8 million users), tranquilizers (1.0 million users), stimulants (0.8 million users), and sedatives (0.2 million users).[4]

Prescription drug misuse is not a new problem. "Approximately 1.5 million persons used pain relievers nonmedically for the first time in 1999. The number of initiates [first-time users] has been increasing since the mid 1980s, when it was below 400,000 per year."[5] From 1990 to 1998, the number of new users of pain relievers increased by 181 percent; the number of individuals who initiated tranquilizer use increased by 132 percent; the number of new sedative users increased by 90 percent; and the number of people initiating stimulant use increased by 165 percent.[6] Although the nonmedical use of prescription drugs is evident in age groups 12 and over, the majority of nonmedical users of

psychotherapeutics are over the age of 26.[7]

Hydrocodone

Hydrocodone is a semisynthetic opioid structurally related to codeine.[8] It is an effective antitussive (cough suppressant) and, as an opiate, an effective analgesic for mild to moderate pain control.[9] "Five milligrams of hydrocodone is equivalent to 30 milligrams of codeine when administered orally."[10] And 15 milligrams of hydrocodone is equivalent to ten milligrams of morphine.[11]

Hydrocodone is available only by prescription as a combination product with acetaminophen (Vicodin, Lortab), with aspirin (Lortab ASA), ibuprofen (Vicoprofen), antihistamines (Hycomine), and in both tablet and liquid forms (Tussionex).[12] "The combination of an antipyretic-analgesic and an opiate agonist often provides more analgesia than a single agent, allowing a lower dose of both agents to give adequate pain relief with minimum side effects."[13]

Due to the effectiveness and safety profile, hydrocodone combination products are more frequently prescribed than other drugs within the same class of drugs.[14] [15]

> Pediatricians cited lower nausea rates as one of the key benefits for younger patients. Physicians treating older populations had fewer patients complain of constipation and nausea, both of which are often associated with other drugs in this group. Obstetricians found hydrocodone superior for use in pain management for breastfeeding mothers as the drug does not pass through into breast milk as readily as codeine or other available drugs. Those physicians who treat patients with intractable pain as well as surgeons who managed post-operative pain in general have better results with fewer complications using hydrocodone. In addition, hydrocodone has the ability to handle varying degrees of pain without having to go to a stronger drug and does not attack any organ in the body unlike other prescription pain

medications.[16]

Federal and State Regulation of Hydrocodone

Federal Controlled Substances Act

The Controlled Substances Act (CSA), Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, vests the federal government with the authority to regulate controlled substances.[17] The CSA establishes five (5) schedules of controlled substances known as Schedule I - V based upon the substance's medicinal value, harmfulness, and potential for abuse or addiction.[18] Schedule I are contraband substances and Schedules II through V relate to prescription drugs. Additionally, the CSA provides a mechanism for a substance to be controlled, added to a schedule, removed from control, rescheduled, or transferred from one schedule to another.[19]

The schedules are set by the United States Attorney General in consultation with the United States Department of Health and Human Services (HHS).[20] Information concerning schedule setting is also obtained from the Food and Drug Administration, from the National Institute on Drug Abuse, and, occasionally, from the scientific and medical community.[21] The recommendations of the HHS to the Attorney General are binding on the Attorney General regarding scientific and medical matters.[22]

"The CSA also creates a closed system of distribution for those authorized to handle controlled substances. The cornerstone of this system is the registration of all those authorized by the DEA [Drug Enforcement Agency] to handle controlled substances."[23]

Texas Controlled Substances Act

Texas has a Controlled Substances Act with a controlled substance schedule that mirrors the federal statute.[24] When the Legislature is not in session, the Commissioner of the Texas Department of Health (TDH) has the authority to establish, change, or modify the controlled substances schedule.[25] The Commissioner is prohibited from changing the class

of any controlled substance that is designated by the Legislature.[26] Change to Texas law is permissible as long as it is consistent with federal law or more stringent than its federal counterpart.[27] The following table describes the schedules with drug examples:

Schedule	Definition	Drug Example
Schedule I	High potential for abuse/no medical use	Marijuana, Heroin, Illicit Cocaine (i.e., 'crack')
Schedule II	Narcotic and non-narcotic substances (i.e., barbiturates and amphetamines) with high potential for abuse / addiction as well as medical efficacy	Ritalin, Morphine, Cocaine, OxyContin, Dexedrine, Seconal
Schedule III	Narcotic preparations and non-narcotic substances with less potential for abuse / addiction than Schedule I & II	Vicodin (hydrocodone with acetaminophen), Lortab, Tylenol w/Codeine, Phenteramine
Schedule IV	Non-narcotic drugs that have a lower potential for abuse than Schedule III	Valium, Darvocet-N
Schedule V	Drugs that may contain narcotics and have a low potential for abuse and are not habit forming	Robitussin AC, Phenergan VC

Source: Texas Department of Health Drugs and Medical Devices Division, http://www.tdh.state.tx.us/bfds/dmd/control_subst_sched.html and United States Drug Enforcement Agency at http://www.usdoj.gov/dea/pubs/scheduling.html

Limitations on Prescribing Practices and Patterns

Pure hydrocodone is a Schedule II narcotic on both the federal and state controlled substances schedules.[28] [29] Hydrocodone combination products, i.e., Vicodin and Lortab, are in Schedule III.[30] Not only do the schedules differentiate between medical use and abuse potential of the controlled substance, but the schedules also (1) influence

prescribing behavior, and (2) influence prescribing practices.

Both the federal and state CSA control prescribing patterns based on the schedule of the controlled substance.[31] For example, a Schedule II controlled substance may not be refilled.[32] Schedules III and IV controlled substances may not be filled or refilled more than six months after the initial prescription date or be refilled more than five times after the date of the prescription unless renewed by the practitioner.[33] Finally, prescribing practices are also dictated by the schedule of the controlled substance.

In 1982 the Texas Official Prescription Program, a prescription monitoring program, was originally implemented.[34] The primary reason for the legislation was "to prevent the diversion of medically useful controlled substances from licit to illicit channels."[35] At the time of inception, the program required the use of a "triplicate prescription form" to prescribe or dispense controlled substances in Schedule II.[36] The three-part prescription form was issued to practitioners (physicians), at cost, by the Texas Department of Public Safety (DPS).[37] DPS is the state agency responsible for the:

- overall direction of the state's enforcement efforts against illegal drug traffic;
- supervision of controlled substances registration;
- administration of the triplicate prescription requirements for Schedule II controlled substances; and
- supervision of permits and reporting of precursor chemical activities.[38]

As of March 1, 2002, Texas moved to a single-copy prescription form thereby eliminating the filing of a copy with the practitioner, the pharmacy, and DPS. The "official prescription form" is mandated, in appearance and content, and will be supplied, at cost, by the DPS.[39] To prescribe a Schedule II controlled substance in Texas, the practitioner must:

- date the prescription;

- identify the controlled substance prescribed;
- write the quantity of controlled substance prescribed, shown numerically and followed by the number written as a word;
- identify the intended use of the controlled substance or the diagnosis for which it is prescribed and the instructions for use of the substance, unless it is contraindicated due to the patient's health status;
- identify the practitioner's name, address, department registration number, and Federal Drug Enforcement Administration number;
- the name, address, and date of birth or age of the person for whom the controlled substance is prescribed; and
- not write more than one prescription on an official prescription form.[40]

Additionally, the Texas Administrative Code prohibits refills of Schedule II prescriptions.[41] Currently, the Official Prescription Program is limited to controlled substances in Schedule II.[42]

Frequency of Use

The Texas Controlled Substances Act prohibits a practitioner [physician] from prescribing, dispensing, delivering, or administering a controlled substance except for a valid medical purpose and in the course of medical practice.[43] The Texas State Board of Pharmacy (TSBP) reports that 1,494,799.51 grams of hydrocodone were purchased by Texas pharmacies (4,130) in 2002.[44] Texas was third in the nation in hydrocodone purchases.[45] However, not all of the hydrocodone pharmacy purchases are for Texas residents or prescriptions written by Texas doctors. Texas has several mail-order pharmacies within its borders that fill orders around the country from prescriptions written by non-Texas practitioners. Those non-resident, non-Texas physician prescriptions are included in the numbers reported above.[46]

Several factors influence the frequency of hydrocodone combination product use thereby affecting the total pharmacy purchases of hydrocodone. Combination preparations containing hydrocodone are popular narcotic analgesics due to the effectiveness and safety profile of the drug. As one physician stated, "what other drug is available in its schedule of drugs with the same effectiveness and low incidence of side effects?"[47] Additionally, hydrocodone combination preparations are easily prescribed by physicians because they do not require a "triplicate" or official prescription form. For example, few physicians carry, on their person, the "triplicate" or official prescription form when seeing patients in hospitals. A physician discharging a patient from the hospital, who requires a prescription pain medication, can simply write a prescription for a hydrocodone combination product on a hospital prescription pad unlike Schedule II narcotic analgesics.[48] Moreover, the implementation of the Official Prescription Program in 1982 had a chilling effect on physicians prescribing Schedule II pain medications. "During the first year of the program, there was a 52% reduction in the number of Schedule II prescriptions filled in Texas...."[49] Doctors report reluctance to prescribe pain medication in Schedule II, primarily due to the reporting aspect of the prescription program; hence hydrocodone combination products are prescribed more readily.[50] Thus, a combination of factors has lead to physician preference in prescribing hydrocodone combination products, thereby, contributing to the frequency of use. Based on these factors it is erroneous to conclude that the frequency of use is equal to overuse/misuse of the product.

Drug Misuse, Abuse and Diversion

> "Any substance that changes mental function in a desired manner has abuse potential:
>
> - Prescription, OTC medications
> - Illicit substances
> - Household products, chemicals
> - Herbals, plants and animals."
>
> William D. Watson, PharmD., Professor & Division Chief South Texas Poison Center (2002)

America's war on drugs, during the past 30 years, has focused on drug control as a criminal justice issue rather than a public health issue.[51] According to Travis County District Attorney Ronnie Earle, the nation should develop a policy that results in no more harm than drug use already causes, addresses the underlying reasons for drug abuse, preserves public safety without violating people's civil liberties, and does not overtax public resources such as jails and law enforcement agencies.[52]

Significant monetary resources and extensive study efforts are devoted to the issue of drug abuse. For the purposes of this report, a brief overview of abuse, misuse, and diversion will be presented focusing on hydrocodone combination products in Schedule III and other opioids (i.e., oxycodone or OxyContin) in Schedule II. Where the data is available, the focus will be on Texas. This is not an exhaustive review of abuse, misuse, or diversion.

Drug Abuse Statistics

The Drug Abuse Warning Network (DAWN) of the Substance Abuse and Mental Health Services Administration (SAMHSA) releases annual reports capturing data on the number of drug-related emergency department (ED) episodes in 21 select metropolitan statistical areas. The Dallas metropolitan area [Collin, Dallas, Denton, Ellis, Kaufman, and Rockwall Counties] is the only Texas area currently represented in the DAWN system.[53]

Exhibit 1 shows the number of mentions of hydrocodone [i.e., Vicodin-Schedule III pain reliever the subject of this interim report] and oxycodone

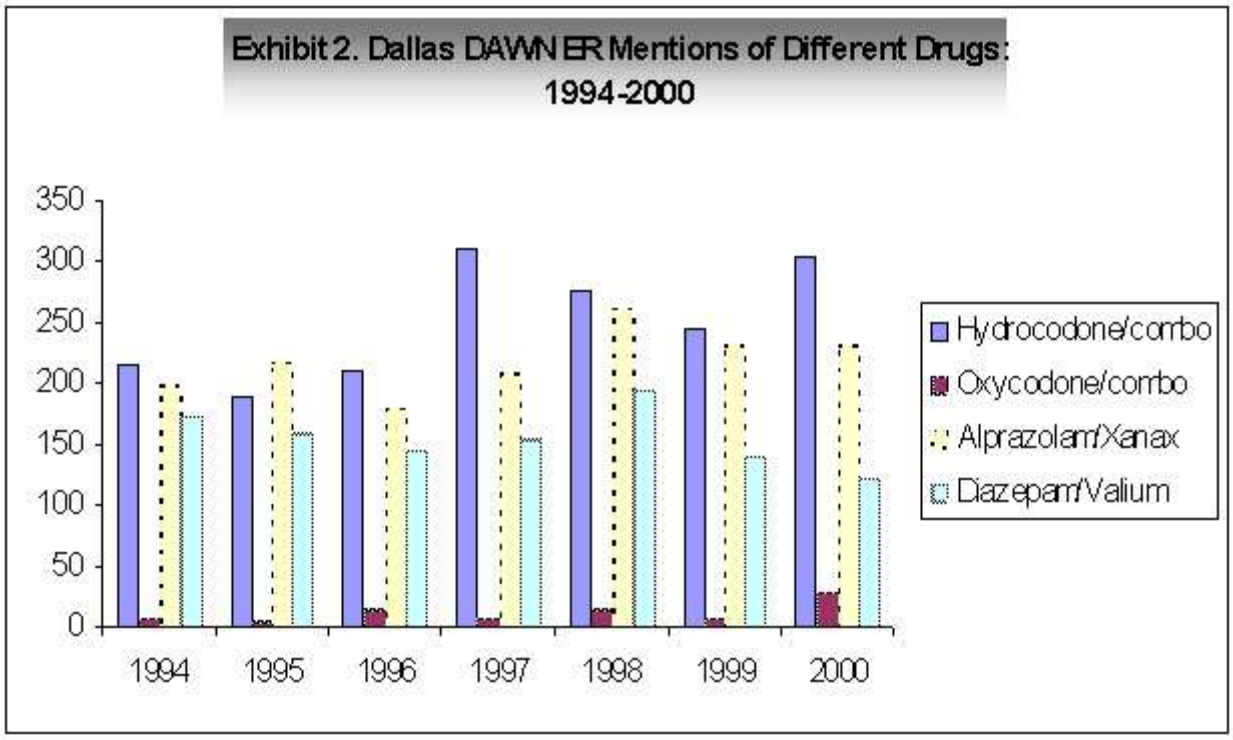
[i.e., OxyContin–Schedule II pain reliever] in combination with other drugs in Dallas area emergency rooms between 1996 and 2001 as reported to DAWN. Exhibit 1 also shows the number of mentions per 100,000 for the Dallas area and the US. The rates per 100,000 for mentions of hydrocodone in combination with other drugs was higher in Dallas than in the US as a whole, while the rates of mentions of oxycodone in combination with other drugs was lower in Dallas. The increases in oxycodone mentions between the first half of 2000 and the first half of 2001 were statistically significant for both the Dallas area and the US as a whole.[54]

Exhibit 1. Emergency Room Mentions of Hydrocodone and Oxycodone in Combination with Other Drugs in the Dallas Area and Coterminous US: 1996-2001

Drug	July-Dec	Jan-June	July-Dec	Jan-June	July-Dec	Jan-June	July-Dec	Jan-June	July Dec	Jan-June
# Dallas hydrocodone/combo mentions	105	150	160	130	146	125	120	146	158	173
Dallas hydrocodone/combo/100,000	4.4	6.2	6.6	5.3	6.0	5.1	4.9	5.9	6.3	5.2
US hydrocodone/combo/100,000	2.1	2.3	2.5	2.7	3.0	2.8	3.5	4.1	4.0	3.8
# Dallas oxycodone/combo mentions	6	3	2	5	8	7	1	23	5	8
Dallas oxycodone/combo/100,000	0.3	0.1	0.1	0.2	0.3	0.3	0.0	0.9	0.2	0.2
US oxycodone/combo/100,000	0.7	1.0	1.1	1.0	1.2	1.3	1.4	2.2	2.2	2.9

"Exhibit 2 provides a comparison of the number of emergency room mentions in the Dallas metro area of hydrocodone as compared to other drugs, including alprazolam [i.e., Xanax–tranquilizer] and diazepam [i.e., Valium–tranquilizer], which are also Schedule III [sic] drugs."[55]

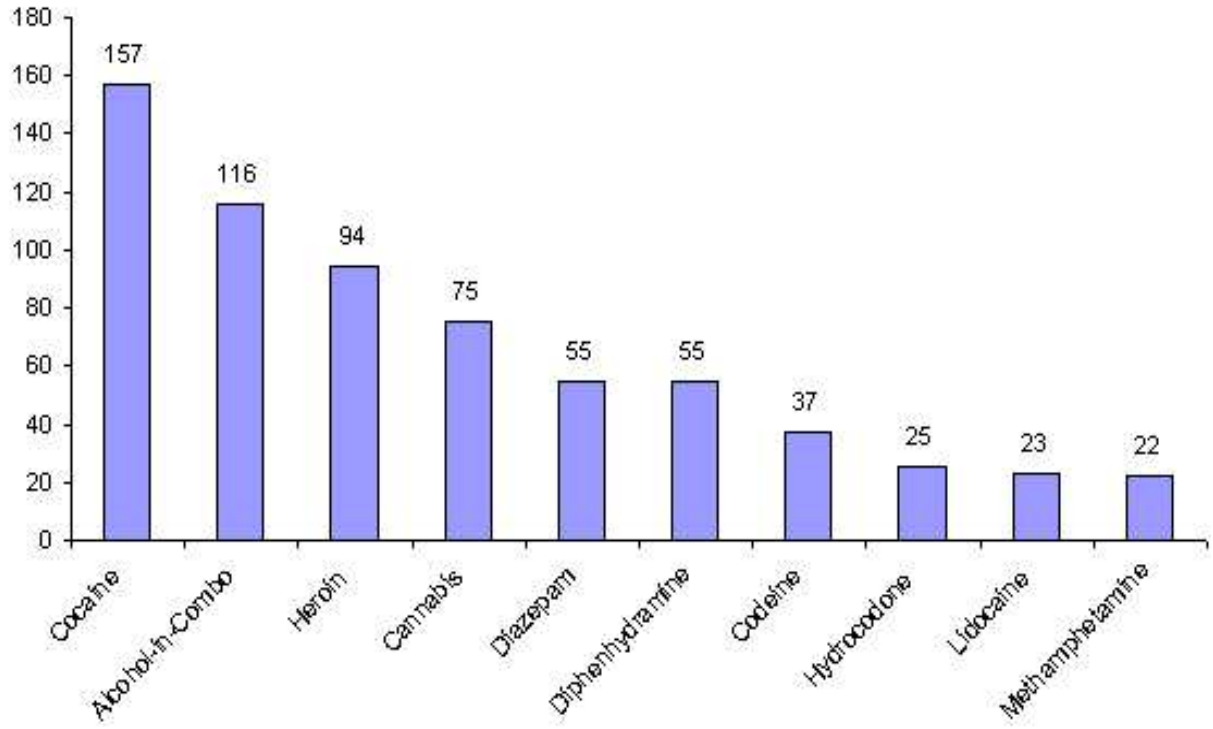
Overall, hydrocodone and oxycodone mentions represent only small percentages of total DAWN ED drug mentions in the coterminous United States reported in 2000 (3 percent and 2 percent, respectively); however, oxycodone mentions have increased significantly from 6,429 in 1999 to 10,825 in 2000.[56]



Overdose death data provides another source of information in substance abuse. Death certificates from the TDH Bureau of Vital Statistics are completed by medical examiners, private physicians, and justices of the peace. There is wide variation in the quality of the reporting and amount of information provided; "some contain detailed information on all the toxic substances found in the decedent's body, while others may not be based on toxicological information."[57] "However, based on an examination of death certificates in 1999, there were 8 deaths in the state with a mention of oxycodone; in 2000, there were 20. In 1999, there were 25 deaths in Texas involving hydrocodone; in 2000, there were 52."[58]

The DAWN format, however, includes all drugs mentioned. Exhibit 3 shows the ten most frequently mentioned drugs in deaths in the Dallas metro area [Collin, Dallas, Denton, Ellis, Kaufman, and Rockwall Counties] as reported to DAWN.[59]

Exhibit 3. Top Ten Drugs Mentioned in Deaths in the Dallas Metro Area: 2000



Drug Misuse

It is reported that addiction rarely occurs among people who use a prescription pain reliever as prescribed; studies have shown that properly managed medical use of opioid analgesic drugs, such as hydrocodone preparations, are safe and rarely cause clinical addiction, defined as compulsive, often uncontrollable use.[60] Opioid analgesics are effective pain relievers that can also affect regions of the brain where pleasure is perceived, thereby resulting in an initial euphoria.[61] Chronic use of opioids may result in tolerance to the drug requiring higher doses to achieve pain relief or to achieve the euphoric effects. Long term use may also lead to physical dependence.[62] However, it is important to differentiate between physical tolerance related to long term use for chronic

pain relief and drug misuse.

"Physical dependence, tolerance, and addiction are discrete and different phenomena that are often confused."[63] Clear terminology is necessary for effective communication regarding prescription pain medication use. Without clear terminology, confusion leads to unnecessary suffering, economic burdens to society, and inappropriate adverse actions against patients and professionals.[64]

Addiction

Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations.

Physical Dependence

Physical dependence is a state of adaption that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.

Tolerance

Tolerance is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time.[65]

Experts in pain medicine and addiction medicine agree that patients on prolonged opioid therapy will have physical dependence and sometimes tolerance, "but do not usually develop addictive disorders."[66] The actual risk of developing an addictive disorder is unknown and probably varies with genetic predisposition.[67]

> Addiction, unlike tolerance and physical dependence, is not a predictable drug effect, but represents an idiosyncratic adverse reaction in biologically

> and psychosocially vulnerable individuals. Most exposures to drugs that can stimulate the brain's reward center do not produce addiction. Addiction is a primary chronic disease and exposure to drugs is only one of the etiologic factors in its development.[68]

Behaviors suggestive of addiction may include: inability to take medications according to an agreed upon schedule, taking multiple doses together, frequent reports of lost or stolen prescriptions, doctor shopping, isolation from family and friends, and/or use of non-prescribed psychoactive drugs in addition to prescribed medications.[69] These are also characteristics of drug misuse.

Some trends in prescription misuse can be observed from the 2001 National Household Survey Data. The nonmedical use of prescription drugs (pain relievers, stimulants, tranquilizers, and sedatives) for men and women are roughly similar except in youths aged 12 to 17 where girls were somewhat more likely to use prescription drugs nonmedically than boys.[70] Among the elderly, the misuse of prescribed medications may be the most common form of drug abuse.[71] This may be attributed to an increase in the number of drugs prescribed in this population [three times more frequently than the general populations] and poorer compliance with directions for use.[72]

Drug Diversion

Drug diversion occurs in a variety of ways, including theft, forgery, and counterfeiting of prescriptions; illegal sales of prescriptions and drugs; fraudulent activities that victimize physicians, pharmacies, and patients; and by a small percentage of physicians who write prescriptions indiscriminately because they are dishonest, disabled, deceived, or dated in their practices.[73] It is thought that hydrocodone abuse in Texas originates through diversion from legal sources into the illicit market.[74]

In Texas, DPS laboratories identified 38,457 drug substances in 2000.[75] Of these

substances, only 1.3 percent was hydrocodone.[76] According to Dr. Jane Maxwell, hydrocodone is a "very small problem" in the picture of illicit drugs.[77] The Dallas-Fort Worth Field Division of the DEA reports that the street value of Dilaudid is $20-$80 per tablet and hydrocodone is $4-$7 per tablet. OxyContin's [oxycodone–Schedule II] street value is $15-$30 per tablet.[78]

The TSBP reports that hydrocodone is the drug most frequently (34%) listed on pharmacy theft and loss reports [FY2001 total theft/loss reports is 428].[79] Upon closer analysis, the theft and loss reports represent only 2% of the total licensed pharmacies in Texas.[80] In addition, of the 233,144 dosage units lost, 55% of the total lost units is due to employee pilferage. Thus, theft or loss of hydrocodone in Texas' pharmacies is primarily a pharmacy security issue.[81]

It is reported that the major source of illicit hydrocodone combination products is through fraudulent prescriptions via telephone or forged prescriptions.[82] In Houston, approximately 98% of all forged prescriptions are for hydrocodone.[83] An "official prescription program" has both a preventive and deterrent effect on drug abuse and drug diversion.[84] This, perhaps, is the reason Texas ranks 47th in the nation in illicit use of OxyContin, a Schedule II drug, that requires a "triplicate prescription" in Texas.[85] Such benefits do not come without an associated cost however, especially for those individuals suffering with chronic pain.

In an attempt to decrease drug diversion in Texas the TSBP, in 1992, petitioned the TDH to reschedule all dosage forms of hydrocodone combination products from Schedule III to Schedule II. TDH found insufficient scientific evidence presented to support reclassification.[86] In 2000, the Florida Legislature reclassified hydrocodone combination products from Schedule III to Schedule II.[87] Citing draconian consequences to patients, within weeks of the effective date of the law, an emergency rule was adopted retaining hydrocodone combination products in Schedule III.[88]

Balancing Adequate Pain Relief and Preventing Drug Abuse

Undertreatment of pain is a serious health problem in the United States.[89] "Preventing drug abuse is an important societal goal, but there is consensus, by law enforcement agencies, health care practitioners, and patient advocates alike, that it should not hinder patients' ability to receive the care they need and deserve."[90] Barriers that prevent the control of pain may be related to physician education or bias, patient reluctance to take strong medications for fear of side effects or addiction, or legislative/regulatory attempts to prevent diversion of these medications for illegal use.[91] Unfortunately, due to the American drug policy, "War on Drugs," and the implementation of strict regulatory controls, the effect on prescription pain medication has been dramatic as evidenced by the 52% drop in Schedule II pain prescriptions in Texas following the implementation of the prescription monitoring program.[92] Quite simply, physicians are reluctant to prescribe pain medication, patients are hesitant to take anything that could cause "addiction," and pharmacists are fearful of filling a prescription that may cause dependence.

Twenty-one health organizations and the Drug Enforcement Administration have joined together in a consensus statement to achieve the delicate balance between the abuse of prescription pain medications while ensuring those medications remain available for patients in need.[93] In Texas, the Intractable Pain Treatment Act (IPTA) was added in 1989 (71st Leg., 1st C.S., Senate Bill 20) to clarify legal ambiguities regarding opioid prescribing, bring Texas law into conformity with the federal intractable pain regulation, and to assure that Texans requiring narcotic pain relief were not denied the medication due to physician real or perceived fear of disciplinary action by the Texas State Board of Medical Examiners (TSBME).[94] The IPTA:

- defines intractable pain;
- authorizes physicians to use controlled substances for treatment of intractable pain;
- prohibits healthcare facilities from restricting the use of such drugs for

intractable pain; and

- prohibits the TSBME from disciplining a physician for prescribing or administering dangerous drugs or controlled substances in the course of treatment of a person for intractable pain.[95]

In 1997 the IPTA was amended by the 75th Legislature (House Bill 120, Representative Hirsch author; Senator Moncrief sponsor) allowing a physician to treat a known or former drug abuser, who develops an acute or chronic painful condition, with a controlled substance.[96] This amendment recognizes that persons who abuse drugs also experience pain and require appropriate pain medication intervention and that "quality medical practice dictates that those citizens of Texas who suffer pain and other distressing symptoms should be adequately relieved so that their quality of life is as optimum as can be."[97]

Conclusion

Individuals taking prescription medications, generally, do so responsibly. However, prescription misuse and diversion is a recognized public health concern. During the past 30 years many regulatory programs have been implemented to address this issue. At the same time some prescription pain medications are made more difficult to prescribe, other prescription pain medications increase in prescriptive use due to less regulatory burdens. When addressing misuse and diversion, ensuring availability and adequate pain management for individuals with chronic pain is an equally important public health objective.

Recommendations

1. **Require the Board of Pharmacy, the Board of Medical Examiners, the Board of Dental Examiners, the Department of Public Safety, and appropriate medical professional associations, (hereinafter the "Advisory Committee") to examine the need for the production of a prescription form on paper that minimizes the potential for forgery. Should the Advisory Committee recommend a prescription form on paper that minimizes the potential for forgery, the Advisory Committee shall draft proposed rules. The draft proposed rules may not include any requirement that sequential numbers, bar codes, or symbols be affixed, printed, or written on a prescription form or that the prescription form be a state produced prescription form. In examining the need for a prescription form on paper that minimizes the potential for forgery, the Advisory Committee shall consider and identify the following:**
   - **Cost, benefits, and barriers**
   - **Overall cost-benefit analysis**
   - **Compatibility with the electronic monitoring system**

   The Board of Pharmacy shall report the findings and conclusions of the Advisory Committee to the 79th Legislature

   Rationale: Prescription fraud, alteration, forgery, or counterfeiting of a physician's prescription is one source of a prescription drug diversion in the United States. This study will provide an analysis of whether this is a cost-effective means to reduce theft and diversion.

2. **Regulating boards of prescribing, dispensing, and administering practitioners shall, through appropriate communications and guidelines, provide to its licensees:**

   1) prescribing and dispensing information on prescription pain medications, primarily those in Class II and III;

2) information on abusive and addictive consumer behavior; and

3) information on common diversion strategies including fraudulent prescription patterns.

This should be done once during each biennium.

Rationale: To create heightened awareness of the appropriate use of pain medication, as well as, the misuse and diversion of addictive pain medication through agency newsletter or other forms of communications and guidelines.

3. **Encourage professional organizations to provide aggressive physician and health care professional education independently and through collaboration with the appropriate regulatory agency.**

   Rationale: To increase attention to old, new, and developing treatment for appropriate pain management. The recommendation will also increase awareness of the evolving practices of diverting pain medication.

4. **Increase education of health care professionals regarding poison center services.**

   Rationale: To increase awareness of the Texas Poison Center Network.

5. **Encourage, through the respective State regulating boards, the medical, dental, nursing, podiatry, and pharmacy schools to require courses in pain management and drug abuse.**

   Rationale: Early practitioner education will increase awareness of proper pain management. It will also increase awareness of drug abuse.

6. **Require a registered manufacturer or distributer to report each delivery or distribution of all materials in Schedules I and II, Schedule III narcotic materials and selected Schedule III and IV psychotropic drugs made to a physician, veterinarian, podiatrist, dentist or scientific researcher to the**

Department of Public Safety. DPS shall share this information with the appropriate state regulatory agency.

Rationale: Reports of diversion of controlled substances have included dispensing from a practitioner's office. This requirement will lead to early identification of unusual amounts of controlled substances being delivered to a practitioner.

Acronyms

CSA	Controlled Substances Act
DAWN	Drug Abuse Warning Network
DEA	Drug Enforcement Agency
DPS	Texas Department of Public Safety
ED	Emergency Department
HHS	United States Department of Health and Human Services
NIDA	National Institute on Drug Abuse
NHSDA	National Household Survey on Drug Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
TDH	Texas Department of Health
TMA	Texas Medical Association
TSBME	Texas State Board of Medical Examiners
TSBP	Texas State Board of Pharmacy

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ISSUE 5 WITHIN THE COMMITTEE'S JURISDICTION

Public Health Preparedness

Public Health Preparedness
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Public Health Preparedness

Issue 5 Within the Committee's Jurisdiction

Evaluate and improve the state's public health preparedness.

Background

The events of September 11, 2001 and subsequent anthrax crisis changed not only the landscape of America but also the nation's sense of security, especially in the area of public health. A victim of long-standing neglect, the public health infrastructure became undervalued and underfunded over the past century; however, the events of last Fall were a wake-up call galvanizing federal and state leaders to bring public health into the 21st Century.

The State of Texas and Public Health Infrastructure

The State of Texas. The TDH [Texas Department of Health or Department] is responsible for protecting and promoting the health of the nation's second most populous state. Texas' estimated population of 21,850,000 is distributed among 254 counties covering 261,914 square miles. Three of the ten most populated cities are in Texas: Houston, Dallas, and San Antonio. The state population is more concentrated in the eastern half of the state in the major metropolitan areas of Dallas-Fort Worth, San Antonio, Houston, and Austin, with El Paso as the westernmost population center.

Of the 120 cities identified in the Nunn-Luger-Domenici legislation, 12 cities are in Texas and all are now participating in the Metropolitan Medical Response System (MMRS) program.

Texas shares 21 border crossing areas and an international border of 1,240 miles with Mexico, much of which is remote, unpopulated and unguarded.

The size and diversity of Texas is hard to comprehend, even for those who live here. Texas is as large as all of New England, New York, Pennsylvania, Ohio, and Illinois combined.

In 1992 Texas was ranked third in the US by its gross state product of $416.9 billion and is ranked first in the US farm acreage: 130,886,608 acres distributed among 180,644 farms. Two-thirds of all trade between the US and Mexico passes through the state. Texas's [sic] 624 mile-long coastline is one of the longest in North America and of that, 293 miles are open for public use. Of the 29 coastal and inland water ports, the Port of Houston, the word's eighth largest port, is Texas' largest, and handles more foreign cargo than any other port in the nation. Texas leads the nation in aircraft landing locations with 1,710, including 1,302 airports, 400 heliports and 8 short takeoff and landing ports. The Dallas-Ft. Worth airport ranks third in the US in total passenger traffic. Seventeen military installations, three nuclear facilities including two power plants, and one facility, (PANTEX) that assembles, maintains, and disassembles nuclear weapons are all located in Texas.

All of these factors provide a large variety of targets for acts of foreign and domestic terrorism.

Public Health in Texas. The Texas Department of Health is a large, complex state agency composed of many diverse programs, all designed to protect and promote the health of the people of Texas. The agency is overseen by a Board of Health and directed by the Commissioner of Health. In addition to the programs and offices of the central office in Austin, TDH provides services to the people through the 8 regional offices located across Texas. For the areas of Texas that do not have a local health department,

these regional offices provide a range of standard public health services. Therefore, regional departments serve two roles: first as the field arm of the state health department, and second, as local health departments.

The vast majority (80%) of the population receives their public health services from local health departments or local health units. These local health departments are independent agencies that are part of city or county government, or a collaborative of several local governments. As such, they are partners with TDH in the provision of public health services in the state.

There are approximately 125 local health departments. However, many of these units provide only minimal or selected public health services and do not receive state support. The remaining health agencies that do provide a full range of public health services are called participating health departments and are generally represented by the Texas Association of Local Health Officials (TALHO). There are 65 such local agencies that are members of TALHO.[1]

This introduction, submitted by the TDH to the Centers for Disease Control (CDC), without question, describes the diversity in population, economic development, agriculture, land, and global impact on the state's borders that make Texas' unique, as well as, the daily challenge presented to the Texas Department of Health in assuring public health preparedness within the State.

76th Legislative Interim

During the 76th Legislative interim the Senate Health Services Committee, under the direction of Senator Jane Nelson, studied bioterrorism. The committee report made the

following four recommendations on bioterrorism preparedness:

1. "Texas must dramatically enhance disease detection capacity throughout the State."[2] The committee determined this would have the dual role of improving the capacity to detect both naturally and unnaturally occurring outbreaks that are missed or receive delayed attention.

2. "Local governments must develop, implement, and exercise integrated bioterrorism response plans which will prepare local systems in the event of an intentional release of a deadly bacterium or virus."[3] The committee recommended these plans be integrated into the current disaster and emergency planning efforts already in place, and that the TDH should assist local governments in developing and implementing their plans.

3. "Texas health care professionals must be educated and made aware of the threat of epidemic disease caused by terrorist intent and be prepared to rapidly identify the diseases of concern and to report suspected concerns to the local and state health department."[4] The committee also identified the need for Texas nursing, medical, and osteopathic universities, as well as, medical, hospital, nursing, and local organizations to take an active role with the TDH in improving epidemiological diagnosis and reporting.

4. "Texas should mirror the steps the federal government has taken to strengthen abilities to prevent or respond to a terrorist attack using chemicals or microbes. Texas should pass laws to establish criminal liability for the unauthorized possession of a restricted microbe or making a threat of using such a microbe."[5] Such laws will assist in the prevention of possible threats against Texas.

77th Legislature

As a result of these interim proposals, Senator Jane Nelson introduced Senate Bill 94, 77th Legislature, Regular Session, specifically addressing bioterrorism. The bill required a local government to create a bioterrorism response plan as part of its emergency management plan, and authorized a local government to consult with the TDH in developing the plan. The bill also amended the Government Code to provide that an emergency management plan, prepared by each local and interjurisdictional agency, must address natural, technological, and man-made hazards, including acts or threatened acts of terrorism involving the use or threatened use of conventional weapons, nuclear devices and materials, chemical agents, or biological agents. In developing the plan to address nuclear devices or materials, and biological agents, the local or interjurisdictional agency would have been authorized to consult with the TDH. The emergency management plans adopted should follow the standards and requirements adopted by the division of emergency management in the office of the Governor. Senate Bill 94 ran out of time in the House and did not pass; therefore, none of the provisions contained within the bill were implemented.[6]

Also, during the 77th Legislature, the TDH sought $3.8 million in a Legislative Appropriations Request to establish eight epidemiological response teams throughout Texas.[7] The request was not approved.

77th Legislative Interim

Prior to the September 11 terrorist attack on America and the subsequent deaths and illnesses caused by anthrax-tainted letters in Florida, New York and Washington, D.C., such events were the subject of popular fiction. For some, like Dennis Perrotta, Ph.D., State Epidemiologist, Texas Department of Health, terror events including biological and chemical weapons were real potential threats to Texas and the United States. In fact, in 1999 ABC News featured a special five-part series, *Nightline's Biowar*, designed to

educate viewers on the potential risks of a terrorist biological attack. The biological agent, anthrax, was the subject of the series. Dr. Perrotta served on the *Biowar* panel discussing how the TDH would respond to the hypothetical anthrax attack.[8]

Dr. Perrotta has described, before the Senate Committee on Health and Human Services, a bioterror incident as a covert attack that could go undetected for days.[9] "When somebody uses a microbe, a bacteria or a virus, nobody knows what's happening. If somebody decides at a football game, an inauguration, a large congregation to release one of those harmful microbes, they can do so without anybody noticing it. There is no first responder. There is no 911 call. There is no emergency that we know about yet."[10] The first signs of an attack would be two to three days after exposure, when a large number of exposed persons seek medical attention for flu-like symptoms.[11] Within days, many would become seriously ill and many die. As a result of managed care and other influences, hospital nursing staff and bed capacity have been cut, thereby all but eliminating "surge capacity" [the ability to expand and accommodate] in a community crisis.[12] Local hospitals could easily be overwhelmed. This is especially devastating since "the public will see local hospitals 'as a vital resource for diagnosis, treatment and follow up for both physical and psychological care.'"[13]

Chemical agents as terror weapons are easier than biological agents "in every way but are generally less lethal."[14] Many chemicals are common in industrial use, such as, cyanide that is used to clean metals.[15] As a result, chemicals are easier to steal than biologic agents like smallpox.[16] "Toxic chemicals are already weaponized."[17] Although more chemical is required than a biologic agent to kill people, delivery of the chemical "is an even lower-tech task than turning 747s into missiles. A truck, perhaps smashed into a concrete barrier, would do fine."[18]

The Texas Department of Health's Public Health Preparedness

On October 10, 2001, Senate Health and Human Services Committee staff met with Sharilyn K. Stanley, M.D., Associate Commissioner, Disease Control and Prevention; Susan U. Neill, Ph.D., M.B.A., Bureau Chief, Bureau of Laboratories; L. Bruce Elliott, DR.P.H., Director, Microbiological Services Division; and Dennis M. Perrotta, Ph.D., C.I.C., State Epidemiologist, from the Texas Department of Health to discuss the State's preparedness for a bioterrorist event. This meeting is summarized below.

The State Laboratory

The 74th Legislature approved $42.3 million for a laboratory and office facilities at the TDH. Former Commissioner Reyn Archer chose to completely redesign the facility. He also ordered an environmental study for the proposed building.

In January 1999, the General Services Commission (GSC) informed the TDH the redesigned structure could not be completed with the original $42.3 million allocated. To complete the building an additional $8.2 million was required. The TDH secured the additional funding internally and obtained capital authority for this increase. Thereafter, GSC informed the TDH that an additional $2.3 million was necessary for the new laboratory but advised the TDH to request capital authority for $3.3 million. The TDH was denied the authority for the $3.3 million; however, it was granted an additional $1.3 million capital authority. Dr. Charles Bell, Executive Deputy Commissioner, was instructed by letter, "that the approval of the $1.3 million in capital authority does not include expenditures related to the completion of the seventh floor of the laboratory building."[19]

Due to the funding issues, as well as, other redesign and construction factors, completion of the TDH laboratory has been set back by more than two years.

The seventh floor of the future State laboratory was slated to house both the organic

chemistry division and the nuclear chemistry division. Due to the lack in funding, the nuclear chemistry division will move into the new laboratory, however the organics chemistry division will remain in the eight to ten-year-old temporary buildings it currently occupies. The TDH has been required to continuously repair and refurbish the temporary buildings in order to keep the organics section operating. Unfortunately, the nature of organics science, prohibits the organics laboratory from being located on any other floor in the new laboratory building due to mandatory venting hoods and other equipment requiring roof access.

Preparedness for a chemical attack

In response to questions concerning the sufficiency of the current organics laboratory to meet the needs of Texas in the event of a chemical attack, it was revealed that the laboratory is insufficient to handle chemical terrorist attacks. Examples of chemical agents include mustard gas, hydrogen cyanide, sarin (this was the gas utilized in 1995 by the Japanese cult killing 12 people in a Tokyo subway) and others. An upgraded facility was originally included in the plans for the new laboratory. Unfortunately, the window of opportunity under the current contract to complete the seventh floor, should the money become available, has passed. Dr. Stanley reported that a new contract would be necessary. Moreover, TDH had “no fat left” with which to complete the seventh floor of the laboratory. The State’s laboratory will be substantially completed by October 2002 and occupied by the end of December 2002.

Preparedness for a biological attack

In the event of a biological attack, through agents such as anthrax, smallpox, salmonella, typhi, and others, the laboratory is adequate. The future laboratory is a biosafety level (BSL) 3 facility. This is sufficient to handle the bioterrorist agents identified. A BSL 4 laboratory (the highest rated laboratory) is necessary for hemorrhagic agents such as Ebola. Texas is fortunate, according to Dr. Neill, to have access to two BSL 4 laboratories in the state; very few exist nationwide. The BSL 4 laboratories in Texas are at the

University of Texas Medical Branch, Galveston, and at the Southwest Foundation for Research and Education, San Antonio.

Bioterrorism Preparedness

After the events of September 11, and the subsequent anthrax scare, the State's preparedness has been tested almost daily. The State Epidemiologist reported that in one week, there were five anthrax scares in Texas, none of which proved valid. By the time the anthrax crisis was over, the state's laboratories analyzed more than 2,100 samples with Dallas being the hardest hit, followed by San Antonio and Houston.[20] People sent in dollar bills with powder on them, key boards, guns, mouse pads, and desk blotters "because they had eaten a powdered doughnut over it and two hours later they forgot about it."[21] The anthrax scare in Texas, lasting over several months, demonstrated "how quickly the laboratory can be overwhelmed by requests."[22] These possible bioterrorism requests use the very same infrastructure that exists for the mandatory reporting of 60 communicable diseases in Texas.

The surveillance infrastructure begins with the initial report made at the local level, and includes laboratory reporting, physician reporting, and local health department reporting. However, in the opinion of TDH officials many reportable communicable diseases go unreported, and 50 percent of the disease reports from the laboratories are received by mail rather than by faster communications systems available today. Mailed reports are not limited to small health departments in rural areas but also involve large metropolitan areas, such as, Dallas. Other areas of the state without local health departments undermine or slow the reporting procedure considerably.

Under-reporting presents another problem. Under-reporting can be due, in part, to the difficulty in obtaining physician compliance, although the failure to report is a Class B misdemeanor. Another factor comes from existing strains on the reporting system.

Following the heavy floods in Fall 2001, some laboratories in Houston are no longer reporting electronically as a result of flood damage to computer equipment.

The laboratory infrastructure is an integral part of the public health infrastructure. TDH partners with five laboratories, Houston, Dallas, El Paso, Lubbock, and San Antonio. With these partnerships, the local laboratories are able to perform their own testing for diseases rather than wasting valuable time shipping everything to Austin. At the time of this meeting, there are other laboratories that had not yet been brought into this partnership including laboratories in Harlingen, Tyler, Amarillo, Fort Worth, and College Station.

Not every local health department has a laboratory or an epidemiologist. For example, the Austin-Travis County Health Department is staffed by four public health nurses. There are 65 local health departments that currently contract with the TDH. A limitation with these partnerships is the local jurisdictional nature of the health department. Since the local health departments are subject to local control, they are also subject to local budgetary control with a distinct and continuing risk of being eliminated entirely from city/county governments. Along the same line, many areas of Texas are without any local health authority whatsoever. In a state with 254 counties, there are approximately 125 local health agencies, of which approximately half provide a full range of public health services. The CDC has acknowledged that Texas is a “big target” for bioterrorism, yet the time it takes to send out a medical alert might vary from four hours to twelve hours.

The final part of the infrastructure is training and education of an adequate public health workforce by the TDH. On September 11, 2001, the TDH had only three people with specific training in bioterrorism response. This concern prompted the TDH’s request for money from the CDC to train state and local public health officials to respond appropriately in the event of a bioterrorism and serious related events.

Funding Issues

In response to a request from Chairman Mike Moncrief, the TDH prepared "a priority listing of the estimated costs, items, and other expenditures necessary to ensure that the Texas Department of Health is fully prepared to respond to a threat of bioterrorism" [Priority Report].[23]

The TDH identified the following six areas to increase state and local health department capacity to detect and respond to bioterrorism events:

- Enhancing epidemiological and surveillance at the regional and local level.
- Increasing microbiological and chemical laboratory capacity.
- Increasing TDH's capacity to rapidly collect and analyze data.
- Training healthcare and public health workers to respond to bioterrorism.
- Enhancing communications with, and providing assistance to, local health departments through a Health Alert Network.
- Creating the Office of State Epidemiologist to serve as the public health focal point for bioterrorism response.

Appendix D.

Chairman Moncrief forwarded these recommendations to Governor Perry by letter on October 24, 2001. Pointing to the need for a coordinated approach to respond to a threat of bioterrorism, Chairman Moncrief noted that, "as the state agency charged with the essential public health functions of disease detection and emergency response, it is critical that we give the agency's request careful and appropriate consideration," and asked Governor Perry to consider allocating additional grant money to TDH, in addition to the $1.2 million in grants that Governor Perry had previously authorized for antiterrorism efforts by the Department of Public Safety.[24]

The Priority Report estimated $12.1 million would be required to remedy the infrastructure gaps. Governor Perry "directed Texas Health and Human Services Commissioner Don Gilbert to find the money in the agency's budget."[25] On October 30, 2001, Commissioner Gilbert sought authority and approval, from the Governor's Office and the Legislative Budget Board, to transfer $12.1 million in general revenue "from health and human services agencies" to "ensure that Texas' public health system is prepared to respond to the increased threat of bioterrorism."[26] After Legislative Budget Board review, Lieutenant Governor Bill Ratliff and Speaker Pete Laney, on November 30, 2001, authorized the expenditure of $6.1 million in general revenue funds to increase epidemiological staff and Health Alert Network systems ($4 million), enhance local and state laboratory capabilities ($2 million), and improve training of local and regional staff ($0.1 million).[27] The Priority Report was subsequently revised to reflect the expenditure authorized. Appendix D. In FY 2002, $2.2 million was transferred to the TDH. No transfer of funds was made in FY 2003 due to the allocation of federal funds to TDH described below.

Addressing Bioterrorism in Texas

Federal Initiatives

In addition to the Priority Report requested by Chairman Moncrief and the partial funding approved by the Legislative Budget Board, at the federal level the Public Health Improvement Act (Act), a comprehensive package of public health bills, was signed into law on November 13, 2000 as P.L. 106-505.[28]

> Title I of the Act, the Public Health Threats and Emergencies Act, addresses the national need to combat threats to public health, and to provide grants to state and local governments to help them prepare for public health emergencies, including emergencies resulting from acts of bioterrorism. Title I provides the authority under which FY 2002 funds for state public health and bioterrorism preparedness are distributed. It amends Section 319 of the Public Health Services Act, codified under Title 42 of the United States

Code, Section 243, et seq.

> The Act establishes opportunities for grants and cooperative agreements for states and local governments to conduct evaluations of public health emergency preparedness, and enhance public health infrastructure and the capacity to prepare for and respond to those emergencies. Other grants support efforts to combat antimicrobial resistance, improve public health laboratory capacity, and support collaborative efforts to detect, diagnose, and respond to acts of bioterrorism.[29]

Funds were not appropriated by Congress for this Act until December 2001 when the Act was included in the 2002 Department of Defense appropriation.[30] On January 10, 2002, President George W. Bush signed the $2.9 billion "Emergency Supplemental Act, 2002 and the Departments of Labor, Health and Human Services and Related Agencies Appropriations Act, 2002," providing "more than a billion dollars to foster State and local preparedness."[31] The funds are targeted to upgrade infectious disease surveillance and investigation, enhance readiness of hospital systems, and expand public health laboratory and communication systems capacities.[32]

Funding to states and communities is divided into three parts with the first portion being provided by the CDC. This money "is targeted to supporting bioterrorism, infectious diseases, and public health emergency preparedness activities statewide."[33] The second portion of funding, from the Health Resources and Services Administration (HRSA) "will be used by the states to create regional hospital plans to respond in the event of a bioterrorism attack."[34] The final portion of the funds, provided by the HHS Offices of Emergency Preparedness "will support the Metropolitan Medical Response System (MMRS)."[35]

The MMRS is a collaboration between fire, EMS and HAZMAT communities, the public,

private and mental health communities. “An effective systems response to chemical, biological, radiological or nuclear incidents will require coordination among hospitals, pre-hospital providers, laboratories, public health officials, poison control centers, mental health professionals, infectious disease experts, surrounding communities, states and the Federal Government.”[36] Originally begun in Washington, D.C. in 1995, and Atlanta in 1996, the Defense Against Weapons of Mass Destruction Act of 1996 (more commonly known as Nunn-Lugar-Domenici), authorized HHS to develop additional MMSRs.[37] Texas currently has 12 cities (Houston; Dallas; San Antonio; El Paso; Austin; Fort Worth; Arlington; Corpus Christi; Garland; Lubbock; Amarillo; and Irving) participating in the MMRS program. With the additional HRSA funding an additional 25 new cities will be added to the MMRS program bringing coverage to “80 percent of the U.S. population."[38] The contracts seek to improve local jurisdictions’ ability to respond to a chemical or biological agent.[39]

Texas' allocation for bioterrorism funding and MMRS is set forth below:[40]

TEXAS ALLOCATION FOR BIOTERRORISM FUNDING, FY 2002						
CDC First Bioterrorism Allocation (20%)	CDC Second Bioterrorism Allocation	CDC Bioterrorism Total	HRSA Hospital First Allocation (20%)	HRSA Hospital Second Allocation (80%)	HRSA Hospital Total	Grand Total
$10.3m	$41.1m	$51.4m	$1.7m	$6.7m	$8.3m	$59.7m

TEXAS ALLOCATION FOR METROPOLITAN MEDICAL RESPONSE SYSTEM (MMRS), FY 2002			
Amarillo	Irving	Garland	Lubbock
$400,000	$400,000	$200,000	$200,000

Critical Benchmarks

Although the states were allowed to immediately begin spending 20 percent of their allotments, the remaining 80 percent was withheld until state plans, reviewed and endorsed by the governor prior to submission, were approved by HHS. Each state plan was reviewed based on the following 17 critical benchmarks for bioterrorism preparedness planning:

I. PUBLIC HEALTH PREPAREDNESS (CDC)

1. Designate a Senior Public Health Official within the State health department, to serve as Executive Director of the State Bioterrorism Preparedness and Response Program.
2. Establish an advisory committee with members from a variety of health agencies and first responders.
3. Prepare a timeline for the development of a statewide plan for preparedness and response for a bioterrorist event, infectious disease outbreak, or other public health emergency.
4. Prepare a timeline for the assessment of statutes, regulations, and ordinances within the state and local public health jurisdictions regarding emergency public health measures.
5. Prepare a timeline for the development of a statewide plan for responding to incidents of bioterrorism.
6. Prepare a timeline for the development of regional plans to respond to bioterrorism.
7. Develop an interim plan to receive and manage items from the National Pharmaceutical Stockpile, including mass distribution of antibiotics, vaccines and medical material.
8. Prepare a time line for developing a system to receive and evaluate urgent disease reports from all parts of the state (or city) and local public health jurisdictions on a 24- hour per day, 7 days per week basis.
9. Assess current epidemiologic capacity and prepare a timeline for providing at least one epidemiologist for each metropolitan area with a population greater than 500,000.
10. Develop a plan to improve working relationships and communication between Level A (clinical) laboratories and Level B/C laboratories, (i.e. Laboratory Response Network laboratories) as well as other public health

officials.

11. Prepare a timeline for a plan that ensures that 90 percent of the population is covered by the Health Alert Network (HAN).

12. Prepare a timeline for the development of a communications system that provides a 24/7 flow of critical health information among hospital emergency departments, state and local health officials, and law enforcement officials.

13. Develop an interim plan for risk communication and information dissemination to educate the public regarding exposure risks and effective public response.

14. Prepare a timeline to assess training needs--with special emphasis on emergency department personnel, infectious disease specialists, public health staff, and other health care providers.

II. HOSPITAL PREPAREDNESS (HRSA)

15. Designate a Coordinator for Bioterrorism Hospital Preparedness Planning.

16. Establish a Hospital Preparedness Planning Committee to provide guidance, direction and oversight to the State health department in planning for bioterrorism response.

17. Devise a plan for a potential epidemic in each state or region. Recognizing that many of these patients may come from rural areas served by centers in metropolitan areas, planning must include the surrounding counties likely to impact the resources of these cities.[41]

The TDH Commissioner, Eduardo Sanchez, reported on June 13, 2002 to the Board of Health that the U.S. Department of Health and Human Services (HHS) approved the Texas public health preparedness grant application on June 6, releasing the remaining eighty percent of the CDC funding, with one restriction. The funds requested for the TDH pediatric antibiotic reserves, totaling $56,000, are restricted pending further discussion regarding optimum use of stockpiles. The Texas hospital preparedness plans, funded through a HRSA grant, were also reviewed and approved for phase one. Funds for phase two are restricted until the plan submitted on July 1 is approved.[42]

The federal funding received by Texas as a result of the 2002 federal supplemental appropriations covered the $12.1 million requested by the TDH in its Priority Report with the exception of the chemical agent laboratory capacity. The CDC did not provide funds for this activity; therefore it remains unfunded.[43]

The Governor's Task Force on Homeland Security

During the Fall of 2002, Governor Rick Perry convened a Task Force on Homeland Security. While the Governor's Task Force made many recommendations to improve domestic security, the following recommendations relate specifically to the state's public health response to bioterrorism:

B8. Request all health licensees to complete at least one hour of continuing education requirements each year on reporting medical events and responding to terrorism.

C2. Assess, identify and provide additional training and resources that may be needed by local emergency response entities.

C3. Support the TDH's recent plan to improve response capabilities in the event of an anthrax or bioterrorism event.

D2. Improve reporting of infectious diseases to the TDH.

D3. Review and update plans for quarantine, hospitalization, and evacuation procedures in the event of a terrorist attack.

D4. Develop a statewide plan to administer a mass vaccination and chemoprophylaxis.

D5. Continue funding the Health Alert Network (HAN).

D6. Request all health licensing organizations and agencies to require licensees to provide business fax numbers and e-mail addresses.

D7. Establish 10 Regional Hazardous Materials Weapons of Mass Destruction Teams.

D8. Monitor the development of communications interoperability for first responders.[44]

Preparing Healthcare Workers for Bioterrorism

On October 16, 2001, the Texas Medical Association (TMA) announced the appointment of a Bioterrorism Task Force chaired by Ronald O. Blanck, D.O., President, University of North Texas Health Science Center, Fort Worth. In establishing this task force, the TMA partnered with the TDH in developing "solid recommendations on how individual physicians and the broader medical community can better prepare to respond to a bioterrorism attack."[45] Immediately following the events of September 11, the TMA established the Bioterrorism Resource Center on its website. Additionally, the Task Force on Bioterrorism created a 16-page bioterrorism toolkit mailed to all Texas physicians in January 2002. Included in the toolkit are "physician protocols on the diagnosis, reporting, etiology, and management of anthrax, botulism, smallpox, and plague, and one-page reproducible patient handouts on each of those diseases."[46]

Updating State Laws

Model State Emergency Health Powers Act

At the same time the U.S. Congress was debating funding for the Public Health Threats and Emergencies Act, the Model State Emergency Health Powers Act (Health Powers Act) was being drafted, through a federally funded project, at Georgetown and Johns Hopkins Universities. The Health Powers Act is a model law based on the assumption that existing state laws are inadequate to address a bioterrorism event and should be replaced by this model law.[47] Fortunately, Texas has several laws including the Texas Disaster Act of 1975, the Communicable Disease and Prevention Control Act, and criminal laws that would be accessed in the event of a biological or chemical terrorist attack.

Texas Statutory Update

The events of September 11 and the anthrax tainted-letters beginning October 4, 2001 have caused many states, including Texas, to perform a critical self-analysis of public health, disaster, and criminal laws in an effort to determine the sufficiency of these laws

during a terrorist event. The TDH, along with committee staff, met with community stakeholders to evaluate Texas' laws. The participants included the American Civil Liberties Union, Consumers Union, Texas Civil Rights Project, Texas Hospital Association, Texas Medical Association, and the Texas Nurses Association. As a result of these stakeholder meetings, recommendations were made to revise Texas' laws. These recommendations were presented to the Senate Committee on Health and Human Services on June 16, 2002, and were favorably voted on by the committee. Other areas, such as, the Public Information Act and Open Meeting Act, Good Samaritan laws, and occupational licensing laws require further analysis by all participants.

Conclusion

Prior to September 11, 2002, and after science removed the public's fear of communicable diseases, the public health system in the United States suffered from neglect. Emphasis was shifted to chronic illness and indigent care. In the post-September 11th world, terrorist events in the United State are no longer popular fiction. Demands have been placed at the federal and state levels to bring the public health system into the 21st Century through funding and other focused activities. At the same time, states' public health laws, including disaster and criminal laws, require change to meet the challenges brought forth in this new world.

Recommendations

1. TEXAS DISASTER ACT OF 1975:

Impose public health emergency provisions following disaster declaration by governor as follows:

Gov't Code § 418.004: Add the definition "Public health emergency means an immediate threat from an occurrence of a communicable disease as defined the Health and Safety Code, Chapter 81:

(A) that poses a high risk of fatalities or serious long-term disability to large numbers of people; and

(B) where there is substantial risk of public exposure because of a high level of contagion or the particular means of transmission of the communicable disease."

Rationale: Other legislative changes discussed in this document use the terms public health emergency or disaster. The term "disaster" is defined in the Texas Disaster Act but "public health emergency" is not currently defined in any state law.

Gov't Code § 418.014: Revise to say that in the original executive order or proclamation to declare a state of disaster or in a subsequent executive order or proclamation, the governor may find that a disaster constitutes a public health emergency. A finding shall be made in consultation with the commissioner of health and shall trigger the "public health emergency" provisions in HSC Chap. 81 and other state laws where the term is used.

Rationale: This change will allow the other provisions in this document relating to a public health emergency to be implemented only upon declaration by the governor.

Gov't Code § 418.014(c): Revise to allow governor to renew a disaster constituting a public health emergency once for an additional 30 days in consultation with the commissioner of health and with approval of designated

legislative leadership after the first renewal.

Rationale: This will provide executive and legislative oversight of the extension of the public health emergency provisions in this document; however there must be further definition/ development of judicial/legislative review. There must be judicial involvement.

2. COMMUNICABLE DISEASE PREVENTION AND CONTROL ACT:

Define "public health emergency" for purposes of the communicable disease law as follows:

HSC § 81.003: Add the definition "Public health emergency means a public health emergency declared by the governor under the Texas Disaster Act of 1975, Gov't Code, Chap. 418."

Rationale: Other legislative changes discussed in this document use the term public health emergency or disaster. The term "disaster" is defined in the Texas Disaster Act but "public health emergency" is not currently defined in any state law.

3. Impose area quarantine or control measures upon suspicion of communicable disease:

HSC § 81.085(a): Add a sentence at the end to state, "An area quarantine may also be imposed if the commissioner has reasonable cause to believe that individuals or property within an area are or may be infected or contaminated with a communicable disease. In such a case the area quarantine would be imposed by the commissioner for the period necessary to determine if an outbreak of communicable disease has occurred in this state and may be continued if an outbreak is identified."

Rationale: Current language only allows imposition of an area quarantine if there is an outbreak of a communicable disease. Because of the time that may be necessary to determine that an outbreak has actually occurred, e.g., to receive test results, this language would allow prompt action to protect public health prior to the determination of an actual outbreak. Reasonable cause to believe there is infection or contamination with a communicable disease could be based on symptoms, medical tests, or proximity to known or suspected exposure. The phrase "reasonable cause to believe" is already included in HSC § 81.083 concerning application of control measures to an individual and HSC § 81.084 concerning application of control measures to property. The same or similar language is found in other statutes, such as the requirement for a professional to report child abuse or neglect if the professional has "cause to believe" a child has been abused or neglected. US Supreme Court has held that "reasonable cause" and "probable cause" is "substantially equivalent."

HSC § 81.085: Add "Quarantine must be accomplished by the least restrictive means necessary to protect the public health while considering the availability of resources to accomplish those means."

Rationale: This addition will help to ensure that an area quarantine is not overly restrictive on individual or property rights.

4. Make local health authority and the department communicable disease powers consistent.

HSC § 81.003(2): At the end of the definition of "health authority," add "a regional director performing duties of a health authority, or a designee".

Rationale: These changes will ensure that each mention of a health authority clearly includes a TDH regional director performing such duties (which is allowed under current law at HSC Chap. 121) and that a designee can act, particularly if there is an emergency during a time that the actual health authority is away.

HSC § 81.061: Add new subsection (d) to state that "A health authority may investigate the existence of communicable disease within the boundaries of the health authority's jurisdiction to determine the nature and extent of the disease and to formulate and evaluate the control measures used to protect the public health. A person shall provide records and other information to the health authority on request according to the health authority's written instructions. Confidential or privileged records or other information shall remain confidential or privileged in the hands of the health authority".

Rationale: These changes will give a local health authority the same investigative powers and record access as TDH and will insure the confidentiality at the local level. The power to perform some level of investigation may be implicit in a local health authority's general supervisory authority and control over the administration of communicable disease control measures (see § 81.082); however, these changes will give clear authority.

HSC § 81.062: Add new subsection (c) to state that "A health authority has the same powers as the department under this section."

Rationale: This section relates to an investigation. If changes are made to HSC § 81.061, this change should be made to HSC § 81.062 for consistency.

HSC § 81.085(b): Delete "and of the governing body of each county and municipality in the health authority's jurisdiction that has territory in the affected area".

Rationale: Receiving such approvals at a posted open meeting of the governing body(s) could unreasonably delay the imposition of the area quarantine. Consultation is sufficient. Each governing body would be able to give specific instructions to its local health authority as to what sort of consultation the governing body expected the local health authority to obtain. For action by the Commissioner of Health, approval of the Board of Health is not required.

HSC § 81.085(b): Delete "and obtains the approval of".

Rationale: Consultation with the Commissioner of Health is sufficient.

HSC § 81.085(c): Add a sentence at the end to say, "The department may impose in a quarantine area additional disease control measures that the department considers necessary and most appropriate to arrest, control, and eradicate the threat to the public health."

Rationale: The department should be able to impose additional control measures just as a local health authority may impose such measures under the current language.

5. Be consistent in delegating grants of authority regarding communicable disease to the commissioner and the department.

HSC § 81.023: Substitute "department" for "board".

Rationale: The department includes the board under HSC § 11.004.

HSC § 81.064: Delete "the commissioner's designee" and "a health authority's designee." Substitute "department" for "commissioner".

Rationale: Changes to §81.003 would add the commissioner's designee to the definition of "commissioner;" therefore, it is not necessary to repeat "designee" in subsequent sections. The term "department" includes the commissioner, TDH officers, and TDH employees under HSC § 11.004.

HSC § 81.066(a): Substitute "department" for "board".

Rationale: HSC § 81.061 references the department handling investigations. The department includes the board under HSC § 11.004.

HSC § 81.067: Substitute "department" for "board."

Rationale: HSC § 81.061 references the department handling investigations. Department includes the board under HSC § 11.004.

HSC § 81.068: Substitute "department" for "board".

Rationale: HSC § 81.061 references the department handling investigations. The department includes the board under HSC § 11.004.

HSC § 81.082(a): Substitute "preempted by the department" for "preempted by the board."

Rationale: The board has delegated many responsibilities under this chapter, other than rule making, to the commissioner who is then authorized to delegate to appropriate department employees. The department includes the board under HSC § 11.004.

HSC § 81.082(b): Substitute "department" for "board."

Rationale: The board has delegated many responsibilities under this chapter, other than rule making, to the commissioner who is then authorized to delegate to appropriate department employees. The department includes the board under HSC § 11.004.

HSC § 81.085(b): Substitute "department" for "commissioner."

Rationale: The department includes the commissioner under HSC § 11.004.

HSC § 81.085(c): Substitute "department" for "board."

Rationale: See HSC § 81.082(b). The department includes the board under HSC § 11.004.

HSC § 81.085(e): Substitute "department's" for "board's."

Rationale: The department includes the board under HSC § 11.004.

HSC § 81.085(f): Substitute "department" for "commissioner."

Rationale: The department includes the commissioner under HSC § 11.004.

HSC § 81.085(h): Substitute "department" for "board."

Rationale: The department includes the board under HSC § 11.004.

HSC § 81.089: Substitute "department" for "board".

Rationale: The department includes the board under HSC § 11.004.

6. Revise provisions on court orders for persons with communicable disease.

HSC § 81.083: Add a new subsection after subsection (e) that says "If there is an immediate threat to the public health due to a public health emergency and without regard to whether a written order of the department or health authority has been issued, an individual may be subject to court orders under Subchapter G if the individual is infected or is reasonably suspected of being infected with a communicable disease."

Rationale: This will allow TDH or a local health authority to go directly into court to obtain a protective custody order in a public health emergency. Waiting for an individual to disobey a written order of the department or a health authority in a public health emergency could result in further transmission of the communicable disease by the individual.

HSC § 81.151(d): After "orders made under Section 81.083", add ", if applicable."

Rationale: This change is necessary to be consistent with the change to HSC § 81.083.

HSC § 81.152 (c)(4): After "orders of the department or health authority under Section 81.083", add ", if applicable".

Rationale: This change is necessary to be consistent with the change to HSC § 81.083.

HSC § 81.162(a)(2): After "orders of the health authority or the department under Section 81.083", add ", if applicable".

Rationale: This change is necessary to be consistent with the change to HSC § 81.083.

7. Apply communicable disease control measures to property to better address a public health emergency.

HSC § 81.084(b): For posting notice, substitute "at a place convenient to the public in the county courthouse" for "on the courthouse door."

Rationale: Posting on the actual door may be impractical.

HSC § 81.084(b): Revise the first sentence to say "…send notice of its action by registered or certified mail <u>or personal delivery</u> to the person who owns or controls the property."

Rationale: An alternative method of providing notice is necessary. Mail could take several days.

HSC § 81.084(a) or (b): Add a sentence to say "If it has already been determined that the property is infected or contaminated as a result of a

public health emergency, the department or health authority is not required to provide the notice under this subsection."

Rationale: This will avoid delay from the time it takes to issue the notice and then an order.

HSC § 81.084: Add a subsection that reads as follows: "In a public health emergency, the department or health authority may require the person who owns or controls the property to impose control measures that are technically feasible to disinfect or decontaminate the property or if there is not a technically feasible control measure available for use, the department or health authority may order the person who owns or controls the property: (insert the same (1), (2), and (3) as found in subsection (d)). The department or health authority may impose additional disease control measures that the department or health authority, as appropriate, considers necessary and most appropriate to arrest, control, and eradicate the threat to public health".

Rationale: Current language in subsections (c) and (d) is too limiting on when orders can be issued in a public health emergency.

8. Revise criminal penalty provisions on communicable disease for consistency and enforceability.

HSC § 81.068: Add "A person commits an offense if the person knowingly refuses or attempts to refuse inspection under § 81.064 or entry or access under § 81.065.

Rationale: Current language in § 81.068 would require issuance of a warrant in order to enforce §§ 81.064 or 81.065 relating to inspection of a public place or entry or access to an individual,

property, area, or carrier under Chap. 81 control measures. This would revise that requirement. Other circumstances would still require a warrant before a criminal penalty would apply. The level of the offense (class A misdemeanor) may need to be considered.

HSC §§ 81.064 and 81.065: Add that any evidence gathered during an inspection or entry by the commissioner or health authority under either section can be used in a criminal proceeding only if the proceeding relates to a criminal penalty under Chap. 81.

Rationale: This change will limit the use of any evidence gathered to a crime related to the communicable disease law, not to other felonies or misdemeanors.

HSC § 81.088(a): Revise to say "a quarantine device, notice, or security item".

Rationale: This change will address the removable of a property notice or security item such as padlocks on fences to secure quarantined property.

9. Allow commissioner to delegate authority under communicable disease law. HSC § 81.003: Add the definition "Commissioner means the commissioner of health or the commissioner's designee".

Rationale: This will ensure that any Chap. 81 actions requiring the commissioner to act could be done by a designee. This is particularly important if a public health emergency should occur during a time when the commissioner is away.

10. Improve reporting of infectious diseases.

HSC § 81.041: Add "In a public health emergency, the commissioner may require reports of disease from providers without board rules."

Rationale: Under the current language the board by rule establishes reportable diseases. In a public health emergency, there would not be time for the board to adopt rules to list new reportable diseases.

11. Authorize law enforcement to receive communicable disease information under additional circumstances.

HSC § 81.046: Revise to allow release in a public health emergency to law enforcement personnel to the extent necessary solely for the purpose of protecting the health or life of the person identified.

Rationale: Current law allows release to medical personnel in a medical emergency, to state agencies or county and district courts to comply with Chap. 81, or to federal agencies with limits on the type of information released. It may be necessary for law enforcement to receive confidential information in order to locate infected or possibly infected individuals in a public health emergency.

12. Authorize Department of Public Safety (DPS) to share additional information on communicable disease with TDH.

HSC § 81.023(d): Add at end of subsection "of the need to receive diagnostic, evaluation, or treatment services for suspected communicable disease".

Rationale: Transportation Code, § 521.049 gives DPS authority to give TDH information in an emergency. The current language only addresses the need for immunizations. Language should be added here and in § 521.049 to cover the sharing of DPS information for the purpose of TDH obtaining names and addresses in order to find and notify individuals about their possible exposure to a communicable disease.

13. Correct typographical error in statute on communicable disease.

HSC § 81.086(l): Change "81.084" to "81.083."

Rationale: The language should refer to HSC § 81.083 concerning control measures applied to an individual.

14. Delete Board of Health form requirement for carriers with communicable disease.

HSC § 81.086(b)(2): Revise to say "… provide information on passengers and cargo manifests that includes details of …"

Rationale: Current language requires the Board of Health to approve a form to provide this information. Use of an approved form is unnecessary.

15. HEALTH INSPECTION OF PRIVATE RESIDENCE

Clarify local health authority's right to seek a warrant to enter private residence.

HSC § 161.011(2): Revise to read "a probable violation of a state health law,

control measure under Chap. 81, or a health ordinance of a political subdivision."

Rationale: This will allow local health authorities to seek a judicially issued warrant for violations of Chap. 81 control measures.

16. CRIMINAL PROCEDURE

Recognize additional diseases as exceptions to autopsy or cremation requirements and address discovery of a body part instead of a body.

Crim. Proc. Art. 49.04(a) and Art. 49.25, § 6(a): Under (3)(A) and (B) require inquest when "the body or a body part of a person" is found and cause or circumstances of death are unknown.

Rationale: This language will address the situation when only part of a body is found.

Crim. Proc. Art. 49.10(d) and Art. 49.25, § 10: Add "In the case of a public health emergency or disaster as defined in the Texas Disaster Act, Gov't Code, Chap. 418, the commissioner of health by order may designate other communicable diseases where a justice of the peace may not order or a medical examiner need not perform an autopsy."

Rationale: Current law says that a medical examiner need not perform or a justice of the peace may not order an autopsy when death was caused by Asiatic cholera, bubonic plague, typhus fever, or smallpox. This change will allow other communicable diseases to be addressed without a need to change the

statute.

Crim. Proc. Art. 49.10(n) and Art. 49.25, § 13: Amend to include "the body or a body part" as a basis for requesting a forensic anthropologist.

Rationale: This language will address the situation when only part of a body is found.

Crim. Proc. Art. 49.25, § 10a: Add "In the case of a disaster or public health emergency as defined in the Texas Disaster Act, Govt Code, Chap. 418, the Commissioner of Health by order may designate other communicable diseases which allow cremation within 48 hours after the time of death."

Rationale: Current law does not allow cremation within 48 hours unless death was caused by Asiatic cholera, bubonic plague, typhus fever, or smallpox or unless the time is waived by the medical examiner or the justice of the peace.

Acronyms

CDC	Center for Disease Control
HAN	Health Alert Network
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
MMRS	Metropolitan Medical Response System
TALHO	Texas Association of Local Health Officials
TDH	Texas Department of Health
TMA	Texas Medical Association

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ISSUE 6 WITHIN THE COMMITTEE'S JURISDICTION

Organ Donation and Allocation

Organ Donation and Allocation
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Organ Donation and Allocation

Issue 6 Within the Committee's Jurisdiction

Improving the state's organ donation and allocation system.

Background

Medical advances in organ and tissue transplants over the last two decades have enabled many people suffering from life-threatening diseases to lead productive lives. However, one of the tragedies in the United States is the number of people who could benefit from an organ or tissue transplant, but never receive one because a donor organ or tissue is not available.[1] A major factor in the shortage of donated organs and tissue is the disparity between those who say they believe in organ donation and those who actually become organ donors. Figures from a national Gallup survey indicate that 85 percent of Americans support organ donation.[2] However, studies show that only approximately 50 percent of families consent to donating a loved one's organs.[3]

In the United States an average of 56 people per day receive a transplant. Twenty thousand people are saved annually due to advanced medical procedures allowing high rates of success in transplantation.[4] Despite these medical advances the need for organs significantly outweighs the number of organs available. Nationally, 12 people die each day in the US while awaiting an organ transplant.[5]

Federal Law

Prior to the Uniform Anatomical Gift Act (AGA) of 1968 there were no Federal laws addressing organ and tissue donation.[6] The AGA was enacted to 1) provide a consistent legal environment across the United States for organ and tissue transplantation; and 2) encourage donations of anatomical gifts. Additionally, the AGA established the donor card, a legal document permitting doctors to recover organs after death. The AGA has been adopted in varying degrees in all 50 states.[7]

The National Organ Transplant Act (NOTA) established a comprehensive national health care policy for organ transplantation. The Secretary of Health and Human Services is authorized to establish and operate a national Organ Procurement and Transplantation Network (OPTN). The OPTN's main purpose is to maintain a national computerized list of patients waiting for organ transplants.[8] The OPTN is designed to assist Organ Procurement Organizations (OPO) in the distribution of organs that cannot be used in the OPO's geographical area. Additionally, the OPTN is required to develop policies that maximize utilization of donated organs and assures patient care. The OPTN is also required to address any other medical issues related to organ transplantation within the United States.[9]

NOTA created the national system of independent, private OPO's that have defined service areas where the OPO's promote organ donation and in which they procure and allocate donated organs. The law requires OPO's to have a system for equitable allocation of organs based on established medical criteria. In addition, the OPTN establishes organ allocation medical criteria and assists OPO's in nationwide organ distribution. The only regulatory provision of the NOTA was a ban on the sale of human organs.[10]

In 1986 the United Network for Organ Sharing (UNOS) was awarded the Federal contract to establish and operate the OPTN. UNOS is a nonprofit corporation qualifying for tax-exempt charitable status as an education and scientific organization. The members of UNOS include all US transplant centers, OPO's, and histocompatibility laboratories, as well as, several other voluntary entities and members of the general public.[11]

The passage of the Omnibus Budget Reconciliation Act of 1986 included a recommendation directing all hospitals participating in Medicare or Medicaid to institute a "required request" policy. Specifically, hospitals are required to:

- have written protocols identifying potential donors and donor families;

- ensure that families have the option of accepting or declining organ and tissue donation; and
- comply with UNOS rules regarding allocation of procured organs.[12]

On March 16, 2000, the US Department of Health and Human Services issued a final rule regarding the equitable distribution of organs. As a result, states must re-evaluate all existing cadaveric organ allocation policies to identify any potential modifications and make recommendations to the Secretary of Health and Human Services in an effort to meet the goals established by the final rule.[13]

State Law

Senate Bill 952 by Moncrief, 75th Legislature, authorized organ donor cards as a statement of a gift for an organ donation. The card is carried by the donor as evidence of the donor's intent regarding organ, tissue, or eye donation. The donor card replaces the driver's license or personal identification certificate and are provided by qualified organ and tissue procurement organizations or eye banks.[14]

Senate Bill 673 by Moncrief, 76th Legislature, established the Anatomical Gift Educational Program to educate persons about making anatomical gifts. It also authorizes the Texas Department of Transportation to collect a voluntary contribution of one dollar at the time driver's licenses are issued or renewed to fund the program.[15]

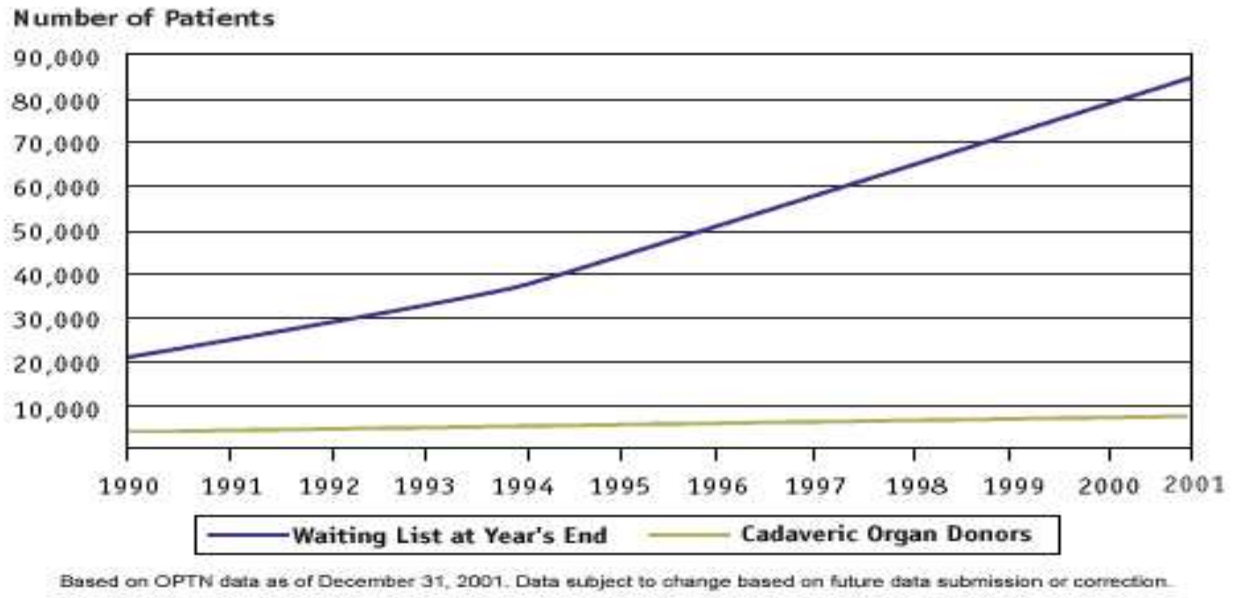
Senate Bill 862 by Gallegos, 76th Legislature, charged the Texas Department of Health with implementing a Task Force to consider the development of an optimum organ allocation system for transplant recipients and methods to increase organ donation.[16] The report, published in December 2000, provides an assessment of the current organ allocation system and examines the technical and policy issues surrounding the current system, including federal guidelines, patient survival rates, transportation issues, and medical urgency.[17]

Organ Donation

Studies show that while most people support organ donation, less than half actually choose to donate.

Source: Texas Department of Health News Feature

In the US, more then 79,000 patients were on a waiting list to receive an organ as of April 2002. Although more than 20,000 people received transplanted organs, approximately 6,000 patients died waiting for an organ, half of them were waiting for a kidney.[18] Due to the limited supply of organs, less than half of the people on the waiting list today will ever receive an organ.[19] Every 14 minutes a new name is added to the national transplant waiting list.[20] Nearly 19,000 kidney transplants are performed each year in the US Because 60 percent of dialysis patients die within three months to five years of receiving a diagnosis of kidney failure, transplantation is viewed as the treatment of choice for End Stage Renal Disease (ESRD).[21]



Source: UNOS Mission for Life Campaign; http://www.unos.org/About/campaign_main.htm source: UNOS Mission for Life Campaign; http://www.unos.org/About/campaign_main.htm

Currently, organs that can be donated and used to save lives include: kidneys, livers, pancreas, heart, lung, heart-lung, kidney-pancreas and pancreas islet cell.

Tissues that can be transplanted include: bone, corneas, eyes, heart valves, skin, tendons, pericardium, veins, fascia, (fibrous tissue that covers the muscle) and dura mater (membrane covering the brain).[22]

Did you know...just one organ and tissue donor can provide seven life saving organs and quality enhancing tissues for another 20 persons. **Organs** include: heart, lung, liver, kidney and pancreas. **Tissues** include: bone, skin, eyes or corneas, and heart valves. Source:http://lifegift.org

Minority Donations

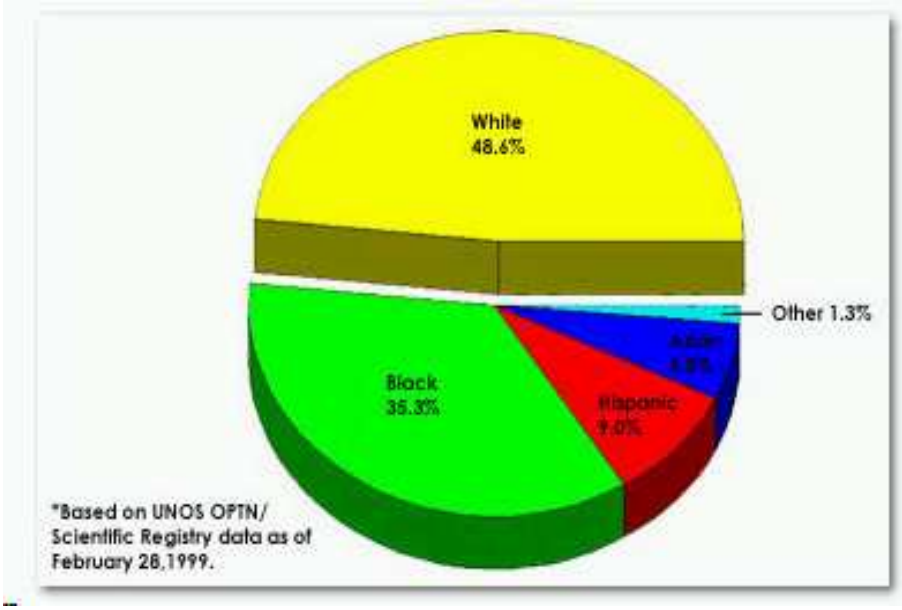
Some diseases of the kidney, heart, lung, pancreas and liver are found more frequently in specific racial and ethnic populations than in the general population. African Americans, Asian, Pacific Islanders and Hispanics are three times more likely to suffer from ESRD disease than Caucasians. Native Americans are four times more likely than Caucasians to suffer from diabetes. Transplantation is the most effective treatment for some of these diseases.[23] Despite the fact that these populations are affected by diseases that can be treated through transplantation, studies suggest that disparities exist in actual transplantation rates.[24]

There is a significant disparity in renal transplantation rates, for instance; though African Americans constitute 34.3 percent of those waiting kidney transplantation, they receive only 24.8 percent of the cadaveric transplants and 14.3 percent of living donor transplants. Additionally, there are fewer transplants among Asians (3.7 percent cadaveric and 4.0

percent living donors) than would be expected from their representation on the waiting list (5.1 percent).[25]

Successful transplantation is often improved by the matching of organs between members of the same ethnic and racial group. A patient is less likely to reject a kidney if it is donated by someone who is genetically similar. Generally, people are genetically more similar to people of their own ethnicity or race than to people of other races. Therefore, a shortage of organs donated by specific racial and ethnic groups can contribute to death and longer waiting periods for transplants in the same population.[26]

Minorities account for more then half of the kidney transplant waiting list as shown in the graph above.[27]



For African American patients awaiting a transplant, disparities in waiting times are due in part to the following:

- the blood group distribution among African American patients awaiting a transplant differs from that of the donor pool, which is predominately Caucasian.

- patients who are African American have a higher positive crossmatch rate than any other ethnic group, regardless of donor ethnicity.
- some Human Leukocyte Antigens (HLA) are more rare among African American patients than they are among Caucasian patients, who, represent 77 percent of very 1000 cadaveric kidney donor pool. HLA determines whether an organ from one individual will be accepted by another.[28]
- HLA antigens occur with greater variety in African American patients than in Caucasian patients, decreasing the likelihood of HLA match between African American recipients and donors, regardless of donor ethnicity.[29]

Currently, in Texas, there are more than 5,000 people on donor waiting lists, a number that has doubled in the last five years.[30] Each year the waiting list grows by 10 percent.[31] Although Texas has a higher number of organ donations than the national average, less than one-third of patients listed are able to receive a transplant because of the shortage of donor organs.[32]

Over 300 people die each year in Texas while waiting for an organ transplant.

Source: www.UNOS.org

Potential donor patients are generally critically ill and on mechanical ventilation or other assistive devices.[33] The successful recovery of organs directly correlates to the efforts made at the hospital level. The support and cooperation of hospital and medical staff are key components in the struggle to save the lives of those needing an organ transplant.[34] Additionally, physicians, more than ever, are considered a vital link in the challenge of raising public awareness about organ donation. Education, and training within the

profession are believed to be the most effective method to inform physicians regarding the need for organ donation.[35]

Living Donors

In addition to cadaveric (after death) donors, living donors provide another source of viable organs. More than 5,600 of the 22,854 organs transplanted in 2000 were from a living donor.[36] Living donation offers an alternative to individuals waiting for transplants and increases the availability of organs.[37] Various family members can donate organs to a family member, such as parents, children, siblings and other relatives. Donors unrelated to the family may also donate their organs if they prove to be a match for the recipient. A living donor may give a single kidney, lobe of a lung, a segment of the liver, or a portion of the pancreas to a recipient.[38]

Living donor transplants are a viable alternative for patients needing new organs. Researchers state that living kidney donors are not likely to develop any significant health problems related to their donation.[39] For liver donors, the segment donated has the ability to regenerate. Lung lobes do not regenerate, but this poses minimal risk to the living donor.[40]

Organ Donation Efforts

A review of organ donation efforts, nationally, demonstrates a diverse approach between states. Each state's donation-related activity is a mix of state statutory requirements, programs developed through federal executive branch action, OPO initiatives, and other private sector activity.[41]

Some states have focused on educating citizens and providing opportunities for them to consider becoming donors. Other states have focused on hospital protocols to ensure that every opportunity for donation is realized. Still other states multifaceted organ donation

initiatives, including donor registries, organ donor consent on the drivers license, and various statewide educational media campaigns.[42]

In surveying the array of various state donor initiatives, organ donation is a collaborative effort among all agencies involved, both public and private.[43] The Texas Department of Health (TDH) plays an important role in organ donation in Texas, along with OPOs, hospitals and other key parties. In other states, the lead role is assumed by the Education agency or the state's department of motor vehicles. There is no consistent pattern among the states surveyed.

Texas Department of Health Organ Related Programs

The TDH has worked toward increasing organ donation in Texas through the development of the Anatomical Gift Educational Program (AGEP) and the creation of the AGEP web page. AGEP is a statewide program with the goal of educating Texans about anatomical gifts.

TDH also initiated a media campaign to increase minority donations in targeted geographic locations. In addition, TDH has consulted with the Texas Education Agency on the development and inclusion of organ donor information in the driver license education curriculum.[44] TDH has facilitated the efforts of the Task Force on Organ Allocation mandated by Senate Bill 862 and provided a report to the Legislature identifying issues related to organ donation and allocation and with recommendations to address these issues.[45]

Additionally, TDH is charged with maintaining the Bureau of Kidney Health Care (KHC) with a goal of improving access to care for Texans with ESRD, and to assist with the financial burden of obtaining essential medical treatment.[46] The KHC was created as a single comprehensive program to combat kidney disease through the combined efforts of

individuals, state and local governments, persons in the field of medicine, universities, and nonprofit organizations.[47]

Donor Education

Along with the work being done by TDH, the three OPO's in Texas are actively conducting donation awareness programs throughout the state. Southwest Transplant Alliance (STA), has a year-round calender of events to keep donation in the forefront of public awareness. Some of their events include hosting a "Circle of Love Run/Walk" in El Paso; sending heart transplant recipients into schools to share their personal stories, honoring donor families and patients during Donor Awareness Month; sponsoring the "Circle of Life Bicycle Tour," that promotes blood, organ, and tissue donation; and co-hosting donor awareness events with the Texas Rangers at Arlington Stadium.[48]

LifeGift also sponsors many donor awareness activities. In furtherance of LifeGift's goal of increasing the number of donors from the Hispanic community, they have developed the "Regalo de Vida" (The Gift of Life), an organization comprised of prominent Hispanic community leaders who provide education and establish a dialogue to inform Hispanic families, neighbors, friends, schools, co-workers, and churches about organ and tissue donation.[49] Additionally, LifeGift, in partnership with the Heart Exchange Support Group, developed and implemented a State of Texas license plate for organ donation awareness.[50] LifeGift also sponsors Teens for Transplant (T4T), a multi-ethnic service organization linking high schools, hospitals, and transplant-related organizations in an endeavor to increase donations. The goals for T4T are:

- to increase organ and tissue donation and donor awareness through public education efforts such as school presentations and community health fairs.
- to provide one-on-one support to transplant patients during their pre-transplant waiting period and post-transplant recovery period.

- to provide career education opportunities for T4T members by working with healthcare professionals in the field of organ and tissue procurement and transplantation.[51]

Texas Organ Sharing Alliance (TOSA) has teamed with San Antonio Spurs' forward Sean Elliott, a living-related kidney recipient, to promote donation awareness in its communities. During the game marking the one-year anniversary of his return to the court, fans received a Sean Elliot trading card and a donor card. Green ribbon lapel pins, representing organ donation, were given out during the game. A silent auction with Sean Elliott autographed memorabilia was held to benefit the National Kidney Foundation. Finally, local hospitals offered free high blood pressure and diabetes screenings, and the National Kidney Foundation of South and Central Texas provided information about kidney disease and organ donation.[52]

The American Medical Association (AMA) has been involved in various initiatives in collaboration with other organizations to promote organ donation among its membership and the general public. The AMA is a member of the Coalition on Donation and is a partner in the United States Department of Health and Human Services' National Organ and Tissue Donation Initiative. For the past two years the AMA has been a partner in the National Donor Day. In 1998 the AMA initiated its own organ donation campaign, Live and Then Give, encouraging locally based donor awareness campaigns.[53]

Organ Allocation

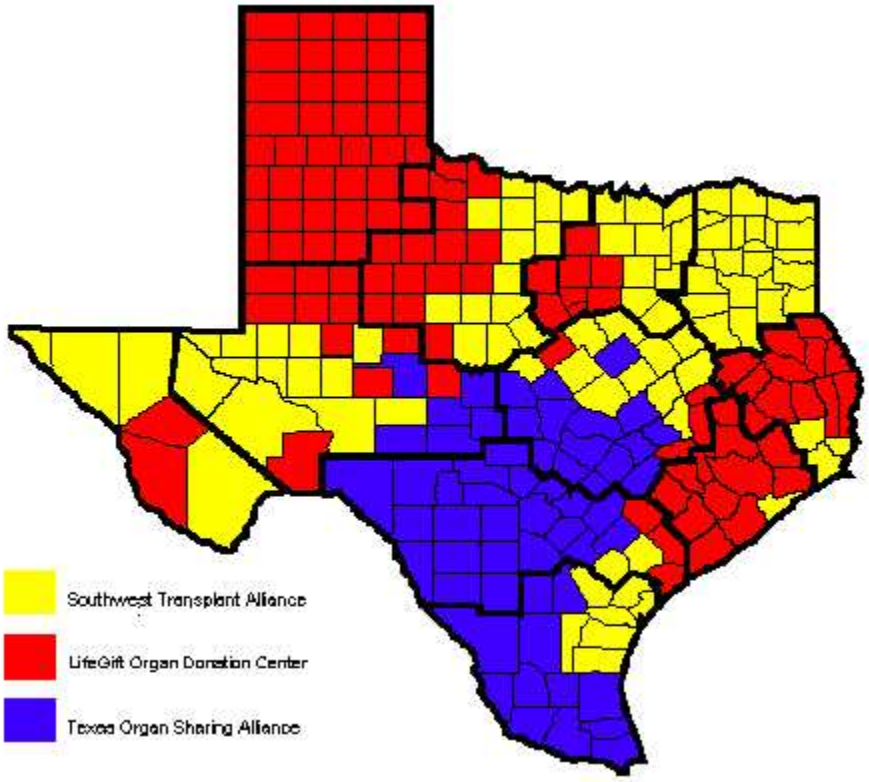
UNOS developed separate organ allocation policies for each type of organ. All cadaveric (after death) organs are allocated first among patients waiting for a transplant at centers

located within the local procurement area.[54] The majority of the transplant community, believe that local organ allocation enhances local organ procurement.[55]

Due to a multitude of factors, the organ distribution system is based upon a three-tier system. Organs are first offered locally, then regionally, and finally, nationally. If the organ being allocated is a kidney, pancreas, liver, or intestine, and it cannot be accepted locally, the region in which the organ is allocated is the UNOS region in which the organ was procured.[56]

Nationally, there are 59 Organ Procurement Organizations (OPO's) that are responsible for carrying out the organ procurement process and allocating organs in accordance with current national policy. Most states have only one OPO; although, some larger states may have more than one. Texas currently has three OPO's: Southwest Transplant Alliance (STA) which covers Dallas, Galveston, El Paso, Corpus Christi, and several smaller metropolitan areas; LifeGift which covers Fort Worth, Houston, and parts of West Texas; and Texas Organ Sharing Alliance (TOSA) which includes Austin, San Antonio, and the Rio Grande Valley.

Additionally, STA has four Alternate Local Units (ALU's) for the purposes of listing and allocating kidneys; LifeGift has three ALU's; TOSA has one patient waiting list for the entire OPO. Alternate Local Units are subdivisions of OPO's which function as distinct areas for organ procurement and allocation. These three OPO's are divided into noncontiguous areas which is unique to Texas. See chart on the following page.



The current allocation process in Texas initiates when the potential transplant recipient is referred to a transplant center for evaluation. If the individual is accepted, he or she is added to the center's waiting list. When a donor organ becomes available, information on that donor (such as blood type, tissue type, size of the organ, and the age of the donor) is transmitted to a centralized computer operated by UNOS, and a list of potential recipients is generated.[57] The patient who is at the top of the waiting list, by virtue of either accrued waiting time or medical urgency, is contacted first. The patient's transplant surgeon is allowed one hour to accept or reject the organ on behalf of the patient. If the surgeon declines the organ, the next person on the UNOS-generated list is contacted, and the process continues until the organ is accepted. Once the organ is accepted the patient undergoes a final medical evaluation and then the recipient is scheduled for a transplant.[58]

Kidney Allocation

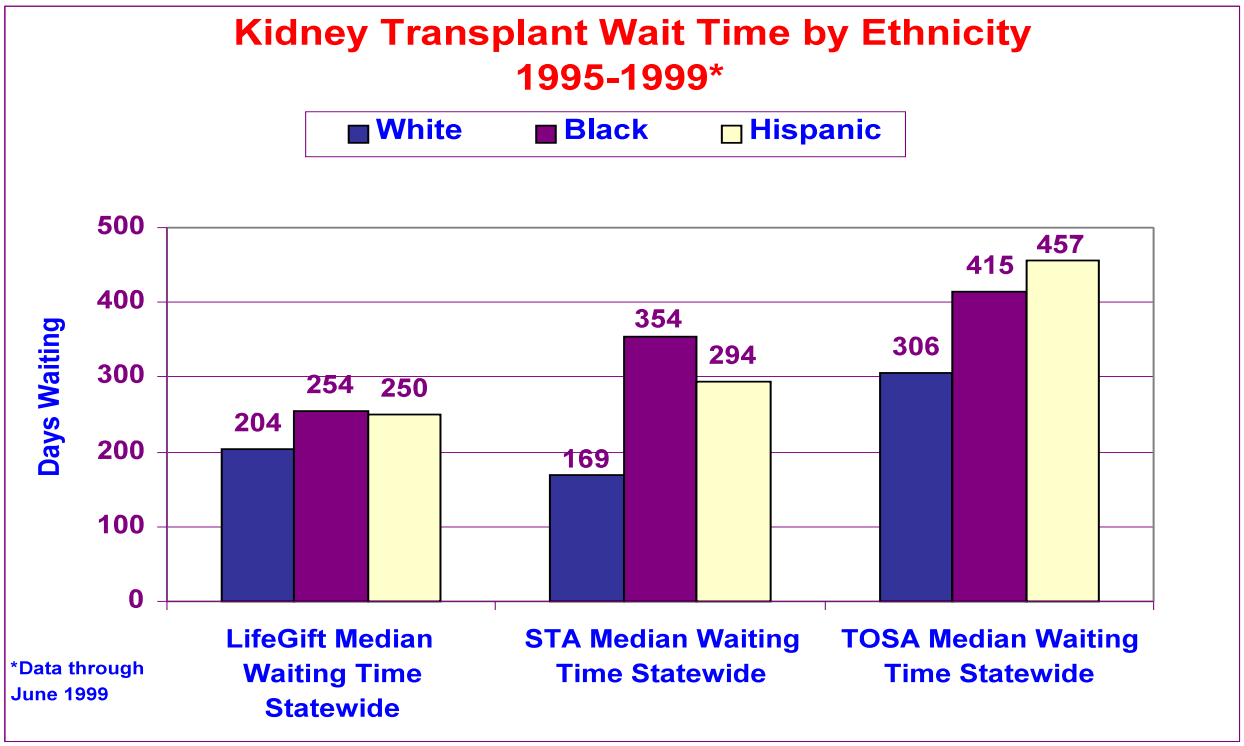
Kidneys are allocated in Texas in accordance with the UNOS guidelines. First, the kidney is offered to highly well-matched patients, such as six-antigen matches. A six antigen match is a perfect match between a donor and recipient; the donor and recipient sharing all six antigens.[59] Second, the kidney is offered to approved payback lists. A payback list is the term used for an organ that is exported in return for a previously imported organ. When a mandatory-shared organ is exported to another OPO's affiliated transplant center, it creates a credit for the exporting OPO and a debt for the importing OPO. These debts and credits are not financial in nature, but rather, part of the national accounting system to achieve a balance among OPO's for organ sharing. Third, the kidney is offered to the approved local list (ALU or OPO) and finally to the entire OPO or UNOS region [Texas and Oklahoma].[60]

The Senate Bill 862 Task Force identified several flaws in the current organ allocation system. Patients in Texas do not have access to every donor organ as a result of the current geographic boundaries. Additionally, there are differences in listing criteria used by the transplant centers to prioritize patients on the waiting list.[61] In Texas' waiting times for minorities vary between OPO's, due in part to the fact that two of the OPO's use HLA matching for allocating organs while one does not. Points are given for each HLA match level to improve transplant outcomes in recipients; being of the same ethnic background is one such match level. Differences in the HLA between the kidney donor and recipient can result in the recipient's immune system rejecting the donor kidney.[62] Kidney transplant success improves progressively with greater HLA match.[63] Other problem areas that were identified include: the failure of hospitals to follow the required referral law, and the difficulty in matching donor organs with highly sensitized patients. Highly sensitized patients are those who have a higher probability of rejecting a donor organ.[64]

Organ allocation is a challenging and controversial issue involving an array of patients, hospitals, physicians, donor families, organ procurement organizations and federal

agencies. In a perfect environment, every person waiting for an organ would receive one. The current situation is that more patients need transplants than there are organs available. The number of organs available for transplants has consistently fallen behind the demand.[65]

Sadly, in a situation where the demand for organs far exceeds the supply, it is necessary to allocate the resources in a way that will equalize every person's opportunity to receive a lifesaving transplant. It is essential that patients on one waiting list do not have to wait longer then patients on another waiting list. An equitable allocation system must be created to alleviate any discrepancies that create an unfair advantage.[66]



The chart above shows waiting times by OPO and ethnicity.[67]

In developing a more equitable system, factors such as medical utility, which entails using organs efficiently to promote the best outcome for patient and graft survival, which is the ability of the body to accept the organ, must be taken into account.[68]

Conclusion

There is no simple solution to the problem of organ donation and allocation issues in Texas. The issue must be addressed on a variety of fronts including raising public awareness, collection of vital data, developing a more equitable allocation system, and educating our medical professionals and families of the importance of donating. The following recommendations represent an effort to resolve, or at minimum, address these issues with the ultimate goal of increasing organ donation rates and devising an equitable allocation system. Increasing donations is a critical component of saving the lives of Texans and it is up to the medical community, the OPO's, the public and the Legislature to make that a reality so that more Texans can maintain a good quality of life.

Recommendations

1. **The Legislature should provide 30 days paid leave of absence for state employees who become living organ donors.**

   Rationale: Living donor transplants are a viable alternative for patients in need of new organs. Federal legislation has been enacted for federal employees who become living donors. This would allow Texas to extend the 30-day leave to state employees. This recommendation would enable more people to serve as living organ donors and it enhances the well-being of living organ donors. It provides a positive example for private industry to offer the same benefit to employees.

2. **The Legislature should encourage, through regulatory agencies, medical and nursing schools require a course on donor education. Also, encourage an advance course in donor education for completion of a neurology or neurosurgery residency.**

   Rationale: Educating medical and nursing students regarding organ donation can facilitate a more thorough understanding of the donation process, which would lead to an increase in potential donors through hospitals. The State of Texas through resolution can encourage medical and nursing schools to incorporate donor education into their curriculum.

3. **The Legislature should provide a mechanism to appropriate funds already collected by the DPS to Texas Department of Health by the Department of Public Safety for the Anatomical Gift Education Program.**

Rationale: Legislation passed in previous sessions created the Anatomical Gift Education Program funded by the one dollar contribution at Department of Public Safety (DPS) offices. Additional funding was added to the Texas Department of Health budget to allow for a more comprehensive program. The Texas Department of Health is not able to access the Department of Public Safety fund, this proposal would correct that oversight.

4. **The Legislature should direct Texas Department of Health to provide education information regarding organ donation to individuals considering living wills and advanced directives and other end-of-life decision making.**

Rationale: As a general principle of the law, competent adults have the right to refuse any type of medical treatment, including life-sustaining treatment. Typical instruments used include Living Wills, Durable Powers of Attorney for Health Care and Advance Care Medical Directives. These can also be used to articulate a person's wishes regarding organ donation. Clarifying end of life issues including the desire to be an organ donor can facilitate families' support of a donor's intent. Many states have already implemented this change and expect to see potential increases in organ donations.

5. **The Legislature should direct Texas Department of Health to assist Organ Procurement Organizations, hospitals and medical communities to: develop Best Practices relating to organ donation in hospital settings; determine the donor potential in all acute care hospitals; review OPO's roles in educating**

hospital staff on informing OPO's when a potential donor is available; and ways to enhance collaboration between OPO's and hospitals in the family-approach process.

Rationale: Using Best Practices regarding organ donation in hospitals can facilitate increases in the number of organs recovered in hospital settings and assist in alleviating the shortage of organs available. Determining donor potential could lead to better collaboration between OPO's and hospitals and would help determine whether sufficient efforts are being made in acute care hospitals to recover organs. Protocols should address points of collaboration between both hospitals and OPO's. This should include but is not limited to identification and early referral of potential organ donor patients, the OPO management of the initial approach for family consent for donations, and the clinical management of the donor patient.

6. **The Legislature should modify existing statute by adding language that includes the term Justice(s) of the Peace with every mention of the terms Medical Examiner and Coroner in the statute, such that all stipulations pertaining to organ recovery will also apply to Justice(s) of the Peace.**

Rationale: Legislation was passed in the 76th Session that required Medical Examiners and Coroners to view a body to determine the need for organs to remain intact prior to denying release of donated organs. Justices of the Peace (JP) where not included in the statute. JP's can currently make that decision

upon recommendation of a medical advisor. This change would correct that oversight.

7. **The Legislature should require Medical Examiners, Coroners, and Justice(s) of the Peace to allow for the recovery of tissue and other transplantable lifesaving items, except in specified circumstances. If the recovery is denied, the Medical Examiner, Coroner or Justice of the Peace shall write a letter to both the family and Organ Procurement Organization stating the reasons for denial.**

   Rationale: During the 76th Session, legislation was passed that required Medical Examiners and Coroners to view a body prior to denying the release of donated organs, however, it did not include the donation of tissue. This proposal would extend that requirement to include donated tissue as well.

8. **The Legislature shall explore first person consent as legally binding and revise procedures by which terms of an anatomical gift may be amended or revoked.**

   Rationale: More than 300 Texans die each year while waiting for an organ transplant. Approximately 17 states, including Texas have implemented first person consent legislation to assist in addressing the shortage of organs available to recipients. Strengthening first person consent, which states that a driver's license or organ donor card is a legal document regarding organ and tissue donation based on the original consent of the donor, has the potential of increasing organs available.

9. The Legislature shall direct Texas Department of Health to work with the three Texas OPO's and submit a proposal for the statewide variance to the current allocation system in Texas for: the creation of Low Panel Reactive Bodies (PRA) and High PRA patient pools; and the creation of the 20 percent organ sharing pool for Low PRA patients.

Rationale: These recommendations from the SB 862 Task Force were unanimously supported. The OPO's should submit a variance to UNOS to obtain approval to implement these pools to address individuals with extended waiting times due to PRA levels or individuals who are highly sensitized to rejecting an organ.

10. The Legislature shall direct Texas Department of Health to assist in facilitating discussion among the three Texas Organ Procurement Organizations on the establishment of contiguous Organ Allocation Areas or a suitable alternative geographic configuration for kidney allocation that addresses organ availability and equalization in patient waiting times for a transplant. Additionally, the Legislature shall direct Texas Department of Health to work with the above-mentioned OPOs to address the current kidney/pancreas and liver allocation system.

Rationale: Current allocation of kidneys in Texas is not considered equitable. Access to organs and waiting lists vary depending on which Organ Procurement Organization operates in an individual's city. Allocation areas are not contiguous. This proposal would require Texas Department of Health to work with the OPO's to develop a more equitable agreed upon

system and request the OPO's submit the proposal to UNOS for approval and implementation.

11. The Legislature shall provide Texas Department of Health with monitoring authority over the allocation activities provided by the variance to ensure that the system is working appropriately and is evaluated to assess the need for changes in the system.

Rationale: This proposal would grant TDH the authority to monitor and review any newly developed allocation system. Additionally, it allows TDH to further evaluate and assess the system for implementation of potential changes.

12. The Legislature shall direct Texas Department of Health to conduct a study to identify barriers to transplantation in Texas for minority populations (procurement procedures/policies, listing criteria, patient perceptions on transplantation.) This should also include the development of a kidney disease registry to collect data on the incidence, prevalence, and mortality of end-state renal disease patients in Texas, and an organ and tissue registry to collect data on organ procurement, allocation, and transplantation in Texas.

Rationale: This proposal would enable the state to obtain data on the prevalence of barriers to transplantation for minority populations as well as developing a data base for all relevant information regarding transplantation, allocation and procurement in Texas.

13. The Legislature shall direct Texas Department of Health to form a Heart and Lung Task Force and make recommendations to the Legislature.

Rationale: Based on recommendations from the Task Force report, further refinement of the heart and lung allocation system is needed to determine best practices. This proposal would address that issue.

Acronyms

AGA	Anatomical Gift Act
AGED	Anatomical Gift Educational Program
ALUs	Alternate Local Units
AMA	American Medical Association
DPS	Department of Public Safety
ESRD	End Stage Renal Disease
HLA	Human Leukocyte Antigens
JP	Justice(s) of the Peace
KHC	Bureau of Kidney Health Care
NOTA	National Organ Transplant Act
OPO(s)	Organ Procurement Organizations
OPTN	Organ Procurement and Transplantation Network
STA	Southwest Transplant Alliance
TDH	Texas Department of Health
T4T	Teens for Transplant
TOSA	Texas Organ Sharing Alliance
UNOS	United Network for Organ Sharing

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ISSUE 7 WITHIN THE COMMITTEE'S JURISDICTION

Increasing Childhood Immunization Rates

Increasing Childhood Immunization Rates
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Increasing Childhood Immunizations Rates

Issue 7 Within the Committee's Jurisdiction

Increasing Texas' rates of immunization against childhood communicable diseases.

Background

A special edition of the Center for Disease Control and Prevention's (CDC) *Morbidity and Mortality Weekly Report,* published in April 1999, highlighted immunizations as one of the most important health inventions of the past century and called vaccines one of the greatest achievements of public health.[1] At the turn of the 20th century thousands of citizens became ill and/or died of a wide range of highly infectious diseases. At that time diseases such as smallpox, measles, diphtheria, and pertussis claimed the lives of countless men, women and children.[2]

Before vaccines were widely used:

- Smallpox infected more than 48,000 individuals and 1,528 individuals died as a result of the disease;
- Polio paralyzed 10,000 to 25,000 children and adults each year;
- Measles infected hundreds of thousands of children every year, killing between 400 to 500 and leaving many others with serious brain damage; and
- An estimated 20,000 cases of Haemophilus Influenzae type b (Hib) occurred each year; Hib was also the leading cause of bacterial meningitis and postnatal mental retardation.[3]

After several decades of widespread use of many vaccines the CDC now reports:

- Smallpox was officially eradicated in 1977;
- The last case of "wild" poliovirus in the United States was reported in 1979;
- In 1998 only 89 cases of measles were reported and the majority were believed to be associated with international importations; and

- In less than a decade, the use of the Hib conjugate vaccine nearly eliminated Hib invasive disease among children.[4]

Immunizations: What are they and why are they important?

Vaccines prepare a child's body to fight illnesses and create immunity. Each injection a child receives contains some form of a germ, either dead, weakened, or partial, which causes a disease. The body practices fighting the disease by making antibodies that recognize specific parts of that germ. Ultimately this "practice" develops immunity so that when a child is exposed to that disease the body is able to defend itself and the child does not become ill.[5]

There are twelve serious diseases with vaccines for each: measles, mumps, rubella (German Measles), diphtheria, tetanus (lockjaw), pertussis (whooping cough), polio, Hib, Hepatitis B, varicella (Chicken Pox), Hepatitis A, and pneumococcal disease. Each of these requires at least one injection while some require multiple doses to provide full protection from the illness.[6] However, in recent years several combination vaccines have been created thus reducing the number of individual injections a child must receive.

Approximately 95 percent of the people in the community must be protected by a vaccine to achieve herd immunity. People who are not immunized increase the chance that they and others will get the disease.

Immunizations protect more than the child receiving the vaccination; they also protect the community in general, called "community or herd immunity." Most immunizations provide approximately 90 - 99 percent immunity for the child receiving the vaccination. The remaining one to 10 percent of children are provided immunity by being surrounded by children who have full immunity. These fully immunized children provide a barrier between the illness and the children who are not fully immunized, or who are unable to be vaccinated due to medical or other reasons, thus preventing the spread of the illness. Herd immunity is more effective

as the number of individuals vaccinated increases.[7] According to the National Network for Immunization Information (NNII), "It is thought that approximately 95 percent of the people in the community must be protected by a vaccine to achieve herd immunity. People who are not immunized increase the chance that they and others will get the disease."[8]

As Immunization Levels Rise, the Rate of Disease Will Drop or Disappear (I.e., Measles Outbreak in Dallas)		
	1989 - 1990	**1990 (w/ increased public education)**
Cases Reported	2175	29
Hospitalizations	238	5
Deaths	9	0

Source: Texas Medical Association. *Immunization Crisis in Texas: Shots "not" across Texas.*

A national survey of thousands of parents indicates the majority (87 percent) believe immunizations are "extremely important" for their child's health.[9] However, 23 percent of those surveyed believed that children receive more immunizations than are good for them. This concern is, in part, an outgrowth of news and other media reports that question the safety of vaccines.[10] However, medical research has shown that the human immune system is able to accommodate hundreds of thousands of organisms. Therefore, the body's ability to respond to a vaccine results in only a small portion of the immune response system being utilized.[11]

Unfortunately, no vaccine or medication is 100 percent effective, and at times, reactions may occur. These reactions are normally mild in nature, such as, a fever or sore arm. However, more serious reactions may occur and parents should discuss the benefits, risks, and possible effects with their physician or nurse prior to the administration of a vaccine.[12] According to the CDC, "What is important to remember is that getting the disease is much more dangerous than getting the shot."[13]

What is important to remember is that getting the disease is much more dangerous than getting the shot.

The United States has one of the most stringent vaccine review processes in the world and the Federal Drug Administration (FDA) closely monitors vaccine safety and efficacy both before and after approval of a vaccine. The licensing process for a vaccine can take from seven to ten years and involves series of clinical trials and multiple phases. After licensing a vaccine, the FDA continues to closely monitor vaccine safety, including the inspection of manufacturing plants, to ensure that vaccines are made in a safe and consistent manner.[14]

Once a vaccine is approved for use by the FDA, the Advisory Committee on Immunization Practices (ACIP) considers the vaccine and determines if it should be recommended as part of the immunization schedule. (See Appendix E) The ACIP is the oldest standing advisory committee in the federal government and consists of fifteen experts in fields associated with immunization who are selected by the Secretary of the U.S. Department of Health and Human Services. They provide advice and recommendations to the Secretary and the CDC on methods to preclude vaccine-preventable diseases. In addition, ACIP monitors national immunization issues and makes recommendations about specific situations and possible problem areas.[15]

In an issue brief from Grant Makers in Health entitled *Victims of our own Success - Will Immunization Remain the Paradigm of Effective Prevention*, a common myth is discussed.[16] Some individuals believe children do not need to be immunized because many of the diseases from which vaccinations offer protection are no longer part of the general consciousness. As a result, many have come to believe the diseases no longer exist. However, vaccine preventable diseases are common in other countries thus persons traveling to those countries may accidentally carry a disease back into the United States thereby creating a risk. Further, many of these diseases still exist in the United States. For example, unvaccinated children still get pertussis, and become sick, or even die. (see the box to the left) The United States has developed a false sense of security due to the absence of outbreaks of these diseases, when in reality, immunizations are the primary reason these harmful diseases are not often observed.[17]

Pertussis Makes A Come Back

In the mid-1970s it appeared pertussis had nearly vanished. Once a major killer, pertussis claimed the lives of 9,000 Americans in 1923 alone. The introduction of a vaccine in the 1940s lead to a drastic decrease in pertussis cases, to the point where only a few hundred were reported in Texas in the 1990s. Sadly, in recent years, pertussis has made a come back. Across the country thousands of new cases and deaths are reported each year.

Pertussis is often referred to as whooping cough, due to the unique whooping sound victim's make when they try to breathe following a coughing attack. It is most common in infants and young children, however, anyone can become infected. The illness is easily spread through sneezing, coughing, or talking and it can lead to pneumonia, seizures, brain damage, and death.

Recently, Texas has experienced a growing number of pertussis cases. In a July 18, 2002 Texas Department of Health (TDH) news release, health officials issued a warning to parents of infants to keep them away from individuals demonstrating cold-like symptoms and to ensure infants and young children are vaccinated against the pertussis. As of August 15, 2002, TDH had reports of over 654 cases in 52 counties this year, including four infant deaths. Burnet County accounts for approximately one third of all the cases, with 202 cases reported as of August 15. This constitutes a community wide outbreak causing health officials difficulty in containing further spread of the disease. In 2001, 615 cases of pertussis were reported to TDH resulting in five deaths. Pertussis has been on an upward trend for several years; the most effective tool to prevent these needless illnesses, and deaths is the pertussis vaccination.

Sources: Texas Medicine, Texas Department of Health

When discussing immunizations there are financial and societal benefits in addition to the obvious health-related benefits. The following chart illustrates how the use of vaccinations saves millions of dollars each year through disease prevention, rather than more costly interventions.

Cost - Benefit Analysis of Commonly Used Vaccines (Savings per Dollar Invested)		
Vaccine	Medical Dollars Saved	Societal Dollars Saved*
Diphtheria, Tetanus, Acellular, Pertussis(DTaP)	$ 8.5	$24
Measles, Mumps, Rubella (MMR)	$10.3	$13.5
Haemophilus Influenzae type b (Hib)	$1.4	$2
Hepatitis B	$2.3	$19.8
Varicella	$.9	$5.4
Inactivated Polio Vaccine (IPV)	$3.03	5.45

* Includes work loss, disability and death

Source: Center for Disease Control and Prevention. *AAP/ASTHO Congressional briefing on immunization.*

In addition to financial savings there are other benefits from an investment in immunizations including:

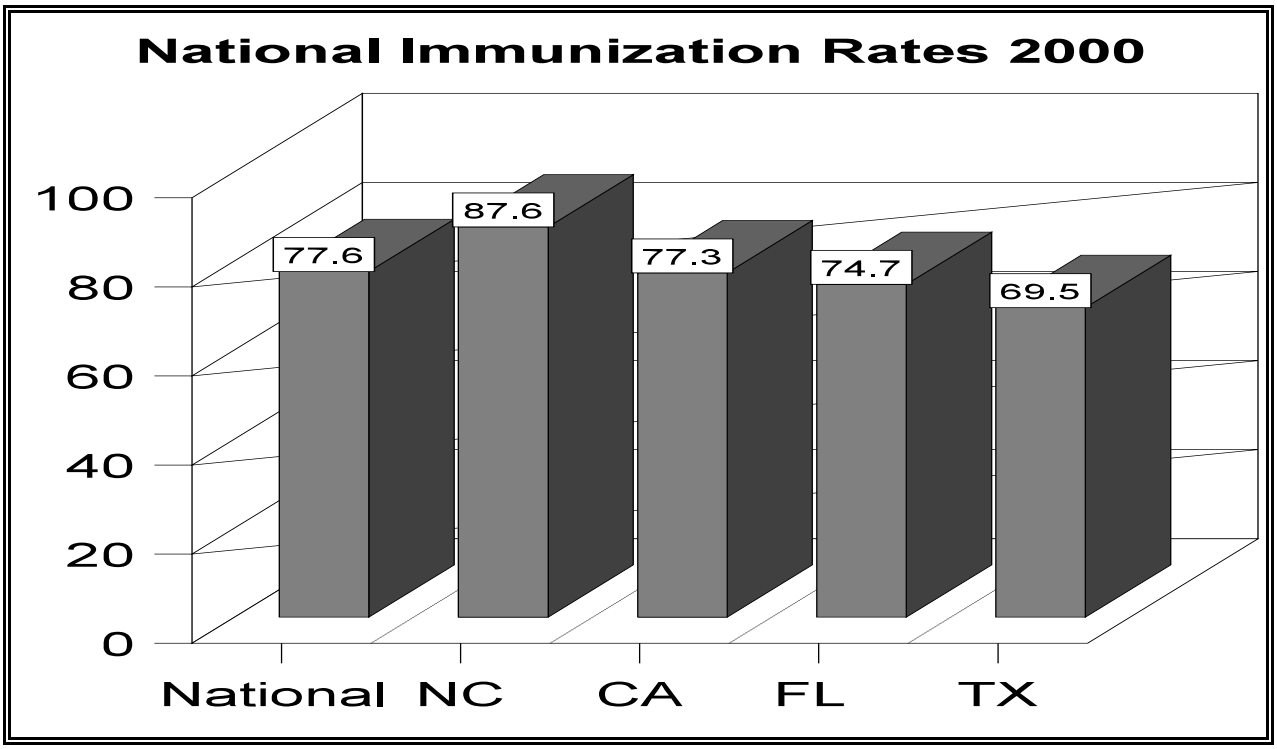
- children remaining in school rather than home sick;
- parents missing fewer work days due to a sick child;
- the disease is not spreading to parents, siblings, classmates, friends, and the larger community; and
- children not suffering pain, disability, or even death.

Immunization Rates

National Statistics

In August of 2001, the CDC released the year 2000 results from the National Immunization Survey (NIS). The NIS has been conducted annually since 1994 and is sponsored by the National Immunization Program (NIP) and the National Center for Health Statistics (NCHS). The purpose of the NIS is to gather national, state, and selected urban area estimates of vaccination coverage rates for children between the age of 19 and 35 months in all 50 states and in 28 selected urban areas.[18]

The 2000 NIS results were compared with the 1999 results. Based on this comparison a national immunization rate of 77.6 percent for the 4:3:1(4 doses of diphtheria-tetanus-pertussis [DTaP], 3 doses of poliovirus vaccine, 1 dose of measles-containing vaccine) combined series was reported. This number is down from a national rate of 79.9 percent in 1999. However, the NIS did report an increase in some individual vaccinations such as varicella and hepatitis B and slight decreases in the diphtheria, tetanus toxoid, and pertussis vaccines. While these slight declines in coverage do not pose an immediate threat to general public health, it will be important to closely monitor these rates in the coming years. If these declines are concentrated in specific geographic areas of the country, state, county or city, they can pose a disease threat. A decrease in coverage can lead to a disease outbreak due to a weakening of the herd immunity.[19]



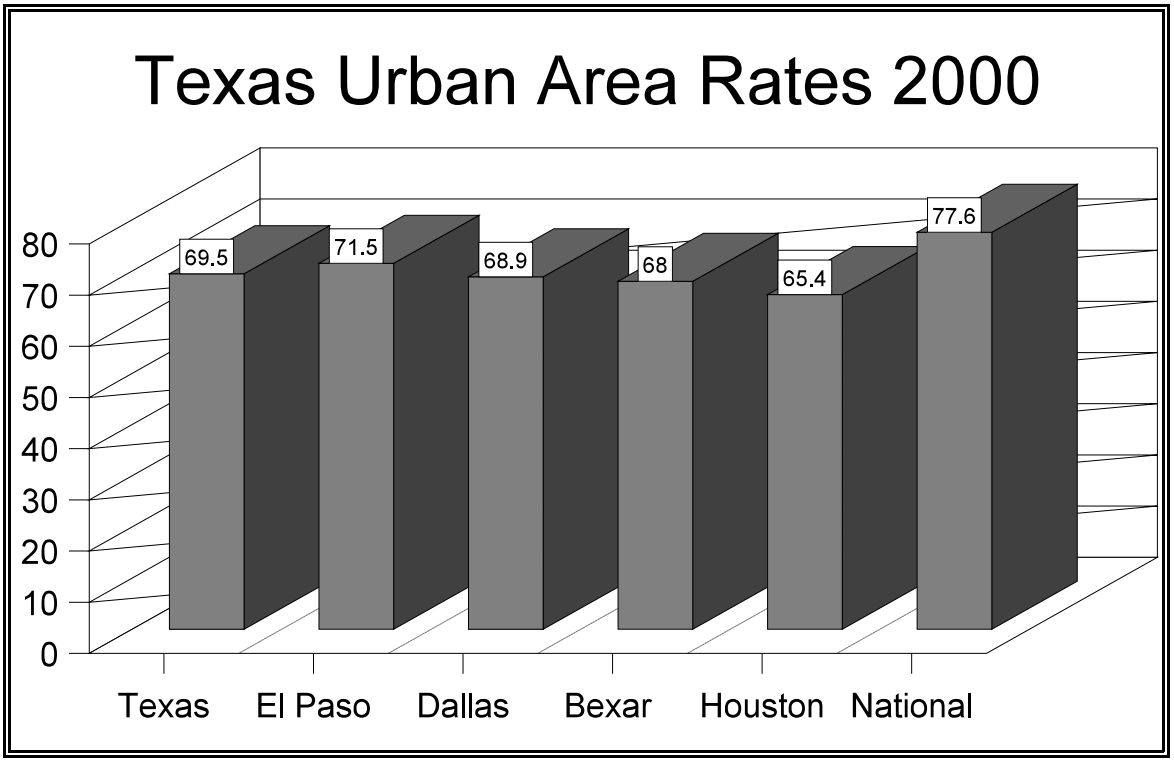
Source: Center for Disease Control and Prevention. National, state, and urban area vaccination coverage levels among children aged 19-35 months - - United States, 2000.

Texas Statistics

In recent years Texas has made great strides toward improving the health of its children. The creation of the Children's Health Insurance Program (CHIP) and Medicaid simplification have demonstrated the state's commitment to the health and well being of young Texans. Despite these steps, in August 2001 with the release of the 2000 NIS, Texas dropped to 50th in the nation for fully immunizing children ages 19 through 35 months against seven diseases.[20]

In the NIS for 2000, only 69.5 percent of Texas children had completed the 4:3:1 series of vaccines by 19 through 35 months of age. The national average for the same 4:3:1 series

was 77.6 percent. This data was collected between January and December 2000 and the children included in the study were born between February 1997 and May 1999. The data is important because Texas rates have significantly decreased from the 1999 survey rate of 74.7 percent. In addition to the statewide Texas rates, the NIS targets four Texas cities/counties. The rates for these areas are as follows: Bexar (68%), Houston (65.4%), Dallas (68.9%), and El Paso (71.5%).[21] The 2000 NIS rate for each individual city/county also reflects a decrease in the overall immunization rates for that community.[22]



Source: Center for Disease Control and Prevention. National, state, and urban area vaccination coverage levels among children aged 19-35 months - - United States, 2000.

On August 2, 2002, the CDC released the results from the 2001 NIS. The results indicate improvement in the national immunization rate from 77.6 percent in 2000 to 78.6 percent in 2001. In addition, the NIS shows a strong increase for Texas from 69.5 percent in 2000 to 74.9 percent in 2001. Of the four urban areas surveyed in the NIS two areas improved (Bexar 75.1 percent and Houston 70.5 percent), one remained the same (Dallas 68.9 percent) and one demonstrated a decrease (El Paso 69.2 percent). Texas remains close to the bottom of the national rankings. The Texas ranking is affected not only by what Texas does but how well other states perform.[23] Although Texas moved from 50th to 43rd in the national standings, the problem of low immunization rates remains and continues to pose a threat to public health.

Vaccine Shortage

One compounding factor in the immunizations coverage battle is the recent vaccine shortage. Since 2000 the United States has experienced a vaccine shortage of five vaccines that provide protection against eight of the eleven vaccine preventable childhood diseases: Diphtheria, Tetanus, Pertussis (DTaP and Td vaccine), Pneumococcal infection (PCV-7 vaccine), Measles, Mumps, Rubella (MMR vaccine), and Varicella. According to the CDC, it appears some of these shortages will be resolved by the end of the summer 2002 and others by the end of the year. Unfortunately, although vaccines will be available, it is unlikely that every child who was unable to get a vaccination due to the shortage will return to obtain the immunization. According to Walter A. Orenstein the Director of the National Immunization Program **"The current vaccine shortages are complex, unprecedented in scope and a result of a number of factors."**[24] This issue is being studied by several groups including the CDC, the National Vaccine Advisory Committee, and the U.S. General Accounting Office (GAO) and each plans to make recommendations about how to handle the current problem and avoid future shortages.

Texas Immunization Survey

In an effort to better assess immunization rates within the state, TDH periodically conducts a more specific statewide immunization survey, the Texas Immunization Survey (TIS), that coordinates with the NIS. The survey instrument is modeled after the CDC survey questionnaire and covers the same time period as the NIS. However, the TIS deliberately surveys children of a slightly different age range, from 3 to 24 months of age (NIS 19 -35

months), in an effort to obtain information on younger children. Further, the TIS provides additional data from counties not included in the NIS report, and provides a comparison of immunization rates between Medicaid and Non-Medicaid children.[25]

TDH completed the most recent survey in the fall of 2001. The TDH report reflects an increase in the overall immunization rate in Texas from 66 percent in 1998 to 70 percent in 2000. The results of the study are used by TDH to identify areas of the state and population groups for whom additional outreach and education would be beneficial. The following table provides additional details regarding the TIS results.[26]

Texas Immunization Survey Results - - 2000 (Percentages represent Immunization levels for that category)						
AGE GROUP	**3 -24 months**	**3-6 months**	**7-15 months**	**16 - 24 months**		
	70%	85%	74%	58%		
RACE	**Hispanic**	**White**	**Black**			
	67%	74%	72%			
FUNDING SOURCE	**Private Insurance**	**Medicaid**	**Uninsured**			
	74%	72%	55%			
PROGRAM	**WIC**	**Non-WIC**	**TANF**	**Non-TANF**		
	68%	72%	74%	70%		
CITY/ COUNTY	**Travis**	**Tarrant**	**Bexar**	**Dallas**	**El Paso**	**Harris**
	74%	73%	67%	69%	59%	69%

Source: Texas Department of Health. *Findings from the 2000 Texas Immunization Survey.*

Texas Immunization Programs

In Texas approximately 1,000 babies are born each day. In 2001, the TDH vital statistics division recorded 364,220 births.[27] Due to the large number of births, it is important that the state remains vigilant and makes every effort to ensure that each child in Texas benefits from the protection of immunizations.

In recognition of the importance of immunization related issues, TDH created the Bureau of Immunization and Pharmacy Support in May 2000. The Immunization Division operates five program areas in an effort to monitor vaccine preventable diseases, facilitate public education and ensure access to immunizations. The program areas include:

- Texas Vaccines for Children
- ImmTrac Registry
- Surveillance and Epidemiology
- Vaccine Management
- Communication and Training

These five program areas represent the state's immunization efforts and carry out the Immunizations Division's mission to:

> Improve the quality and longevity of life for people in Texas by achieving and maintaining a vaccine-preventable disease free environment. This will add to the state's economic base by avoiding substantial health care costs. This mission will be achieved through the utilization of cost-effective immunization programs and efficient epidemiology applied in quality partnerships with public and private participants (local, state, national) who share the common vision of community well-being.[28]

Texas Vaccines for Children

In 1994 the Federal Vaccines for Children Program (VFC) was created to increase childhood immunization rates. The VFC program is federally funded reaching millions of

infants and children who qualify. Nationally, immunization rates have improved since the inception of VFC. Texas has participated in VFC since its inception under the name Texas Vaccines for Children (TVFC).

Through federal funds TVFC obtains vaccines from the CDC and provides them to public and private health care providers who serve TVFC eligible children. Currently, TVFC has over 10,000 providers enrolled and continually seeks to add additional providers. The following groups are eligible for TVFC:

- uninsured or underinsured children;
- children who are on Medicaid; and
- children who are of Native America or Native Alaskan heritage.[29]

Immunization Registry - ImmTrac

The CDC and NIP strongly support the development of immunization registries. This support is based on a number of factors, but the most evident are the four million babies born each year in the United States. This translates into a new birth cohort of 11,000 infants each day with no immunization protection. Efforts to ensure children receive this protection face a variety of challenges. These challenges include an increasingly complex childhood immunization schedule, incomplete immunization records, missed opportunities to vaccinate, inaccurate assessment of immunization status, and growing public complacency about the need for immunizations.[30]

Immunization registries can provide a solution to some of these challenges. Registries are confidential, population-based computerized information systems that hold information about a child's immunization history. A child's record is generally entered into a system at birth and their immunization records are updated with each vaccination received. If a registry includes all the children in a given area, such as a state, that data can provide

public health officials information about that area's immunization status and other important information regarding other immunization related challenges.[31]

In 1994, the Texas Department of Health established an immunization tracking system to monitor the immunization rates for children across Texas. The system was implemented in response to the measles outbreak which occurred in Dallas in 1989-90.[32] This system (ImmTrac) serves as an information repository for health care providers enabling providers to determine the child's immunization status. For children who do not regularly see the same health care provider, the system serves to protect them from both over and under immunization. However, the current ImmTrac system lacks data from the majority of the commercial insurance sector; thus, it does not provide a complete picture of immunization rates or status in Texas, or accurate immunization records for individual children.

The Benefits of Immunization Registries

- Record Consolidation - Combines immunization information from different sources into a single record.
- Decision Support - Helps providers and parents to determine when immunizations are due and helps ensure that children get only the vaccines that they need.
- Reminder/Recall System - Reminds families when an immunization is due or has been missed.
- Provider Information Source - Keeps health care providers informed about new vaccines and changes in the recommended schedule.
- Identification of High Risk Areas - Identifies children susceptible to vaccine-preventable diseases and promote immunization efforts in their communities.

Source: Center for Disease Control and Prevention. *Frequently asked questions about immunization registries.*

According to a Texas State Auditor's Report issued in 1999, the ImmTrac system has not realized its full potential because fewer than half of the children living in Texas are included in the registry, and because data collection is incomplete.[33] According to the Auditor, the vast majority parents agree to participate in the registry on their child's birth certificate and

so it is likely an individual child's name will be listed in the registry. However, because the data collected is incomplete, an individual immunization history is not generally reliable. The Auditor suggests that the poor quality of the data collected by ImmTrac is caused by several factors including consent issues, confidentiality concerns, and under "population" of data.

The Auditor states regulations regarding consent, in which parents must consent or "opt in" before providers can submit immunization information into the ImmTrac System, often place a burden on hospital registrars, nurses, and other health professionals who must obtain parental consent for each child.[34] Also, the "opt in" system makes it difficult for providers to know if a parent has given consent to the registry and therefore they feel obligated to obtain written consent each time a vaccine is given.

> According to the Auditor, an alternative to the "opt in" system would be an "opt out" system. In this system, all children would automatically be included in the system unless a parent chooses otherwise. This type of system would typically have higher participation, as the consent issue would be eliminated. The administrative burden may be reduced with the "opt out" system, as only those few individuals that did not want their child tracked in the registry would require consent paperwork.[35]

A second factor affecting the quality of the data collected, is confidentiality. The Auditor reports the concept of the state tracking all children under 18 years of age raises concern with some parent groups. However, a well designed "opt out" system would include a strict "firewall'. Data would only be collected on those individuals choosing to remain in the registry. Any information sent to ImmTrac regarding those who have "opted out" would be deleted by the system; never seen by department staff.[36]

Finally, the "under population" or lack of collected data in the system presents a challenge to the success of ImmTrac. Since the data is incomplete, providers do not use the system, and in turn, because providers do not use the system the data remains incomplete. Again, the problem of populating the data pool could be addressed with a change from an "opt in" to an "opt out" system.

Implementing the change from "opt in" to "opt out" was also recommended by Elton Bomer in his August 2001 report, *Texas Department of Health Business Practices Evaluation*. In the report, Mr. Bomer states that making such a change would create a more effective immunization registry, thus improving public health and immunization rates. Further, he suggests the improved "opt out" system could produce a recall and reminder campaign, provide centralized record-keeping and reveal particular areas of the state with low immunization rates so area specific problems could be addressed.[37]

With a fully functioning registry Texas would gain the ability to target education efforts, give parents reminders of upcoming immunizations, recall a child if they have missed an immunization, and track the status of immunizations in case of a disease outbreak. The "opt out" registry moves Texas one step closer to reaching the goal of increased immunization rates.

Federal and State Funding for Childhood Immunizations

The cost of immunizing more than 1000 babies born in Texas each day is rising as new vaccines are recommended which, although more effective, are also becoming more expensive. The cost of liability protection for manufacturers is also on the rise. As new vaccines are added to the immunization schedule the cost for providing the full series has increased, from $34 in 1987 for a publicly funded series to $176 in 1997 for the new schedule of publicly funded vaccinations.[38]

Federal sources pay for approximately 90 percent of the total public vaccine expenditures through two programs, VFC and Section 317 of the Public Health Service Act (317 Program).[39] Under the VFC program, the CDC negotiates vaccine contracts with vaccine manufacturers and then makes these vaccines available to VFC registered providers. The CDC is able to negotiate a much lower contract price for vaccines thus is able to serve more children. In the 317 Program, grants are provided to states to purchase vaccines for underinsured children and to facilitate special programs such as outreach and disease surveillance.[40]

In Texas TDH Immunization Programs are funded through five different sources:

- VFC - a population-based entitlement program (53%);
- 317 - a program to serve underinsured children (23%);
- General Revenue - (20%);
- Non - Permanent Tobacco/Medicaid - (2.5%); and
- Appropriations Receipts - (1.5%).[41]

The Texas Immunization Partnership

Over the course of the last year, TDH convened a group of key stakeholders with the goal of creating a statewide plan to increasing immunization rates. The group focused on TDH's ability to increase rates, but also, on the broader question of what various stakeholders across the state can do to increase rates. In an effort to obtain feedback and suggestions from across the state, thirteen local stakeholder's meetings were held. At these meetings, both barriers to and successful immunization efforts were identified along with recommendations of methods to address the identified barriers. The local stakeholder feedback was then combined with similar input from a larger statewide stakeholder group. This resulted in a series of suggestions including, initiating a public education campaign,

enhanced provider education, modifying the ImmTrac system, increasing the vaccine reimbursement rate and detailing the barriers and success of Texas immunization programs.[42]

Barriers	Successes
✗ Lack of knowledge by parents & providers	✓ Partnerships
✗ Lack of adequate funding for vaccines and immunization programs	✓ Provider incentives
✗ Vaccine shortages	✓ TVFC program
✗ ImmTrac Issues	✓ Patient education
✗ Lack of a reminder/recall system	✓ Provider education
✗ Lack of agency collaborations	✓ Evening or late clinic hours
	✓ Utilization of reminder/recall programs
	✓ Local registries[43]

Public education and awareness is considered one of the most effective means of increasing rates. Many parents do not deliberately fail to immunize their children, rather the failure is due to the complicated nature of the vaccination schedule, thus parents are not always aware of when to immunize. In addition, if a child does not have a regular medical home/physician parents may not be fully informed about immunizations. Misinformation is generated by the media and other public forums and parents are given incorrect medical information. It is critical that Texas' public health agency, TDH, counter this misinformation and appropriately educate citizens regarding the value of immunizations. The state's formal immunization campaign ended in 1996 and rates have not improved since that time. An investment in public education would have a direct impact on the state's immunization rate.

Due to an increasingly complex immunization system and funding mechanisms, providers can also be confused about best practices, funding streams, paperwork requirements, program rules and other administrative issues. In an attempt to address these, TDH recently created and distributed an educational toolkit for physicians. Materials such as this can be valuable tools, with input from organized medicine. In addition, many providers do not fully understand the VFC program and regard it as another administrative burden on their practice. Clarification of the requirements of the VFC program, such as those related to vaccine storage, paper work, and practice evaluation could enhance provider participation.

Last, the current fee paid to Texas Medicaid providers for the administration of vaccines is well below the cost of providing the vaccine. The state reimburses providers $5 for each vaccine administered; physicians indicated it costs approximately $8.12 to administer the vaccine.[44] The Centers for Medicare and Medicaid Services (CMS) permits a state reimbursement maximum for administration ranging from $12.24 to $17.85. The reimbursement is funded through a 60 percent federal and 40 percent state general revenue match. Increasing the reimbursement rate for the administration of vaccines to cover the provider's cost would also increase the TVFC's ability to enroll providers, and ultimately increasing access to immunization services.[45]

Universal Vaccine Purchase

One method which has simplified administrative burdens in other states is Universal Vaccine Purchase(UVP). In a UVP program, the state purchases vaccine for all the state's children, regardless of their financial status, and distributes it to participating providers at no cost to the family or providers. Under this system providers do not charge for the vaccine itself, but are permitted to charge a state-determined administration fee. The purpose of UVP is to remove cost as a barrier to immunizations and to ensure children have a medical home or a stable location where they receive medical services. The program is funded through a combination of VFC and state funds.[46]

Currently, 13 states operate a UVP program and of those states, seven are among the top ten ranking states with age appropriate vaccination coverage rates.[47] Unlike Texas, of those seven states, six also have "opt out" registry systems. These programs have met with mixed success in the states which have implemented UVP. In each of these states, additional efforts and steps were taken to increase rates; UVP was not solely responsible for the improvement in the rates in those states. UVP is most successful when used in conjunction with a fully functioning immunization registry and an aggressive public outreach campaign.

Universal Vaccine Purchase is most successful when used in conjunction with a fully functioning immunization registry and an aggressive public outreach campaign.

Since UVP programs allow states to purchase in bulk at a significantly reduced cost, such programs can have an impact on vaccine manufacturers. In ten years the vaccine industry has gone from twenty manufacturers to four.[48] This has affected the supply of vaccines and has, in part, led to shortages in some vaccines. In general, a UVP program limits the profit margin manufacturers make on vaccines because the state is able to purchase vaccine at a discounted rate. If enough states institute a UVP program, the effect on the entire vaccine industry could be devastating. A careful balance much be achieved between a critical health objective and programs that would further jeopardize the supply of vaccines by driving companies out of the business.

Conclusion

The Legislature, state agencies, the medical community and most importantly parents must act in concert to ensure the health and well-being of Texas children. No single method will increase immunization rates in Texas. The problem must be attacked on a variety of fronts including raising parental awareness, improving information and data collection, increasing provider education, and developing ready access to immunization services. The following recommendations attempt to address these components with the ultimate goal of increasing Texas' childhood immunization rates.

Recommendations

1. **The Legislature shall direct the Texas Department of Health to institute a continuous statewide immunization education campaign and increase coordination between local, regional, and state stakeholders on immunization issues through a statewide coalition.**

   Rationale: In 1994 the Texas Department of Health initiated the "Shots Across Texas" campaign to fully immunize children, ages birth to two-years-old. "Shots Across Texas" was a public-private partnership that included a coalition of leaders from hundreds of businesses, associations, agencies and nonprofit organizations. Local coalitions in almost all of Texas' 254 counties participated in statewide "Shots Across Texas" media campaigns that included press tours and statewide prime time media coverage. During 1994, "Shots Across Texas" earned a great deal of support from the Department of Health, the Legislature and the Governor. Through 1996, Texas saw an increase in immunization rates and a decrease in disease outbreaks, thanks in part to "Shots Across Texas". The formal campaign ended in 1996. However, components of the campaign have been absorbed into the work of the TDH Immunization Division. Unfortunately, funding for local immunization coalitions has decreased since 1996. A campaign building on the success of the "Shots Across Texas" program, which develops a continuous, sustainable and statewide immunization education campaign, facilitates collaborative efforts at all levels, and supports, maintains and

expands existing infrastructures, could be a strong step toward increasing immunization rates.

2a. The Legislature shall modify the state's current immunization tracking system, ImmTrac to increase participation.

Rationale: This change would increase reporting to the system by providing protection from liability for entities reporting immunization information to the Texas Department of Health.

2b. The Legislature shall modify the state's current immunization tracking system, ImmTrac, to increase data collection.

Rationale: The goal of this modification is to increase reporting to the system by changing the registry from an "opt-in" system to an "opt-out" system while continuing to protect individual privacy.

3. The Legislature shall direct the Comptroller to conduct a study on the feasibility of utilizing a Universal Vaccine Purchase (UVP) program in Texas to determine:

- **the fiscal impact of such a program;**
- **the administrative feasibility of such a program;**
- **any potential simplification a program like this would create;**
- **best practices in those states with UVP which are similar to Texas in size/population and immunization requirements; and**
- **the potential impact on the vaccine industry.**

Rationale: Before implementing UVP, the state must fully research this type of program and determine the benefits and effects it

would have on providers, patients, and the pharmaceutical industry. The study should include input from all private stakeholders, as well as the TDH, the CDC, local health departments and the Legislative Budget Board. Finally, the study should include other delivery options to increase immunization rates.

4. **The Legislature shall direct the Texas Department of Health to report on the Texas Pediatric Society's EPIC (Educating Physicians in your Community) pilot program. TDH shall make recommendations for expansion, if the pilot proves successful and cost effective, and in making these recommendations, TDH shall identify possible funding sources.**

   Rationale: The Texas Pediatric Society, in partnership with Baylor College of Medicine and Texas Children's Hospital of Houston, received a grant funded through the CDC and TDH to pilot a physician-to-physician immunization education program in the Houston area. The mission of the program is to improve the health of children through practical, community-based, quality medical education delivered by all members of the provider's office including nursing, medical, and support staff.

5. **The Legislature should direct the Texas Department of Health to expand the AFIX/CASA Program to include providers outside the Vaccines for Children (VFC) Program if funding is located.**

   Rationale: AFIX/CASA is a quality assurance process that is used to assess immunization provider practices. It is an evidenced-based strategy proven to be an effective way to improve

immunization coverage. It is referred to as AFIX because it is a methodology that provides for **A**ssessment of immunization records, **F**eedback on findings to the provider with **I**ncentives, and e**X**change of results and ideas for improving the practice. Clinic Assessment Software Application, developed by the CDC, is referred to as CASA. It is the tool through which a provider's practice is assessed. Feedback to the provider and office staff is given based on specific case findings such as missed opportunities to immunize a child. Incentives set by the individual practice, local medical societies, public health departments and others to improve coverage can be used to award high performance. The ultimate goal is to increase immunization rates, and reach providers who are unlikely to join VFC and to bring additional providers into the VFC program.

6. **The Legislature shall require all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) to be covered by state regulated health plans.**

Rationale: Currently in Texas, only those vaccines mandated by law are required for coverage by health plans. As a result, Hepatitis A, pneumoccoccal, and influenza may not be covered by a child's health plan. Several other states (i.e. Pennsylvania) use this model, with great success.

7. **The Legislature shall direct the Texas Department of Health to explore methods to increase physician education and participation in the Vaccine for**

Children (VFC) Program including provider education, administrative simplification, and increased vaccine administration reimbursement.

Rationale: Increasing and improving current provider education regarding immunization programs, rules, and other related issues can be an effective tool to increase immunization rates. Streamlining paper work requirements and increased coordination between programs, such as, VFC and CHIP also has the potential to increase immunization rates. Finally, increasing vaccine administration reimbursement rates will provide an incentive to providers to participate in the VFC program and adjust the reimbursement rate to cover the cost of administering the vaccine.

8. The Legislature shall pass a resolution to the United States Congress asking that they:

a. Eliminate the inconsistent policy that does not allow CHIP children to be eligible for the Vaccines for Children (VFC) Program although Medicaid Children are eligible for VFC.

Rationale: Currently, children who receive VFC vaccine are children from birth through 18 years old who: are eligible for Medicaid, have no health insurance, are Native American or Alaska Natives, or who have health insurance which does not cover immunizations and who go to a Federally Qualified Health Center. If Texas had implemented the Medicaid expansion option for CHIP , CHIP children would be eligible for VFC. However, since the state designed a separate state health

plan, children in the CHIP program are ineligible for VFC. The cost to the state of Texas to buy vaccine for these children could be significantly reduced if the recommended change was made.

b. Pass Federal legislation which requires coverage for ACIP recommended vaccines for ERISA health plans.

Rationale: The Employee Retirement Income Security Act (ERISA) was enacted to ensure that employees receive pension and other benefits promised by employers. ERISA supersedes almost all state laws that affect employee benefit plans and has thus created a single federal standard for employee benefits. As a result, a change is needed at the Federal level in order to ensure that all children have insurance coverage for ACIP recommended vaccines.

c. Take steps to address the vaccine supply shortage.

Rationale: Congress is well aware of the vaccine shortage issue and is awaiting a report from the GAO with recommendations for steps that should be taken to address this issue. Texas should encourage Congress to move forward with recommendations made by the GAO which are designed to improve access and availability of vaccines.

Acronyms

ACIP	Advisory Committee for Immunization Practices
AFIX	**A**ssessment of immunization, **F**eedback on findings to the provider with **I**ncentives, and e**X**change of results and ideas
CASA	Clinic Assessment Software Application
CDC	Center for Disease Control and Prevention
CHIP	Children's Health Insurance Program
DTaP	Diphtheria, Tetanus and Pertussis
EPIC	Educating Physicians in your Community
FDA	Federal Drug Administration
GAO	General Accounting Office
Hib	Haemophilus Influenzae type b
IPV	Inactivated Polio Vaccine
MMR	Measles, Mumps and Rubella
NCHS	National Center for Health Statistics
NIP	National Immunization Program
NIS	National Immunization Survey
NNII	National Network for Immunization Information
TDH	Texas Department of Health
TIS	Texas Immunization Survey
TVFC	Texas Vaccines for Children Program
UVP	Universal Vaccine Purchase
VFC	Vaccines For Children Program

Endnotes

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ISSUE 8 WITHIN THE COMMITTEE'S JURISDICTION

Restraints and Seclusion

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Issue 8 Within the Committee's Jurisdiction

Increase reporting and training regarding the use of restraints and seclusion in facilities.

Background

At the October 11, 2002 hearing of the Senate Committee on Health and Human Services, Chairman Mike Moncrief charged the committee with studying the use of restraints and seclusion in facilities and methods to increase reporting and training.

What are restraints and seclusion?

There are a variety of definitions for restraints and seclusion, frequently, depending on the type of facility in which the behavioral device is being utilized. To gain a better understanding of this subject area various definitions are set forth below.

Restraints

Definitions of restraint distinguish between physical, personal, mechanical, or chemical; others use the term to include all types of restraints.

Physical

> "Physical restraint, which involves direct physical holding of an individual, is used to secure someone who is threatening immediate harm to themselves or others."[1]
>
> "Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body."[2]
>
> "Physical restraint is defined as any manual method or physical or mechanical device that the individual cannot remove easily, and which restrict the free movement of, normal functioning of, or normal access to a

portion or portions of an individual's body. Examples of manual methods include therapeutic or basket holds and prone or supine containment."[3]

"Personal restraint - the application of physical force, including escorting, without the use of any device for the purpose of restricting the free movement of the whole or a portion of a child's body in order to control physical activity."[4]

"Restraint - the use of physical force alone, the use of a device, or the use of emergency medication in order to assist a child in regaining control. This includes personal restraint, mechanical restraint, and emergency medication as defined in this section."[5]

Mechanical

"Mechanical restraint involves holding an individual in place by means other than human contact; for instance, using wrist and ankle restraints."[6]

"Mechanical restraint - the application of a device for the purpose of restricting the free movement of the whole or a portion of a child's body in order to control physical activity."[7]

Chemical

"Chemical restraint uses medication to calm or otherwise alter a resident's behavior. A common drug used would be Haldol (trade name), a well-known anti-psychotic."[8]

"Chemical restraints is defined as any drug that is used for discipline or convenience and not required to treat medical symptoms."[9]

"Chemical restraint is the use of any chemical, including pharmaceuticals, through topical application, oral administration, injection, or other means,

> solely for the purpose of immobilizing a child or sedating a child as a mechanism of control."[10]

Seclusion

Seclusion, another method of behavior control, is entirely different from restraints. Various definitions of seclusion follow.

> "Seclusion is used to isolate a resident from the general population by moving them to some other remote area or room that may be locked or unlocked. The use of seclusion is intended to reduce the stimulus and stress of interacting with others in an attempt to de-escalate the behavior of an individual who is becoming agitated or upset."[11]

> "Seclusion- the placement of a child, for any period of time, in a room or other area where the child is alone and is physically prevented from leaving by a locked or barricaded entryway. An intervention that restricts a child to a room which involves a care giver placing his or her body between the child and the exit from that area is not a seclusion because the child is not alone."[12]

Who uses restraints and seclusion?

Texas Department of Human Services

The Texas Department of Human Services (TDHS) license and regulates long term care facilities [skilled nursing facilities and nursing facilities], assisted living facilities (ALF) and private intermediate care facilities for the mentally retarded (ICF-MR). For those long term care facilities that are Medicaid certified, additional regulatory authority is found in the Centers for Medicare and Medicaid Services (CMS) [formerly Health Care Finance Administration] guidelines or conditions of participation for the Medicaid program. The ICF-MR facilities that participate in the Medicaid program have federal participation requirements, as well. Since these requirements are the same for state operated ICF-MR

facilities, further discussion of this type of facility and program rules are located in the Texas Mental Health and Mental Retardation section, below.

Nursing Facilities

"The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms."[13] "The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion."[14] The federal law and the regulation implementing the statute form one of the core conditions of participation in the Medicare and Medicaid programs for skilled nursing facilities and nursing facilities, sometimes known as "nursing homes."

"A nursing home is a residence that provides a room, meals, skilled nursing and rehabilitative care, medical services, and protective supervision to residents. It also provides residents with help with daily living and recreational activities. Many nursing home residents have physical, emotional or mental impairments which keep them from living independently."[15] The TDHS defines a nursing home or nursing facility as "an institution that provides organized, structured nursing care 24-hours a day."[16]

Clients Served

Based on the definitions above, the type of client served by a nursing facility, generally, is unable to live independently, needs 24 hour services, and requires some type of nursing intervention. Essentially, the nursing facility client is dependent on others for activities of daily living and health care.

Rules, Training, and Reporting

The TDHS rules for restraints incorporate, verbatim, the language set forth above as a condition of participation in the Medicare and Medicaid programs.[17] The rules require:

- the restraints to be released and the resident repositioned as necessary to

prevent deterioration in the resident's condition;

- the resident be monitored hourly; and
- at a minimum, restraints must be released every two hours for a minimum of ten minutes, and the resident repositioned.[18]

Finally, the use of restraints and their release must be documented in the clinical record.[19]

Involuntary seclusion is prohibited in nursing facilities by federal guidelines and the same prohibition is included in the TDHS nursing facility requirements for licensure and medicaid certification.[20]

The "DHS requires that nurse aides working in licensed facilities receive eight hours of training on restraints within their initial required 75 hours of training before they can have contact with residents."[21]

"The training specifically targets:

- the role of the nurse aid [sic] in avoiding the need for restraints;
- dangers of using restraints;
- requirements for using restraints;
- and the role of the nurse aide aid [sic] in the care of residents when restraints are, in fact, needed."[22]

Nurse aides are required to have 12 hours of annual education on topics determined by their employer.[23] There are no specific requirements for continuing education on restraints.

Nursing facilities are required to report "all alleged violations involving mistreatment,

neglect, or abuse, including injuries of unknown source, and misappropriation of resident property" "immediately to the administrator of the facility and to other officials in accordance with Texas law."[24] "The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress."[25] These state requirements mirror the federal conditions of participation for Medicaid certified facilities.[26]

Assisted Living Facilities

"An assisted living facility [ALF] is an establishment that furnishes, in one or more facilities, food and shelter to four or more persons who are unrelated to the proprietor of the establishment; and provides personal care services."[27] "Assisted, living services are driven by a service philosophy that emphasizes personal dignity, autonomy, independence, and privacy. Assisted living services should enhance a person's ability to age in place in a residential setting while receiving increasing or decreasing levels of service as the person's needs change."[28]

Clients Served

Unlike other types of facilities, the Texas Administrative Code describes, by rule, the type of client served in an ALF. "General characteristics of assisted living residents include, but are not limited to, the following. A resident may:

(1) exhibit symptoms of mental or emotional disturbance, but is not considered at risk of imminent harm to self or others;

(2) need assistance with movement;

(3) require assistance with bathing, dressing, and grooming;

(4) require assistance with routine skin care, such as application of lotions, or treatment of minor cuts and burns;

(5) need reminders to encourage toilet routine and prevent incontinence;

(6) require temporary services by professional personnel;

(7) need assistance with medications, supervision of self-medication, or administration of medication;

(8) require encouragement to eat or monitoring due to social or psychological reasons of temporary illness;

(9) be hearing impaired or speech impaired;

(10) be incontinent without pressure sores;

(11) require established therapeutic diets;

(12) require self-help devices; and

(13) need assistance with meals."[29]

Rules, Training, and Reporting

Each resident in the ALF has the right to be free from physical and chemical restraints that are administered for the purpose of discipline or convenience and not required to treat the resident's medical symptoms.[30] Physical or chemical restraints may only be used if it is authorized, in writing, by a physician or "if the use is necessary in an emergency to protect the resident or others from injury."[31] "A physician's written authorization for the use of restraints must specify the circumstances under which the restraints may be used and the duration for which the restraints may be used. Except in an emergency, restraints may only be administered by qualified medical personnel."[32]

Training and continuing education in the use of restraints in an ALF is identical to the training required for nurse aides in nursing facilities.[33] Abuse, neglect, and exploitation is a reportable event to the TDHS.[34] The rule delineates certain information to be reported,

but it does not identify injuries or deaths resulting from the use of restraints as a reportable event.[35]

Texas Department of Health

The Texas Department of Health (TDH) license and regulates general and special hospitals, private psychiatric hospitals, and special care facilities. Additionally, the operation of private psychiatric hospitals includes regulations, adopted by rule, of the Texas Department of Mental Health and Mental Retardation (TDMHMR). Finally, those facilities that participate in the Medicare program also have federal regulatory requirements.

General Hospitals and Private Psychiatric Hospitals

There are 524 general and special hospitals, 30 psychiatric hospitals, and nine special care facilities in Texas.[36]

A general hospital is "any establishment that offers services, facilities, and beds for use for more than 24 hours by two or more unrelated individuals requiring diagnosis, treatment, or care for illness, injury, deformity, abnormality, or pregnancy. A general hospital must maintain, at a minimum, clinical laboratory services, diagnostic X-ray services, treatment facilities including surgery or obstetrical care or both, and other definitive medical or surgical treatment of similar extent, and has a medical staff in a regular attendance, and maintains records of the clinical work performed for each patient."[37] A general hospital may include patients seeking mental health services.

> Psychiatric Hospital is an establishment offering inpatient services, including treatment, facilities, and beds for use beyond 24 hours, for the primary purpose of providing psychiatric assessment and diagnostic services and psychiatric inpatient care and treatment for mental illness. Such services must be more intensive than room, board, personal services, and general medical and nursing care. Although

substance abuse services may be offered, a majority of beds must be dedicated to the treatment of mental illness in adults and children.[38]

Texas has a third type of facility, special care facilities. These facilities provide "a continuum of nursing or medical care services or services primarily to persons with acquired immune deficiency syndrome or other terminal illnesses. The term includes a special residential care facility."[39]

Clients Served

The general hospital may include adults and children seeking medical interventions and/or mental health services for more than 24 hours. The psychiatric hospital client, by contrast, seeks services primarily for mental illness. The client may be an adult or child. In the special care facility the client is a person with acquired immune deficiency syndrome or other terminal illness.[40]

Rules, Training, and Reporting

All 524 general and special hospitals are Medicare certified.[41] Therefore, the hospitals are required to comply with the federal rules on restraints and seclusion in the Medicare Conditions of Participation: Patients' Rights.[42] The regulations limit the use of restraints for acute medical and surgical care except "to improve the patient's well-being and less restrictive interventions have been determined to be ineffective."[43] The restraint order must be written by a physician or other practitioner authorized by the State to write such orders and never written as a standing order.[44] The patient's treating physician must consult on the patient, as soon as possible, if the order was written by a person other than the treating physician.[45] The rules further require continuous assessment, monitoring and reevaluation.[46] Finally, all staff having "direct patient contact must have ongoing education and training in the proper and safe use of restraints."[47]

In the behavior management milieu "the patient has the right to be free from seclusion and

restraints, of any form, imposed a means of coercion, discipline, convenience, or retaliation by staff."[48] Seclusion or restraint is limited to emergency situations if needed to ensure the patient's physical safety and less restrictive interventions have been unsuccessful.[49] In addition to the restraint requirements stated above, when these interventions are used in behavior management, additional rules are mandated. When used for behavior management, a physician or other licensed practitioner must see and evaluate the patient within one hour after the initiation of a physical restraint or seclusion.[50] The written orders for seclusion or restraint is limited to four hours for adults; two hours for children and adolescents ages nine to 17; or one hour for patients less than nine.[51] The original order may only be renewed according to the limits described above for a maximum of 24 hours.[52] Before another seclusion or restraint order may be written a physician or other licensed practitioner, as allowed by State law, must see and assess the patient.[53] "A restraint and seclusion may not be used simultaneously unless the patient is–

(i) Continually monitored face-to-face by an assigned staff member; or

(ii) Continually monitored by staff using both video and audio equipment. This monitoring must be in close proximity [sic] the patient."[54]

A patient that is restrained or in seclusion must be continually assessed, monitored, and reevaluated.[55] Direct care staff must receive ongoing education and training in the proper and safe use of seclusion and restraint application and techniques.[56] Additionally, the staff must learn "alternative methods for handling behavior, symptoms, and situations that traditionally have been treated through the use of restraints or seclusion.[57] The federal rules also require reporting to CMS "any death that occurs while a patient is restrained or in seclusion, or where it is reasonable to assume that a patient's death is a result of restraint or seclusion."[58]

The Texas hospital licensing rules do not contain any additional requirements for restraint and seclusion.

Approximately 75% of the licensed hospitals are also accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).[59] The JCAHO standards include restraint and seclusion; these standards are substantially similar to the federal regulations.

Reporting is limited to the federal regulation cited above and any remedial action taken to address deficiencies found is through the facility's quality assurance program.[60] This information is reviewed as part of a survey/complaint investigation to evaluate the effectiveness of the quality assurance program.

The psychiatric hospitals are required, by adoption in the licensing rules, to follow the TDMHMR restraint and seclusion rules.[61] For the 27 private psychiatric facilities that are Medicare certified, they must also comply with the federal rules on restraint and seclusion located in the Conditions of Participation: Patients' Rights, as set forth in the previous paragraph.[62] Finally, the TDMHMR rules require all licensed facilities comply with the inpatient standards set forth by the JCAHO; the TDMHMR rules take precedence when the other standards are less restrictive.[63]

Reporting requirements include the federal requirements set forth above and the requirements located in the TDMHMR rules for abuse and neglect, and deaths occurring on facility grounds.[64] The state rules are not specific to deaths or injuries related to the use of restraints or seclusion.

Special care facilities do not have rules for the use of restraints or seclusion.[65] Other rules do however require that "all accidents, whether resulting in injury, and any unusual incidents or abnormal events, including allegations of mistreatment of residents by staff, personnel, or visitors, shall be described in separate administrative records filed in the facility director's office."[66] These reports, as well as, patient records are reviewed as part of the annual on-site survey.[67]

Texas Department of Mental Health and Mental Retardation

The TDMHMR, created in 1965, provides "for the effective administration and coordination of mental health and mental retardation services at the state and local levels."[68] "The agency is mandated to serve those individuals with mental illness and mental retardation in greatest need of services (the priority population)."[69]

State Hospitals, State Schools, and Intermediate Care Facilities-Mental Retardation

The TDMHMR operates nine mental health components for individuals with mental illness.[70] It regulates seven state hospitals for individuals with mental illness, the Waco Center for Youth and the Rio Grande State Center.[71] The State mental health components provide short and long-term residential inpatient mental health services.[72] Two special components exist, North Texas State Hospital, Vernon Campus, and Waco Center for Youth.[73] Both serve the entire state.[74] The adult unit of the Vernon campus is a maximum-security facility that treats individuals who are incompetent to stand trial, not guilty by reason of insanity and/or manifestly dangerous.[75] "The facility also operates an inpatient program for adolescents with mental illness and involvement in the juvenile justice system."[76]

The TDMHMR also includes 13 mental retardation components for individuals with mental retardation.[77] "Eleven state schools provide campus-based mental retardation services. El Paso and Rio Grande State Centers also provide residential services to individuals with mental retardation."[78]

The Intermediate Care Facilities for the Mentally Retarded (ICF-MR) program "is an institutional model of residential placement and training for persons who have mental retardation or a condition related to mental retardation."[79] Services are provided in a highly structured setting emphasizing training in independent living skills.[80] This program is federally regulated dictating the services provided and the living environment.[81]

The TDMHMR is the regulatory agency for the above described facilities and programs, with the exception of private ICF-MR facilities who are regulated by TDHS.[82]

Clients Served

"The agency is mandated to serve those individuals with mental illness and mental retardation in greatest need of services (priority population)."[83]

"State mental health facilities [State hospitals] provide specialized intensive inpatient services. The department's priority population for mental health services consists of:

- Children and adolescents under the age of 18 with a diagnosis of mental illness who exhibit severe emotional or social disabilities which are life-threatening or require prolonged intervention.
- Adults who have severe and persistent mental illness such as schizophrenia, major depression, bipolar disorder or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment. The type of facility dictates the type of priority population served."[84]

Mental retardation campus-based services include 11 state schools. These facilities provide residential services and supports for individuals requiring 24 hour supervision and active treatment.[85] Individuals with a severe and profound level of mental retardation (IQ of 0-34) constitute 79% of the residents in state mental retardation facilities in Fiscal Year (FY) 1999.[86] "Many have physical disabilities and require a substantial level of supervision or basic physical care to live. Others have behaviors that require close supervision or intervention for maintenance of individual health and safety."[87]

Rules, Training, and Reporting

TDMHMR has extensive rules, regulations, policies, reporting procedures, quality assurance, monitoring, and training regarding restraints and seclusion for its state schools

and state hospitals. Public and private ICF-MRs have federal regulations related to restraints and seclusion.[88] Recently, TDMHMR sent an interim directive to all state mental health facilities to ensure restraint and seclusion practices were used appropriately and only in specific situations as outlined within their regulations.[89]

The TDMHMR facilities and their respective community-based programs; community centers; psychiatric hospitals; and any program contracting with these entities is required to follow the rules set forth as rights of persons receiving mental health services.[90] At a minimum these rights include "the right not to be secluded or have physical restraint applied to the individual unless it has been prescribed by a physician, except in emergency situations. If physical restraint or seclusion is utilized, the reason for the medical order, the length of time restraint or seclusion has been ordered, and the behaviors necessary for the individual to be removed from restraint or seclusion shall be explained to the individual, and the restraint or seclusion shall be discontinued as soon as possible."[91] This right is further defined in the Texas Administrative Code, Health Services, Chapter 405, Subchapter F.

Each facility must have written policies and procedures consistent with the TDMHMR rules and the following general principles concerning the use of restraint or seclusion:

- "It is the department's [TDMHMR] intent to reduce the use of restraint or seclusion as much as possible and to ensure other alternatives are first attempted, when appropriate.
- Restraint or seclusion should only be used as an intervention of last resort following attempts to intervene in a less restrictive, less invasive manner. Before ordering restraint or seclusion, the physician should take into consideration any potential medical (including psychiatric) contraindications, e.g., history of physical or sexual abuse;
- When restraint or seclusion is the appropriate intervention, it should be used

for the shortest period of time."[92]

- The rights of the individual as described in the Rights of All Persons Receiving Mental Health Services and Rights of Persons Receiving Residential Mental Health Services, must be preserved at all times during the use of restraint or seclusion.[93]

- Restraint or seclusion may not be used as punishment; for the purpose of convenience of staff or other individuals; or as a substitute for effective treatment or habilitation.[94]

- "Restraint or seclusion must be initiated in a way that avoids undue physical discomfort, harm, or pain to the individual. Only the minimal amount of physical force that is reasonable and necessary may be used to implement restraint or seclusion, and only PMAB [Prevention and Management of Aggressive Behavior] interventions or, at psychiatric hospitals or CSUs [Crisis Stabilization Units], those of a comparable curriculum, may be utilized."[95]

Additionally, PRN (pro re nata or "as needed") orders are prohibited for restraint or seclusion.[96] Restraint or seclusion orders must be initiated by a physician or clinically privileged nurse.[97] A face-to-face assessment must be conducted and a written order must be issued, if the physician is available, prior to the use of restraints or seclusion.[98]

"The written order must:

- designate the specific procedure authorized, including any specific measures for ensuring the individual's safety, health, and well-being and the protected, private nature of the setting;

- specify the date, time of day, and maximum length of time, not to exceed

four hours for adults, two hours for adolescents and children ages 9-17, and one hour for children under the age of nine, for which the procedure may be used, unless continuation is authorized;

- stipulate if the physician's order may be continued based on a face-to-face evaluation by a clinically privileged registered nurse;
- if the order can be continued, state the maximum duration for renewal, not to exceed 12 hours total, including the original order;
- describe the specific behaviors which resulted in the need for restraint or seclusion; and
- describe the specific behaviors necessary for the individual to be removed from restraint or seclusion."[99]

When a physician is not immediately available, a clinically privileged nurse must obtain and document a physician's verbal order by phone no later than one hour following initiation of restraint or seclusion.[100] "The physician must personally sign, time, and date the phone order within 12 hours of the time the order was issued."[101]

> "Restraint or seclusion cannot be ordered and continued for more than 12 hours. A physician should see a secluded or restrained patient as frequently as necessary to monitor any changes in the patient's physical or mental status. Frequency of these visits may vary; however, a physician shall visit the patient a minimum of twice a day, no more than 12 hours apart. Prior to issuing a new order that would continue restraint or seclusion beyond 12 hours, the physician must perform a face-to-face evaluation of the individual and personally sign, time, and date the original order and the new order."[102]

The rules further contain detailed requirements for monitoring and care of the individual.[103] Additional rules include documentation, emergency medical situations, falling asleep in

restraints and falling asleep in seclusion, and providing "the individual with an appropriate transition and the opportunity to return ongoing activities."[104] Finally, the TDMHMR rules incorporate the CMS conditions of participation for the Medicare and Medicaid programs.[105]

Detailed behavior management rules exist for the ICF-MR setting.[106] The use of seclusion, however, is prohibited in this setting.[107]

Prior to "assuming job duties involving the implementation of verbal, physical, or mechanical restraint interventions, employees receive training and demonstrate competence in personal restraint intervention techniques as described in Prevention and Management of Aggressive Behavior or PMAB and in the use and application of approved mechanical restraints appropriate to the employees' position and responsibilities. Annual training is required."[108] Employees at TDMHMR-operated facilities are required to have training appropriate to each employees' position and responsibilities. This includes the appropriate level of PMAB training and training on the use and application of approved mechanical restraints, as well as rights of consumers, prevention of abuse and neglect, behavior management, observing and reporting, CPR, etc."[109] The TDMHMR training requirements incorporate the federal training requirements as a condition of participation in the Medicaid program.[110]

Any injury requiring treatment, including minor first-aid, must be reported by the state mental health facilities and the state mental retardation facilities.[111] The reports of these injuries may be reviewed by a registered nurse, physician, safety officer, Superintendent, social worker, the Texas Department of Protective and Regulatory Services, TDHS, law enforcement, or the central Austin office of TDMHMR.[112] The nature of the injury dictates who reviews the report.[113] CMS conditions of participation also contain a reporting requirement.[114]

"In FY 2003, the State Mental Health Facility Management Plan includes new strategies

to improve the specificity and accuracy of the restraint and seclusion data collected."[115]

> Historically data has been collected on the episodes of restraint and seclusion, the time in restraint and seclusion and the rate per 1000 bed days. The data has also been separated into categories of adults and children/adolescents. New data to be collected will be on specific number and types of mechanical restraints used for behavioral purposes. This data, along with data on seclusion and personal restraints, will be tracked and correlated with injury data from the same episode of restraint and seclusion–if any. After analysis of the data, policy decisions could be made regarding the use of a particular type of restraint.
>
> Although significant injuries related to the use of personal or mechanical restraint are rare, it is hoped that this data will be used to identify the types of restraints that afford the most safety to patients who require this procedure. This information can then be shared with other mental health providers in facilities similar to SMHFs [state mental health facilities] in order to improve quality of patient care, safety and outcomes.[116]

Texas Department of Protective and Regulatory Services

"The mission of the Texas Department of Protective and Regulatory Services [TDPRS] is to protect the unprotected - children, elderly, and people with disabilities–from abuse, neglect, and exploitation."[117] TDPRS regulates child care; investigates allegations of abuse and neglect against children, the elderly, and people with disabilities.[118]

Residential Treatment Centers, Institutions Serving the Mentally Retarded, and Emergency Shelters

Residential Treatment Centers (RTCs), institutions serving the mentally retarded (MR) and emergency shelters (ES) are licensed and regulated by the TDPRS.[119]

Clients Served

The RTC is an operation that provides care and treatment for 13 or more emotionally disturbed children up to the age of 18 years.[120] An ES provides short-term care (less than 30 days), for 13 or more children up to the age of 18 years. Facilities providing MR services "provides care for 13 or more children up to the age of 18 years. The children in care are significantly below average in general intellectual functioning and also have deficits in adaptive behavior."[121]

Rules, Training, and Reporting

TDPRS has detailed rules for personal restraint, mechanical restraint, and the use of seclusion.[122]

Personal restraints may be ordered by a licensed psychiatrist or psychologist.[123] As needed or "PRN" orders are permitted.[124] Children under the age of nine (0-8 years) may only be in personal restraints up to 30 minutes before a continuation of orders is required.[125] For children ages nine to 17 the maximum time permitted before a continuation of orders is required is 60 minutes.[126] Generally, the maximum number of times this intervention may be administered is three times in a seven-day period.[127]

Certain personal restraints are prohibited:

- "restraints that place a child face-down and place pressure on the child's back;
- restraints that obstruct the airways of the child or impair the breathing of the child;
- restraints that obstruct the caregiver's view of the child's face; or
- restraints that restrict the child's ability to communicate."[128]

Mechanical restraints may only be ordered by a licensed psychiatrist.[129] The same time limits apply before a continuation of orders is required; however, this restraint may only be utilized twice in a seven day period.[130] The maximum amount of time mechanical restraints can be administered is three hours.[131] As needed orders are not permitted for mechanical restraints.[132] Finally, mechanical restraints may only be utilized in RTCs and MR facilities.

Written orders are required for the use of seclusion except in ES.[133] This intervention may be ordered by a psychiatrist, psychologist or a physician.[134] As needed orders are permitted.[135] Seclusion is limited to 60 minutes for children ages zero to eight and two hours for ages nine to 17.[136] The maximum time allowed in seclusion is 12 hours.[137] The use of seclusion is limited to twice in a seven-day period.[138]

Training of all new caregivers must be competency based, include training on restraint or seclusion, and must require pre-service training with at least three quarters of the pre-service training focus on early identification of potential problem behaviors and strategies and techniques of less restrictive interventions.[139] Four hours of annual retraining is required including the proper use and implementation of restraints and/or seclusion.[140]

"All reports to Licensing [TDPRS] of child death, suicide attempts, and incidents in which a child experiences substantial bodily harm must include the complete documentation of any emergency medications, restraints, and/or seclusion which were implemented within 48 hours prior to the incident."[141]

Texas Commission on Alcohol and Drug Abuse

The Texas Commission on Alcohol and Drug Abuse (TCADA), among other things, assists individuals who are addicted to drugs or alcohol recover.

Substance Abuse Treatment Facilities

Substance abuse treatment facilities are licensed and regulated by TCADA.[142]

Clients Served

Substance abuse treatment facilities serve chemically dependent clients.[143]

Rules, Training, and Reporting

The treatment facility is required to adopt a policy to authorize or prohibit the use of personal restraint, mechanical restraint, and/or seclusion.[144] However, programs accepting emergency detentions must authorize use of personal restraint.[145] Restraints or seclusion may not be used unless a client's behavior endangers the client or others and least restrictive methods have been tried and failed.[146] Authorization must be obtained from the supervising qualified credentialed counselor before commencing a restraint or seclusion or as soon as possible after implementation.[147] Standing authorizations for restraints or seclusion is prohibited.[148] A client in restraint must be under continuous and direct observation. Seclusion rooms must be set up to prevent clients from harming themselves and allow staff to observe clients in all parts of the room.[149]

> All direct care staff working in programs that use restraint or seclusion shall have face-to-face training and competency in the safe methods of the specific procedures used within 90 days of hire. This includes all direct care staff working in adolescent residential programs, detoxification programs, and programs that accept emergency detentions. The training shall last approximately four hours and shall include hands-on practice under the supervision of a qualified instructor.[150]

Regardless of whether the incident is related to abuse, neglect, or exploitation, an incident report must be completed when a restraint or seclusion is used.[151] "The chief executive officer or designee shall review all incident reports involving restraint or seclusion and take action to address unwarranted use of these measures."[152] If there is an allegation of abuse, neglect, or exploitation related to the incident, it must be reported to the TCADA Investigations Division within 24 hours.[153]

Legislative History

During the 76th Legislative Session, Representative Manny Najera authored House Bill 3424, relating to the regulation of the use of restraints, seclusion and emergency medication in psychiatric hospitals and other entities providing long term care services. The bill was introduced late in the session and was left pending in the House Committee on Public Health.[154]

The 76th Legislative Senate Committee on Human Services' interim report included a recommendation regarding restraints and seclusion to "establish, in statute, guidelines for updated definitions and policies relating to restraints, seclusion and emergency medications in residential facilities (e.g., nursing homes, psychiatric hospitals, ICF-MRs, assisted living centers and residential childcare facilities)."[155] The proposal was intended to bring consistency across different facility types so patients would have the same protections regardless of where they were receiving services and to clarify the procedures agencies are required to follow when developing rules on restraints, seclusion and emergency medications.[156] The issue of restraints and seclusion was highlighted in the report due to several deaths occurring in Texas that were linked to restraints and seclusion. "The precise cause of death in such cases is not always clear. Whether these deaths occur as a result of staff actions or inactions or from underlying medical conditions exacerbated by the stress of the incident, and regardless of the state agency charged with regulating the facility, the critical need for staff training and safety procedures remains."[157] Recently, Advocacy, Inc. reported 16 deaths, in Texas from September 1999 to July 2002 subsequent to the use of a behavioral intervention, most often a personal restraint hold.[158]

During the77th Legislative Session, Senate Bill 876 by Senator Mike Moncrief, relating to the administration of restraint, seclusion, and emergency psychoactive medication to residents of certain health care facilities, died in the House Calendars Committee at the end of session.[159] As originally introduced, the bill contained detailed, standardized guidelines for nursing homes, assisted living facilities, ICF-MRs and residential treatment

centers for children. After much discussion with stakeholders, a substitute version was introduced focusing on the essential elements of Senate Bill 876: staff training, reporting of deaths or serious injuries related to restraints and seclusion, and the collection of de-identified information, was passed in the Senate but never made it to the House Floor.

Issues

Extensive stakeholder meetings were held during this interim where several issues were identified: reporting, training, and evidence-based best practices. Within these issues two subissues emerged: injuries or deaths related to specific holds and staff turnover.

Although some incident reporting is done at the agencies reviewed in this report, no data on usage (frequency) appears to be collected. Frequency data collection is part of the future FY 2003 state mental health facility management plan, however, the data is currently unavailable. Moreover, data collection for injuries or deaths relating to restraint or seclusion use is virtually nonexistent. This problem was recognized by the U.S. General Accounting Office in a report to the U.S. Senate Committee on Finance.

> Improper restraint and seclusion can be dangerous to both people receiving treatment and staff, but the full extent of related injuries and deaths is unknown. There is no comprehensive reporting system to track such injuries and deaths or the rates of restraint and seclusion use by facility. We identified 24 deaths associated with restraint or seclusion during fiscal year 1998. Because reporting is so fragmentary, we believe many more deaths related to restraint or seclusion may occur.[160]

"Extending seclusion and restraint laws to all health care facilities is consistent with the General Accounting Office (GAO) recommendations in its 1999 report, *Mental Health: Improper Restraint or Seclusion Use Places People at Risk*. The GAO report also advocates that the Health Care Financing Administration (HCFA) improve the reporting of seclusion and restraint use, as well as any deaths or injuries associated with the

practices."[161]

Data collection provides the opportunity to compare across similar facilities (nursing home to nursing home), as well as, compare across different types of facilities (nursing home to mental hospital). Information derived from these sources allow the development of evidence-based recommendations and may provide the basis for medical interventions.

Some of the deaths reported to the Senate Committee on Health and Human Services during its April 16, 2002 hearing have been associated with certain personal restraints placing the client in a face-down and prone position. The TDPRS is the only state agency that prohibits this type of personal restraint. This life-threatening physical restraint was banned in Connecticut in 1999.[162]

While most facilities require staff training, not all require training in the use of restraints or seclusion. Annual retraining is not consistent in the agencies reviewed. CMS recognized that the safe use of restraints and seclusion requires staff training and annual retraining; thereby making this a condition of participation in the Medicare and Medicaid programs. Unfortunately, staff turnover, especially in nursing facilities and in MHMR facilities, is so high that correct and consistent implementation of appropriate behavioral intervention techniques, including restraints is lacking. Increasing wages for these direct care providers may decrease the turnover rate.

The TDMHMR has an extensive training program in behavior management. Private psychiatric hospitals, regulated by the TDH, are required to follow TDMHMR restraint and seclusion rules. However, the TDMHMR behavior management training program is unavailable to any other agency or facility due to copyright protections. This appears to create a conflict between mandatory agency regulations and training availability. Making this training available to other agencies and programs may improve patient safety when implementing these behavioral interventions.

Finally, there is a need to address the areas of uniformity in definitions, standardized reporting, and a subsequent meaningful analysis of the data collected. To this end, a best practices workgroup should be convened to address these issues. Since the populations are vastly different by agency, state-wide uniformity may not meet the needs of the populations served.

Conclusion

The appropriate use of restraints and seclusion is both a federal and state issue. The reform provisions in the 1987 Omnibus Budget and Reconciliation Act mandated patient protection, in the long term care setting, from inappropriate use of chemical and physical restraints, including seclusion.[163] Subsequent federal conditions of participation requirements were implemented for the Medicare and Medicaid programs. Texas has progressively implemented restraint and seclusion rules by agency. To further the protection of clients on whom behavioral management techniques, such as, restraints and seclusion may be used, additional statutory and regulatory development is required.

Recommendations

1. **Texas Department of Human Services (TDHS), Nursing Facilities (NF) and Assisted Living Facilities (ALF): Agency-wide initiative to reduce unnecessary and inappropriate restraints in NFs and ALFs, coordination of activities in enforcement, educational services, policy and quality monitoring to provide comprehensive training, policy clarifications and targeted enforcement actions directed toward reducing the use of restraints. (Report to Senate Committee and 78th Legislature in January 2003.) Initiatives include:**
   a. **Meet with provider associations to further plans to make restraint reduction a major objective during the remainder of calendar year.**
   b. **Enhanced training of surveyors to recognize and understand appropriate and inappropriate intervention and/or restraint techniques.**
   c. **Analyze and report on the resources necessary to educate and train nursing home professionals on the use of restraints and appropriate alternatives to the use of restraints.**

Rationale: TDHS and the NF and ALF industries are committed to work together to reduce the use of restraints in long-term care facilities through an agency-wide initiative. The emphasis on this project is not only restraint reduction but also on meaningful alternatives to restraints, particularly for residents at risk for falls and those whose cognitive impairments cause them to wander.

Rider 30, 77th Legislature, directs TDHS to perform on-site case reviews and Quality Monitoring of nursing home resident care in specific areas (including, but not limited to restraints) to identify preventable areas of adverse outcomes to residents.

(Rider 30 Report due January 2003.)

d. Close collaboration with federal officials is necessary. Plans include meeting with the Texas Medical Foundation and the Texas Nurses Foundation to determine how NFs can work together on this initiative.

Rationale: The Centers for Medicare and Medicaid Services (CMS) is launching a nationwide effort to monitor and improve nursing home resident outcomes in seven areas including psychotropic medications and restraints. Therefore, TDHS and industry collaboration with CMS will improve resident outcomes.

e. If feasible, analyze and report on innovative approaches to reduce use of restraints.

Rationale: By using innovative approaches, facilities may be able to further reduce use of restraints especially for special needs populations such as Alzheimer's.

2. Develop legislation to establish an evidenced-based "Best Practices" Workgroup under the auspices of the Health and Human Services Commission (HHSC) comprised of the Texas Department of Human Services (TDHS), the Texas Department of Health (TDH), the Texas Department of Mental Health and Mental Retardation (TDMHMR), the Texas Department of Protective and Regulatory Services (TDPRS), and the Texas Commission on Alcohol and Drug Abuse, recognized experts and consumers, to develop and recommend best practices in policy, training, safety, and risk management to manage behavior, focusing on verbal, behavioral, and physical interventions

including specific holds and techniques.

Rationale: This compromised approach sets a framework for the rule promulgation process, compels stakeholders to work out the details and directs agency implementation of Best Practices based on population served.

The workgroup should support uniformity in definitions, reporting and training. The recommendations should address specific populations and community versus institutional settings including hospital/nursing home restraining.

Rationale: Various agencies define terms differently by facility type. Family members and providers should be clear on common meanings.

Final recommendations should include a discussion on prevention via de-escalation techniques and minimum standards and be submitted to the Senate Committee on Health and Human Services.

Reporting and Data Analysis. The Best Practices Workgroup should address and make recommendations on a reporting system (including data collection and analysis) with consideration of federal reporting requirements where they exist.

Rationale: Reliable data is captured and analyzed more reliably over a multi-year period from which scientific and medically sound conclusions may be drawn. Long-term data collection is

necessary to provide a sound basis to improve state policy and medical decisions. While many agencies participate in a variety of reporting processes, a comprehensive, meaningful analysis of data collected is lacking.

Include documentation of deaths and serious injuries.

Rationale: The HHSC workgroup should define serious physical injury and insure reporting uniformity across state agencies and with Medicaid.

HHSC agencies should subsequently develop and adopt rules supporting Best Practices per population served.

HHSC shall report implementation to the Senate Committee on Health and Human Services and the 79th Legislature.

3. Develop legislation to prohibit holds that:

a. obstruct the person's airway, including procedures that place anything in, on, or over the individual's mouth or nose;

b. impairs breathing by putting pressure on the diaphragm or chest; or

c. interferes with the person's ability to communicate.

HHSC agencies shall adopt rules that identify and define acceptable holds that minimize the risk of harm to the client, patient or consumer.

Rationale: These specific procedures are suggested as those which most

directly increase risks of death by positional asphyxia. Advocacy, Inc. reports 14 restraint-related deaths have occurred in Texas since 1999; 4 since April, 2001.

The legislation should also require that consumers, legally-authorized representatives and families be made aware of agency rules and policies related to restraints and seclusion.

Rationale: Some incidents of abuse are unreported and inappropriate techniques are also unreported because consumers and families are unaware of existing rules. Currently, there are no mandates that require they be informed. Informed choice advances the public policy of this state.

4. **Direct the Advisory Committee on Inpatient Mental Health Services (ACIMHS), in collaboration with TDH, to develop a means to move toward consistent training in private psychiatric hospitals in support of TDMHMR current rules and report the results to the Senate Committee on Health and Human Services in January 2003.**

Rationale: This committee has been an effective forum for facilities, patient advocates and state agencies to share information and discuss issues related to inpatient mental health services. Private psychiatric hospitals (under TDH) are required to adhere to TDMHMR rules on restraints, however, these hospitals do not have training that supports consistent implementation of these rules. The TDMHMR training program, PMAB, is not available outside of that agency and

therefore creates difficulty in training and adherence to agency rules.

5. **Increase Direct Care Staff Wages. The Legislature should consider, when reviewing TDMHMR budget, identifying state funds to increase wages and benefits to MHMR Aides.**

Rationale: TDMHMR reports the starting salary for an MHMR Aide is $1322 per month or $15,864 annually. After six months, the salary is $17,532. TDMHMR reports a 99.4% annual turnover rate in MHMR Aides. Community Centers report similar positions pay 10-20% lower salaries. Stakeholders suggest, and research indicates, low salaries contribute to frequent staff turnover impacting correct and consistent implementation of appropriate behavioral intervention techniques, including restraints.

Acronyms

ALF	Assisted Living Facilities
CMS	Centers for Medicare and Medicaid Services
GAO	U.S. General Accounting Office
ICF-MR	Intermediate Care Facilities for the Mentally Retarded
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MR	Institutions serving the Mentally Retarded
PMAB	Prevention and Management of Aggressive Behavior
RTC	Residential Treatment Center
TCADA	Texas Commission on Alcohol and Drug Abuse
TDH	Texas Department of Health
TDHS	Texas Department of Human Services
TDMHMR	Texas Department of Mental Health and Mental Retardation
TDPRS	Texas Department of Protective and Regulatory Services

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