STAFF EVALUATION

Texas Department of Health

A Staff Report
to the
Sunset Advisory Commission

1984

TEXAS DEPARTMENT OF HEALTH

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SUMMARY

The Texas Department of Health operates many programs designed to provide services to restore health to those suffering from certain illnesses, to prevent the spread of diseases and to plan with other agencies on how to coordinate health service efforts to promote and protect the quality of life in Texas. The department also conducts many regulatory and consultation programs designed to protect the public health from hazards related to damaged or adulterated food products, waste disposal activities, the uses of radiation, unsanitary condition in public places, and unsafe working conditions.

Because of the size and diversity of the operation of the department, it was necessary to design the sunset review in a manner which focused staff efforts on selected areas of operation. These focusing efforts were guided by criteria which attempted to select programs that were primarily state funded; have had significant past, present or potential problems identified through review of legislative proposals of past sessions and discussions with agency staff and those knowledgeable of the agency's operations; or have specific 1985 sunset review dates. This focusing effort identified 11 separate programs for review. These programs include the Early Childhood Intervention Program, the Bureau of Dental Health, the Bureau of Crippled Children's Services, the Bureau of Communicable Diseases, the Bureau of Long Term Care, the Bureau of State Health Planning, the Bureau of Licensing and Certification, the Bureau of Radiation Control, the Food and Drug Division of the Bureau of Consumer Health Protection, the Bureau of Solid Waste Management and the Occupational Safety Division of the Bureau of Environmental Health. The review also examined the policy making structure of the department as well as its overall administration. In total, the funding of the aspects and programs reviewed represents 54 percent of the total state funding allocated to the department. The programs selected are also representative of the major service and regulatory methods used by the department to carry out its duties.

The need for each of the programs was analyzed and the review indicated that except in one instance, there is a continuing need for state involvement in these areas. In regard to the current operations, the review determined that while these programs are generally operated in an efficient and effective manner, there are changes which should be made in the event the legislature decides to continue these programs. In addition, an analysis of alternatives to the current operations of the agency indicates that one alternative exists where potential benefits

outweigh disadvantages. Six issues were identified which offered both a change in state policy as well as major advantages and disadvantages.

Approaches for Sunset Commission Consideration

I. MAINTAIN THE AGENCY WITH MODIFICATIONS

A. Policy-making Structure

1. The statute should be amended to specify when the governor designates the chair and vice-chair of the board.

The current statute specifies that the governor shall designate a chair and vice-chair biennially but does not specify a time frame for when the term will begin and end. To provide a structure for orderly transition, the terms should begin on September 1 of each odd-numbered year.

2. The Board of Health should be reduced from eighteen to nine members and the specific categories of membership modified.

The current structure requires that the 18 members of the board represent 10 separate occupations and the public. This is unlike the other major health related agencies, restricts the flexibility to act as a whole and is unnecessarily expensive. To address these concerns it appears appropriate to reduce the board from 18 to nine members, require that six members be appointed who have a proven record of interest in the field of public health and that the remaining three members represent the public.

3. The statutory status of the Board of Health advisory committees should be removed.

The agency utilizes many advisory committees to help carry out its diverse duties. Thirteen of the 23 committees examined are structured in statute. This structured system inhibits the use the board and agency may make of the committees and leads to delays in appointments as well as excludes from membership on the committees certain persons representative of pertinent concerns of the agency. Overall, it appears the board should determine how the committees should be structured and used rather than specifying such matters in statute.

4. **The Dental Advisory Committee of the Board of Health should be abolished and its broader advisory functions transferred to the newly established Health and Human Services Coordinating Council.**

The Dental Advisory Committee is designed to examine issues affecting the department's dental services as well as those delivered by other state agencies. The committee is required to funnel all its work through the Board of Health. This structure does not provide a proper forum for the committee's work regarding agencies other than the Health Department. The Health and Human Services Coordinating Council does have a broad mandate to examine health and human services delivered by all state agencies. It appears that this body should carry out the function of the Dental Advisory Committee itself or through the appointment of an advisory committee if it so chooses.

B. Overall Administration

Financial

1. **TDH should have clear authority to establish fees for all services and seek third-party reimbursements.**

The department has authority to charge fees for the public health services it delivers. Although this authority was recently enacted, the department has taken action in only one area (Title XX Family Planning) to begin the collection of fees for its services and the statute should be amended to allow TDH to charge fees for any of its services. Other health related agencies do charge fees for certain services based on the ability of the service recipient to pay. Based on the state's current budget constraints, it does appear that the department should begin charging fees for its services. Although department-wide service fees might prove impractical due to security problems, it does appear it should begin charging fees where feasible (such as laboratory services).

2. **The department should establish administrative policy guidelines concerning the reimbursement rates of clinic physicians. (management improvement - non-statutory)**

The current system used by the department to establish fee amounts paid to local physicians for its clinic services around the state varies between programs. The fees now vary from $18.50 to $150 per clinic.

In the area of consultant (non physician) fees the department has established a policy which establishes an upper limit and a specific method for variance from the policy. The development of a similar policy for physician fees which can vary depending on physician specialization would ensure consistent application of the fee determination process around the state.

3. **The department should establish reimbursement rates for pharmaceuticals that are consistent with other state health agencies. (management improvement - non-statutory)**

Three programs within the agency provide reimbursement for pharmaceuticals purchased by program participants. The rate of reimbursement is at the billed rate of the provider. The Department of Human Resources uses a different process which excludes the profit margin (about 5 percent) built into the billed rate. It appears that using the DHR process could save some $69,000 per year in two of the TDH programs and should be implemented at the Health Department.

4. **The method used for allocation of block grant funding to programs should be reviewed and formally adopted by the Board of Health and require board approval prior to allocation. (management improvement - non-statutory)**

The department currently receives $22 million in federal block grant funds which are distributed between 11 programs. In 1983, the 68th legislature enacted statutory provisions to establish a structure for administration of these funds in a manner that is responsive to public input. The department does hold public hearings regarding the block grant fund use but does not obtain input from the Board of Health prior to the allocation of dollars to its programs. The Department of Human Resources (which receives $221 million in block grant funds) does obtain board approval prior to the distribution of the funds to its various programs. This kind of policy level participation appears appropriate and should be in place at TDH.

Organizational Structure

5. **The Department's Legal Division should serve as a central point for the management of complaints. (management improvement - non-statutory)**

The handling of complaints by the agency is primarily the duty of each separate program. Given the complexity and size of the Department of Health, this type of complaint process gives little assurance to the public that complaints will be properly referred. The decentralized process used by the agency also makes it difficult for agency management to easily judge whether complaints are being handled appropriately by agency divisions. The department's Legal Division should assist in a review and improvement of complaint systems in use by the programs and serve as a central receiving and distribution point for complaints regarding the agency's activities.

6. **TDH should adopt formal policies concerning the lines of authority involving the Associateship for Community and Rural Health and its relationship to the other divisions. (management improvement - non-statutory)**

The department carries out a large number of its services through regional offices and sub-offices around the state. In Austin, program policy and technical information is developed by central office staff which applies to the operations of the service or regulatory activities carried out by field staff. The communication between the central office personnel and the regional field personnel is funneled through the Associate Commissioner for Community and Rural Health. The routing of information and approval of certain personnel actions (e.g., merit raises) go through an elaborate chain of command involving several steps and persons. The department has not formally adopted policies and procedures concerning how this process is to occur. Due to the size of the department, the diversity of its services and the decentralized nature of its regional operations, the lack of written policies regarding such matters can cause confusion. To document the process so it can be understood and followed by those involved, the lines of authority and communication routing process should be developed as agency procedures and placed in the agency's Administrative Policy Manual.

Internal Control

7. **The Board of Health should develop a policy for the internal audit function. (management improvement - non-statutory)**

The Internal Audit function at the TDH is dependent on funding from the programs it audits. This process tends to restrict the efforts of the audit program and leaves unreviewed small programs or programs that can defend their program dollars. Further, the Board of Health is not included in the information loop concerning the findings of the audits or in discussions concerning the general direction and scope the internal audit function should take. To maximize the use of the internal audit the members of the Board of Health should discuss the issues concerning the funding of the audit process and its scope and usefulness to the agency. These discussions should result in a clear policy regarding the audit's function and structure in the agency.

8. **The Internal Audit Division should monitor the implementation of the management improvement recommendations adopted by the Sunset Advisory Commission. (management improvement - non-statutory)**

In all, the Sunset review of the TDH has produced some 16 management improvement recommendations. Many of them will require monitoring and oversight for a period of time to ensure that there is continuity in the procedural changes and that there is coordinated implementation of changes spanning several divisions of the agency. The Internal Audit Division can and should perform this function.

C. Evaluation of Programs

1. Early Childhood Intervention Program

a. **The Early Childhood Intervention Program statute should be amended to clarify program operations and authorize current practices.**

The ECI program was established in 1981 to better coordinate services to children (ages 0-3) who demonstrate developmental delays. The council made up of representatives of the TDH, MHMR, TEA, DHR as well as a public member involves the activities of four agencies and governs the allocation of $8 million per year to fund programs providing ECI services in 60 communities across Texas. Since the council's establishment, certain difficulties have been encountered in statutory provisions

governing funding allocations, grant submissions, contracting, and program standards. The council appears to have worked out alternative methods of operation in these areas and the statute should be modified to authorize these methods.

2. **Bureau of Dental Health**

   a. **Statutory authority should be enacted for the current programs of dental health provided by the department.**

The dental health programs performs three distinct functions: 1) dental treatment; 2) dental education; and 3) floridation grants to certain communities. None of the functions is statutorily authorized. A basic statutory framework for these functions and services should be developed.

3. **Bureau of Crippled Children's Services**

Crippled Children's Services Program

   a. **The Crippled Children's Services program should clarify the eligibility determination procedures used. (management improvement - non-statutory)**

The CCS program considers five criteria in determining client eligibility for the program. Two of the criteria, financial need and the potential for improvement through treatment are not easy to determine, but are critical in the eligibility determination process. The program has not developed specific rules concerning how these criteria are reviewed and client file documentation on the determinations is not complete. Lastly, the notification to the applying family does not include an explanation of how the determination for eligibility was reached. A similar effort conducted by the Texas Rehabilitation Commission provides a good model to follow to address the above concerns and should be used to improve the eligibility determination process at the TDH program for Crippled Children.

   b. **The Crippled Children's Services statutory provisions regarding medical eligibility should be amended to allow the Board of Health to increase services.**

The Crippled Children's Services program is primarily designed to assist children of low income families who have certain crippling diseases. Since the program's establishment in 1933 certain

diseases have been added to enlarge the list of coverable conditions to seven. The coverable conditions are laid out in statute. The program does not have authority to add coverable conditions in contrast to two other TDH programs treating communicable and venereal diseases. The evolution of the CCS program indicates that it designed to cover children in extreme need due to effects of severe chronic illness but the lack of flexibility in the program prevents it from serving certain conditions. It appears appropriate to provide a more flexible process to allow the program to treat additional conditions or diseases. The statute should be amended to allow the Board of Health to add a condition or disease if the legislature specifically appropriates dollars for the treatment.

Hemophilia Assistance Program

c. The Hemophilia Assistance Program's enabling statute should be amended to clarify "payee of last resort" provisions.

The intent of the Hemophilia Assistance Program (HAP) is to provide payment to eligible persons for pharmaceuticals only after the patient's other medical benefits have been used. However, the statute governing the program is not clear regarding what must be considered in making sure the HAP is the payee of last resort. The Crippled Children's statute provides a good model for such language and should be used to amend the HAP statute in this regard.

d. The Hemophilia Assistance Program should adopt financial eligibility guidelines through the Texas Register process. (management improvement - non-statutory)

The HAP is designed to serve only those persons in financial need. The regulations regarding financial eligibility are not clearly defined and the program serves 24 persons, 12 of which are employed. The program expects to double the population served in the next year and directing its resources to those most in need will become increasingly important. To improve the determination process, more specific guidelines patterned after the Rehabilitation Commission's regulation should be adopted as rules of the program.

Children's Outreach Heart Program

e. Statutory authority should be developed for the operation of the Children's Outreach Heart Program.

The Children's Outreach Heart program is operated by the Children's Heart Institute of South Texas (CHIST). One hundred forty-seven thousand dollars of the Institute's $415,000 budget is provided through an appropriation to the TDH. There is no statute which governs TDH's participation or provides authority for the current structure. In keeping with attorney general rulings, the current structure needs statutory guidance. It appears appropriate to allow the program to operate statewide and such authority should be established in statute.

f. The department should adopt rules for the operation of the Children's Outreach Heart Program. (management improvement - non-statutory)

The TDH contracts biennially with the CHIST to provide screening and evaluation services related to congenital heart disease. The department has not developed rules governing the contract process as it has for a similar program serving persons with epilepsy. To comply with the Administrative Procedure Act and to provide guidelines covering the type of clients to be served and other aspects of TDH's participation in the outreach program, rules should be adopted for the program.

SSI - Disabled Children's Program

g. The SSI - Disabled Children's program should renegotiate and reinstitute MOUs with the related state agencies. (management improvement - non-statutory)

The SSI - Disabled Children's Program provides casework services involving individualized assessments of eligible (SSI) children's needs and the availability of treatment services in the community. Program staff combine their efforts of counseling and casework with services available through TDMHMR, DHR, TEA and others to assist the child and family in meeting their needs. Prior to the transition to federal block grant funding (in 1981), involved agencies were required to develop Memoranda of Understanding to govern the interrelationships between the many

agencies. Without the MOUs, a great deal of the policy decisions needed to operate the program must be made by regional staff. The type of decisions that must be made (e.g. interagency transfer of confidential information) indicate that they need guidance from administrators that have a statewide perspective. This kind of perspective can be gained through the redevelopment of the MOUs previously required under federal categorical funding. The MOUs should be reinstituted to provide a formal mechanism for negotiation between the various agencies regarding how the program should operate.

4. **Bureau of Communicable Disease Control**

Venereal Disease Control Program

a. **The Texas Venereal Disease Act should be amended regarding the application of certain medication in the eyes of newborns.**

Several state laws govern the administration of certain prescription drugs. The Venereal Disease Act requires the application of silver nitrate or other similar solution in the eyes of newborns to avoid opthalmia neoratorum. This is a beneficial requirement but the current statute allows the person in attendance at childbirth to apply the solution even though other laws restrict the distribution and use of such a solution to physicians, or nurses and midwifes with standing delegation orders. To bring the Venereal Disease Act in line with other governing statutes (e.g. Medical Practice Act) it should be amended to specify that only the above authorized personnel can receive and use the drug.

5. **Bureau of Long-Term Care**

a. **The statute regarding the regulation of nursing homes should be amended to provide a funding source for trustee appointments.**

Current statutes governing nursing homes allow for the appointment of a trustee to oversee the operation of a nursing home under conditions which "present an immediate threat to health and safety of the patients." The department reports that in the past and possibly in the future, funding to allow the trustee to operate has and will be difficult to find. It appears appropriate to

establish a "loan fund" controlled by the department that can be quickly accessed in situations where a trustee is needed but no funds are available to operate the home.

b. Hearing and appeal provisions of the nursing home licensing statutes should be amended to conform to the Administrative Procedure Act.

The nursing home regulatory statutes date back to 1953. Current provisions relating to hearings on license revocation cases and the appeal of those decisions are not current. To remedy this, the hearing procedures should be amended to comply with the Administrative Procedure Act and the current "de novo" requirement for appeal considerations should be changed to "substantial evidence."

c. The Department of Health should be authorized to assess administrative penalties in its regulation of nursing homes.

The use of administrative penalties is important in situations where quick regulatory action is needed to protect the environment or human life. Although the department has many enforcement tools to use in the regulation of nursing homes, the attorney general has indicated that administrative penalties would be a useful addition. Further, modifications in DHR's vendor hold process do not appear to be having the desired effect as 17 facilities have already reached contract cancellation status since new rules were instituted in November 1983. Allowing the TDH, the regulatory agency in the state for nursing homes, to impose administrative penalties would provide a useful addition to its regulatory tools.

d. The statute should be amended to allow the Board of Health to determine which Life Safety Code should be used in the regulation of nursing homes.

The Life Safety Code provides guidance in the construction of public buildings to help ensure that persons can safely leave such buildings when a fire emergency exists. The code is frequently updated by the National Fire Protection Association and the department now must follow by statute at least three separate codes and a new code is expected in November 1984. The hospital

regulatory effort uses the code but the governing statute does not specify that a particular dated code be used. This appears to be a more reasonable approach. To provide public and industry input into how the appropriate code is selected, the statute should require the decision to be made through the rulemaking process of the Board of Health.

e. The Nursing Home regulatory statutes should be amended to require the department to collect fees in relation to the costs of the regulatory program.

The current statutes require the collection of a licensing fee to help offset the cost of the licensure of nursing homes. The current fee level will offset about 25 percent if the cost of the current licensure effort. The current structure varies the fees depending on the size of the facility. Although this approach provides a rough approximation to how much it costs to carry out licensure aspects of various sized homes it does not provide for the collection of fees for the department's construction plan review and approval function. As a general rule, fees collected in regulatory efforts should offset 25 to 50 percent of the cost of the program and should be reasonably related to the cost of the agency's various activities. To comply with this approach the fee structure should not be specified in statute but the department should be required to develop a fee structure in keeping with above general concepts through its rulemaking processes.

6. <u>Bureau of State Health Planning and Resource Development</u>

a. The statute should be amended to clarify the duties of the SHCC.

The Statewide Health Coordinating Council (SHCC) is a federally required policy body designed to provide guidance to the SHPDA in the development of the State Health Plan. Sate statutes make passing reference to the SHCC and provide no indication of its function within Texas government. To rectify this situation the statutes relating to health planning should be amended to specify the functions of the SHCC.

b. The statute should be amended to clarify the State Health Plan's purpose.

Current statutes regarding the health planning do not indicate what the purpose of the state health plan is. Texas has taken the approach of using the health planning process to address global issues as well as specific data needs of the Health Facilities Commission in its certificate of need review. This approach has been criticized as ultimately unworkable and in need of reassessment. To provide a framework for the reassessment process, statutory language should be developed outlining the purpose of the plan. This language should emphasize the need for the plan to examine both global and specific goals and to be developed in close coordination with interested local, regional and state entities.

c. Statutes should be amended to require affected agencies to address funding aspects of the State Health Plan.

The current proposed State Health Plan addresses several issues which will require funding. Although affected agencies are consulted during the plan development stage they are not required to comment on the plan and its funding requirements to the SHPDA or the Governor's or Legislative Budget Offices. It appears appropriate for agencies affected by the plan to comment on its recommendations, whether or not the agency is requesting funding in keeping with the plan and a justification of deviation from the planning recommendations. This information should be submitted to budget offices by November 1 of even numbered years to coincide with the biennial legislative cycle.

d. The statute should be amended to require the adoption of the Approved State Health Plan by November 1, of even-numbered years.

Current statutes do not specify when the State Health Plan should be developed. The recent plans have been approved by the Governor in May 1982 and the current plan is scheduled for approval in November 1984. Since the plan contains recommendations for both statutory and budgetary action, its development should be timed to be worked into pre-legislation session

activities regarding budget and revenue estimates. The timing of the current plan appears to be appropriate for such considerations.

e. **The statute should be amended to provide for improved coordination between TDH and the Texas Health Facilities Commission.**

The federal law requiring health planning contemplates that health planning should occur to ensure that health facilities and resources are developed in an orderly and economical fashion. The certificate of need (CON) process is designed to help this occur. As mentioned earlier, Texas uses the health planning process to address global or strategic goals and to provide specific data of use to the CON process carried out by the health Facilities Commission. A continuing debate has developed between the SHPDA and the THFC concerning the degree of specificity in the plan and that is not sufficient for the CON process. To help settle this debate the two agencies should update their memoranda of understanding (last done in 1978) and the statute should specify that one of the duties of the SHPDA is to collect and disseminate data necessary to support state health plan goals which can be implemented through the certificate of need process.

7. **Bureau of Licensing and Certification**

Pharmacy Division

a. **Local Health Departments should comply with the Pharmacy Act using their own staff resources. (management improvement - non-statutory)**

The pharmacy services of 64 of 72 Local Health Departments are supervised by two TDH pharmacists located in Austin. This appears to unnecessarily stretch the already thin resources of the TDH. Local Health Departments routinely obtain physician and nursing services to carry out their duties and it appears appropriate that they develop resources to supervise and monitor the activities of their pharmacies.

b. The department should increase its licensed pharmacist staff in the Pharmacy Division to comply with the Texas Pharmacy Act. (management improvement - non-statutory)

As mentioned above, the TDH has two pharmacists to supervise pharmacy activities in its 84 licensed "Class D" pharmacies. Rules of the pharmacy board issued in July 1984 now require the pharmacists to supervise another 240 temporary clinic pharmacy locations. These requirements stretch beyond reasonableness the abilities of the two pharmacists in Austin to supervise the activities occurring in so many different areas of the state. The agency indicates that by adding seven additional pharmacists it could comply with the Pharmacy law and regulations. This appears to be an appropriate area for increased funding.

8. **Bureau of Radiation Control**

a. The Radiation Control Act should be modified to allow the health department to impose administrative penalties.

The Bureau of Radiation Control regulates certain uses of radiation in the state. The regulation is aimed at preventing the severe consequences that can occur to workers, the public and the environment if radiation sources are mismanaged. The bureau carries out an active inspection and enforcement program designed to prevent such mismanagement but its program lacks one enforcement tool that appears to be useful in similar regulatory efforts. This tool is the "administrative penalty" and has been successfully used by state and federal agencies to prevent or stop dangerous practices like those regulated by the bureau. The bureau's and department's radiation regulatory program should be modified to include this tool.

b. The Radiation Control Act should be amended to clarify the definition of its registration provisions.

The Radiation Control Act provides for a multi-faceted approach to regulating the various uses of radiation in the state. "Registration" is used to regulate the use and servicing of radiation machines - those machines, like x-ray, that emit radiation only when turned on. The definition of "registration" in the Act, however, includes references to the use, handling, etc. of radio-

active materials. The bureau regulates these activities through "licensing". The statute (originally enacted in 1961) should be amended to conform to the registration approach now used by the bureau.

c. Requirements of the Radiation Control Act relating to the granting of registrations and licenses should be modified.

The Act currently requires that an opportunity for a hearing concerning the granting of registrations and licenses be afforded by the bureau. Although it appears appropriate to provide notice of the granting of a license to process uranium or the disposal or processing of radioactive waste, it appears inappropriate and costly to provide notice of the several hundred other licensing and registration actions the bureau takes each year. The bureau should develop rules on what types of license or registration granting actions should be afforded an opportunity for hearing and the statute should be amended to remove the granting requirement and add the rulemaking provisions.

d. Memoranda of understanding developed by the Bureau of Radiation Control with other state agencies should be processed through the APA rulemaking procedure.

The bureau has developed an MOU with the Department of Water Resources concerning in-situ uranium mining. This memoranda was adopted as a rule in compliance with the Administrative Procedure Act. To ensure future MOUs and modifications to the current MOU receive this treatment, the statute should be modified to require such action.

e. The Bureau of Radiation Control should consider "size of operation" of its regulatees as it refines its fee schedule structure. (management improvement - non-statutory)

The bureau recently completed development of a fee structure designed to support a portion of the costs of running the program. A criticism of the fee schedule is that

it does not take into account the "size of operation" or the number of radioactive sources a licensee may have. It is argued that the flat fee applied to these licensees does not take into account the varying amount of time needed to inspect a licensee with one source versus the amount of time needed to inspect a licensee with many sources. This criticism appears valid and as the bureau continues to refine its fee structure, this "size of operation" concept should be included in its fee recalculations.

9. **Bureau of Consumer Health Protection**

Division of Food and Drug

a. The Food and Drug Act should be clarified to allow the commissioner of health to issue emergency rules or an emergency order to stop violations of the Act.

In responding to the EDB situation, the commissioner has noted that the Food and Drug Act is unclear in granting authority to the commissioner to issue rules to stop such actions as selling food products containing EDB. To clarify his authority to act quickly, the act should be amended to allow the issuance of emergency rules by the commissioner and the issuance of an emergency order by the commissioner or his designee.

b. The penalty for violation of the Food and Drug Act should be increased to a Class A misdemeanor.

Acts of the 67th and 68th Legislatures established the penalty for failing to register as a wholesale distributor of drugs or a food manufacturer as a Class A misdemeanor. The penalty for violating provisions of the Food and Drug Act has been left unchanged at a Class C misdemeanor (Class B upon second conviction). It appears that the penalty provisions of the Act should be brought into uniformity and establish a violation of the Act as a Class A misdemeanor.

c. Fees collected by the Food and Drug Division should be increased to offset a greater portion of its operating costs.

For three of its four registration and enforcement activities, the division is authorized to charge fees. In fiscal year 1984, it appears these fees will support about 16 percent of the division's

effort to regulate certain food, drug, salvage, and methadone treatment operations. As a general rule, regulatory program's should support 25 to 50 percent of their state operational costs through fees. The statute should be modified to require the division to establish a fee schedule, through rulemaking, which will better meet this standard.

d. The Food and Drug Act should be amended to allow the health department to assess administrative penalties.

The Food and Drug Division carries out an active inspection and enforcement program designed to protect consumers from unfit food and drugs. The program lacks one enforcement tool that appear to be useful in regulatory areas where substantial harm can occur if regulated persons are not in compliance with laws and regulations. This tool, known as an "administrative penalty" provides a timely and effective deterrent to dangerous practices in industries that can substantially harm workers, the public and the environment. Since the Food and Drug Division carries out a regulatory program designed to protect the consuming public, it appears that addition of the administrative penalty to its range of enforcement actions is appropriate.

10. <u>Bureau of Solid Waste Management</u>

a. The Solid Waste Disposal Act should be amended to authorize the Department of Health to assess administrative penalties.

The Bureau of Solid Waste regulates the management of municipal solid waste (hazardous and non-hazardous) in the state. The regulation is aimed at preventing the severe consequences that can occur to the public and the environment if wastes are not properly managed and disposed of. The bureau carries out an active inspection and enforcement program designed to prevent such problems, but its program lacks one enforcement tool that appears to be useful in similar regulatory efforts. This tool is the "administrative penalty" and has been successfully used by state and federal agencies to prevent or stop dangerous practices like

those regulated by the bureau. The bureau's and department's solid waste regulatory program should be modified to include this tool.

b. The Department of Health should be required to collect fees to offset the state cost of regulating municipal solid waste management activities in the state.

The bureau's budget for fiscal year 1984 is approximately $2.8 million (about 55 percent state dollars) but the bureau is authorized to collect only one fee which will bring in about $11,000 for the year. As a general rule, regulatory programs should support at least 25 to 50 percent of their state operational costs through fees. The statute should be amended to require the bureau to establish a fee schedule, through rulemaking which will better meet this standard.

c. Memoranda of Understanding developed by the Bureau of Solid Waste Management with other state agencies should be processed through the APA rulemaking procedure.

The bureau has developed several MOUs with state agencies addressing various areas of potential overlapping jurisdiction. The Bureau of Radiation Control has also developed an MOU with the Department of Water Resources and adopted that MOU through the rulemaking procedures of the Administrative Procedure Act. The MOUs adopted by the Bureau of Solid Waste Management have not been adopted as rules. Since the MOUs do appear to meet the definition of "rule" as found in the APA, the Solid Waste Disposal Act should be amended to require future MOUs and revisions to the current MOUs be adopted as rules under the Administrative Procedure Act.

11. Bureau of Environmental Health

Occupational Safety Board and Division of Occupational Safety

a. The Occupational Safety Board should be abolished.

The Occupational Safety Board was originally created in 1967 as a board to regulate certain work places to ensure the safety of the workers. In 1975, the legislature removed the state funding for this function and the board no longer performs any traditional

regulatory functions. The development of regulations for other divisions is handled by the Board of Health. Further, the independent structure of the board and its oversight of the activities of the Division of Occupational Safety (a program staffed by employees of the Health Department) appears unneeded in comparison to other programs of the department. The function the board performs in selecting the division director of occupational safety can appropriately be handled by the commissioner of health or by someone delegated this function. For these reasons, it appears the Occupational Safety Board should be abolished.

b. An advisory committee for the Division of Occupational Safety should be established.

The non-regulatory functions now performed by the Board of Occupational Safety are more like those of the many advisory committees used by the Department of Health. It does appear that the division of occupational safety could benefit from the advice and counsel of an advisory committee appointed by the Board of Health made up of representatives of the general public, employers and employees, professional safety engineers and state agencies related to the work of the division.

c. The statute governing the Division of Occupational Safety should be amended to include only those activities currently carried out by the division.

The statute governing the activities of the Division of Occupational Safety was enacted in 1967. Since 1975, the division has had federal funding to carry out "consultative services" relating to occupational safety but the regulatory functions contemplated by the statute have been left unfunded by the legislature. It appears that the current functions of the division are those sanctioned by the legislature and the statute governing the division should be modified to authorize only the consultative services now carried out by the division.

D. Open Meetings/Open Records

1. Board of Health committee meetings should be "posted" and "open" in compliance with the Open Meetings Act.

The Board of Health currently has nine committees. Each carries out a specific function designed to expedite the work of the board. The meetings of these committees are not posted in accordance with the Open Meetings Act. Although the Act itself does require such posting, two Attorney General opinions indicate such meetings should be open.

2. The Hospital Licensing Act should be amended to remove language which closes hospital licensing information.

The Hospital Licensing Act, enacted in 1959, closes certain types of information to the public which is readily available in other sections of the department. This restriction appears unnecessary and should be removed.

E. Public Participation

1. The Public Health Promotion Division should assist in a one time assessment of agency program's public literature development and be assigned an oversight function concerning program public information on a continuing basis. (management improvement - non-statutory)

The department currently has a division which assists programs in the development of information of interest and use to the public. Of the programs reviewed some had public information regarding their activities and others did not. In keeping with the general sunset criteria, it appears each program should develop information concerning the program's function and services for dissemination to the intended users of the services. To ensure the effort is complete, the Public Health Promotion Division should assist in a one time assessment and be assigned an oversight function regarding public information developed by the programs.

2. The department's Office of General Counsel should establish a centralized, coordinative system to ensure that program rules are adopted in compliance with state statutes. (management improvement - non-statutory)

The adoption of rules to govern the operation of agency programs is important. Currently, the duty to determine when and how rules are developed rests with the individual programs. While the regulatory programs of the department have developed rules,

several of the service programs have not. It appears the department's legal office should develop a coordinative system to ensure that all program develop rules as required by the Administrative Procedure Act.

II. ALTERNATIVES

1. The Health and Human Services Coordinating Council could be designated as the State Health Planning and Development Agency.

The development of the State Health Plan is now carried out by the Health Department as the State Health Planning and Development Agency (SHPDA). Considerable criticism has been leveled at the SHPDA concerning its operations in the past. The criticisms are generally aimed at: 1) the State Health Plan itself; and 2) the unusual structure within which the SHPDA must operate. The department or SHPDA has taken steps to improve the plan, but certain problems associated with the structure can only be solved by a major reorganization. The staff of the SHPDA have two policy bodies to answer to; the Board of Health and the SHCC. The work product of the SHPDA, the State Health Plan must address issues affecting many state agencies, not just the TDH. The SHCC itself is not made up of key policy makers who can take the work of the SHPDA and the goals of the State Health Plan and get them implemented through legislative and budgetary action. Finally, the 68th Legislature created the Health and Human Service Coordinating Council (HHSCC) chaired by the Governor and designed to serve as the "primary state resource in coordinating and planning for health and human services." To address the concerns identified in the review it appears the HHSCC could serve as the SHPDA. Although such a transfer would need to be carefully planned and handled, it appears that the council can provide an appropriate structure as well as appropriate guidance in the development and implementation of an effective health planning process.

III. OTHER POLICY CONSIDERATIONS

1. Should the department's dental service program be restricted to dental treatment services only?

The TDH dental treatment program assists about 20,000 children per year. Estimates indicate that over 250,000 low income children have need of such service, but have no available resource for emergency treatment. The department now spends $1.4 million on treatment and $600,000 on education. It can be argued that due to the large number of children in need, the education dollars would be better spent on treatment. The argument against such a change is that education has been a part of the TDH dental program since 1936. Further, minimal efforts to educate children to take care of their teeth will prevent the need for later treatment efforts.

2. Should the age restriction be removed from the department's Dental Treatment Services programs?

Programs operated by the TDH and the DHR provide treatment services to nearly 100,000 children every year. However, children are not the only population at risk. Dental disease is found at a higher rate in adults and is more serious when found in some adult age groups than in children. Testimony delivered to the Task Force on Indigent Health Care indicated that only extremely limited dental services are available to persons over 18 regardless of income, circumstance or disability level. One alternative to increase services to the adult population is to remove the age restriction now on the TDH dental treatment program. Arguments against this relate to the necessary reduction in service to those under 18 unless funding was increased. Extending the current dental treatment program to the 400,000 adults eligible for Medicaid in 1984 would increase the cost of the program $6 million assuming a 20 percent utilization rate experienced in other states.

3. **Should the Texas Department of Health be given the authority to impose sanctions on persons who fail to provide data determined to be necessary for effective health planning and resource development?**

The proponents of authorizing TDH to utilize sanctions in the collection of health-care data argue that it is essential to the health planning process. As issues become more controversial, dependence on a totally voluntary system will mean the virtual absence of data in a number of critical areas, for example, information on the costs of obtaining health-care services in Texas. With the ability to enforce their authority in the area of data collection, TDH could receive information in a timely manner and would no longer have to limit their surveys to "non-controversial" issues in order to be able to maintain a good response rate. If sensitive data is received, it could be closed to the public to protect those submitting the data. The opponents of this idea argue that sanctions would be detrimental to the "spirit of cooperation" which currently exists between TDH and health-care providers. Further, it is difficult to determine the "public harm" that occurs if health care data is not submitted to the TDH in a timely and complete fashion. Sanctions are generally applied only when such harm can be demonstrated.

4. **Should the portion of the state's hazardous waste program currently under the jurisdiction of the Department of Health be transferred to the Department of Water Resources?**

The Health Department has jurisdiction over municipal hazardous waste, and TDWR has jurisdiction over the much larger category of industrial hazardous waste. If responsibility over all hazardous waste were consolidated in TDWR, confusion among the general public and the regulated industry over the specific division of authority would be eliminated, and administrative costs could possibly be reduced. An opposing view would be that the program split is now defined and understood adequately, and that consolidation would merely cause new confusion in other areas.

5. **Should the Food and Drug Act be amended to allow the attorney general to seek an injunction to restrain persons from violating provisions of the Act?**

Allowing the attorney general to seek injunctions independent of the agency might provide for a quicker response to future EDB type situations. An opposing view is that allowing the attorney general to take independent action is a significant departure from other statutes that allow him to take action only upon request of the regulatory agency. It can be argued that the TDH is the one entity with staff with sufficient medical and health backgrounds to make the initial decision to take enforcement action concerning areas under its jurisdiction.

6. **Should the statutory requirement that the Commissioner of Health be a licensed physician be removed?**

The position of the Commissioner of Health, which has existed under various titles since 1879, has always been filled by a physician licensed to practice medicine in Texas. Proponents of maintaining this requirement indicate that the mission of the TDH is to promote and protect the health of the people of Texas and in serving such a mission, a high level of medical knowledge is required. Further, the commissioner must interact with a wide variety of physicians heading up local health departments as well as members of the department's own staff. It is argued that the chief administrator needs to be able to deal with medical program personnel on a equal professional footing. Opponents of maintaining the requirement argue that it unduly restricts the ability of the Board of Health in its selecting a commissioner. Further, the responsibilities of the commissioner have changed over the years requiring skills not necessarily gained through medical training to manage a complex organizational structure with a staff of 4,775. It is also pointed out that ample medical advice is available within the agency and that the chief administrators of the DHR and TRC are not required to be physicians even though these agencies are involved in the administration of major medical programs.

AGENCY EVALUATION

The review of the current operations of an agency is based on several criteria contained in the Sunset Act. The analysis made under these criteria is intended to give answers to the following basic questions:

1. Does the policy-making structure of the agency fairly reflect the interests served by the agency?
2. Does the agency operate efficiently?
3. Has the agency been effective in meeting its statutory requirements?
4. Do the agency's programs overlap or duplicate programs of other agencies to a degree that presents serious problems?
5. Is the agency carrying out only those programs authorized by the legislature?
6. If the agency is abolished, could the state reasonably expect federal intervention or a substantial loss of federal funds?

BACKGROUND

Organization and Objectives

The Texas Department of Health is the public health service and planning agency for the state. In that role the department administers programs designed to prevent disease or illness, restore or improve the health of persons with certain conditions and to plan with other agencies and organizations to promote and protect the quality of life in Texas. Organizationally, the department can be divided into one overall administration program (Support Services) and five major service programs: Community and Rural Health Services, Personal Health Services, Preventable Diseases, Special Health Services, and Environmental and Consumer Health Protection. As depicted in the agency's organizational chart (Exhibit 1), each of the major programs is headed up by an "associate commissioner." A brief description of each of the associateships follows.

The Associateship for Community and Rural Health helps coordinate the activities of the many different service and regulatory functions carried out by the department in all areas of the state. The department utilizes a regional structure to carry out its duties and has established 10 regional offices and 12 regional areas to provide localized management of of its regulatory and service functions. In fiscal year 1984, 3,113 (65 percent) of the department's 4775 employees were stationed in regional areas. The 12 regions and 10 regional offices are identified in Exhibit 2. In general, the programs at central office provide for the policy and technical guidance for the work done in the regions. The associate commissioner for Community and Rural Health coordinates the distribution of policies and technical guidance to the regions where the services are delivered or the regulation functions carried out.

Other duties of the associateship include the management and coordination of services delivered by state-participating local health departments, the provision of educational and career development consultations to public health nurses throughout the state and the state level management focus for the two hospitals operated by the department. In 1984, the total associateship employed 1131 persons and budgeted $31,801,057 to carry out its activities.

The associateship for Personal Health Services provides diagnostic and restorative health services to persons with disabling health problems. A wide variety of problems are screened, diagnosed and treated in this program and the

Exhibit 1

Texas Department of Health

Organizational Chart
JUNE 1984

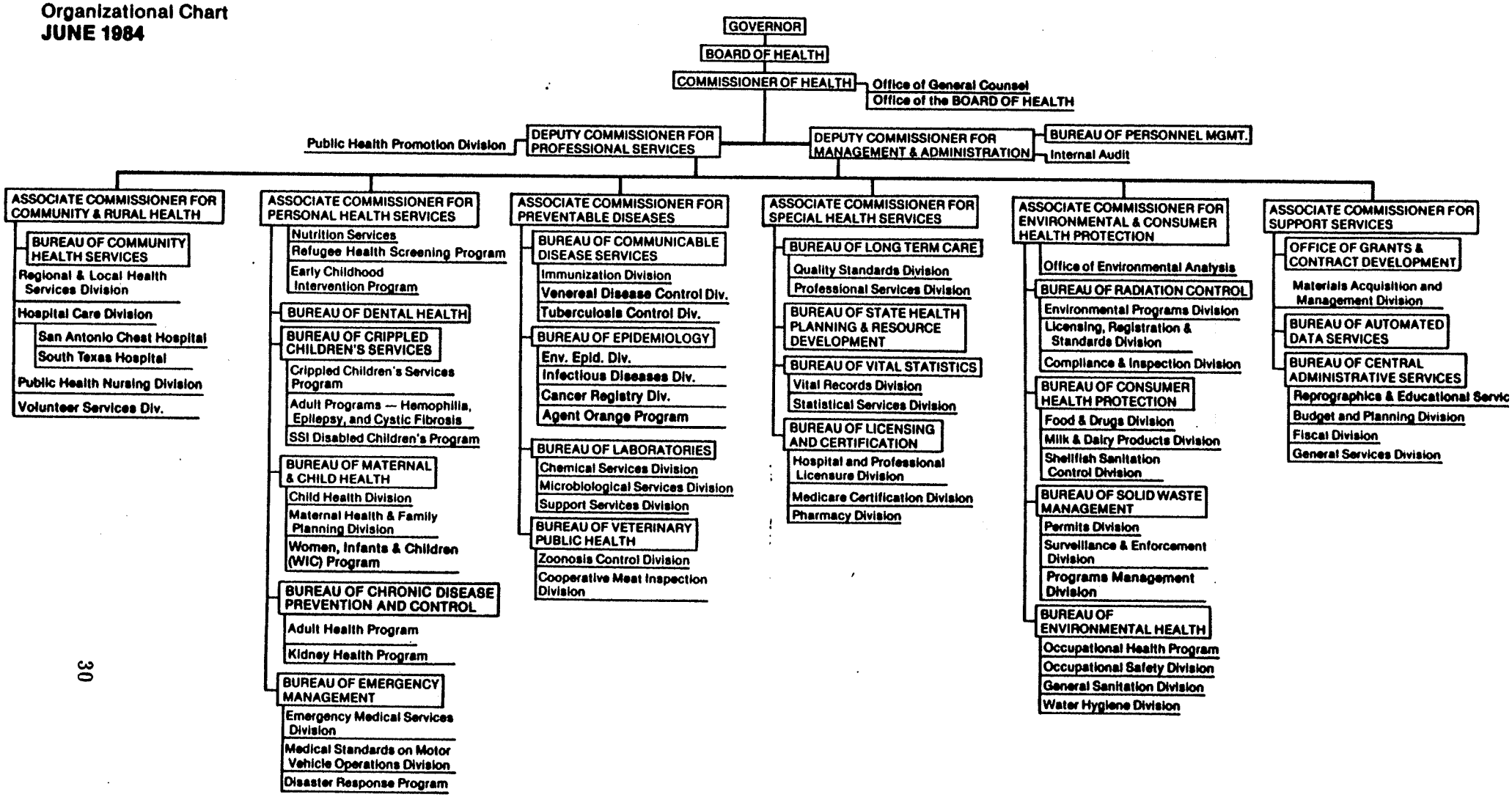
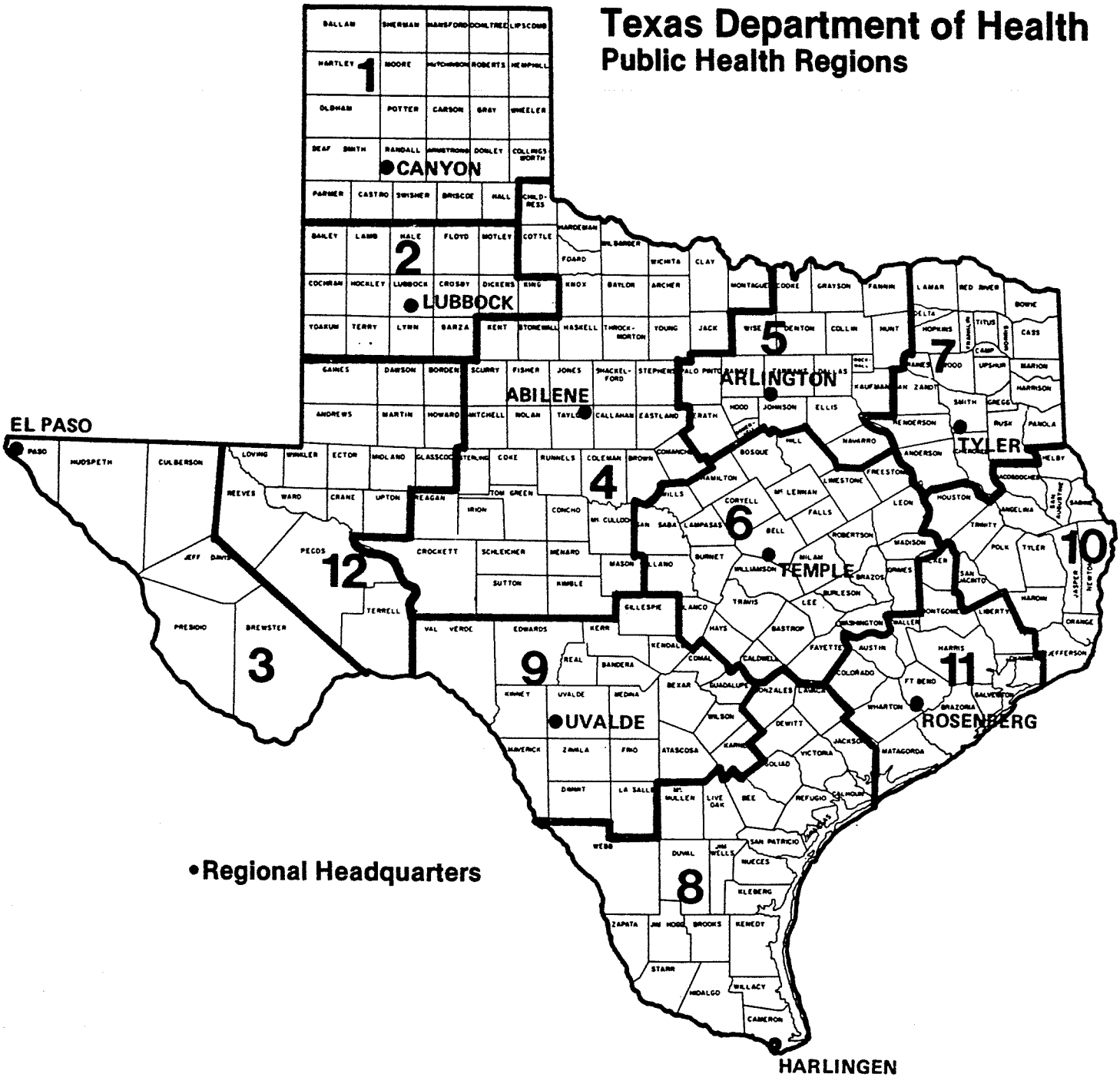


Exhibit 2


Texas Department of Health
Public Health Regions
1
2
3
4
5
6
7
8
9
10
11
12
CANYON
LUBBOCK
ABILENE
ARLINGTON
TYLER
TEMPLE
UVALDE
ROSENBERG
HARLINGEN
EL PASO
•Regional Headquarters

department estimates that over 6,000,000 persons received its services in fiscal year 1984. Major programs of the Associateship include Maternal and Child Health, Crippled Children's, Women Infants and Children (WIC), Kidney Health Care, Early Childhood Intervention, Family Planning, Dental Health, and Emergency Management (EMS). In 1984, the total associateship employed 831 persons and budgeted $152,083,717 to carry out its activities.

The Associateship for Preventable Diseases provides services designed to prevent or reduce the incidence of illness in the state. The major portions of the program include the following activities: immunization services, venereal disease control, tuberculosis services, epidemeological surveillance, laboratory services and veterinary health services (designed to prevent the transmission of diseases from animals to man). In 1984, the associateship employed 1,095 persons and budgeted $31,345,431 to carry out its activities.

The Associateship for Special Health Services operates programs designed to regulate certain health care providers and facilities, (e.g. hospitals and nursing homes) to collect and maintain vital statistics on persons residing in Texas, and to perform state health planning functions. In 1984, the associateship employed 790 persons and budgeted $21,765,166 to carry out its activities.

The Associateship for Environmental and Consumer Health Protection operates programs to provide for the protection of the public health through inspection and regulation of industries which produce or provide milk and dairy products, food and drugs, shellfish products, hazardous household products, drinking water, wastewater, sanitation services, occupational hazards, radiation, and hazardous and non-hazardous solid wastes. In 1984, the associateship employed 453 persons and budgeted $15,280,981 to carry out its activities.

The agency is provided general policy guidance by the Board of Health. This 18 member body, appointed by the governor, meets monthly and is active in the oversight of the many activities of the department. Due to numerous and diverse functions of the agency, the board has delegated many decision-making duties to the commissioner. By law the board reserves final rule-making authority. In total, the agency employs over 4,700 persons and operates at least 42 separate programs. Total budgeted funds for the agency in fiscal year 1984 exceeded $269 million.

REVIEW OF OPERATIONS

The evaluation of the operations of the agency is divided into general areas which deal with: 1) a review and analysis of the policy-making body to determine if it is structured so that it appropriately reflects the interests served by the agency; and 2) a review and analysis of the activities of the agency to determine if there are areas where the efficiency and effectiveness can be improved both in terms of the overall administration of the agency and in the operations of specific agency programs.

Policy-making Structure

In general, the structure of a policy-making body should have as basic statutory components, specifications regarding the composition of the body and the qualifications, method of selection, and grounds for removal of the members. These should provide executive and legislative control over the organization of the body and should ensure that members are competent to perform required duties, that the composition represents a proper balance of interests affected by the agency's activities, and that the viability of the body is maintained through an effective selection and removal process.

The Board of Health is composed of 18 members appointed by the governor with the consent of the senate for staggered six-year terms. Each biennium the chair and vice-chair are designated by the governor. In addition to the board, over 30 advisory committees have been established through statutes and board actions. These committees serve both as technical and consumer advisors to the board and some serve as the regulatory body for certain licensing functions within the department.

The review indicated that substantive changes are needed in both the structure and composition of the board. Additionally, changes are needed in the current structures used to set up the many advisory committees to the board.

The statute should be amended to specify when the governor designates the chair and vice-chair of the board.

The statute creating the Board of Health states that the governor shall designate a chair and vice-chair biennially, but does not specify a time-frame for when the term will begin and end. Currently, the board members hold office for staggered six-year terms, with six terms expiring on February 1 of each odd-

numbered year. The past two chairs have been appointed at separate times of the year: one in July of 1980 and one in October of 1983. The current vice-chair was appointed in August of 1980. In order for there to be a structure for orderly transition, it appears beneficial to specify in statute when the terms of the chair and vice-chair will begin. It is recommended that the terms begin on September 1 of each odd-numbered year, which will coincide with the beginning of the fiscal year.

The Board of Health should be reduced from eighteen to nine members and the specific categories of membership modified.

The Board of Health serves as the policy making and governing body of the Department of Health and as such is charged with protecting and promoting the health of the people of Texas. To carry out this comprehensive duty the department employs some 4,700 people and expends more than $250 million a year. These resources enable the department to operate at least 42 separate programs designed to regulate, serve, advise and assist individuals and units of government throughout Texas.

The board itself consists of 18 members appointed by the governor. The members are appointed to fill 11 separate categories in the following way:

1.	Physicians	- 6 members
2.	Hospital Administrators	- 2 members
3.	Dentists	- 1 member
4.	Nurses	- 1 member
5.	Veterinarians	- 1 member
6.	Pharmacists	- 1 member
7.	Nursing Home Administrators	- 1 member
8.	Optometrists	- 1 member
9.	Professional Engineers	- 1 member
10.	Chiropractors	- 1 member
11.	General Public	- 2 members

This composition makes the board one of the largest policy bodies in the executive branch of state government.

Generally, the composition of a policy-making body should reflect a proper balance of representatives of those affected by the actions of the body as well as representation of the geographic areas of the state. It appears that this principle has reached a logical extreme in the Board of Health. As a part of the review of the structure, a comparison was made with other major health-related boards in the state, and possible alternatives for a board structure for an agency the size and

diversity of the Department of Health were considered which would achieve a proper balance of interests and geographic representation and still provide flexibility.

The review of other major health service boards indicates the state has taken a significantly different approach in establishing their size and composition. As seen in Exhibit 3, the largest of the boards has nine members and none have compositions made up of particular professions. This appears due, in part, to a recognition that any agency of significant size and function will have need to use many different professions to carry out its tasks. This appears particularly true in the health services field which utilizes many different professionals including physicians, attorneys, nurses, social workers, and psychologists to serve its clients. The vast number of professionals needed to carry out public health functions is too large to guarantee a slot for each group. The structure of the Board of Health has tried to capture representation for professions, representing the largest program segments but even with the large number of members, it falls short. Second, the board's current structure prohibits true geographic representation of the state through its requirement that eight different persons represent eight different categories of memberships. The one person representing pharmacists cannot represent five different regions of the state. Third, the size of the board appears to be unnecessarily large when compared to the boards of four other health-related agencies (see Exhibit 3). The large number of board members can lead to difficult decision making processes and unnecessary costs to the state. The cost of the 18 member board travel and per diem for fiscal year 1984 is estimated to be $36,000.

Finally, the diverse makeup of the board and its size appears particularly unnecessary in light of the board's many advisory committees. As seen in Exhibit 4, the board has at least 23 such committees which assist it in obtaining the viewpoints of those providing, receiving its services and subject to its regulatory functions.

It appears that in the creation of this structure, flexibility has been traded to ensure that representation is achieved. While it cannot be proven through data gathering techniques, an assumption could be made that an overall state policy on public health is hampered by this structure. Where there is a diversity of programs, requirements for specific occupational or professional categories of board memberships should be carefully weighed.

Exhibit 3

MAJOR HEALTH AGENCY BOARD MEMBERSHIP

	AGENCY	NUMBER OF MEMBERS	QUALIFICATIONS	FISCAL YEAR 1984 APPROPRIATIONS FOR THE AGENCY
1.	Department of Human Resources	3	"...demonstrated interest in public welfare and experience as an executive or administrator..."	$1,977,339,930
2.	Department of Mental Health and Mental Retardation	9	None specified.	$ 589,129,351
3.	Department of Health	18	10 separate occupations and the public must be represented	$ 233,371,291
4.	Rehabilitation Commission	6	"...outstanding citizens who have demonstrated a constructive interest in rehabilitation services..."	$ 111,811,968
5.	Youth Commission	6	"...citizens who are recognized in their communities for their interest in youth..."	$ 54,653,399

The issues identified above can be addressed through a different structure and composition for the Board of Health and a better balance can be achieved. Using the number of members on the Board of Mental Health and Mental Retardation (nine) as an outside standard, it appears that the number of members of the Board of Health should be reduced from 18 to nine. This number provides for a significantly smaller board, reducing cost of operation, but does provide for sufficient numbers for the board to breakdown into committees as needed to help expedite the work of the board. Secondly, a broad definitional approach should be taken in specifying its composition which would add flexibility. The current approach is inflexible in that it attempts to provide at least one slot on the board for each of the many service providers in the field of public health. This not only appears unnecessary, but essentially impossible as the number of professions in public health continues to grow and the current structure already excludes such groups as physician assistants, vocational nurses and social workers. It appears the composition should not be so rigidly drawn, but designed like that of other major health-related boards. To ensure that the members have some background useful to the operations of the agency and board, the qualifications of those appointed by the governor should require that those appointed have demonstrated a proven record of interest in the field of public health. This would allow appointees to generally represent the five geographic areas of the state and leave four appointments to be selected from the state at large. To balance the board's perspective, three of the four remaining slots should be filled by public members.

The statutory status of the Board of Health advisory committees should be removed.

The Sunset Act requires review of advisory committees along with the review of the parent agency. The Texas Department of Health has many advisory committees and the review focused on the overall usefulness of the committees as well as the manner in which they are appointed and structured. The review included only those committees which assist the department or the board in carrying out a program function assigned to the agency or board. As can be seen in Exhibit 4, 23 committees are considered in this examination. These 23 committees involve the participation of over 250 people and the expenditure of over $80,000 in fiscal year 1984.

While an advisory committee may be created for political purposes, in general, an advisory committee is a special management technique used by

Exhibit 4
TEXAS DEPARTMENT OF HEALTH - ADVISORY COMMITTEES

	COMMITTEE NAME	Created	Statutory Board of Health (BOH)	# of Members	# of Meetings 82/83	COST Expended 1982	COST Expended 1983	COST Budgeted 1984
1)	Agent Orange	1983	Art. 4447w, VACS	12	0/0	$ ---	$ ---	$ 5,500.00
2)	Children's Speech, Hearing & Language	1983	Art. 4419g, VACS	5	0/0	-0-	-0-	1,750.00
3)	Children's Vision	1979;1983	Art. 4419f, VACS	6	0/2	-0-	1,092.11	1,090.00
4)	Community Health	1983	Art. 6252-13e, VACS	9	0/0	---	---	---
5)	Crippled Children's Cardiovascular	1969	BOH	10	1/1	690.95	873.80	1,200.00
6)	Crippled Children's General	1937	BOH	17	2/3	2,333.39	5,654.49	5,000.00
7)	Education	1977	BOH	5	0/0	-0-	-0-	-0-
8)	Emergency Medical	1975	P.L. 93-154; P.L. 94-573 Art.4447o, VACS	18	4/3	3,920.91	2,332.85	18,000.00
9)	Hemophilia	1977	Art. 4477-30, VACS	12	1/1	733.99	540.01	900.00
10)	Hospital	1946	Art. 4437d, VACS	12	0/0	-0-	-0-	-0-
11)	Hospital Licensing	1959	Art. 4437f, VACS	9	2/2	3,036.95	2,617.10	3,000.00
12)	Kidney Health Care	1973	BOH	12	3/3	2,690.50	3,739.16	4,000.00
13)	Maternal & Child Health Genetics	1979	BOH	13	1/1	734.53	576.02	600.00
14)	Maternal & Child Health Technical	1977	BOH	12	3/3	3,308.06	3,405.35	4,650.00
15)	Nursing Home Affairs	1975	BOH	15	4/4	6,207.86	6,432.18	7,000.00
16)	Radiation	1961;1981	Art. 4590f, VACS	18	6/4	15,615.11	8,936.85	9,000.00
17)	Sanitarian	1965	Art. 4477-3, VACS	5	2/2	1,365.88	1,364.74	1,400.00
18)	Solid Waste Management	1983	Art. 4477-7c	15	0/0	-0-	-0-	11,000.00
19)	Solid Waste Technician Training & Certification	1982	BOH	11	0/3	-0-	2,844.13	5,484.00
20)	Synthetic Narcotic Drugs	1971	Art. 4476-11, VACS	10	0/0	-0-	-0-	-0-
21)	Tuberculosis	1978	BOH	12	0/1	-0-	1,364.95	1,500.00
22)	Water Works Operators and Sewage Operators	1945	BOH	9	2/1	766.16	1,033.17	1,100.00
23)	Youth Camp Safety	1973	Art. 4447-1,VACS	12	0/1	-0-	404.15	900.00
	GRAND TOTAL		# Statutory - 13 # BOH - 10	259	82 - 31 83 - 35	$ 41,404.29	$43,211.06	$ 83,074.00

agencies and their policy bodies. Like internal and external audit processes they provide technical advice or indications of how agency clients view the quality and quantity of agency services. This information provides the board or staff with a periodic "window" into agency operations. Unlike other management techniques however, the agency has less control of the results of the work of the committees and certain amounts of "self interest" are evidenced in their work. Persons performing internal and external audits generally have no stake in the outcome of the information supplied and they are controlled by the fact that their operating money comes directly from the agency. On the other hand, advisory committees have a stake in how regulations are drafted or how programs are designed and services are delivered. There is also less control of such a committee because they volunteer their services and can withdraw at any time without consequence. Therefore, while they can provide useful information and assistance, their use does present certain risks to the agency that do not exist in the use of other management techniques. The review focused on the use the Board and department makes of its committees and whether or not the committees and their structure within the TDH provides the optimum use of this special management technique.

The TDH has over thirty advisory committees. Those specifically considered in this review are depicted in Exhibit 4. As can be seen, ten of the committees have been established by the Board of Health and 13 are established by statute. The number of members varies from five to 18 with budgets ranging from $0 to $18,000 for fiscal year 1984. Discussions with agency personnel and committee members as well as observations of committee work sessions indicate that, in general, the committees are directed to areas that are appropriate. They are primarily used to assist program staff and eventually board members in the development of rules and regulations, the screening of service providers used by the department (e.g. Crippled Children's program physicians) and to provide insight into potential advantages or disadvantages concerning program modifications or legislative proposals. Certain concerns have been encountered however, relating to the lack of consistent representation of all affected parties, and potential insulation from the board they are designed to advise.

The Governor's Handbook for Members of Texas State Boards and Commissions indicates that the general purpose of an advisory committee should be to provide the board or agency staff with advice and counsel not available from agency sources on matters of agency responsibility. To provide this advice, most

of the committees at the TDH consist of members representing pertinent industry, academic and consumer or public perspectives. As a general standard public members should be included in the composition of the committees but two of the 23 committees have no public members in their composition. Further, the composition of the committees does not always include representatives of all necessary groups. For example, the Radiation Advisory Committee, an 18 member body created by statute, provides no slot for dentists. This group appears to be necessary in that the radiation control program has 12,800 registrants of which 8,700 are dentists using regulated x-ray equipment. In this case, the advisory committee has made allowances and has named a dentist as a consultant to the committee but is ultimately constrained from adding a dentist as an official member of the committee since its composition is structured in statute. In another situation relating to the Hemophilia Advisory Committee, a 12-member body created by statute, no provision is made for representation of a pharmacist or of blood banks. Since these types of persons and entities are integrally involved in carrying out the objective of the program, it appears they should be represented on the advisory committee designed to "review the program and consult with the department in the administration of the program." (Sec. 5(a), Art. 4477-30, V.A.C.S.) A director of a local blood bank has attended recent meetings but the agency is constrained from adding official members representing pertinent groups since the committee's composition is set in statute.

The second concern encountered during the review of the advisory committees relates to the structure currently in place regarding their relationship to the board. In practice the committees depend on the agency to help provide staff resources to coordinate their meetings and provide general support in the conduct of their duties. Recommendations are funneled through the staff to the board in the form of comments on various matters such as rules and regulations or funding considerations. The process developed by the agency, in accordance with the Administrative Procedure and Texas Register Act regarding the adoption of rules is quite involved and involves the presentation of proposed rules to the board, publication in the Texas Register, the receipt of comment, the holding of a public hearing if requested and then the presentation of final rules to the board for adoption. At both stages involving the board, the agency staff prepare comments on the rules assessing the potential fiscal impact and whether or not the rules or changes are supported by the advisory committee related to the program. A

review of documents developed for the rule consideration process indicates that advisory committee and public comments are routinely incorporated in the material presented to the board. However, representatives of the committees do not routinely report to the board at the board meetings held to consider either the proposed or final rules. Their input is primarily provided through written documents presented to the board at its meetings. A review of the past 25 meetings of the board dating back to July 1982 indicate that representatives of seven of the committees have been present and have interacted with the board on only eight occasions. This frequency of interaction does not appear to provide opportunity for ongoing assistance to the board the committees are designed to assist. Further, since the "interaction" with the board is usually through written documents prepared by staff, the committees are somewhat insulated from the persons they are designed to advise.

A third concern related to the advisory committees involves the timeliness of appointments to the committees. The members of the various committees are appointed in at least four ways: by the governor (three committees), the board (16 committees), the commissioner (one committee) or by nature of the members' positions (three committees). This presents a complicated mixture of appointment processes and leads to delays in filling vacancies. A review of the department's Advisory Committee Report to the Sunset Commission indicates that at the time of submission (October 1983), 44 terms had expired and five were vacant. Although the length of time of the expiration was usually only two to four months, some dated back ten months to January 1983. The delays in the appointment process causes general confusion, detracts from the continuity of advice given by the committees and in the some cases might delay the ongoing work of the agency.

Although the problems discussed above can be rectified through modification of certain agency procedures and statutes, they appear to be indicators of an improperly structured system which does not allow for balanced use of the TDH's advisory committees. As discussed earlier, the use of an advisory committee carries with it certain risks to the agency as well as the committee but these risks can be minimized when the policy makers seeking advice have direct control over critical aspects of the committee's operations and when there is a clear understanding of the roles of each body. The current structure does not provide that control since 13 of the 23 committees examined are established in statute nor has the board formally addressed the role question. Although the board appoints many

of the committee members, the composition and general duties of the committees are set in statute, which substantially reduces flexibility for no benefit. To address this basic structural problem and the specific concerns noted above, the following actions should be taken. First, the statutory provisions establishing the specific committees should be repealed and the board's power to appoint committees structured in the following way. The boards general governing statute (Art. 4414b, V.A.C.S.) should be amended to allow the board to determine how the committees are appointed and structured. Each committee should have a balanced representation of pertinent groups, the public and geographical interests. Second the board should determine to whom the committee should report, in what manner and how often. The board should also establish the specific function or "mission" of each committee and the information that is needed. Lastly, the procedures to accomplish the above actions should be developed as rules of the board.

The Dental Advisory Committee of the Board of Health should be abolished and its broader advisory functions transferred to the newly established Health and Human Services Coordinating Council.

The Dental Advisory Committee of the Board of Health was established by the Legislature in 1979. Leading up to its creation, TDH had conducted a study which showed that public dental services were provided through a complicated and uncoordinated array of expensive programs by federal, state, and local entities. At that time, the Department was the major state agency providing public dental services outside state institutions. The advisory committee was established to serve four functions: 1) advise the Board of Health on its dental services program policies; 2) survey all public dental programs, identify the funding sources, and recommend to the Board of Health how best to administer those funds; 3) study all dental services in the state and develop procedures for approval and implementation by the Board of Health, for the coordination of all dental services to provide an economical and effective services delivery system in Texas; and 4) conduct a study of the supply and demand of dental services in Texas and advise the various governmental entities concerning the need for professional dental education.

Since 1979, conditions have changed which make it inappropriate for the advisory committee to remain attached to the Board of Health. The agency is no longer the major state agency providing public dental services. Most of the state's dental services are now carried out by the Texas Department of Human Resources.

Also, the Department of Mental Health and Mental Retardation and the Texas Department of Corrections continue to provide dental services in their respective institutions. Further, the major functions of the committee involve obtaining and analyzing information on all public dental health services not just those provided by the Department of Health. Based on the analysis the committee is to formulate procedures for the coordination of all dental services to provide an economical and effective service delivery system in Texas. These procedures are to be implemented by the Board of Health.

The current division, between a number of different agencies, of the responsibility for dental services practically prevents the Department of Health and its board from performing any real oversight and coordination of public dental services. The structure which requires the committee to examine all dental health services but funnel its recommendations through the Board of Health does not allow for statewide attention and implementation of the committee's recommendations. Many agencies over which the Board and Department of Health have no control, provide public dental services. To work properly the committee's function should be performed by a policy body whose perspective and authority can provide assistance in coordinating the public dental services of all involved agencies.

In 1983, the 68th Legislature established the Health and Human Services Coordinating Council. This agency has broad coordinating responsibilities concerning all aspects of health and human services. The council is also made up of key executive and legislative members as well as the chairmen of the major state health human service agencies. This council has authority to create advisory committees if one is required to assist them in the execution of this function.

It would appear the statutory authority for the Dental Advisory Committee should be abolished and its broader advisory functions should be transferred to the coordinating council, which can act as a state-wide forum. If TDH determines that it needs an advisory committee related to its specific dental health programs then the department has the authority to create one.

Overall Administration

The evaluation of the overall agency administration was designed to determine whether the administrative policies and procedures used by TDH are adequate, and whether the monitoring of management practices and the internal reporting requirements of the agency are appropriate for the consistent and coordinated management of time, personnel and funds. Several areas have been identified where improvements could be made to enhance the administrative system and these are discussed below.

Financial

TDH should have clear authority to establish fees for all services and seek third-party reimbursements.

The department was provided the authority to charge service fees and recover insurance reimbursements for "public health services" by the 68th Legislature through the enactment of S.B. 1047. Local health departments have had the authority for a number of years and are using recipient fees as a regular source of revenue. The department continues to provide services such as medical treatment (e.g. immunizations and treatment of venereal disease) and laboratory analyses, free of charge to the general public without regard to income level and other medical resources. The agency points to this as consistent with the original intent of the department which is foremost to protect the public. However, in consideration of the current high cost of medical services, coupled with a limited budget, a growing population, and expanding medical resources (e.g. Medicaid and private insurance) this potential source of revenue deserves examination.

Of the 72 participating local health departments who are responsible for a major portion of the service delivery for the department, 32 have initiated some form of health service fee collection effort as of 1982. While these fees are usually nominal, they do provide the LHD's with a significant source of revenue. In a 1982 survey conducted by TDH, 55 percent of the local health departments that charged fees stated that the discontinuation of charging fees would have a significant impact on their operations.

Local providers that are affiliated with the department are also using fees to supplement their program budgets in the Early Childhood Intervention Program. The local agencies that contract with TDH to provide intervention services are awarded grants based on several criteria, one of which is the availability of other funding sources including parent payments. The program requires that local

agencies report how the service fee rate will be determined and the estimated amount of revenue the rate should generate, as a component of the agency's share of the cost.

Charging fees for health services is also not new to other state agencies and the department has started charging fees in its Title XX Family Planning efforts. The Texas Department of Mental Health and Mental Retardation regularly looks to both the patients and their families to share in the financial burden of psychiatric hospitalization based on a sliding scale fee. The Texas Department of Human Resources, in its Title XX Family Planning program, also requires a co-payment based on a sliding scale for its services. It seems inconsistent that TDH is not attempting to recover any of its costs through service fees in more cases where the recipient has the resources available.

Certain problems do exist for TDH, in the implementation of department-wide services fees, that deserve consideration. TDH's venereal disease treatment services require a high degree of confidentiality to remain effective. For this program, the regular recovery of insurance payments through employer-provided group insurance may jeopardize use of such services and the effectiveness of the control effort. Another problem is presented in the rural areas of the state. TDH employees often hold temporary clinics and there is a concern that these employees' safety might be in jeopardy if they were required to carry a cash box. For these specific areas of services, the agency should plan carefully and possibly exempt certain recipients from fee collection efforts. Last, the department has statutory authority to charge fees for "public health services." Although this appears to include both medical and other services (e.g. lab work) this phrase should be clarified to allow the department to charge fees to persons who receive any of its services.

With this clear authority, particular areas could be targeted for the collection of fees. The laboratory division could charge for the services it now provides free of charge through its central office lab. Several examples of these services include water analysis for individuals, metabolic screening, and venereal disease testing performed for non-TDH physicians. The state health department in Minnesota has initiated a $5 fee for most of its tests. They exempt agencies that are receiving state or federal funds administered by their health department and exempt certain critical tests. In fiscal year 1983, Minnesota collected $635,000 through this nominal fee even with exemptions. Another area of potential income,

is in the area of third party reimbursements (insurance). TDH is currently undertaking a survey of all of its recipients to determine the extent to which third-party reimbursements present a significant dollar resource to the department. Services such as immunizations, prenatal care, medical laboratory tests and prescription drugs all have the potential for reimbursement from most forms of insurance including Medicaid. These are only a few of the areas throughout the department where service fees appear feasible. The department should make a careful review of all the various forms of services it provides to discover other services for which fees could be recovered from those who can afford to pay.

In conclusion, the review indicates that the department needs clear authority to charge a complete range of service fees. Other state and private agencies regularly use this source of revenue to support the cost of their services. The department should place a priority on the development and initiation of a plan to institute service fees based on the service recipients ability to pay. The plan should look first to areas where the least disruption would be caused by such a process.

The department should establish administrative policy guidelines concerning the reimbursement rates of clinic physicians.

TDH regularly employs local physicians on a clinic basis to provide physician services in its field offices. These physicians are reimbursed a flat fee, or "clinic rate", for a set number of hours (usually two to four hours) during which time the physician assists as many patients as possible. The department has taken this approach instead of hiring full-time physicians that travel between many clinics in order to: 1) reduce physician down-time due to travel; 2) utilize existing local physician resources; and 3) provide the flexibility to only purchase services when they are needed. However, some problems have been found in the policies used to set the reimbursement rates.

The department negotiates the rate for clinic reimbursement through several divisions of the agency. In TDH regional clinics, the negotiation is accomplished through either the regional office (for more comprehensive clinic services) or by the central office program staff (for categorical clinics treating problems such as tuberculosis). For participating local health departments (LHDs) and regional clinics, the rate is negotiated according to informal policies established through the Associateship for Community and Rural Health. For the categorical clinics,

informal policies on rates are provided by the central office program staff. These informal policies set a maximum reasonable rate with consideration given for experience and the availability of other physicians. However, these informal policies are not consistent across departmental divisions, allow for a significant amount of negotiation in the rate, and are not consistently followed.

This decentralized, flexible, and informal approach to clinic reimbursement rate setting has resulted in widely varying reimbursement rates. The department reimburses physicians at rates ranging from $18.75 to $150 per clinic. While some of this variance is accounted for by special expertise required for the clinic, there is no clear policy as to how the actual rate is set. Instead, the agency personnel are left to negotiate the rate on a physician-by-physician basis. A more usual approach for an agency of this size and diversity is to provide the agency personnel with policy guidelines within which to set the rate. This provides the agency administration more control over the consistency and fairness of such rates.

The department has recognized the need for such policies due to past problems with using a similar flexible, decentralized approach in setting of rates for non-physician consultants. In the past, programs with more adequate funding paid high reimbursement rates for consultants (mainly speakers) while the less well-funded programs could not compete for quality personnel. As a result in 1981, the department adopted the following administrative policy for the reimbursement of all non-physician consultants:

> "The policy for payment of consultant fees paid by any program in this department shall be:
>
> > Not more than $150 per day, plus expenses for doctorate level consultants, or not more than $100 per day, plus expenses for all other consultants.
>
> If these rates are not adequate for your program needs, proper justification to exceed these rates must be submitted to the Deputy Commissioner for Professional Services."

While this policy does not speak to rates for only a few hours, it does provide a framework for a physician compensation rate in that it establishes a maximum rate and sets out allowances for how expertise can be figured in to the rate.

In looking at the informal guidelines used by the programs, a similar structure is found with regard to the level of expertise of the physician. The following chart reflects these guidelines:

Participating Local Health Depts.	$50 usual $75 maximum
Tuberculosis Services	$70 - $100 based on experience
Maternal and Child Health	$50 non-board/$75 board certified
Family Planning & JOBS Bill	$25 per hour

While these guidelines do reflect the norm, as state previously, some physicians are reimbursed at rates significantly below or above these norms. Formalizing and standardizing these policies at a central administrative level would not only standardize the rate but also encourage the consistent application of such guidelines. It is therefore recommended that a department-wide policy be adopted for the reimbursement of clinic physicians. The policy should reflect how the rate should fluctuate due to the level of specialization required for the clinic and the availability of local physician resources.

The department should establish reimbursement rates for pharmaceuticals that are consistent with other state health agencies.

There are currently three programs within the department that provide reimbursement for pharmaceuticals purchased by program recipients - Crippled Children's Services, Hemophilia Assistance Program, and Kidney Health Program. In addition, several other state health agencies provide pharmaceutical reimbursements. The Texas Department of Human Resources, through its Vendor Drug Program for Medicaid recipients, supplies the largest total amount of reimbursements (approximately $80 million in fiscal year 1984).

The medical care reimbursement programs provided through the various agencies such as the Texas Rehabilitation Commission, Texas Commission for the Blind, TDH, and TDHR, are generally able to use similar methods and rates of reimbursement. For example, in comparing physician and hospital reimbursement rates for the various agencies and programs little variation is found. In all instances, these agencies use the Maximum Allowable Payment Schedule (MAPS), which is developed by TRC, and the Ratio of Cost to Charges (RCC), used by Medicare, to determine hospital and physician reimbursement rates. Both of these more standard rate structures are set to reimburse either the actual documented costs of the service or a set rate that is roughly 50% of the usual charges for the service. However, such consistency in state-wide policy is not found in pharmaceutical rates. In this area, the Texas Department of Health has adopted pharmaceutical reimbursement rates that are at variance with the other major

providers. TDH programs are using a reimbursement rate that allows pharmaceutical reimbursements at the billed rate of the provider. This rate customarily includes a profit margin, and was determined to add, on the average, five percent to the total reimbursements of a program the size of the Vendor Drug Program. That program regularly obtains customary charge information from its providers and the five percent figure was calculated from the actual reimbursement records of the program in 1984. Caution needs to be exercised when applying the five percent estimate to the TDH programs due to the usually higher mark-up on the types of medication needed for the treatment of TDH program patients. However, when the savings rate identified by the Vendor Drug program is applied to the fiscal year 1984 TDH drug reimbursement budgets, which totalled $3.1 million, a potential savings of $155,000 per year, is identified.

A more standard rate of reimbursement and one used by the Vendor Drug Program is to reimburse the pharmacy for either: 1) the cost of the product, whether purchased wholesale or direct from the manufacturer, plus a 3.50 handling fee, or 2) the pharmacy's usual charge for the medication, whichever is less. The program relies on the pharmacy to report their purchase method on the reimbursement request voucher. These rates, Average Wholesale Price and Manufacturer's Direct Price, are published annually by the pharmaceutical industry and are easily obtained in book form. The program pays the additional handling charge of $3.50 per prescription to cover the pharmacist's cost of packaging and overhead.

The reimbursement rate system used by the Vendor Drug Program, incorporates certain qualities that are recognized as important criteria for a fair reimbursement rate structure. First, the resulting rate is more in line with the rate of reimbursement used for other providers and thereby does not discriminate by reimbursing any certain type of provider at an above cost rate. For example, hospitals are reimbursed only for their documented cost and physicians are reimbursed at a fixed rate which is roughly 50 percent of customary charges and, under the proposed rate pharmacist would be reimbursed only for its actual cost (product cost and handling fee). Secondly, the rate is one at which there is no evidence that it impairs the distribution of services. The Vendor Drug Program regularly uses 3,200 providers in rural and urban regions of the state and reports that since the program's start in 1971, this rate has had no significant impact on the distribution of participating providers. Thirdly, the rate is one at which the provider is reimbursed for all cost but not profit. In consideration of the system's

incorporation of these qualities and the state-wide acceptance of this rate by the pharmaceutical community it appears that the Vendor Drug program should serve as a model for TDH programs to follow, when feasible, to reduce costs and provide adequate access to a participating pharmacy.

In conclusion, it is recommended that TDH revise the policies of the Crippled Children's Services Program, the Hemophilia Assistance Program, and any other program which is reimbursing pharmaceutical costs at the pharmacy's billed rates to be more in-line with the policies of TDHR's Vendor Drug Program. This change represents a potential savings of $69,000 in fiscal year 1984 operations for the two identified programs. At present the procedures of the Kidney Health Program are designed to reimburse the patient's costs to the patient rather than the provider's costs directly to the provider. Should the reimbursement system in the Kidney Health Program be changed in the future to reimburse the provider, the pharmaceutical rate should be adjusted to the more standard Vendor Drug Program rate. This change would represent a savings of $86,000 when applied to the fiscal year 1984 budget for the program.

The method used for allocation of block grant funding to programs should be reviewed and formally adopted by the Board of Health and require board approval prior to allocation.

The federal Omnibus Reconciliation Act of 1981 substantially changed the operations of several TDH services programs by consolidating the numerous federally authorized categorical programs (e.g., Crippled Children's Services and SSI-Disabled Children's Services) into two block grants and shifting the primary administrative responsibility to the states. The block grant flexibility has allowed TDH to alter program priorities and some services to better meet the needs of Texans. Generally, Texas has continued to support activities that were similar to those funded under the prior categorical program funding although they have discontinued funding to two of the smaller programs, Lead Based Paint Poisoning Program and Sudden Infant Death Services and expanded the larger Crippled Children's Services Program and Maternal and Child Health Program.

The Texas legislature enacted S.B. 117 (Art. 6252-13e, V.A.C.S.) in 1983 in response to the transfer of responsibility for block grant administration in Texas to the Texas government. The Act establishes a structure and some control for the consistent administration of these funds in a manner that is responsive to public

input. Its specific purpose, as stated in section one of the Act, is to "provide for a transition of responsibilities that enhances public participation in agency decision making and that further ensures the use of funds for the benefit of geographic areas, entities, and individuals most in need." The majority of the provisions of the Act address public participation in the development of the state's annual applications for continued block grant funding, entitled the "Intended Use of Funds Report". The Act requires that the agency take steps to ensure public participation in the development of this document. These steps are to include the public posting of any changes being proposed to the scope of services, holding public hearings on the proposed changes, and responding to all comments. While TDH has implemented these steps, it is unclear as to how the public comment enters into the actual allocation of the funding to individual programs since the Intended Use of Funds Report does not contain fund allocation information. The actual allocation of funds is determined by the Deputy Commissioner for Professional Services after consultation with either the Associate Commissioner for Preventable Diseases (concerning the Preventive Health Block Grant) or the Associate Commissioner for Personal Health Services (concerning the Maternal and Child Health Block Grant). This procedure has not been documented or formally adopted by the Board of Health and is not formally subject to their approval. The grants subject to this process total $22 million a year and are distributed between 11 programs.

In contrast, the procedures used by the Texas Department of Human Resources for the allocation of its two block grants, which total $221 million annually, are very different than those used by TDH. While the TDHR procedures of receiving public input in the development of the Intended Use of Funds Report follow the provisions of Art. 6252-13e, V.A.C.S. as do those of TDH, additional board involvement is required in the actual fund allocation process of TDHR. The Board of Human Resources holds an additional public hearing after the regional hearings required by the Act. In this public meeting the board sets priorities, according to the public comments received, for not only the money requested but also how the agency should distribute the funds when they are received. Once the funding is received by the agency, an Annual Operating Plan is developed according to those priorities which specifies any deviation in fund allocations from what was authorized in the Appropriation Bill. This Annual Operating Plan must be approved

by the Board of Human Resources prior to the internal allocation of the funding to the programs.

There is noticeably wide variation in the policies of the two agencies concerning the methods of allocating block grant funds when such allocations deviate from the Appropriation Bill. An examination of such decision-making processes indicates that the allocation of over $22 million should be accomplished through a well-defined policy and procedure that is established and approved by the agency's policy-making board. As such, and in consideration of the legislature's intent found in Art. 6252-13e, V.A.C.S., it is recommended that the Board of Health adopt a formal policy for the allocation of block grant funds and that any deviations in such allocations from the Appropriation Bill should be formally approved by the Board of Health prior to allocation.

Organizational Structure

A central point for management of complaints needs to be established.

The procedures used by an agency to handle complaints from persons receiving its services have been of concern in the sunset process since its inception. Recognizing the need for improvement of complaint processes in various agencies, the sunset commission has adopted standards to ensure that agencies keep complaint records and provide timely notification to persons about progress being made on their complaints.

The complaint process in an agency such as the Department of Health is of particular importance. This agency administers programs critical to the health and well being of many Texas citizens. The complaint process of an agency of this nature and size should be structured and operated so that agency managers and the public can easily determine if complaints are being handled properly.

The review indicated that different complaint procedures have developed around the myriad of state and federal programs operated by the agency. These differences are, to a degree, due to varying state and federal requirements associated with the various programs. Therefore, when a complaint is received by the agency, much of the responsibility for proper referral of the complaint to the appropriate part of the agency lies with the switchboard operator. There is no central location in the agency where complaints are logged in and tracked, or where any oversight of the varying complaint procedures is provided.

Given the complexity and size of the Department of Health, this type of complaint process gives little assurance to the public that complaints will be properly referred. The decentralized process used by the agency also makes it difficult for agency management to easily judge whether complaints are being handled appropriately by agency divisions.

An example of the kinds of deficiencies which can occur through this process can be seen in the differing methods used to advertise the individual complaint procedures used in different programs. Some programs have defined and advertised their procedures formally and visibly through rules, while other programs have not. For example, the process used in the Women Infants and Children Program (WIC) is defined in federal regulations adopted by reference as program rules and posters explaining the complaint process must be posted where the service is provided. Also, the program requires the person to acknowledge the understanding of their right to file a complaint and how the process is initiated. In contrast, no information was found concerning a complaint process in program rules, program literature or posters for the following programs: Dental Treatment, Tuberculosis Services, Venereal Disease Control, and Immunization Services. The lack of formal procedures in these programs makes it more difficult for the public to use the complaint system. This type of problem could be more easily identified by management, and the inconsistency corrected, with some form of oversight over the agency's complaint procedures as a whole.

The review indicated that other major state agencies providing services to individuals generally provide more oversight for their complaint process. This control is established through use of one of two methods: 1) a uniform complaint process followed by all divisions; or 2) a centralized division which coordinates the varying complaint procedures in different divisions and provides for quality control. The following chart illustrates which approach the specific agencies have adopted:

Agency	Agency-wide Formal Process Type	How System Is Accessed	How Access Information is Disseminated
Texas Department of Mental Health and Mental Retardation	Decentralized Non-uniform System	a) Toll free number or b) Direct to various facility "Public Responsibility Committees"	Pamphlet with toll free number and rights information distributed to each patient on admission and client signs for it.
Texas Commission for the Blind	Decentralized Non-uniform System	a) Toll Free Number or b) Direct to various facility or program staff	Service Plan contains toll free number and info on access (which client signs).
Texas Rehabilitation Commission	Uniform Process	Through the particular office where services are obtained.	Verbally explained and client signs saying rights understood.
Texas Department of Human Resources	Uniform Process	Through the regional office in the client's area.	a) Posters in waiting rooms. b) Notice of right to appeal, and how, is contained in all written notification of adverse action.

As stated previously, due to the various types of complaint procedures required by both state and federal law of the individual programs, it appears that developing one uniform process for all divisions of TDH may be impractical. The approach of having a decentralized system with special staff designated to facilitate the client's use of the system does appear feasible and is working in other similar agencies. Further, the coordination and oversight function inherent in assisting clients in accessing the system should, in time encourage the development and documentation of a more consistent approach to complaint resolution procedures across the agency. It is therefore recommended that TDH designate the Legal Services Division to serve as the centralized complaint receiving point for all service recipients. This division should then refer the person to existing formally defined complaint procedures operated by programs and oversee the processing of the complaint through reporting procedures. It is not intended that access be restricted to being handled through this office when other easily accessible systems exist, but rather that this division serve as an alternate centralized access point

for the person unaware of the existing process. Further, until formal procedures are developed for each program, this division should place a priority on assisting in the design and documentation of the various processes that are not appropriately formalized and advertised.

In summary, the review found that TDH services and the size of the agency makes crucial the existence and accessibility of a process by which to voice complaints and have them resolved. The department currently has a confusing approach to such a process which is inconsistent with that taken by other major state health-related service agencies. It is recommended that TDH develop an administrative structure to meet the constraints of the agency which provides easy access to the public, a systematic review of the effectiveness of the individual program's procedures in the handling of complaints, and technical assistance when needed. Such a centralized system of complaint management, when combined with the Sunset across-the-board approaches for agency complaint procedures, should strengthen the Department's overall responsiveness to the affected public.

TDH should adopt formal policies concerning the lines of authority involving the Associateship for Community and Rural Health and its relationship to the other divisions.

TDH has continued to implement procedural changes in its regional operations due to the 1981 reorganization of the agency. This reorganization involved the creation of a sixth major section within the agency, the Associateship for Community and Rural Health. The creation of this associateship was designed to facilitate the agency's transition from providing clinic medical services categorically, to the provision of services comprehensively whereby the various medical needs of the family can be addressed in one clinic visit (e.g., family planning, well baby examination, and cancer screening). The Associateship for Community and Rural Health serves as a buffer to transform the categorical program service policies into comprehensive clinic operational procedures and ensures that TDH program policies are implemented consistently in the 10 TDH regions.

For example, The Tuberculosis Services Program (administered by the Associateship for Preventable Disease) is responsible for establishing the policies used in all TDH regional clinics to treat tuberculosis patients, as well as administering TDH's budget for tuberculosis (T.B.) treatment. These policies are then implemented by staff who are paid on the T.B. Services budget and work out of the 10

TDH regional offices under the direction of the 10 Regional Medical Directors. The Regional Medical Directors are in-turn responsible to the Associateship for Community and Rural Health, who has the authority to encourage consistent implementation of the policies.

One reason for this unusual arrangement is the agency's change in policy from the previously mentioned categorical provision of services to a more comprehensive approach to the provision of services. Prior to this change, a T.B. nurse served only tuberculosis patients. That nurse traveled from town to town, often right behind the nurse that provided treatment for venereal disease, who was a few days behind the nurse that provided immunizations. TDH now encourages a comprehensive approach in which one nurse provides the services of several programs in the same clinic visit. This approach is being adopted as more cost-effective for the agency and more convenient to the patients. Under the past TDH organizational structure the implementation of such a comprehensive service approach would have lead to each comprehensive regional nurse being directly responsible to over five categorical program directors in central office but with no on-site supervisor.

Overall, the creation of the Associateship for Community and Rural Health appears to facilitate the agency's ability to make this major change in the service delivery approach. However, for categorical central office programs that continue to administer the budgets through which regional staff are paid and who continue to develop the policies by which the services are delivered, this associateship's integration into the decision-making process appears to present confusion. Without clearly distinguished lines of authority, the effectiveness of central office program efforts may be limited in that they do not have direct influence over the policies used in the regional operations. Also, the mandatory inclusion of this associateship and the various programs operated by it to the communication routing process slows the timeliness of communications. In addition, any veto powers that can be exercised concerning program communications, policy statements, and personnel actions initiated by the central office programs, can present confusion.

The review examined the procedures used for implementing policy changes, communication routing, and personnel actions such as merit raises to determine the complexity of the existing process. Each of these procedures was found to involve a complex network of participants. For example, a communication, such as a nursing policy up-date, originates in a central office program office. It then must

go to the bureau chief that is responsible for the program, then to the associate commissioner for the bureau, then to the associate commissioner for Community and Rural Health who then sends it to the Regional Medical Director for that area of the state who forwards it to the Regional Nursing Director, who then sends it to the clinic nurse. Every person in this communication process informally has the authority to veto the communication. Even more complex, confusing, and new is the decision-making processes used for merit raises and promotions and yet no clear formal specification of the process has been developed by the agency.

In cases where agency policies concerning authority lines are complex and potentially confusing, agency administrators should clarify the policy formally, and document it, to insure that it is understood by all, consistently followed, and is not revised without approval of the specified administrative personnel. The size of TDH, the diversity of its services, the decentralized nature of its regional operations, and the changes taking place due to the creation of the Associateship for Community and Rural Health make the application of this standard approach of policy formalization even more critical. It is therefore recommended that TDH formally adopt policies concerning the lines of authority and communication routing process involving the Associateship for Community and Rural Health as it relates to the other divisions of TDH. These policies should be added to its recently completed Administrative Policy Manual.

Internal Control

The Board of Health should develop a policy for the internal audit function.

Like most state agencies, with a budget of any size, the department has an internal audit function. The purpose of the function is to ensure that the proper financial controls are applied to the expenditure of funds and to provide selected program and financial data to key individuals within the department. The importance of this type of function to state agencies was recently highlighted by the creation of the State Agency Internal Audit Forum in May of 1984.

In an agency like TDH, the function is extremely important because of multiple funding sources, outside contractors and diverse programs. The review of the manner in which the department carries out the function covered several key aspects which included the dollars allocated to the effort; the structure through

which the function is used by the board, commissioner, and division personnel; and whether the function had a proper focus.

The department's internal audit function is staffed by 11 people and operates on a budget of $304,255 for fiscal year 1984. The program is primarily funded through charges to the programs being audited. An example of this approach is the audit done on the Kidney Health Care Program in 1984. The internal audit division charged the program $40,165 for performing the audit. While this financing technique is not unusual, it does have drawbacks. Audits may be directed to programs that can pay for them and other programs which cannot pay or which can defend their program dollars may not get enough attention. A review of the audits conducted since June 1981 indicated that this might be the case. Fourteen of the audits dealt with programs that were charged for the audit and that also had significant budgets and none of the audits dealt with programs that only had modest budgets. The department has recognized this problem and has requested additional general revenue dollars in its past and in 1986-87 budget request to directly fund its internal audit function rather than receive payment from the programs audited. If the full request is not granted then the internal audit staff will be reduced.

A review of the scope of the audits was also made to determine if their focus tended to be toward potential high dollar problem areas of the programs and to critical programmatic concerns. The review indicated that the audits primarily examine those areas where potential overpayments to programs outside the agency might occur. Several recommendations have been made in the audits concerning the need for the Crippled Children's and ECI programs to recoup specific overpayment amounts from hospitals or community programs. This kind of focus appears appropriate. On a less routine basis, the audit staff have recommended that rules be developed in certain situations and that statutes should be amended in others. These kinds of findings are useful to program managers as well as top level administrators and policy-makers and should be expanded.

The review of the structure used to examine the results of the audits could be improved however. Interviews at the board level, the commissioner level and the division level indicated that the board has never formally discussed the function as it relates to them and that it is not used by the board except in isolated instances. There are no routine reports to the board on problems that exist within the department and proposed solutions. At the present time, this material stops with

the commissioner. Within the department an informal procedure is carried out by the commissioner and the deputy commissioner for management and administration as to the need for, the direction of and the results reported from the audit findings. A review of this part of the structure indicates that the organizational status within the department is sufficiently high enough that reports cannot be blocked and the results sidetracked by programs being reviewed. The current structure also appears to protect the objectivity of the reports. The lack of board involvement, however, leaves the key policy makers out of the information loop. Although the commissioner is ultimately responsible for running the agency, the board members need to be apprised of any significant problems such as large program over-payments or needed statutory changes. Since they are not informed of the internal audit process, they do not have a clear view of overall agency operations. At the same time, the top administrative personnel are not informed of the direction and scope the policy-making body of the agency feels the internal audit function should take.

The results of the review indicate that two problems exist in the internal audit process. First, the funding structure of the program does not allow for the internal audit function to properly perform its duties. Second, the audit scope should be expanded in the area of program results reviews. Third, the board is not included in the information loop concerning the potential use of the audit function and its actual findings. To address these issues, the board members of the TDH should formally discuss and develop a policy concerning the function of the internal audit operation and determine what types of information should be developed through this management technique for review by the board on a periodic or ongoing basis. The policy should also address the kinds of reports developed for internal use by the commissioner and division level personnel. As part of developing this policy, the board should consider the current audit scope and determine if there would be any benefits to emphasizing basis program results audits on a routine. Additionally, the board should carefully examine the current procedure for charging the resources of a program for the audit. If it is determined that this method should be revised, then the board should prioritize its efforts to obtain the funding requested for the internal audit function in its 1986-87 budget request to the legislature as well as any additional funding needed as a result of its analysis.

The Internal Audit Division should monitor the implementation of the management improvement recommendations adopted by the Sunset Advisory Commission.

Throughout the review of TDH, issues have been identified in the individual programs concerning functions which are normally monitored by an internal audit division in its over-sight role for an agency the size and diversity of the department. These issues are varied but include, for example, the absence of formally adopted program rules in programs which have been carried on since the early 30's, inconsistent reimbursement rates to service providers, and inadequate documentation of eligibility determination processes. Some of the management deficiencies identified indicate that TDH has not complied with recently passed state laws. In all 16 management improvement recommendations have been identified for action in the review process.

Many of the recommendations made will require monitoring and over-sight for a period of time to ensure that there is continuity in the procedural changes, and that there is coordinated implementation of changes spanning several divisions of the agency. In other state agencies the size of TDH, such an administrative over-sight and review function is usually accomplished through the internal audit division. TDH has an internal audit division and it has performed oversight activities in TDH programs in the past. It appears reasonable that the internal audit division of the TDH should be given the responsibility to monitor the department-wide implementation of the management improvement recommendations adopted by the Sunset Advisory Commission in its review of the Texas Department of Health.

Evaluation of Programs

To evaluate an agency of the Health Department's size in a meaningful way, it is necessary to focus carefully on the areas to be emphasized in the review. Several guidelines were developed for this purpose. These guidelines or criteria attempted to select programs that: are primarily state funded; have had significant past, present or potential problems identified through review of legislative proposals from past sessions and through discussions with the agency, interest groups and persons knowledgeable of the agency's operations; or have specific 1985 sunset review dates. Additionally, various other state task forces or committees are actively studying aspects or issues relating to the department's operations. (e.g. the Governor's Task Force on Indigent Health Care). In the areas where other groups were active, less staff time was devoted to such areas and efforts to coordinate review topics with the groups were made.

This "focusing" effort yielded the selection of 11 bureaus or programs for review. The programs selected are representative of the agency's two main functions; the provision of health services and the regulation of activities which present potential danger to the public health. The primary activities and recommendations concerning the programs are described below.

Early Childhood Intervention Program

The Early Childhood Intervention Program is authorized by Chapter 73 of the Human Resource Code in 1981 to coordinate the future development and operation of community early childhood intervention programs that are partially funded through grants from state agencies. Early childhood intervention (ECI) services are directed towards children, birth to age three, who demonstrate a delay in development in one or more major areas such as language, motor skills, or cognitive processes. The intervention service usually involves individualized instruction or therapy for the child and the parent and may include skills training, counseling, referral, physical and occupational therapy, and home training. Most of the community ECI programs are operated in conjunction with either community mental health-mental retardation centers or school districts. Prior to the establishment of this program, both the Texas Department of Mental Health and Mental Retardation (TDMHMR) and the Texas Education Agency (TEA) funded these local programs. In addition to the educational services provided through ECI, the Texas Department of Human Resources and TDH provide medical services for the identification and treatment of these children.

The program is administered through an interagency council that serves as the program's policy body, independent of the Board of Health. The Interagency Council for Early Childhood Intervention is made up of four staff persons representing TDH, TDMHMR, and TEA, and Texas Department of Human Resources (each appointed by the agencies' Commissioners) and one lay member appointed by the governor. These agencies include the four major state agencies with responsibility to provide services to these children. The council's primary responsibility concerns policy development and administration of the ECI program in: 1) its allocation of funds to programs through a grant process; and 2) the program's efforts to coordinate the ECI services with other state and local services provided to these children.

The ECI program structure is unusual in state government. All funds for early childhood intervention services are appropriated to TDH which serves as the fiscal agent for the program. The Interagency Council defines the program policy, selects the ECI program staff, operates the entire grant awarding process and establishes the contract monitoring guidelines. Once grant awarding decisions are made by the Council, TDH is then directed by the Council to negotiate a contract with the local entity and allocate the appropriated funds. Staff from both TEA and TDMHMR, funded through the ECI program money appropriated to TDH, are responsible for monitoring the contractee's compliance with the contract and the Council's guidelines.

The unusual structure of the program was designed to build on the existing efforts of TDMHMR and TEA and create an interagency coordination effort. The need for this and the "blueprint" for the program was established through a Senate Sub-committee study conducted from 1979 through 1981 which identified significant gaps in services available to these children. The unusual structure has not been without problems. Such interagency operations have resulted in the continuous redefinition of roles, authority lines, and areas of responsibilities for each of the participating agencies. The funding arrangement causes further concerns for the participating agencies that must look to the ECI Council, not the legislature, for funding of their ECI activities and the programs that the agencies' staff monitor. Over the three years of operation, the Council and participating agencies have however, made progress in working out such problems.

In fiscal year 1984, the program operates with a total budget of $8,012,583 and a staff of seven full-time budgeted position. In the last six months the

program, which used to be within the Bureau of Crippled Children's Services, has taken a new place in TDH's organizational structure. The program now reports directly to the Associate Commissioner for Personal Health Services. In 1984, the program provided funding to 60 local programs throughout Texas which assisted 4,537 of the 127,000 children in the state estimated by the program to have developmental delays.

The review focused on the administration and the policies of the program, as well as the accessibility of the services, the grant awarding and contracting processes and the program's compliance with other state laws. One change is recommended concerning the statutory authority for the program. That recommendation follows.

The Early Childhood Intervention program statute should be amended to clarify program operations and authorize current practices.

The Interagency Council for Early Childhood Intervention was established in 1981 to coordinate the future development and operation of community early childhood intervention programs. Early childhood intervention (ECI) services are directed towards children, birth to age three, who demonstrate a delay in development. The intervention service usually involves individualized instruction or therapy for the child and the parent. The actual services are provided through community agencies that are funded partially with state funding allocated by the Council.

The Council is authorized to allocate all new and expansion funding provided by the state to community programs through a grant process. This funding is appropriated directly to TDH but the decisions concerning the awarding of the contracts rests with the interagency council. This process is described more fully later.

The ECI council directly provided funding to 60 programs throughout Texas which assisted 4,537 children in 1984 on a $8 million dollar budget. A survey conducted by the program, in March 1984, revealed that the funding this program provides makes up an average of 43.5 percent of the total funding of these 60 programs.

Prior to the creation of the interagency council, TDMHMR and TEA were both involved in funding local entities for the provision of ECI services. Starting in 1973, each agency has provided limited funding for early childhood services

primarily to its affiliated entities. In other words, TDMHMR funded community MHMR centers that initiated such services and TEA funded school districts wanting to implement ECI services. A Senate Subcommittee was formed in 1979 to study this multi-agency approach to early childhood programs in Texas. In their 1981 report to the legislature they identified gaps in services and a general lack of coordination in the efforts of various agencies to address this problem. The committee made 22 recommendations for changes in the service delivery system. Most of the changes were incorporated in S.B. 630 of the 67th legislative session which created the Interagency Council on Early Childhood Intervention. This bill, which passed in 1981, attempted to establish a program that spanned the operations of three agencies, but was owned by none. Discussions with those active in the passage of the legislation indicate that certain details were left non-specific in the legislation with the intent of developing statutory clarification when workable solutions were achieved.

The Interagency Council is made up of four staff persons representing TDH, TDMHMR, and TEA, and Texas Department of Human Resources (each appointed by the agencies' Commissioners) and one lay member appointed by the Governor. The council has independent rulemaking authority and serves as the policy body for the implementation of the program's grant process and coordination efforts. All funds for Early Childhood Intervention Services are appropriated to TDH which serves as the fiscal agent for the program. The Interagency Council defines the program policy, selects the ECI program staff, operates the entire grant awarding process, and establishes the contract monitoring guidelines. Once grant awarding decisions are made by the Council, TDH is then directed by the Council to negotiate a contract with the local entity and allocate the appropriated funds. Staff from both TEA and TDMHMR, funded through the ECI program money appropriated to TDH, are responsible for: 1) monitoring the contractee's compliance with the contract and the Council's program guidelines; and 2) providing technical assistance to ensure consistent, high quality services throughout the state.

As can be seen, the program has an unusual structure in that TDH receives the funding, an independent council allocates the funding, TDH initiates the contract, and non-TDH staff are responsible for monitoring contract compliance and the quality of the service. The unusual design has proven difficult to negotiate for three major agencies, TDH, TDMHMR, and TEA. In fact, over the two years of

program operation certain provisions of the enabling legislation have been found impractical or cumbersome and the actions governed by the provisions have been modified in practice with the approval of the participating agencies. It appears timely to modify the statute to conform to the developments occurring since the council's establishment in 1981. The needed modifications are outlined below.

1. Funding allocation methods - TDH serves as the fiscal agent and allocates the funds only according to council direction. To clarify this relationship the following changes are recommended.

    a. The statute authorizes the reimbursement of council members for expenses and further states that the agencies represented on the Council should equally bear this cost. This should be changed to authorize the current practice of each agency bearing the expenses of its representative and the Council reimbursing the public member's expenses through ECI program funds.

    b. The statute directs the department to allocate funds appropriated for the program to other agencies that assume program implementation responsibilities. This should be amended to require the Council to advise the department on any such allocations.

2. Grant Submission Methods - the ECI Council has an administrative office and now has a policy of accepting grant requests directly from the providers thus removing an unneeded procedural layer from the process. To clarify this process the following change is recommended.

    a. The statute directs providers to submit grant proposals first to either TEA or TDMHMR who later forwards the proposals to the Council. This should be changed to direct providers to submit proposals directly to the Council office.

3. Contracting - the ECI council determines which proposals should be funded and then instructs TDH to execute a contract with the provider which specifies program standards established by the Council. To clarify this process the following changes are recommended.

    a. The statute states that TDH should require the provider to execute a contract in accordance with particular agency guidelines. This should be changed to require TDH to contract with the provider, on the direction of the Council, and that the guidelines would be Council guidelines rather than guidelines of a particular agency.

    b. The statute instructs the agency (TEA or TDMHMR) that if in monitoring they find that the provider is not in compliance with their contract, the agency should notify TDH to

withhold further funding. This should be changed to provide only the Council with the authority to notify TDH to withhold funds except in cases of gross mismanagement. In these cases the department should be able to take independent action.

4. Program Standards - the ECI Council establishes the standards with which funded programs must comply. To clarify this process the following changes are recommended.

   a. The statute requires programs to operate within the guidelines established by the agency (TEA or TDMHMR). This should be changed to specify compliance with Council guidelines.

   b. The statute allows the agency (TEA or TDMHMR) to modify guidelines established in another section as needed for specific providers. This should be changed to allow only the Council to modify such guidelines.

   c. The statute requires the agency (TEA or TDMHMR) to establish provider-specific guidelines for provider operations. This should be changed to allow only the Council to set such guidelines.

In summary, this statute is an attempt to establish a program that is a new approach to coordination in between several agencies through an independent policy body. As in any new statutory approach, certain provisions were included that have either been found unworkable or which need clarification. These provisions primarily deal with fund allocation authority, the grant and contracting procedures and the authority to establish and enforce program standards. The recommended changes clarify the Council's authority to establish the policies through which the ECI program operates.

Bureau of Dental Health

The Bureau of Dental Health is responsible for the implementation of programs for the prevention of dental disease in the general public and for the treatment of severe dental disease in low-income children. To provide these services, the bureau has developed three programs. The Floridation Program, established in 1980, is conducted to provide citizens of Texas the beneficial effects of low levels of floride in drinking water for the prevention of tooth decay. The Dental Education Program, dating back to 1936, assists Texas school teachers in providing oral hygiene instruction to children and also provides some dental education to the elderly. The Dental Treatment Program unlike the other two programs, is aimed only at children in low-income families. The program, which was established in 1936, provides basic dental services to these children for the relief of dental pain and infection. The bureau provides all of these services through the three programs' various efforts of grant awarding, classroom education, curriculum development, technical assistance and direct dental services.

In fiscal year 1984, the bureau operates three programs with a total budget of approximately $2,279,000 and a staff of 63 full-time positions. The bureau's total budget is allocated to the three programs in the following manner: Floridation Program — 14 percent; Dental Education Program — 26 percent; Dental Treatment Program — 60 percent. The Floridation Program is fully federally funded through the Preventive Health Block Grant. Also, 6.8 percent of the Dental Education Program's funding is allocated from the Maternal and Child Health Block Grant. The rest of the bureau's funding, which represents 85 percent of the total, is supplied through general revenue funds.

The review of the programs of dental health focused on the administration and policies of all programs, the continued need for the services, and the efficiency and effectiveness of the services. Several problems were identified in the bureau that appeared on further examination to constitute agency-wide problems needing agency-wide attention and have been addressed either in Overall Administration recommendations (e.g. lack of complaint mechanism and confusing authority lines with regional staff) and Other Sunset recommendations (e.g. lack of program rules and public information). However, an additional change is needed that is directly related to the bureau. The recommendation for this change follows.

Statutory authority should be enacted for the current programs of dental health provided by the department.

Dental services were first provided by the department in 1936 as a component of the federally funded Maternal and Child Health Program. In 1945, the bureau of dental health was formed under the authority of the commissioner of health to "organize and maintain within his department such divisions of service as are deemed necessary for the conduct of the work of the department" (Article 4418b, V.A.C.S.). However, in 1975 this authority of the commissioner was repealed.

The program received its first state funding in 1976, however a rider was attached to the appropriation prohibiting the use of any of the dental funds for activities other than direct treatment to children. This sharply influenced the activities of the bureau since it was rapidly developing dental education curriculum materials at the time. In 1978, the General Appropriation Bill attached a rider to dental funds again limiting the use of funds to the delivery of direct care services to indigent children through the age of 18. The rider also authorized the expenditure of not more than $98,000 of the appropriation to the bureau for a four county pilot demonstration project concerning education and prevention. The review of the program indicates that this has been the extent of legislative direction in development of the program.

TDH is left with little legislative guidance and authority by which to operate its three dental health programs. According to a 1979 attorney general's opinion, "administrative agencies have only those powers expressly granted by statute or implied from statutory authority and duties." (MW-42). A review of the department and board of health's enabling legislation also indicates that their authority speaks only to the implementation of statutory provisions and not to the establishment of new programs not statutorily authorized. Even though the agency only has such limited authority, TDH has operated this program for some time with only the Appropriation Bill serving as legislative authority. The General Appropriation Bill does not contain, nor was it designed to contain, the programmatic information needed to provide the degree of legislative direction to authorize and operate the program.

There should be legislative direction, through statute, to continue the present dental services. The statute should include an authorization for the three specific

programs of the bureau. It should authorize a program of dental care to provide low-income chidren age 18 and below basic dental services to treat severe dental disease. It should also authorize a program of dental education for Texas school children, and certain adult populations, to encourage prevention through the development of good oral hygiene habits. Finally, it should authorize the preventive program of floridation for Texas communities which provides floridation equipment and chemicals through grants to communities having natural floride levels below optimum therapeutic levels.

Bureau of Crippled Children's Services

The Bureau of Crippled Children's Services, established in 1933, is responsible for the provision of physical restoration and specialized educational services to children who are severely or chronically disabled by medical conditions. Such services are provided with the goal of preventing a family's financial hardships or a community's lack of resources from resulting in a treatable medical condition leading to a child's permanent disability or death. To serve the special needs of these children, Texas has developed five programs that provide various services to approximately 32,000 people annually. These programs include: the original Crippled Children's Services Program, the SSI-Disabled Children's Program, the Hemophilia Assistance Program, the Epilepsy Program, and the Children's Outreach Heart Program. These programs provide assistance to children and families through the following types of activities: direct service, purchased medical services and equipment, case management, casefinding, and contracts for service.

Bureau operations consisted solely of the Crippled Children's Services program of reimbursement for medical services for the first 40 years. Over the last eight years, four additional programs have been created either by state or federal legislation, each attending to the needs of special groups of people within the severely or chronically disabled population. The Department of Health added the Supplemental Security Income (SSI) Disabled Children's program to the bureau in 1977 with 100 percent federal funding made available through the Social Security Act. The program continues to be 100 percent federally funded and is now administered through a block grant. It provides diagnostic, case management, and social services to children birth to age 16 who receive SSI. The primary goal of the program is to assure that services are available to these children to maximize their developmental potential and prevent the eventual need for institutional placement. That same year (1977) the state legislature created the Hemophilia Assistance Program to aid in financing the purchase of costly blood products for persons of all ages with hemophilia. The following session, in 1979, the legislature created the Epilepsy Program for the provision of counseling and medical assistance to persons of any age with epilepsy. In 1981, the legislature appropriated funding for the Children's Outreach Health Program. The program funds a mobile casefinding team of cardiac specialists to evaluate children in rural south Texas areas who are suspected of having heart defects or disease.

In fiscal year 1984, the bureau operates five programs with a total budget of approximately $38.8 million and a staff of 129 budgeted full-time positions. The bureau's total budget is allocated to the programs operated by the bureau in the following manner: Crippled Children's Services - 93 percent; SSI-Disabled Children - 5 percent; Hemophilia Assistance - .6 percent; Epilepsy Program - .7 percent; and Children's Outreach Heart - .3 percent.

The review indicates that improvements are needed in either the management or statutory provision of each of the bureau programs with the exception of the Epilepsy Program. Further information on the operations of each program along with the recommended changes are provided below.

Crippled Children's Services Program

The Crippled Children's Services (CCS) Program was established in 1933 for the physical restoration of children below the age of 21. To provide these services, the program conducts activities including the screening of children to identify certain serious illnesses and disabling conditions, and reimbursement to approved providers for the diagnosis and treatment of the low income children identified as having covered conditions. The program also actively monitors the quality of care it finances. Physicians and hospitals must be approved by the Board of Health to participate in the program. The program is authorized to reimburse providers for the care of children whose families have no other resources to finance their rehabilitative treatment for bone, muscle or joint defects, neurological disorders, cystic fibrosis, neurofibromatosis and cancer. The program serves a range of children with coverable conditions who either have exhausted Medicaid resources or have family resources above Medicaid eligibility levels. For example, in 1984 the Medicaid maximum eligible monthly income for a three-person single parent family is $148 while CCS income eligibility is set at $1,060 for the same sized family and no eligibility restriction is placed on the number of parents in the family.

The program began in 1933 as a part of the Vocational Rehabilitation Division of the State Department of Education. In 1945, the program was transferred to TDH. For many years, the program served a vital role in assuring that the most current technology and medical resources were available to care for the critically ill and disabled children of Texas. Such role was crucial since most medical services were then provided by rural physicians who were somewhat isolated from the growing field of medical technology. For example, in 1974 the program, with a

staff of 24 and a budget of $8.9 million, used the services of only 30 hospitals, and an equal number of specialists, and cared for 2,500 children. Over the past 10 years the program has rapidly expanded the types of conditions it covers and the number of children served, as well as the number of facilities and specialists whose care the program reimburses. In contrast to the 1974 operations, for the care of the 19,723 children assisted in 1984, the program reimbursed 1,200 Texas physicians (95 percent of whom are board certified as specialists) and 147 hospitals that are approved for participation in the program. The program also maintains a registry of the 78,000 children reported to the program as having various forms of the conditions covered by the program.

In fiscal year 1984, the program operates with a total budget of $36,191,532 and a staff of 64. The 1983 average annual reimbursement per case was $1,524 which represents an eight percent increase over that of 1982. The program receives 12 percent of its funding through the federal Maternal and Child Health Block Grant. The program uses two advisory committees, the Crippled Children's Services General Advisory Committee and a separate CCS Cardiac Advisory Committee. Both are quite active and aid the program with expertise in a mix of the various aspects of medical care and parenting of children with coverable conditions. Services provided by both committees include technical assistance, screening and recommending the disposition of applications for provider participation in the program and evaluation of the quality of care in participating cardiac centers. Both committees have been established by the Board of Health primarily to assist them in the approval of providers for participating in the CCS program. Neither is currently mandated in statute.

The review focused on the program's administration and policies as well as the accessibility of the services, the eligibility determination process, the reimbursement process, and the two advisory committees used by the program. Problems were identified with the program's high pharmaceutical reimbursement rates and a recommendation for improvements in this area are provided in the Overall Administration section of the report. Also, it was noted that the program's complaint and appeals process is not adequately advertised and documented and recommendations for improvements are also covered in the Overall Administration section of the report. Finally, two specific changes are recommended in the program's eligibility determination process. The first is a management improvement recommendation aimed at better definition, use, and documentation of the

criteria used to establish eligibility. The second covers a needed statutory amendment. These recommendations are explained below.

The Crippled Children's Services program should clarify the eligibility determination procedures used.

The Crippled Children's Services program (CCS) uses five criteria to determine eligibility: age, residency diagnosis, financial need, and whether treatment can improve the child's condition. These criteria are based on statute and further defined in program rules. The first three, age, residency and diagnosis, are relatively easy criteria to measure from material submitted in the application and are explained clearly in the program rules. The other two criteria, financial need and the potential for improvement through treatment, are more difficult to determine, but are critical in the eligibility determination process. In 1983, 1,021 or eight percent of the program's new cases were screened out based on these criteria. In general, these kind of determinations need to be well documented to ensure that all persons seeking the services of the program are treated fairly. Problems were noted in the review that indicate improvements are needed in the current system.

First, rules governing the screening process are not specific regarding how the process operates and which particular elements of the family's financial and child's medical background are considered in determining eligibility. Second, an examination of case files indicated that documentation of the procedures used and what factors are considered by the program staff are not included in the case records. Third, the notification to the family regarding its ineligibility for service does not include an explanation of how the determination was made. The major goal of the program is to serve only those children who can benefit from and need medical treatment and who have inadequate resources to obtain such treatment. Due to the lack of consistent and complete documentation regarding the financial and medical eligibility determination process it was not possible for the sunset review to determine if the process is carried out in a fair and equitable manner.

The Texas Rehabilitation Commission conducts a similar program that also provides rehabilitation services which primarily includes vocational training and some financing of corrective medical care. To carry out this program the TRC has similar statutory criteria it must follow to determine who is eligible for its services. In contrast to the TDH Crippled Children's program, TRC has established

procedures clarifying how the criteria are evaluated and how the determination must be documented. Concerning financial eligibility, the TRC policy goes much further than the Crippled Children's Services policy which only states that the factors considered include family income and assets, the projected cost of treatment, current medical indebtedness, and insurance or other third party resources. On request, the crippled children's program will provide the financial income guidelines but this does not include any explanation of how the rest of the factors are considered and how family income is defined. The TRC policy, in contrast, delineates whose income and assets must be considered, what types of income and liquid assets to include, what cost of living deductions should be allowed for, what amount of adjusted income and assets constitute financial eligibility, and how to authorize exceptions. This formalized policy appears to be an appropriate model for TDH to use in setting the policy of the Crippled Children's Services financial eligibility determination function. Such formalization should clarify the fairness and consistency of the process.

TRC has also developed formal procedures to determine and document eligibility based on potential for rehabilitation. This determination is somewhat similar to CCS's criteria with regards to the determination of whether the treatment can improve the child's condition. TRC's procedures are well documented concerning both how the client's potential for rehabilitation is evaluated and how it is to be documented in the case record, particularly if the client is found ineligible. The evaluation is to include for example, information concerning medical status, psychological functioning, past and current educational achievement, client and family motivation for change, and, if needed, an extended evaluation. The TRC procedure for documenting ineligibility requires the client's case record to include at a minimum: 1) a summary of medical and other data used as a basis for the determination; 2) an analytical justification for the ineligibility; and 3) a summary of the client counseling with evidence that the client had an opportunity to use the services, was unable to use the service, and was referred to another appropriate agency. The procedure further requires that the client be notified in writing of the basis for the decision and client's right of appeal. In contrast, CCS program rules state only that the person's disability must be such that it is reasonable to expect that significant improvement will occur through the provision of services.

In conclusion, there is a need to adjust the documentation of the procedures used by CCS to determine client eligibility concerning financial need and degree of improvement possible through treatment. An acceptable model for improved procedures for eligibility determination are those used by the Texas Rehabilitation Commission. Such procedures can provide valuable information for potential users of the Crippled Children's Services and will better assure that the program makes its determinations in a fair and equitable manner. Therefore, it is recommended that, using TRC's procedures as a model, the program clarify their procedures for determining eligibility and establish a method for documenting the basis for the determination in the case record and information transmitted to the client.

The Crippled Children's Services statutory provisions regarding medical eligibility should be amended to allow the Board of Health to increase services.

The Crippled Children's Services program (CCS) was first established in 1933 to ensure that parents' economic hardships were no barrier to the medical treatment of poor children with catastrophic crippling conditions. Specifically, in the original act the medical eligibility was established as follows:

> "A crippled child is defined as any person of normal mentality under 21 years of age, whose physical functions or movements are impaired by reason of joint, bone, or muscle defect or deformity to the extent that the child is or may be expected to be totally or partially incapacitated for education or remunerative occupation."

At the time this legislation was enacted, polio was the most common disease that produced long-term disability or crippling effects. Another major crippler was birth deformities and injuries due to unavailable prenatal care and obstetrical services. The apparent intent of the legislature in establishing the target population for the program as 'crippled children' was to encompass what were then the major, treatable, catastrophically disabling conditions of childhood.

From 1933 to 1979, the statutory provisions for medical eligibility for CCS remained essentially unchanged with the exception of adding cystic fibrosis in 1963. However, in the last decade, five additional medical eligibility categories have been added in the statute. The current categories of disorders covered in the CCS statute are:

1. bone, muscle, and joint defects and deformity
2. neurological defects and disorders

3. cancer
4. cystic fibrosis
5. neurofibromatosis
6 ossicular chain (middle ear) defects
7. spina bifida (open spine)

The legislature has attempted to continue the original intent of the program by adding debilitating diseases to CCS coverage as medical technology, and the state's budget, make it feasible. Yet gaps in the CCS coverage do exist. Therefore, some children with severely disabling conditions that are ineligible for Medicaid, or for whom Medicaid benefits are exhausted, remain ineligible for CCS assistance. The more common conditions which remain ineligible include, for example, juvenile diabetes, complications of premature birth, asthma, and the non-orthopedic complications of sickle cell anemia. The sheer numbers of children who are disabled to varying degrees with these disorders, and the cost of the various treatments, has made extending coverage to all of the children that fall into any one of these diagnostic categories, fiscally prohibitive. And yet for the most severely affected of these children, who are not eligible for Medicaid, medical assistance, only possible through CCS assistance, is critical to the child's future potential.

Another group of children excluded from CCS benefits are those children with extremely rare disorders. For these children, it is impractical for the legislature to address the condition specifically in statute due to the small number affected, even though once again, CCS assistance is critical to the child's health.

While the Board of Health is provided the authority to limit coverable conditions to meet budgetary constraints, it is not provided the authority and flexibility to add coverable conditions in response to available resources. For the two groups of children previously identified as excluded from eligibility (both those with severe forms of common disorders and those with severe rare disorders) the current method of expanding medical eligibility only through the statute needs adjustment.

In contrast to the CCS statute, two medical service programs operated by TDH do have flexibility in dealing with statutory direction as it pertains to the rapidly changing field of medicine. In the control of sexually transmitted disease, the potential problem of disease specific legislative authority was highlighted by the recent identification and public concern over the control of Acquired Immune

Deficiency Syndrome (A.I.D.S.) and Herpes. Also in the immunization effort of the department, medical advances may soon make chicken pox vaccine available and affordable. To deal with these issues, both the Communicable Disease Act (Article 4419b-1, V.A.C.S.) and the Texas Venereal Disease Act (Article 4445d, V.A.C.S.) allow the Board of Health to expand coverage of the program to treat communicable diseases not named in the statute. For example, Sections 1.04, 2.02, and 2.03 of the Communicable Disease Act provide the broad definition of communicable disease and authorize the Board of Health to determine, by rule, what diseases present a risk to the public requiring control efforts, such as treatment or immunizations. Similarly, sections 1.03, 2.01, 2.05 in the Venereal Disease Act provide the broad definition of venereal disease and list specific diseases it includes. The Board of Health is further authorized to provide treatment to persons with venereal disease and is given rulemaking authority to add, delete, or modify the list of venereal diseases on the condition that the disease causes significant morbidity or mortality and can be cost-effectively diagnosed and treated in public health programs.

The flexibility established through these provisions allows the department to respond quickly to medical advances and disease outbreaks so that the public health is protected from communicable diseases to the maximum extent possible. It provides the department with the authority to identify certain diseases as not feasible to address either due to the lack of effective medical treatment (e.g., herpes) or the prohibitive cost of prevention (e.g., flu shots for the general public). It further allows the department to expand its services, by rule, to treat and control diseases that, due to medical advances, become economically feasible to diagnose and treat (e.g., chlamydial infections).

In consideration of the unique needs of the Crippled Children's Services program in fulfilling the original intent of the program and adjusting to rapid advances in medical technology, it appears reasonable to simplify the process used to add diseases or conditions to the program's coverage.

The current structure requires basically two actions to effectively add a condition or disease to the program's treatment categories. The first action requires the amendment of the statute to specifically name the disease or condition and the second action requires the appropriation of funds by the legislature so the department can pay the bills associated with the treatment of the disease or condition. This presents two significant hurdles that must be dealt

with to provide services to children in need. Simply allowing the board or program to add diseases or conditions as it can in certain communicable disease programs could solve the problem but would place inordinate and difficult decision-making requirements on the board due to the high costs that are associated with treating certain problems. The decisions regarding the addition of the diseases or conditions covered by the program needs to be carefully made. The addition of one condition, such as complications of premature birth could easily jeopardize the funding available for treatment of other conditions already covered. To provide the department and interest groups some flexibility to identify and treat additional conditions or diseases yet ensure that expansion of the program is carefully guided the following steps should be taken.

The statute governing the Crippled Children's Program should be amended to allow the Board of Health to authorize the program to treat a disease or condition not specified in statute if the department has received an appropriation to treat the disease or condition. The appropriation should take the form of a line item or rider specifically identifying the disease or condition and the amount of funding available for treatment. This approach would simplify the process to expand the program but also provide legislative guidance in its expansion. This easier access can be used by both the department and those outside the department when a disease or condition is identified that warrants coverage by the program.

Hemophilia Assistance Program

The Hemophilia Assistance Program (H.A.P.) was established in 1967 and is fully state funded. Hemophilia is a genetic condition occurring in males only. It is characterized by deficient blood clotting often resulting in uncontrolled internal bleeding which leads to major medical and orthopaedic complications. The condition is controlled through medications and blood transfusions. The Hemophilia Assistance Program is designed to assist with the cost of the blood products and medication and also maintain a registry of all hemophiliacs in Texas. While the statutory authority for the program authorizes these services for all persons with hemophilia, the department has split the assistance between the Crippled Children's Program and the H.A.P.. The Crippled Children's Services Program covers all medical expenses (including hospitalization costs) for persons under 21 and the H.A.P. assists adult men with blood products and maintains the hemophilia registry.

In fiscal year 1983, the Hemophilia Assistance Program provided assistance to 24 adult men ranging in age from 21 to 59. The average annual reimbursement per patient was $2,373 and the maximum per patient was $6,250 for that year. In addition, TDH maintained contact through its registry with 570 persons having hemophilia and estimates the total possible population in Texas to be near 700 according to national incidence rates. (The Crippled Children's Program assisted 158 children of whom 18 will "graduate" to the adult program in the next biennium.) The budget for the program has increased significantly over the past few years as follows: $65,285 in fiscal year 1982; $94,197 in fiscal year 1983; $235,202 in fiscal year 1984; and $243,353 in fiscal year 1985. One program director is employed to administer the program. The program is also required by statute to consult with a Hemophilia Advisory Committee for advice on the operations of the program.

A review was made of the program's administration and policies as well as the accessibility of the service, the eligibility determination process, the reimbursement process, and the advisory committee. The program's advisory committee needs some changes due to the increased lack of attendance at meetings, a more general change is recommended in the Policy-making section of the report concerning advisory committees. Also, problems were found with the program's high pharmaceutical reimbursement rate, and a recommendation to improve all TDH pharmaceutical reimbursement rates is made in the Overall Administration section of the report. Finally two specific changes are recommended in the program's eligibility determination process. The first covers a clarification in statute concerning the use of other medical benefits prior to program resources and merely authorizes current program policies. The second is a management improvement recommendation aimed at better definition, use, and documentation of financial eligibility criteria.

The Hemophilia Assistance Program's enabling statute should be amended to clarify "payee of last resort" provisions.

The enabling legislation for the Hemophilia Assistance Program (Article 4477-30, V.A.C.S.) is unclear in providing TDH the authority to ensure that its resources are used to assist patients with the cost of pharmaceuticals only after the patient's other medical benefits have been used. Assistance in the purchase of pharmaceuticals is the only direct service provided by this program which is

operated in conjunction with the Crippled Children's Services Program. In fiscal year 1983, the Hemophilia Assistance Program (H.A.P.) assisted 24 patients, all of whom were either employed or had Medicare or Medicaid. The average annual reimbursement per patient was $2,373 that year. While the total amount of reimbursements and the number of patients assisted by this program is much less than that of the Crippled Children's Services Program, which assisted over 17,000 children at an average of $1,524 annually per case and spent $29 million in reimbursements, there is the same potential for reducing program costs through tightening the requirements for use of other medical benefits available to H.A.P. recipients. Also, the fact that most are employed, to some extent, further makes the issue of payee of last resort provisions pertinent for this program.

While the program routinely applies the same procedures as used in CCS concerning the use of other medical benefits prior to program resources, the H.A.P.'s statutory provisions are much less specific than those found in the CCS statute. The Hemophilia Assistance Program provisions that relate to other benefits are as follows:

> Sec. 2 (a) There is established in the department a hemophilia assistance program to assist persons who have hemophilia and who require continuing treatment with blood, blood derivatives, or manufactured pharmaceutical products but who are unable to pay the entire cost.

In comparison, the CCS statute specifies that a child is not eligible unless TDH has determined that every person legally obligated to pay such costs is unable to do so, and the child and family are not eligible for other benefits including court judgments, insurance, worker's compensation and certain other federal assistance programs. This statute also provides TDH with authority to recover the cost of services provided from persons failing to report other benefits that they receive.

Since the statutory provisions of the Crippled Children's Services Program were designed to meet the special circumstances of minor children, some of the CCS provisions are not appropriate in the Hemophilia Assistance statute since all recipients are adults. The other medical benefit provisions however, do appear appropriate due to the employment and benefit status of the present recipients. Also, these provisions are currently being used by the program and should be authorized. Therefore, the Hemophilia Assistance Program statute should be amended to incorporate the payee of last resort modeled after provisions found in the Crippled Children's Services Statute.

The Hemophilia Assistance Program should adopt financial eligibility guidelines through the Texas Register process.

The Hemophilia Assistance Program is authorized to provide assistance to persons with hemophilia who are unable to pay the entire cost of their care. The enabling legislation (Article 4477-30, V.A.C.S.) directs the department as follows:

> Sec. 2 (b) The department shall, in the order of priority listed:
>
> (1) set standards of eligibility for assistance under this Act;
>
> (2) provide financial assistance for medically eligible persons, through approved providers, in obtaining blood, blood derivatives and concentrates, and other substances for use in medical or dental facilities or in the home."

The program has adopted rules for eligibility determination which require that three factors be considered in this determination process: legal residency, medical eligibility, and income eligibility. The residency and medical eligibility guidelines appear consistent with statutory authority and are clearly defined in rules. However, the financial eligibility guidelines have not been clearly defined. Instead the policy is as follows:

> Financial status. To determine the financial inability of the party legally responsible to pay for blood products, each case is individually considered, and no automatic denial or approval is based upon income alone. The factors considered include:
>
> 1. Size of family.
> 2. Total family net income.
> 3. Current family medical indebtedness.
> 4. Insurance or other third party payment sources available to the applicant.
> 5. Cost of blood product required by the applicant.

The program staff indicate that, in general, they use the financial guidelines of the Crippled Children's Program, but rarely deny assistance. The program provided services to 24 adult men (ages 21-43) with hemophilia in fiscal year 1983. The following chart shows the employment status of these recipients:

Social Security Disability - Medicare	3
Social Security Disability	2
Medicaid and Partial employment or unemployed	4
Intermittently employed	3
Employed	12
TOTAL	24

Financial eligibility determination is particularly important in this program due to three factors: 1) the employment status of the program's recipients; 2) the expense of serving each recipient (averaging $2,373 per year in FY 1983 and ranging up to $6,178 annually; and 3) the anticipated doubling of the program's service population over the next year. Further, the legislative mandate is clear in directing the department to set eligibility standards.

The procedures used by the Texas Rehabilitation Commission measure similar criteria as those set up in the H.A.P. rules but TRC's further delineate these criteria. This policy explains whose income and assets must be considered, what types of income and liquid assets to include, what cost of living deductions should be allowed for, what amount of adjusted income and assets constitute financial eligibility, and how exceptions should be authorized. This formalized policy appears to be an appropriate model for the policy of the Hemophilia Assistance Program's financial eligibility determination function. Such formalization should clarify the fairness and consistency of the process.

The program should adopt, through rule-making, objective financial eligibility guidelines that take into consideration the factors currently listed in the program rules and more clearly state how those factors will be defined and weighted, the final eligibility criteria, and how often redetermination will be required. These should be developed using the TRC guidelines as a model. Further, the use of such standards should be documented in the patient's case record to aid in future redeterminations. Both of these improvements are also suggested improvements for the Crippled Children's Services Program policies and are covered in another portion of this report. The adoption of clearer, more objective financial eligibility guidelines will not only bring the Hemophilia Assistance Program's operation in closer compliance with the statutory mandate, but also ensure equity in the future distribution of services to meet the needs of the expanding service population.

Children's Outreach Heart Program

The Children's Outreach Heart Program was established by the Children's Heart Institute of South Texas (CHIST) which is a private non-profit organization operated out of Corpus Christi. The program is partially funded through a contract with TDH. The funding for the program is allocated through a TDH sub-line item appropriation for the Children's Outreach Heart Program. The program was established to screen low-income children in south Texas for heart disease and then refer them for further diagnostics and care, if needed. Currently, screenings are provided in 22 clinic sites throughout south Texas. Two other services provided through the TDH contract with CHIST are: 1) the periodic training of interested local physicians in cardiac pre-diagnostics, diagnostic and follow-up evaluation services, and 2) the provision of monthly training sessions for public health nurses in cardiac screening procedures. In addition to this program, cardiac outreach screening activities are also provided in the Port Arthur area by a physician who is reimbursed for each clinic through the Crippled Children's Services Program funds.

Until 1980, the CHIST was funded by donations and grants from foundations. Since 1980, however, state funds have been provided to partially fund this organization's activities. After the governor's veto of the program's first appropriation in the 1980-81 biennium, funds were made available to the program by TDH out of the Crippled Children's Services budget. The following biennium TDH requested and received funds for the program in the amount of $147,000 per year. The total budget of the CHIST is $415,000 per year. In addition to the funds provided through TDH, the CHIST receives funds through TDMHMR, private donations, and foundations. The program employs four non-physician trained cardiology associates and one counselor.

In fiscal year 1983, CHIST provided 6,283 evaluations through its staff and of those 6,004 were also evaluated by a pediatric cardiologist. Of these evaluations, 31 percent were first time pre-diagnostic evaluations and 69 percent were return or follow-up evaluations. Through the pre-diagnostic evaluations, 29 percent of the children seen were found to have no heart disease and a total of 452 children were referral for specialized diagnostics or medical treatment. The total number of persons served by CHIST was 4,167. Since there is no specific program within the Institute that only uses Children's Outreach Heart Program funds provided by TDH, the exact number of children assisted through the TDH funding cannot be established.

TDH's current involvement in the Children's Outreach Heart Program is limited to the contract administration. Due to TDH's limited involvement in the program, the review focused on CHIST's and TDH's compliance with the contract, TDH's contract administration and the program's compliance with pertinent state laws. Problem's were identified in the program's lack of public information disseminated to the intended recipients of the service. However, on further examination, this problem was identified as an agency-wide concern and corrective action has been recommended in the Other Sunset section of the report. Two changes are recommended to bring the program into compliance with other state laws. These recommendations are explained below.

Statutory authority should be developed for the operation of the Children's Outreach Heart Program

The Children's Outreach Heart Program is presently carried out by the Children's Heart Institute of South Texas (CHIST) with funding made available through a sub-item appropriation designated for these services in the TDH appropriation pattern. Prior to fiscal year 1980, when this funding was first made available, CHIST operated this service funded through donations and grants from foundations. The program provides congenital heart disease pre-diagnostic and follow-up evaluation services to children of low income families of South Texas and provides training in heart disease screening procedures to local physicians and public health nurses. The program provides these services to approximately 4,000 children and performs twelve training sessions per year on a total budget of $415,000 in fiscal year 1984 of which $147,000 is funded on contract through TDH.

Funding was first appropriated to TDH for the program under the heading Children's Heart Program of South Texas in the amount of $150,000 per year by the 66th Legislature in 1979. However, this appropriation was vetoed. Later that year, some funding was made available to CHIST out of the Crippled Children's Services budget to compensate for the vetoed appropriation. TDH requested funding for the program in the following session citing the authority for the program as the previous appropriation bill. The 67th Legislature appropriated $147,000 and the 68th Legislature continued the funding. The department is again requesting funds for the program citing the previous General Appropriation Bill as the statutory authority under which the program operates.

An examination of the appropriation bills showed no specific program information to guide implementation of the program, other than the current "Children's Outreach Heart Program" sub-item appropriation heading. This leaves TDH without legislative guidance and authority by which to operate the program. According to a 1979 attorney general's opinion, "Administrative agencies have only those powers expressly granted by statute or implied from statutory authority and duties." (MW-42). A review of the department and Board of Health's enabling legislation further indicates that their authority speaks only to implementation of statutory provisions and not to the establishment of new programs not statutorily authorized. TDH has operated this program and others, for some time with only the General Appropriation Bill serving as legislative authority. The General Appropriation Bill does not contain, nor was it designed to contain, the programmatic information needed to provide the degree of legislative direction to authorize and operate the program.

The Children's Outreach Heart Program operations are not authorized in other TDH program statutes due to its current single-provider contract policy, disease specific focus, use of non-physician providers, and provision of educational services to the private practice physician community. Further, it appears unnecessary to limit the coverage of this program to only south Texas. There is no clear consensus of opinion in the field of medicine that cardiac problems are more common in either the hispanic population or south Texas. In fact, the Crippled Children's Services (CCS) Program currently authorizes a cardiologist from the Galveston area to conduct outreach cardiac clinics in east Texas but funds such activity through the CCS appropriation rather than the Children's Outreach Heart Program. Also, CCS does have plans to expand various types of diagnostic outreach work to other remote areas of the state as resources permit. As such, and in consideration of the attorney general's opinion limiting agency authority to the implementation of programs with explicit statutory authority, it is recommended that, to continue the program, statutory authority be developed which authorizes the current operations of the Children's Outreach Heart Program. The statute should include authorization for the program to provide: 1) pre-diagnostic cardiac screening of children from low income families throughout Texas; 2) follow-up cardiac screening; and 3) training of local physicians and public health nurses in pre-diagnostic, diagnostic, and follow-up cardiac evaluations. Further, the statute should specify the methods of reimbursement and contracting,

and the Board of Health's authority to issue rules to implement the provisions of the statute. The appropriate content of the rules is discussed in the next recommendation.

The department should adopt rules for the operation of the Children's Outreach Heart Program.

At present, the department negotiates a contract biennially with the Children's Heart Institute of South Texas to provide the Children's Outreach Heart Program (C.O.H.). This contract broadly sets out the scope of services, reimbursement methods and reporting requirements. The conditions of the contract state that "services are to be carried out in accordance with the applicable fiscal and legal rules and regulations, policies, and guidelines as promulgated by (TDH)".

In addition to these contract requirements, the Administrative Procedure Act (Article 6252-13a, V.A.C.S.) specifies that each agency must adopt rules of practice setting forth all formal and informal procedures but excluding internal management procedures that do not affect private rights. The C.O.H. program does provide services that directly affect the private rights of 4,000 children annually.

Formal rules have not been adopted for the operation of the Children's Outreach Heart Program. The TDH administrative policy manual was reviewed as were the program rules of the various related programs within TDH but, rules covering the specific operation of the Children's Outreach Heart Program were not found. The newly established Epilepsy Program was however identified as similar to C.O.H. in that TDH contracts out all of the services of both programs to one or two providers and both programs have small budgets. TDH has adopted formal rules for the operation of the Epilepsy Program. These rules cover client service guidelines such as the type of service, eligibility determination procedures, client appeals procedures, confidentiality and non-discrimination. The rules also cover contracting policies such as the content of the contracts and modification procedures. Such rules are helpful in clarifying the specific activities of the programs especially when the primary providers of the service are not TDH staff and the operations are not under direct TDH supervision. However, the rules adopted for the administrative operations of TDH and its various programs do not provide specific guidance for the operations of the Children's Outreach Heart

Program. It is therefore recommended that TDH adopt formal rules for the specific operation of the Children's Outreach Heart Program.

SSI-Disabled Children's Program

Services to severely disabled children are provided through a number of programs located in various state agencies. TDMHMR, TEA and TDHR all regularly provide various services to certain segments of this population. The Texas Department of Health also provides similar services through their SSI-Disabled Children's Program.

The SSI-Disabled Children's Program was established by federal law (Section 1615 of the Social Security Act) in 1976 to ensure that needed services are provided to children (birth to age 16) who are determined by the Social Security Administration to be totally disabled and impoverished and are therefore eligible for Supplemental Security Income (SSI). This program is 100 percent federally funded through the Maternal and Child Health Block Grant but all federal regulations concerning its operation were repealed in the federal Omnibus Reconciliation Act of 1981 (PL 97-35). The program, through a team of regional social workers, aids children by performing an individualized assessment of the child's needs and the available treatment resources in the community. The program staff then develop and implement an individualized plan for how the available resources should be used to best help the child meet his or her full potential. Services provided directly by the program include, diagnostics, counseling, referral, interagency liaison, and follow-up concerning the child's progress. In certain circumstances the program also provides for the direct purchase of services and adaptive equipment when such is needed and not available through other resources. All program services are provided by workers located in each of TDH's ten regional headquarters. One major purpose of the program's services is to allow children to remain in their community, receive the benefit of available treatment, and prevent unnecessary placements in institutions.

In fiscal year 1984, the program operates with a total budget of $1,945,166 and has a staff of 64 full-time budgeted positions. The previous year, fiscal year 1983, the program assisted 59 percent of the 13,881 children in Texas that were eligible for SSI. Two major changes have taken place in the operation of the program since the repeal of the federal regulations in 1981. First, the program now also assists other children eligible for TDH services on a referral basis from TDH programs. While this is currently used mostly for Crippled Children's Services

clients, expansion to assist the clients served by TDH Maternal and Child Health programs is taking place as staff resources permit. In 1983, 7,783 other TDH eligible children were provided casework assistance by the program's team of 40 social workers. However, due to the high demand for such a program and the restricted federal funding of the program, 2,263 requests for services had to be denied that same year. The average case load of assigned and active cases per worker in this program is 116 with the maximum ratio being 206 children per worker in TDH's Region 3 in West Texas. Another change since 1981 is the program's discontinuation of the cooperative agreements with the major state agencies. These were previously required by federal regulations, but deemed unimportant by staff since the major interagency differences have been worked out.

The review of this program focused on the program's administration and policies as well as, the accessibility and availability of the services, interagency coordination, and possible duplication with other agency efforts. Several problems were identified in the program that, on further examination, appeared to constitute agency-wide problems concerning public participation (e.g., the lack of information distributed to potential service users on the availability of the services and the degree to which program rules are outdated and inaccurate). Recommendations concerning the agency-wide correction of such problems are found in the Other Sunset section of the report. Also, due to the amount of regional staff involved in the program, a potential problem exists for this program as well as others, concerning confusing lines of authority. Correction of this problem is addressed in the Overall Administration section of the report.

Finally, one change is recommended in the management of the program due to the degree of interagency coordination involved and the potential for overlap and duplication of this program's services with those of other state agencies. The recommendation for this change follows.

The SSI - Disabled Children's program should renegotiate and reinstitute MOUs with the related state agencies.

Prior to the federal Omnibus Reconciliation Act of 1981, the TDH SSI-Disabled Children's Program was operated according to federal law and regulations. Under these federal requirements, certain state agencies operating programs targeted to this client population were required to enter into Memorandum

of Understanding (MOU's) with the department. These MOU's were designed to ensure that rules and regulations adopted by the several agencies concerning counseling, case management and referral services fitted together and that clients could receive program benefits as easily as possible. Memoranda of Understanding had been negotiated with: 1) TDMHMR, which along with its affiliated local providers, is the primary public resource for family counseling, case management, and long term treatment (both inpatient and outpatient) for developmentally disabled Texans; 2) TDHR which is recognized as a primary resource to this population through its Medicaid and Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT); 3) TEA which serves as the primary resource in the state for educational services to this population and is required to provide these services to all non-institutionalized handicapped children who are between the ages of three and twenty-one; and 4) other agencies such as the Texas Commission for the Blind and the Texas Commission for the Deaf who also provide services to specific segments of the client population.

As a result of the federal Omnibus Reconciliation Act of 1981, the SSI-Disabled Children's Program was included in the Maternal and Child Health Block Grant and all federal rules and regulations concerning the program were repealed, including those that required and set standards for the MOU's. Due to the repeal of the federal laws pertaining to the program, the MOU's that were in effect in 1981 have not been renewed by the various agencies.

The MOU's served a beneficial purpose in clarifying and formalizing inter-agency relationships. They addressed points of agreements concerning mutual objectives and respective responsibilities; a system for reciprocal referrals; mechanisms for financing services rendered; systems to ensure exchange of client information; and joint evaluation efforts. All of these aspects are important because the services are accomplished through decentralized agency field staff and because they provide support to disabled persons who may not be able to negotiate complicated interagency referrals on their own.

The lack of an MOU negotiated by the agency heads of the involved agencies, leaves much negotiation to the field staff who carry out the day to day activities of the program. In this program the field staff, involved primarily in casework, must therefore also make basic policy decisions such as whether services should be provided through the resources of one agency or another, how interagency transfers of confidential information should be handled, and whether referrals from the

program deserve priority status on other agencies' waiting lists. These negotiations and decisions are better made centrally by policymakers and administrators that have the authority and state-wide perspective to make these decisions. Such a decentralized process of coordination leaves the client's services dependent on the expertise of the social worker. If such negotiation fails, the handicapped child and parents can do little to attempt further negotiations or appeals since no formal responsibilities of the various agencies are established.

In conclusion, it appears that the decision made by the program in 1981 to adopt rules requiring MOUs with the various related agencies was beneficial with respect to the degree of potentially overlapping services, similar service populations of the various state agencies, the extent of regional and field operations of the SSI Disabled Children's Program and the vaguely set out responsibilities of the various agencies. Conditions have not changed significantly since that time making them no longer needed. It is therefore recommended that the MOUs previously negotiated with the related state agencies should be updated, and reinstated, and then revised on a regular basis. The timing of the revisions should be determined by the participating agencies. Further, the adoption of the MOU should comply with the rule-making procedures of the Administrative Procedure and Texas Register Act to provide input from interested parties as well as valuable information to users of the services of each agency.

Bureau of Communicable Disease Control

The Bureau of Communicable Disease is one of the oldest and most traditional of the service programs of the department. The first action the legislature took to address health issues was the creation of the position of State Medical Officer in 1879 following disastrous outbreaks of yellow fever, cholera, and smallpox along the Texas coast. The department was then named the Texas Quarantine Department. Since that time, vaccines have been added to the department's control efforts and the department has expanded its overall scope. The department now controls communicable disease through three separate programs.

The Immunization Division was established in 1968. The program with a staff of 135, now provides 6.3 million vaccinations per year and monitors immunizations. In 1983, Texas had an 80 percent immunization rate in two year olds and a 90 percent immunization rate in children attending schools and day care for vaccine-preventable diseases (smallpox, polio, mumps, tetanus, measles, diptheria, whooping cough, rubella and typhoid). In 1968 when TDH's immunization efforts first began, 20,710 children were infected and 44 children died from the previously listed diseases. In contrast, only 482 children became infected with those same diseases in 1983 and only two died. The Venereal Disease Control Program was established in 1936 and maintains a program of case-finding, treatment and outbreak investigation. Texas has an unusually high rate of V.D. (19.5 percent of the nation's syphilis cases are reported in Texas). This program treated and investigated the 250,000 reported exposures to VD and the 89,000 actual cases of syphilis and gonorrhea in 1984 with a staff of 106 people. The third division of the bureau is the Tuberculosis Services Program which was established in 1965. That year this program was a major division of the department including overseeing treatment delivered in four tuberculosis hospitals and treating the 3,037 patients with TB. The treatment of tuberculosis has changed a great deal since that time. Although the state still has two chest hospitals for the care of cases more resistent to treatment, this program currently uses medical treatment, and outbreak investigation for the control of tuberculosis on an out-patient basis. Once treatment now available is begun, most patients become non-infectious within one month. The program is also active in the control of Hansen's Disease (leprosy) and treated 1,100 cases in 1984. In fiscal year 1984, the program treated 1,950 cases of tuberculosis and provided preventive therapy to an additional 14,000 persons at

risk of T.B. with a full-time staff of 273. The three programs of the bureau control the spread of communicable disease through various efforts of immunization, public education, outbreak investigation and medical treatment.

In fiscal year 1984, the bureau operates the three programs with a total budget of $15,454,778 and a staff of 516 budgeted full-time positions. Federal funds support one percent of the Immunization Program's budget and 63 percent of the V.D. Control Program's budget. The bureau's total budget is allocated to the three programs in the following manner: Immunizations - 24 percent; V.D. Control - 21 percent; Tuberculosis Services - 54 percent. The bureau allocates .5 percent of the budget for the operation of the bureau office which employs two full-time persons.

The review of the programs of communicable disease control focused on the administration and policies of all the programs, the continued need for the services, and the efficiency and effectiveness of the services. Even though Texas has an unusually high rate of venereal disease, it appeared that program is operated in an efficient and effective manner and is seen by other state and federal programs as exemplary in the nation. Several problems were however identified in the operation of the programs that appear to constitute agency-wide problems needing agency-wide attention. These have been addressed either in the recommendations concerning Overall Administration (e.g. inconsistent physician reimbursement rates, lack of complaint mechanism, failure to collect service fees and insurance, confusing authority lines with regional staff) or recommendations concerning public participation covered in the Other Sunset section of the report (e.g. lack of formally adopted rules). However, an additional change is needed that is directly related to the statute of the bureau's V.D. Control Program. Further information on that program and the recommendation for needed change follows.

Venereal Disease Control Program

The Venereal Disease Control Program was established in 1936 to control the rapid spread of sexually transmitted disease in Texas. In this control effort, the program maintains activities of coordinating, and advising both state and local community programs, screening, laboratory testing, diagnosis, treatment, contact investigation, consultation with private physicians, epidimology, and some drug distribution. The program also maintains information on all cases of venereal disease in Texas and assists in the development and distribution of public education materials concerning the control of venereal disease (VD). All cases of VD are

required by law to be reported to TDH. Further, Texas law permits the quarantine of persons refusing to comply with the treatment of VD and sets out the intentional exposure of another to venereal disease as a Class B misdemeanor.

While there are approximately 20 identified sexually transmitted diseases, the TDH control effort primarily focuses on two of these, syphilis and gonorrhea. This is mainly due to the limited resources of the program, the high cost of identifying and treating other diseases, and in some cases the lack of medical technology to diagnose and treat the condition. Disease statistics for 1983 indicate there were 76,903 cases of gonorrhea and 12,210 cases of syphilis in Texas. Among all the various types of communicable diseases reported in the state in 1982, syphilis ranked fifth and gonorrhea second only to the common cold. Nationally, Texas' incidence rate of syphilis is the third highest of all states, and ranks 13th for gonorrhea. While the state's incidence rate of gonorrhea has been steadily declining over the past five years (down 20 percent overall), the incidence rate of syphilis has shown a marked increase of 68 percent over the same time period. In adults, both of these extremely contagious diseases can cause severe illness, sterility and even death but both are usually curable through a two to four week regimen of medication. Infants born to mothers having venereal disease during pregnancy are also critically affected by both diseases. Of the 49 cases of congenital syphilis that were reported in 1983, 21 babies were either stillborn or died shortly after birth. The congenital effects of syphilis include stillbirth, early death, mental retardation, deafness, orthopedic problems and seizures. Babies born to mothers who had gonorrhea during the pregnancy develop a form of blindness (opthalmia neonatorum) without appropriate treatment. To control the congenital effects of both diseases, Texas law requires pregnant women and newborns to be tested for syphilis and that medication to prevent blindness from gonorrhea be applied to all newborn's eyes. Failure to comply with these provisions is a Class B misdemeanor. TDH is required to distribute the medication for application to newborn's eyes if the parents are unable to pay for the medication and annually distributes about 30,000 single doses of the drug.

In fiscal year 1984, the program operates with a total budget of $3,319,240 and a staff of 106 full-time budgeted positions. That year, the program screened 450,000 women for gonorrhea, 100,000 other people for VD, and identified 250,000 persons requiring services due to exposure or infection.

The review focused on the administration and policies of the program, as well as the accessibility of the services, the effectiveness and efficiency of the control efforts, and the program's compliance with pertinent state laws. Several problems were identified that on further examination appeared to be agency-wide concerns. Recommendations for corrective actions to these problems are covered in the Overall Administration section (e.g. inconsistent physician reimbursement, lack of complaint procedures, failure to collect service fees, and confusing lines of authority with regional staff). Also a recommendation made in the Other Sunset section of the report concerning the lack of formally adopted program rules, pertains to this program, as well as others. Finally, one change is needed in the statutory provisions of this program. That recommendation follows.

The Texas Venereal Disease Act should be amended regarding the application of certain medication in the eyes of newborns.

The Texas Venereal Disease Act (Art. 4445d, V.A.C.S.) requires the application of "prophylactic medication" (a medication administered to prevent a disease) in the eyes of every newborn within two hours of the child's birth. The applicable portion of the statute is quoted below.

> "Every physician, nurse, midwife, or other person in attendance at childbirth shall use or cause of be used in the chid's eyes a one percent solution of silver nitrate or other prophylactic solution approved by the board (Texas Board of Health) within two hours of the birth in order to prevent opthalmia neonatorum in the newborn." (Art. 4445d, Sec. 3.02(a), V.A.C.S.)

The application of such treatment prevents opthalmia neonatorum which is a form of blindness that infants may contract if the mother has gonorrhea during the pregnancy and birth process. Although such treatment is effective and is a medically accepted practice when administered under the supervision of a physician, the medications used for such treatment (silver nitrate, tetracycline and erythromycin) have been determined by the federal Food and Drug Administration to be dangerous unless used under the supervision of a physician and therefore require a prescription. The improper use of silver nitrate has been found by the manufacturer to produce adverse reactions including cauterization of the cornea leading to blindness especially with repeated applications, severe and possibly fatal gastroenteritis (if swallowed), and irritation of the skin and mucous membranes. The prohibition against the application of prescription medications unless under the

supervision of a physician is found in the Dangerous Drug Act (Art. 4476-14, Sec. 3, V.A.C.S.) Pharmacy Act (Art. 4542a-1, Sec. 19, V.A.C.S.), Nurse Practice Act, (Art. 4518, Sec. 5, V.A.C.S.) and the recently enacted Lay Midwifery statute (Art.4512-i, V.A.C.S.). In recognition of the prohibitions on the use of this medication and the possible dangers and benefits of its use, it is recommended that the Section 3.02(a) of the Texas Venereal Disease Act be amended to allow only physicians, and nurses and midwifes who are authorized through standing delegation orders by a supervising licensed physician, that are in attendance at a childbirth, to use such medication.

Another change is needed in the following section (Section 3.02(b)) of the Texas Venereal Disease Act. This section also conflicts with the Pharmacy Act and the Dangerous Drug Act in requiring the Texas Department of Health to distribute this medication to health-care providers. It states:

> "The department shall furnish silver nitrate solution free of charge to health-care providers if the newborn's financially responsible adult is unable to pay." (Art. 4445d, Sec. 3.02(b) V.A.C.S.)

The department has reported that they interpret health-care provider to include midwives and nurses, and regularly distribute the medication to these providers (totalling 30,000 doses per year). Yet the department's distribution of this prescription drug to them is prohibited by the Pharmacy Act and the Dangerous Drug Act. An exception is made in these laws if the person is a trained provider under the supervision of a licensed physician and has been given a standing delegation order for the use of the drug by that physician. In consideration of the prohibitions on the distribution of this medication except as authorized by a standing delegation order from a supervising licensed physician and the dangers of the unsupervised uses of this medication, Section 3.02(b) of the Texas Venereal Disease Act should be amended to require the Texas Department of Health to furnish the prophylactic solution, approved by the board for such use, to licensed physicians and licensed nurses and midwifes with standing delegation orders for the use of such medication from a supervising licensed physician. The broadening of the choice of medication (instead of specifying silver nitrate) is due to recent pharmaceutical advances which may change the drug of choice for this use in the near future.

In summary, the recommendation is made to correct a conflict in the Texas Venereal Disease Act with several Texas laws concerning the distribution and

application of certain prescription drugs. The amendments recommended would require only those persons authorized through the other existing laws to apply this medication and would require the department to distribute this medication only in compliance with the other existing state law.

Bureau of Long Term Care

The Bureau of Long Term Care is assigned the responsibility of regulating long term care facilities under a complex arrangement involving state and federal laws and regulations as well as an interagency contract between the TDH and the Department of Human Resources. The Department of Health performs routine inspection duties of the facilities to carry out both licensure and certification functions.

The Department of Health staff have been involved in the "licensure" of certain long term care facilities since 1953. The facilities covered under licensure include nursing homes, custodial care homes, personal care homes, maternity homes, facilities for the mentally retarded, adult day health care facilities and adult day care facilities. An "institution" covered by the licensure program is defined in statute to include "an establishment which furnishes (in single or multiple facilities) food and shelter to four or more persons unrelated to the proprietor, and, in addition, provides minor treatment under the supervision of a physician licensed by the Texas State Board of Medical Examiners, or services which meet some need beyond the basic provision of food, shelter and laundry." (Sec. 2, Art. 4442C, V.A.C.S.).

The department states that the goal of licensure is to assure, through a program of regular inspections, that facilities meet minimum health and safety standards and that residents receive adequate care. Current law requires at least two inspections annually to examine the facilities' operations. These inspections review the facilities' building construction and maintenance, administrative services, nursing services, dietary services, pharmacy services and housekeeping services. As of June 1984, 1,133 facilities were licensed providing a total of 108,756 beds.

Another major function of the bureau involves the "certification" of long term care facilities. Although similar in purpose to the licensing program, certification is voluntary and is connected to the facility's participation in federal reimbursement programs (e.g. Medicaid). To receive reimbursements from these federal programs the facilities must be certified on an annual basis. Once certified the facility receives a mix of state and federal Medicaid dollars on a per patient per day basis. The department estimates that nearly every long term care facility participates in the Medicaid program (approximately 1,092 of the 1133) while less than 60 participate in the Medicare program. The basic difference in the two

programs is the degree of medical care and physician supervision involved in the Medicare program. Certification efforts are also aimed at facilities serving the mentally retarded. Included in this program are small group homes and portions of the state schools operated by the Department of Mental Health and Mental Retardation. As of August 1984, 156 MR facilities were certified with a total of 13,828 beds.

Since 1977 the program has conducted "utilization review" functions. These functions basically involve an inspection of the care each patient receives in a certified facility and a determination that the placement of the patient in the facility is appropriate. Particular attention is given to the degree of medical care needed by the patient and whether or not another "level of care" (e.g. more skilled nursing services) is appropriate. This system is conducted in cooperation with the Department of Human Resources which is responsible for determining the per patient per day payment rates paid to the facilities through the Medicaid program. In total the DHR estimates that $436,900,000 in Medicaid payments were made in fiscal year 1984 to certified facilities for their care of an average of 55,966 persons per month.

Although the bureau carries out other consultation functions and the certifications of medication aides, the other major function of the bureau is the response to complaints regarding the operation of facilities it regulates. The department has established a toll free hot line to assist the public in voicing complaints and conducts an active program to respond to each complaint. A review of documents maintained by the department indicates it receives some 780 complaints per month with 270 of those relating to patient care. In response to these complaints and its own enforcement and inspection program the department takes punitive actions ranging from compliance notices or letters to closure of the facility. Material developed by the Attorney General's Office indicates that in 1983 the department issued 573 compliance letters, 263 vendor hold recommendations, 112 decertification proposals involving 531 separate facilities. Four facilities were closed during the year with assistance of the Attorney General.

To carry out the duties of the bureau, the department employed 561 persons (472 in the regions) and budgeted $15.9 million in 1984. The review of the bureau involved overview discussions with the staff concerning the major functions of the bureau. The review focused on the bureau's activities involving the regulation of nursing homes as well as the bureau's relationships with other state agencies in

carrying out its regulatory duties. Improvements were found to be needed in the enforcement ability of the program, in the method of selecting the Life Safety Code used in inspections and the framework used in assessing fees to offset the cost of regulation. The recommendations concerning these improvements are set out below.

The statute regarding the regulation of nursing homes should be amended to provide a funding source for trustee appointments.

The TDH currently has authority to initiate injunction proceedings against a nursing home to restrain it from violating standards of care when such violations create an immediate threat to the health and safety of the residents of the home. Use of this remedy is a drastic action because as a practical matter a home cannot be closed quickly and such action may not be in the best interests of the patients.

In recognition of this kind of situation, the legislature amended the nursing home regulatory Act in 1981 to provide for the appointment of a "trustee". The purpose of the provisions added in 1981 was to "provide for the appointment of a trustee to assume the operations of these facilities in a manner calculated to emphasize resident care and reduce resident trauma." (Sec. 6c(a), Art. 4442c, V.A.C.S.). The Act specifies that a trustee can be requested by persons holding a controlling interest in the home or can be appointed by the courts when so requested by the attorney general. In the latter case the licensing agency can request the action of the attorney general under conditions which "present an immediate threat to the health and safety of the patients." The process is used infrequently and the department reports that in the last three years only three trustees have been appointed. Although this appears to be a useful mechanism to protect patients of homes which are not operated properly, one concern regarding the procedure was identified during the review.

The department reports that in situations calling for the appointment of a trustee by the courts, the facilities are in such poor condition that the facility ownership might not have money readily available for food, supplies, payroll or other expenses needed to meet the very basic needs of the residents. The review of the last three trustee reports to the appointing court verify that the conditions of the homes involved had seriously deteriorated but that the trustees were able to obtain funds to improve conditions in the home to an acceptable and safe level. The department contends, however, that in situations prior to the last three

trusteeships and in future situations the lack of quickly available funding has and could present delays in obtaining a trustee to rectify situations which threaten the health and safety of the residents of the home. To remedy this problem it appears a trustee funding mechanism, controlled by the Department of Health, should be developed.

The development of such a process was the subject of past legislation. Although none of the related bills passed they do provide good frameworks for the development of a trustee fund. Basically, the statutory amendments need to provide for three items: 1) a method to establish the fund; 2) assurances that loans from the fund will be used only as a last resort and only when other funding sources are not available; and 3) a method to recover any dollars dispersed from the fund.

To establish the fund, it appears that the current licensee population should bear the responsibility. The department has indicated that a $1.00 fee could be added to the per bed licensee fees now paid by nursing homes and that this would generate approximately $100,000. This approach appears reasonable in that licensure fees are designed to support regulatory permitting and enforcement efforts. A comparable example exists where the insurance industry utilizes a similar concept to cover the costs associated with bankrupt insurance companies. In this case, each insurance company pays guarantee funds which are utilized by the Board of Insurance to cover any outstanding policies a bankrupt company may leave behind. The concept of requiring an additional per bed fee to the license renewal of nursing homes will provide an adequate trustee fund should it be needed in the future.

If the fund is authorized, the department should be allowed to make a loan from the fund only as a last resort. The current nursing home regulatory act provides that the trustee has access to any medicaid or third party payments available to the facility for the care it has rendered to the patients. It appears prudent to require that a loan from the fund can only be made upon justification to the department that other funds are not available and that an emergency exists that presents an immediate threat to the health and safety of the residents.

The fund will need to be replenished once it is used. The replenishment of the fund can be accomplished by using two systems in tandem. First, provisions should be enacted to require the loan to mature at the end of one year. The unpaid principal of the loan at maturity should bear a significant amount of interest. Second, the Board of Health should be empowered to examine the balance of the

fund on an annual basis and to assess an additional fee to replenish it to a specified level deemed adequate by the board but not to exceed $125,000.

In summary, the development of a fund controlled by the department to assist in the appointment of a trustee for a nursing home appears reasonable. Such a fund, operated under pertinent controls will enable the department to seek the prompt appointment of a trustee when the condition of a nursing home deteriorates and threatens the health and safety of the patients.

Hearing and appeal provisions of the nursing home licensing statutes should be amended to conform to the Administrative Procedure Act.

The statutes governing the licensure of nursing homes (originally passed in 1953) allows the health department to deny suspend or revoke the license of a nursing home under certain conditions (Sec. 6, Art. 4442c, V.A.C.S.). The Act also sets out that the licensee must be afforded an opportunity for a "fair and prompt" hearing conducted in accordance with agency rules. The agency reports that one such hearing was conducted in the last year.

The procedures followed by the agency in the hearing are those set out in the Administrative Procedure Act (Art. 6252-13a, V.A.C.S.) passed in 1975, some 22 years after the initial passage of the licensing act. To simplify and update the licensing statute it appears appropriate to amend it to specify that the procedures followed by the agency in the denial, suspension or revocation of a license should be in conformity with the Administrative Procedure Act (APA).

In a related matter, the current Act (Sec. 10, Art. 4442c, V.A.C.S.) requires that an appeal from a revocation action must be "de novo". The effect of the trial de novo requirement is to nullify the administrative actions taken prior to appeal. The APA provides the "substantial evidence" rule as an alternative to the de novo process to reduce the time needed in court to "re-try" a case on appeal. This approach is used in other TDH regulatory programs (e.g. Radiation Control) and in nursing home contract cancellation cases handled by the Department of Human Resources. Modifying the statute to require the use of the substantial evidence rule rather than trial de novo appears to be a useful modification to the nursing home licensure statutes as they are updated to match the current provisions of the Administrative Procedure Act.

The Department of Health should be authorized to assess administrative penalties in its regulation of nursing homes.

The purpose of the statute governing the licensure of nursing homes is "to promote the public health, safety and welfare by providing for the development, establishment and enforcement of standards; 1) for the treatment of individuals in institutions...; and 2) for the establishment, construction, maintenance and operation of such institutions which in light of advancing knowledge will promote safe and adequate treatment of individuals in institutions." (Sec. 1, Art. 4442c, V.A.C.S.) The review of the department's activities under this statute have been focused on its efforts to regulate and enforce standards regarding nursing homes.

The department reports there are approximately 1,100 nursing homes with a total bed capacity of approximately 100,000 beds. Each home is inspected on a regular basis and the department staff carry out an active survey and enforcement program to determine if facilities are operating in compliance and to follow up on any complaints. In general, the survey and enforcement functions are governed by federal laws and regulations related to the medicaid and medicare programs. Specific standards have been established and THD staff inspect the facilities at least twice a year and more often if complaints are lodged concerning the operations of the facilities. The structure of the nursing home regulation program requires coordination between the TDH and the Department of Human Resources. The DHR pays for the care of some 56,000 Medicaid - Title XIX patients in nursing homes at a total cost of $436.9 million (FY 1984 figures). The state picks up approximately 45.8 percent of the cost of this program ($200.2 million) with the federal government paying for the remainder. To operate the program TDH performs the inspection and enforcement functions of the program through contract with DHR and DHR handles the general administration of the patient payment system.

In general, the TDH program, known as the Bureau of Long Term Care, has several enforcement tools it can use upon discovery of a violation of standards or law. In order of severity the following actions can be taken:

1. Compliance Notice - demand of facility that violations be corrected within a specified time frame.
2. Recommendation for Vendor Hold - TDH recommendation to DHR that medicaid payments to facility be held until violations are corrected. Administrative appeal to DHR.

3. Denial of Certification/Decertification - TDH action to withdraw medicaid approval. Administrative appeal to TDH.

4. Denial or Revocation of License - TDH action to deny license or remove license. Administrative appeal to TDH with further appeal to district court.

5. Injunction and Temporary Restraining Order - request through TDH to district court to prohibit continuing violations by facility.

6. Civil Penalties - not less than $100 nor more than $500 for each act of violation. Penalty assessed by district court upon petition of TDH.

7. Emergency Suspension and Closing Order - an order issued by the commissioner of health when violations create an immediate threat to the health and safety of residents. The facility is closed and residents are relocated.

The most common actions taken by the health department involve the first two steps. Compliance notices are almost always issued upon inspection and basically provide the facility with notice that certain violations of the standards have been encountered and that the facility must establish a time frame within which specific actions will be taken to correct the situations. The violations noted in these compliance notices usually relate to deficiencies in the sanitation of the facility or possibly minor life safety code violations that do not pose a threat to the health and safety of the patients. If however, the deficiencies do pose an immediate threat or hazard to the health and safety of the patient then the enforcement actions are escalated and can result in action by DHR upon request of TDH to cancel the facility's medicaid contact or place the facility on "vendor hold". The vendor hold action temporarily suspends the flow of reimbursement dollars from DHR to the facility. This system serves as a deterrence to violation of regulations since the average per day payment for a medicaid patient in a nursing home is $21.39 (1984). Should a home have 100 medicaid patients, a vendor hold represents the loss of $64,170 monthly ($21.39 X 30 days X 100) until the vendor hold is released. The release of a vendor hold is of course dependent on a reinspection of the facility by the TDH staff and a finding that the deficiencies have been corrected.

In general, it appears the enforcement program has a number of effective tools to encourage compliance with the regulations. Steps have been taken in recent months to strengthen the vendor hold system and the TDH staff efforts appear prompt in responding to complaints and initiating sanction action when necessary. A review of 122 enforcement actions taken in 1984 (January thru May)

indicate that compliance was achieved in 86 of the cases within the time frame of the sample, which represents a 70 percent compliance rate. The average time between the date the deficiencies were discovered and the date of revisit to verify that the deficiencies had been corrected averaged 32.2 days. Of the 36 cases where compliance had not been reached, the department reported that 16 continued on vendor hold, 12 were "pending", three contracts had been cancelled, two facilities had been recommended for contract cancellation, two had closed and one was denied initial certification for the medicaid program. The age of these cases ranged from 5 to 63 days.

Although the agency is active in its enforcement efforts concerning nursing home regulation it appears that modification of its current range of sanctions could improve its efforts. The enforcement effort regarding nursing home problems needs to be quick and effective. The patients cared for in nursing homes are often times not able to "fend for themselves" and regular inspection and enforcement actions of the department need to ensure that a safe environment is continually maintained in the facilities. The common enforcement method now used when conditions in the facility deteriorate to a hazardous level is to impose the "vendor hold". This sanction requires the action of two state agencies, TDH and DHR. Although the agencies appear to have streamlined the paper flow to initiate the vendor hold it takes 7 to 14 days to transmit the inspector's observations through TDH to DHR to initiate the vendor hold. The facility's payments actually stop five days after the date of the letter from DHR to the facility notifying it of its vendor hold status. Even recent changes in the vendor hold sanction program made by DHR do not appear to be having the desired effectiveness. On November 9, 1983, DHR instituted rule changes which require the cancellation of a facility's medicaid contract when two vendor holds are made against a facility within a twelve month period. Since the initiation of the program 9 months ago, 17 facilities have already reached this contract cancellation status. Further, the Department of Health is responsible for regulating some 39 facilities with approximately 2,850 beds that do not participate in the medicaid or medicare programs. In these cases the department does not have the vendor hold or contract cancellation enforcement tool and must depend on revocation of license or court actions to take care of deteriorating conditions in these facilities.

In February 1984, the Attorney General presented material to the Joint Committee on Nursing Home Reform that urged the addition of administrative

penalties to the range of sanctions available in the nursing home regulatory program. In part, the attorney general's testimony says the state needs to be able to impose penalties in a manner that is less cumbersome and time-consuming than seeking civil penalties through the court system.

An administrative penalty is different from other enforcement actions in that a fine is levied by the agency for a violation. Currently, civil penalty action is taken in a court suit rather than an administrative procedure and the vendor hold process requires the action of two agencies rather than one. The advantage of quick application of a penalty is particularly appropriate in the regulation of nursing homes since time delays in correcting deficiencies can have serious consequences for the patients of the nursing home.

The implementation of the administrative penalty process for the Department of Health will require close cooperation and coordination between the department and the Department of Human Resources. The structure of the penalty system should impose different levels of fines based on the severity of the situation. The process developed to impose the fines will require a structure that is unlike that found in the department's traditional regulatory actions. To develop a process that is fair to the facility being fined and fits into the unique board and departmental set-up, the following steps should be provided for:

1. The decision at the bureau (central office) level to take the action to fine a facility and a determination of the amount of the fine to be assessed and recommended to the commissioner. The commissioner then assesses the fine upon approval of the board of health at its next regularly scheduled meeting.
2. If the violator protests the application of the fine then a hearing will be held by a hearing examiner of the department's general counsel's office. The hearing examiner then makes a recommendation to the commissioner concerning the fine. The commissioner then assesses the fine upon approval of the board of health at its next regularly scheduled meeting.
3. If the final decision of the commissioner, approved by the board of health, is appealed, the appeal will be held under the Substantial Evidence Rule. Additionally before an appeal can be made, the penalty should be paid into an escrow account.

Concerning the amount of the fine, the fine amount should vary according to the severity of the violation. Although the details of the fine system should be worked out by the bureau through rulemaking it appears appropriate to provide a statutory cap of $25,000 per violation.

The statute should be amended to allow the board of health to determine which Life Safety Code should be used in the regulation of nursing homes.

The Life Safety Code, developed by the National Fire Protection Association (NFPA), provides guidance in the construction of public buildings to help ensure that persons can safely leave such buildings when a fire emergency exists. More specifically, it covers construction, protection and occupancy features to minimize danger to life from fire, smoke, fumes or panic before the buildings are evacuated. The code has undergone numerous revisions and is periodically updated and approved by the NFPA. The first efforts leading to today's code were finalized in pamphlet form in 1916 - "Outside Stairs for Fire Exits" and in 1918 - "Safeguarding Factory Workers from Fire." Since the early beginnings, the code has covered an increasing number of topics and first specifically addressed nursing homes in 1955. The revision process has produced complete codes on basically a three year cycle since 1967. The changes in the codes are usually minor and reflect changes in technology which allow certain potentially hazardous conditions to exist if an effective fire fighting mechanism, such as a sprinkler system, is also present.

The code is used in Texas in the regulation of nursing homes and buildings used for nursing homes must meet its standards. Nursing home statutory provisions (Sec. 4A, Art. 4442c, V.A.C.S.) currently allow for the use of different codes depending on the age of the facility. For example, homes approved for construction or remodeling after September 1, 1979 must meet the provisions of the 1976 code and those constructed and approved prior to that date can meet the provisions of the 1967 or 1973 code, depending on the timing of the construction or remodeling of the particular facilities. The 1981 code is now used for new nursing homes participating in the medicare or medicaid programs. The department indicates that application and use of one code is preferable and that the 1981 code does provide allowances to approve homes constructed under previous codes. In fact, copies of the 1967 code are no longer available and the department reports

that the use of the many different codes makes the job of the agency's inspectors unnecessarily complicated.

The apparent solution to the situation is to adopt the 1981 code for the department to use in its inspection processes. The fact that the code is continually updated, however, does present the problem of having to amend our state statutes frequently in this area. In fact, there is now a 1985 code expected to be approved in November 1984 by the NFPA.

In the regulation of hospitals, the department is not required by state statute to follow any particular code. In practice, it has adopted the 1981 code for its medicare participating hospitals and for its non-participating facilities it has built into its governing rules the provisions of the most current code. These rules can be changed as new codes are developed without having to amend the regulatory statutes. This kind of approach appears suitable to the nursing home situation.

To avoid the problem of having to continually amend the nursing home regulatory statutes it appears feasible to provide the board of health the statutory authority to specify which code should be used and the rules of the board governing the regulation of nursing homes can be amended as needed. Requiring that the board's decision be developed through rulemaking will allow nursing home industry input into the process. This will serve a similar purpose yet avoid the more cumbersome process of specifying in statute which code or codes will be used.

The Nursing Home regulatory statutes should be amended to require the department to collect fees in relation to the costs of the regulatory program.

The purpose of the licensing Act governing nursing homes is to "promote the public health, safety and welfare by providing the development, establishment and enforcement of standards; 1) for the treatment of individuals in institutions of the character defined and covered herein; and 2) for the establishment, construction, maintenance and operation of such institutions which in the light of advancing knowledge will promote safe and adequate treatment of individuals in institutions" (Sec. 1, Art. 4442c, V.A.C.S.). To accomplish this goal the department carries out an active application review, license renewal and enforcement program regulating nursing homes and related institutions (e.g., custodial care homes). One of the significant activities of the licensure effort is the review and approval of nursing home construction projects. The department is authorized to collect initial and

renewal licensing fees of $50 per facility and $2 for each bed in the regulated facilities. These fees will bring in approximately $335,000 for fiscal year 1984.

The department reports that the total cost of the licensure program for fiscal year 1984 is approximately $1,370,000. This total includes employee benefit as well as administrative overhead costs. A comparison of this figure to the fees collected for the program indicates that approximately 25 percent of the cost of the licensure program is paid for through the fee structure currently in place. The remaining cost of the program is paid for through the use of general revenue funds (approximately $1 million).

As a general rule, some portion of the cost associated with regulating an industry or business should be borne by those regulated. In another program operated by the department's Bureau of Radiation Control, the fee collections are set to recoup approximately 50 percent of the program's cost to the state. Further, a fee structure should provide for the assessment of fees that are reasonably related to the costs to the agency for performing the various aspects of regulation. The current fee structure is inflexible in that it charges all facilities a flat rate dependent on the size of the facility. This structure requires all facilities to help support regulatory efforts of the program, such as the construction plan and approval process. The department reports that in a recent 12 month period the nursing home regulatory staff received 418 plans for review, conducted 97 consultation visits and another 97 on-site approval inspections. The department estimates that the cost of these construction review efforts totalled $373,000 in fiscal year 1983 and $269,000 through May of fiscal year 1984. The current fee structure does not allow for any direct fee assessment to offset the cost of these construction review efforts. The end result is that all facilities, under the current fee structure, help support this distinct effort even though most do not engage in new construction or remodeling on an annual basis.

To address the above issues, it appears appropriate to modify the authority of the department to collect fees in its nursing home regulatory program to offset a greater amount of its cost using a fee structure related to the specific costs of the program. Three factors should be considered in the fee development process.

First, the fees should be set to recover at least 25 to 50 percent of the program's cost of operations. This guideline is in keeping with fee amounts set for another TDH program regulating the uses of radiation in the state. The range of fees gives the agency the flexibility to determine an amount most appropriate for

its effort, while also encouraging increases in dollars to offset the cost of regulation without creating a strong disincentive to compliance with the licensing standards of the agency.

The second factor which should be considered in the development of the fee structure is that the fees charged should be reasonably related to the costs to the agency for performing the various aspects of regulation. For example, fees should vary in accordance with the efforts needed to approve initial and renew licenses, to conduct its enforcement program and to review and approve construction projects.

The third factor which should be considered in the development of the fee structure is that all affected parties should have ample opportunity for input into the process. The information necessary to examine the impact on the nursing home industry and the actual costs to the agency for its licensing enforcement and construction review activities need to be complete. Requiring that the fee structure be adopted through the rulemaking and hearing provisions of the Administrative Procedures Act (APA) will assist in ensuring that the work will proceed with specified schedules and opportunities for those concerned with the proposal to have input.

Bureau of State Health Planning and Resource Development.

The Health Department is designated by state law as the federally required State Health Planning and Development Agency (SHPDA). The Bureau of State Health Planning and Resource Development within the TDH carries out certain duties of the state regarding health planning. In fiscal year 1984, 39 staff persons and $1,175,296 budgeted funds allow the TDH to conduct a range of planning, data gathering, data analysis and technical assistance activities which culminate in basically two functions: 1) the development of the State Health Plan for Texas and 2) the provision of data to the Texas Health Facilities Commission in its conduct of the "certificate of need" or CON process. The federal law (PL 93-641 as amended) which requires these efforts, has a history dating back to 1966. The goal of this law is to help the nation and its component states develop an orderly system for the development of health services in the most economical manner. The need for such a system is graphically represented in material developed by the SHPDA and included in its recently released "Proposed State Health Plan" for 1985. According to the plan, the total cost of health care services and supplies in Texas increased from $5.8 billion in 1975 to $15.3 billion in 1982. As a nation, health care expenditures increased from $132.7 billion in 1975 to $322.4 billion in 1982 representing 10.5 percent of the gross national product in 1982. In 1950, all health care expenditures totaled $12.7 billion for the nation. Based on these figures, it appears continuing efforts are needed in Texas to ensure that health care services are wisely developed and health care dollars are wisely spent.

The review of the health planning system in Texas has included an examination of the duties and functions of the two major facets of the current system, the Statewide Health Coordinating Council (SHCC) and TDH in its role as the State Health Planning and Development Agency (SHPDA). The Texas Health Facilities Commission also plays a crucial role in the planned development of health resources but that agency is being reviewed separately under sunset and recommendations concerning its operations are developed in a separate report.

The governor influences the state's health planning system in at least two ways. First, the governor appoints the members of the SHCC. Second, the governor under federal law is also able to "opt out" of the requirement that the state establish local "health systems agencies" to provide local perspectives on health planning issues. These health systems agencies or HSAs were eliminated by Governor Clements upon approval of the Secretary of the Department of Health

and Human Services in the fall of 1982 on the condition that the governor develop an alternate plan for obtaining local input. The local input previously provided by the HSAs has been carried on in modified fashion by the SHPDA since that time. During the course of the review, the staff of the governor's office have been working on a plan to develop an alternative structure to obtain the local input once provided by the HSAs. Since this process is still under way, the review did not examine alternatives to the current system of obtaining local perspectives. Instead, the review has focused on the functioning of the health planning process at the state level.

Another component of the overall health planning process in Texas involves the newly created Health and Human Services Coordinating council. This 19-member body chaired by the Governor, was established by the 68th Legislature in 1983. The council has many broad duties one of which is to "serve as the primary state resource in coordinating and planning for health and human services." The transfer of the TDH planning functions to the coordinating council was considered and the results of the review are presented in the Alternatives section of the report. Although the transfer appears feasible it needs to be carefully planned.

The review also examined the overall structure of the health planning process, as carried out by the TDH, the function of the Statewide Health Coordinating Council, the general purpose of the State Health Plan, and the interaction of the SHPDA with the Health Facilities Commission. The review indicates that several actions need to be taken if the state continues to use the current health planning structure. First, the purpose and duties of the SHCC are not clearly delineated in statute. Second, current statutory provisions do not provide a clear picture of what the State Health Plan is, when it should be developed and how the plan and its recommendations should be tied into the state's legislative and executive decision-making processes. Third, the relationship between the SHPDA and the Texas Health Facilities Commission needs improvement. The following recommendations address these concerns.

The statute should be amended to clarify the duties of the SHCC.

The statute establishing the state's health planning process includes minimal and passing reference to the Statewide Health Coordinating Council or the SHCC. Thus, little guidance is provided in determining what its duties and activities are and how the council fits into the overall state agency structure needed to conduct

health planning. The SHCC is a federally required body and its specific duties are controlled largely by federal legislation - specifically P.L. 93-641 and subsequent amendments.

A similar kind of federally required policy body, the State Job Training Coordinating Council (SJTCC) was established in 1983 by the 68th Legislature in response to the Federal Job Training Partnership Act (PL 97-300). This council is designed to oversee the state's implementation of the federal Act and provide a planning and evaluation focus concerning employment and training services in the state. In establishing the SJTCC, the legislature took a specific approach in outlining the basic duties of the council. Although it does not appear necessary to detail each of the duties of the SHCC in statute, a statutory framework similar to that of the training council would provide general guidance for the SHCC and its activities. The review indicates that the following basic elements are needed in statute.

First, the statute should indicate that the SHCC is appointed by the governor and that its composition is structured to comply with applicable federal laws. Second, a brief statement of the purpose of the SHCC is needed. Overall, the purpose of the SHCC should be defined as follows:

1) provide guidance to the SHPDA (the Health Department) in the development of the State Health Plan;
2) approve the State Health Plan for submission to the governor;
3) encourage the implementation of State Health Plan recommendations; and
4) perform other functions in keeping with responsibilities required by applicable state and federal laws and the governor.

Third, the statute should require that the details of the SHCC's efforts to accomplish its functions be developed as rules of the council and adopted in accordance with the Administrative Procedure Act (Art 6252-13a, V.A.C.S.). These changes will provide a basic framework for the operation of the SHCC and better define its role in the state health planning process.

The statute should be amended to clarify the State Health Plan's purpose.

Past criticisms of the State Health Plan have been numerous. They mainly relate to the plan's size and lack of focus which make the plan impractical to use. In 1982 the plan was over 700 pages in length and included more than 350 goals.

The plan was primarily narrative, and served as a reference and survey document rather than a plan for achieving specific goals. Further, in recent years the Texas Health Facilities Commission has indicated that the data included in previous plans was not specific enough to guide the certificate of need process as required by federal law (PL 93-641).

The staff of the State Health Planning and Development Agency (SHPDA) who are responsible for the development of the State Health Plan, are well aware of the criticism of the previous plans and have taken steps to correct the past problems in the development of the 1985 State Health Plan. The plan is currently much smaller and provides a better focus, addressing 13 major issues and proposing specific actions to be taken to address these issues.

Currently, the state statutes, simply require that "the department shall prepare, review, and revise a preliminary state health plan." (Art. 4418h, sec. 4.04, V.A.C.S.). The National Health Planning and Resources Development Act of 1974 (P.L. 93-641) mandates that the State Health Plan set goals for the number and type of services needed to provide citizens of the state with accessible, high quality health-care, at a reasonable cost. According to the federal act, this should include a survey of what services are currently available, and the identification of specific services and facilities needed to address deficiencies in the system. From this perspective, the State Health Plan should provide guidance in evaluating the need for proposed health-care services and facilities in the state. Through the coordination of health planning and the certificate of need process, it is felt that unnecessary health-care expenditures can be avoided, and resources can be directed to areas where there is a true need for additional services or facilities.

Texas has taken a broader approach to health planning and uses the health planning process not only to develop information of use for the certificate of need process, but has also attempted to develop information of use in the overall development of health services throughout the state. The most recent effort, the 1985 Proposed State Health Plan, includes information on the specific nursing home bed need projections for 1989 but also more global recommendations. For example, the plan contains recommendations concerning the need for a case-management system for the clients served by the Texas Department of Mental Health and Mental Retardation. Although these efforts stretch the resources available for the development of the health plan, they do appear appropriate attempts to comply

with the federal statute and to provide state decision makers with information needed to make policy decisions.

Critics of the plan argue that by trying to provide specific and global or strategic planning information that the plan will continue to be a document of little utility. It appears timely to develop guidance concerning the purpose of the plan to avoid the critics' prognostication. A standard method to provide such guidance is through the development of statutory language which sets out the purpose of an effort, in this case the State Health Plan, and the expectations of what is to be gained by the effort. The enactment of a statute provides interested persons opportunity to shape the purpose of the effort and to establish a general measuring stick to evaluate the effectiveness of the effort as it is carried out. The current statute is inadequate to provide this measurement of effectiveness and the continuing criticisms of the plan and its lack of usefulness indicate that an opportunity is needed for interested parties to address their concerns through the legislative process.

As a framework for this process the following broad purposes of the State Health Plan appear appropriate for inclusion in statutory language. First, it should be made clear that the primary purposes of the plan are to identify:

1) major statewide health concerns;
2) the availability and use of current health resources of the state; and
3) the future health service and facility needs of the state.

Second, the statute should require that the plan:

1) propose strategies for the correction of major deficiencies in the service delivery system;
2) provide direction for the state's legislative and executive decision-making processes to implement the strategies so identified.

Third, the statute should require that the information needed to develop the plan be gathered through systematic methods designed to include local, regional and statewide perspectives. Fourth, the statute should require that overall directives for the development of the plan be generated by the SHCC through joint participation with the Health and Human Services Coordinating Commission. Finally, the statute should require the State Health Plan be reviewed and commented upon by the Health and Human Services Coordinating Council prior to its submission to the Governor.

The placement of the broad mandates in statute will serve as guidance for the development of the plan. They will also provide a method to determine the effectiveness of the current planning process. This method is currently missing due to the vague nature of our present state statutes.

Statutes should be amended to require affected agencies to address funding aspects of the State Health Plan.

The State Health Plan currently in preparation for 1985 is designed to make recommendations requiring legislative actions. These actions many times relate to the appropriation of funds to address issues identified through the health plan development process. For example in the Proposed 1985 State Health Plan, the "Health Protection" section presents several recommendations "to bring the health and environmental dangers of hazardous waste under control." In conjunction with recommendations being developed by the Governor's Task Force on Hazardous Waste Management the plan recommends that the legislature take the following actions:

"1. Levy a waste end tax on hazardous waste disposed in Texas to provide an economic incentive to encourage treatment, recycling, waste exchange, or reuse and reduce unsafe disposal methods. The tax should be placed in a dedicated fund to finance the actions in paragraph (2), (3) and (4) as follows:

2. Appropriate additional funds to TDWR and TDH for permitting and inspection and for the enforcement of laws regulating hazardous waste disposal.

3. Appropriate additional funds to supplement federal "Superfund" monies for the cleanup of abandoned waste sites which are a threat to public health.

4. Appropriate additional funds for research and development of new methods of safe conversion or disposal of hazardous wastes."

In the section of the plan dealing with mental health and mental retardation the plan recommends in part that :

"1. The 69th Texas Legislature should provide state funding to TDMHMR to implement a case management system for mentally ill and mentally retarded members of the priority population who have been released from a state facility or who are at risk of admission to a state facility.

2. The 69th Texas Legislature should provide funds to develop an array of residential alternatives. This request, in the case of mental retardation, shall include funds to provide residential alternatives to mentally retarded persons and funds to provide residential alternatives to mentally retarded persons needing placement from state mental hospitals.

3. The 69th Legislature should provide funds and authority to construct on a priority basis those buildings in communities that house service activities demonstrated by scientific research to be effective alternatives to care and treatment in state facilities."

These kinds of recommendations appear appropriate for the health planning process in that they propose specific actions that need to be taken to address those issues which have come to the forefront during the plan development process. A review of the process indicates that the agencies referenced in the recommendations are consulted on a continuing basis throughout the plan's development and their input is received along with other agencies, associations and interested persons as the staff of the SHPDA prioritize the items to be addressed in the State Health Plan. One concern has been identified, however, in how the agencies address the ideas presented in the plan in their separate budget requests to the governor and legislature.

State agencies currently develop biennial budget requests for submission to the Legislative Budget Board (LBB) and Governor's Budget Office (GBO). The request documents provide detailed fiscal and performance information concerning the agencies' programs and activities. The information is formatted to provide expended and budgeted data for three years and similar data regarding requested funds for the next two years. The fiscal information is accompanied by narratives explaining the various programs and funding requests and both the chairman of each board and the administrator of each agency develop "General Statements" for the request documents. These administrator's general statements address several overview items related to the agency's operations including: 1) recent accomplishments of the agency; 2) outstanding results achieved through new methods or changes in organization or operations; 3) legal provisions which create difficulty for the agency; 4) proposed solutions for any difficulties caused by provisions of the most current appropriations act; and 5) discussion concerning any proposed federal legislation which might significantly affect the agency's operation.

As mentioned earlier, the recommendations found in the State Health Plan often times address issues which can only be resolved through funding. However,

affected agencies are not required to address the recommendations in their budget requests to the state's budget offices and the legislature.

The State Health Plan is a broad based document which is developed through the research efforts of one agency, the State Health Planning and Development Agency (the Texas Department of Health). It does not appear appropriate to require agencies to incorporate in their budget requests the items found in the plan. State government is structured to place responsibility for certain functions in separate agencies. Among the responsibilities of the separate agencies is the duty to request funds, as the agencies see fit, to carry out their separate functions in an effective manner. However, to improve the coordination of efforts to assess the value of the State Health Plan and its implementation, it does appear appropriate to require agencies affected by the recommendations of the plan to address the recommendations in the following manner. The affected agencies should submit cost data to the SHPDA and SHCC concerning recommendations contained in the State Health Plan and to indicate whether or not the agency is seeking funds in a manner consistent with the plan. If not, the agency should provide an explanation and justification of deviations from the plan. This information should be submitted to the budget offices as a separate fiscal analysis by November 1, of even numbered years.

The statute should be amended to require the adoption of the Approved State Health Plan by November 1, of even-numbered years.

There are four major stages in the development of the plan prior to the final adoption of the Approved State Health Plan by the governor. First, the plan is prepared by the State Health Planning and Development Agency (SHPDA) for submission to the Statewide Health Coordinating Council (SHCC) as the Preliminary State Health Plan. Second, the SHCC reviews and makes needed changes to the plan, which is then distributed for public comment as the Proposed State Health Plan. Third, the SHCC incorporates changes necessitated by information received through public comment and forwards the plan to the governor as the Adopted State Health Plan. Fourth and finally, the governor reviews the plan and adopts it as the Approved State Health Plan.

This process is currently not guided by a consistent timeline. The previous plan was approved by the governor in May of 1982 while the current plan is not

scheduled for the governor's approval until November of 1984. The Approved State Health Plan's purpose is to identify major health concerns, current health resources, and anticipated future health needs of the state, and then propose strategies to correct any current or anticipated deficiencies in the health care system either through budgetary or legislative changes. To achieve this purpose and ensure implementation of the needed changes, the Approved State Health Plan should be available as a part of the consideration of total revenues available as contrasted with total spending needs. This type of information is generally prepared for the incoming legislative session in January of odd-numbered years and the state health planning revenue requirements could be added to this analysis.

The 1985 plan recommendations speak mainly to changes that require legislative action or state budgetary decisions and the plan will become the Approved State Health Plan in November of 1984. This should provide enough time to work the overall dollar needs into revenue and spending data presented to the legislature in January of the odd-numbered year. It is therefore recommended that the timeframe of the development of the plan be established in statute so that the Approved State Health Plan be available by November 1 of even-numbered years.

The statute should be amended to provide for improved coordination between TDH and the Texas Health Facilities Commission.

The purpose of both the federal (P.L. 93-641) and the state (Article 4418h, V.A.C.S.) health planning laws is to "insure that health-care services and facilities are made available to all citizens in an orderly and economical manner". The state statute designates the health department as the state health planning and development agency, or SHPDA with the responsibility for developing the state health plan to guide the coordinated development of health services. Federal law also contemplates that each SHPDA conduct certificate of need reviews to determine whether or not a "need" for a proposed health-care facility or service existed, prior to its development. However, due to the strong feeling in Texas that the planning and regulatory aspects of health-care development should be kept separate, the Texas Health Facilities Commission was established as a separate agency to conduct certificate of need reviews, rather than having it done through the agency designated for resource development and planning which is TDH. This structure requires that Texas establish more specific mechanisms for coordination between

the two separate agencies, if the system is to have a meaningful impact on the cost and distribution of health-care services and facilities, as intended by federal law.

The National Health Planning and Resources Development Act of 1974 (P.L. 93-641) mandates that the State Health Plan, developed by the SHPDA which in Texas is TDH, set goals for the number and type of services needed to provide citizens of the state with accessible, high quality health-care, at a reasonable cost. According to the federal act, this should include a survey of what services are currently available, and the identification of specific services and facilities needed to address deficiencies in the system. The State Health Plan should thus provide guidance in evaluating the need for proposed health-care services and facilities in the state. Through the coordination of health planning and the certificate of need process, it is felt that unnecessary health-care expenditures can be avoided, and resources can be directed to areas where there is a true need for additional services or facilities.

During the review, coordination between the health department and the Texas Health Facilities Commission (THFC) was examined. The first area reviewed was the health department's annual survey of over 3,000 health-care facilities throughout the state. This data is made available to the THFC through computer printouts which summarize this information for each county in Texas. The health department plans to have a new "on-line" computer system operational by January of 1985, which will provide an increased ability to manipulate and analyze current data on the health-care system. In addition, the capability will then exist for the THFC to access the data directly by use of a terminal located in their offices, which interacts with the TDH computer. This will greatly facilitate the THFC's access to the data for use in the certificate of need process.

Second, the state health plan was reviewed to determine the type of guidance it provides for the certificate of need process, and if the THFC appropriately considers the consistency of proposed facilities with the state health plan. The proposed plan for 1985 identifies 13 major health concerns, with a specific priority goal within each area. According to the federal Department of Health and Human Services, "state health plan goals should be statements of desired levels of health status or performance of the health system". The goals in the Texas health plan are not this specific. For example, concerning long-term care, the plan recom-

mends the provision of supervised living facilities to the elderly and disabled. However, the goal does not address any desired level or number of facilities necessary to implement this goal. In certain areas the plan is more specific but falls short of the needs of the THFC. In the area of nursing home beds the plan provides projections on the number of needed beds in 1989. The information is broken down by Health Systems Areas (HSAs - 12 regional configurations) and smaller state planning regions (the 24 Councils of Government boundaries). Although this does provide THFC with some guidelines to use in making decisions for new nursing homes, the commission contends that smaller levels of aggregation such as county bed needs are required.

In order for planning to be effective, realistic goals must be set, and the activities necessary to accomplish the goals must be clearly defined. While identification of certain health care priorities in the state health plan may result in state agencies implementing those parts of the plan which relate to state government, or the legislature passing laws which improve the health status of Texans, a significant way in which the plan can directly impact the health-care system has been, for the most part, disregarded. The THFC in the certificate of need process is required by state and federal law to consider the relationship of any proposed health care project to the state health plan. In Tennessee, the one other state with a system similar to Texas, a program evaluation of the health planning agencies concluded that "if the established system is to effectively control statewide health care expenditures and the number of beds, there must be more congruence between the planning and regulatory process." Translated to Texas, this means that the THFC must have more specific data than is being collected by TDH at the present time.

The Texas Department of Health and the Texas Health Facilities Commission last executed articles of agreement on the coordination of their dual functions under state and federal law in June of 1978. A number of changes have occurred since that time which impact the agreement, and it appears that the process has not developed as provided for in federal law. Due to the importance of cooperation and interaction between the two agencies, it is recommended that the statute be amended to require TDH and THFC to develop and mutually agree to a "memorandum of understanding" (MOU) which clearly outlines the duties of each agency in the execution of their dual functions under both federal and state statute. The MOU should be adopted as formal rules of each agency, and reviewed and updated

annually. Secondly, it is recommended that the statute be amended to clarify that one of the health department's responsibilities is the collection and dissemination of data necessary to support specific State Health Plan goals which can be implemented through the certificate of need process. It is only through a regulatory process based on clearly defined and realistic health care goals, that Texas can improve the distribution of health care facilities across the state and attempt to contain the rising cost of health care services.

Bureau of Licensing and Certification

The Bureau of Licensing and Certification carries out many separate regulatory functions governing both institutions and individuals. The program was initially established in 1959 to regulate hospitals. The duties of the bureau now include the regulation of hospitals and home health agencies, the certification of health care providers for participation in the Medicare cost-reimbursement program, and the regulation of certain individuals including professional counselors, dieticians, speech pathologists/audiologists and athletic trainers. The bureau also coordinates the requisition, distribution, and storage of prescription and non-prescription drugs and biologicals for use by the public health clinics in Texas. In fiscal year 1984, major activities of the bureau include the issuance of approximately 9,400 professional counselor licenses, 1,500 speech pathology and audiology licenses, 500 athletic trainer licenses, 530 hospital licenses, the survey of 1,239 facilities for medicare certification and the supervision of 84 licensed "Class D" (public health) pharmacies. In total, the bureau employed 64 persons and budgeted $2,296,622 to carry out its activities.

As can be seen, the bureau carries out many diverse activities. The review of the bureau focused on two district activities, the licensure of hospitals and the supervision of the department's Class D pharmacies.

Hospital Licensure

The regulation of hospitals in the state dates back to 1959. As of September 30, 1983, department records indicate that there were 491 general hospitals and 35 special (e.g. children's) hospitals with total bed capacities of 66,491 in general hospitals and 2,172 in special hospitals. Of the 526 hospitals on record as of September 1983, 325 (62 percent) had bed capacities of 100 beds or less. Only 29 hospitals had bed capacities of more than 400.

The licensure of hospitals in Texas is primarily aimed at ensuring that the buildings used as hospitals are safely constructed allowing for quick evacuation in case of fire and that the hospitals are operated in a manner to ensure sanitary conditions. The Act itself limits the scope of licensing rules and regulations to "...safety, fire prevention, and sanitary provisions of hospitals..." (Sec. 5, Art. 4437f, V.A.C.S.). To accomplish the goals, annual fire safety reports are received either from departmental staff or from local fire authorities. Inspections in conjunction with hospital licensure are conducted in accordance with statutory

provision which limit the activity of the licensure staff to the inspection of 18 of the 530 hospitals.

Since the late 1950s, payment systems to reimburse hospitals for their cost of delivering services have evolved. Two major programs, Medicare and Medicaid, established in the mid 1960s have had a significant impact on the financial structure of the health care industry. Along with these programs, review mechanisms were established to ensure that the programs made payments to hospitals delivering a certain standard of care. Another review mechanism in place for hospitals is that conducted by the Joint Commission on Accreditation of Hospitals or JCAH. This commission, a private non-governmental survey body accredits hospitals that volunteer to be surveyed. The American Osteopathic Association (AOA) provides a similar survey function for Osteopathic Hospitals. In general these surveys examine the ability of the facilities to provide quality care in a safe environment.

In recognition of these many survey processes, the 65th Legislature enacted statutory provisions which exempt certain hospitals from licensure inspection. The department reports that any licensed hospital that is either accredited by the JCAH or the AOA or certified under Title XVIII of the Social Security Act (Medicare) is not subject to the annual licensing inspection specified under the Hospital Licensing Act. Currently, 186 hospitals are Medicare certified, 334 are JCAH or AOA accredited and 18 are subject to the licensure inspection process carried out by TDH hospital licensure staff. This structure leaves the licensure staff with basically two functions: one, the review of plans for new hospital or remodeling construction; and two, the receipt and verification of annual license renewal fees and applications.

The review of these functions indicate that they are carried out in an appropriate manner. The review of hospital construction plans provides a general public service to ensure that hospitals are safely constructed as well as a service to the hospital industry in avoiding unnecessary remodeling costs to meet licensure codes and regulations. The licensure renewal function provides a continuing check that hospitals are appropriately surveyed and regulated within the provisions of the Texas licensing act and serves as a point of contact concerning complaints regarding hospitals. However, concerns relating to the Health Facilities Commission and the general thrust of health care cost containment may indicate that the activities of this function of the department, both in licensing and

medicare certification, should be refocused. This new focus will be discussed as a part of the additional review work being done on the Health Facilities Commission.

Pharmacy Division

The Pharmacy Division coordinates the pharmacy activities of the department and is responsible for ensuring that the activities are carried out in compliance with the Texas Pharmacy Act (Art. 4542a-1, V.A.C.S.). The division is responsible for the distribution of all medications provided in TDH clinics. This activity includes pre-packaging and label preparation by the central office licensed pharmacists. The non-pharmacist clinic personnel only enter the names of the patient and doctor, the date delivered, and provide the packaged medication to the patient. In addition to this function, the division staff monitor TDH clinic pharmacy activities and provide technical assistance as needed both to comply with the Pharmacy Act and to ensure that pharmaceuticals are provided in the safest manner possible. Drugs used in TDH clinics range from the more common birth control pills to tuberculosis medications and various vaccines. Each of these medications has been examined by the Federal Food and Drug Administration and classified as "dangerous" requiring a prescription written by a physician and filled by a licensed pharmacist.

The Texas Pharmacy Act requires clinic pharmacies, such as those operated by TDH, to be licensed as class "D" pharmacies. Specifically, all public health facilities maintaining an inventory of prescription drugs for later dispensing at the site must be licensed by the Texas State Board of Pharmacy (TSBP). Such licensing requires each clinic pharmacy to designate on the license a "pharmacist-in-charge" who is responsible for the continuous supervision of the personnel at the facility performing the pharmacy activities and who is also responsible for the pharmacy's compliance with the Pharmacy Act. TDH and its affiliates operate 84 permanent and an additional 260 temporary clinic pharmacies across the state. The pharmacy supervision and support services such as drug pre-packaging and technical assistance for these pharmacy activities are carried out with only two registered pharmacists and eight staff persons. TDH cannot supervise 84 pharmacies with two pharmacists because the Texas Pharmacy Act requires "continuous" pharmacist supervision. TSBP has issued TDH several warning notices, but no complaints have been filed with the State Board of Pharmacy concerning improper activity in such clinics and TDH staff reports no such complaints have been filed with them. However, the pharmacy activities of TDH clinics, if performed improperly, could

present a danger to the public. The following recommendations are made to improve the agency's staffing and policies to bring the operations of the TDH clinic pharmacies into line with the intent of the Pharmacy Act.

Local Health Departments should comply with the Pharmacy Act using their own staff resources.

In 1984, the two licensed pharamcists employed by the department in its Pharmacy Division have taken on professional responsibility as Pharmacist-in-Charge of the pharmacy activities in 65 of the 72 participating local health departments. They have taken on this responsibility because the local health departments' (LHDs) have not hired the number of pharmacists needed to comply with recently adopted pharmacy licensing provisions. Participating local health departments are local, independently operated clinics usually under the direction of city and county governments. The LHDs are partially funded on contract with TDH to provide certain public health services such as family planning and immunizations. LHDs are operated in all areas of the state. The size and operating budgets of the various LHDs vary greatly, from $42 million for the Harris County Health Department to $42,000 for the Dimmit County Health Department, annually. While the operations of the various LHDs are not all identical, TDH does require that they meet certain minimum standards by requiring them all to provide their services in compliance with the laws of the state. While medical treatment and nursing services have been regulated by state law for many years with regard to public health services, the specific regulation of clinic pharmacy activities has been in place only since 1981. Some of the LHDs in Texas have been slow to arrange for their compliance with the Pharmacy Act. The review indicated that only seven LHDs in Texas provide licensed pharmacists as pharmacist-in-charge for their activities. These LHDs are listed below.

Austin-Travis County Health Dept.
Corsicana-Navarro County Health Dept.
Chambers County Health Dept.
Galveston County Health Dept.
Hardin County Health Dept.
Houston City Health Dept.
San Angelo-Tom Green County Health Dept.

In comparison, some of the largest local health departments in Texas depend on TDH to provide the pharmacy supervision required for licensing. These include for example,

Dallas County Health Department, Bexar County Health Department, and El Paso County Health Department.

Local Health Departments regularly obtain physician and nursing coverage necessary to comply with state and federal professional practice regulations through their own resources and those provided in the TDH contract. The professional regulations for the practice of pharmacy are similar in intent to the regulations concerning other medical practices. Since TDH looks to the local health department to ensure that medical and nursing services are carried out in compliance with state law, this responsibility should be extended to delegate the responsibility for compliance with the Pharmacy Act to the local health department. It is therefore recommended that TDH adopt a policy of requiring that local health departments provide the necessary personnel resources to comply with the Pharmacy Act.

The department should increase its licensed pharmacist staff in the Pharmacy Division to comply with the Texas Pharmacy Act.

The ratio of licensed pharmacists to licensed class "D" pharmacies operated by TDH in fiscal year 1984, is two pharmacists to 84 pharmacies located throughout the state. In July of 1984 the Texas State Board of Pharmacy (TSBP) interpreted the Texas Pharmacy Act to include the licensure of 240 other temporary clinic pharmacies under TDH operation. The Pharmacy Act requires such pharmacies to "be under the continuous supervision of a pharmacist whose services shall be required according to the needs of the pharmacy" (Art. 4542a-1, Sec. 29(c)4, V.A.C.S.). The TSBP has further specified the meaning of "continuous supervision" in rules defining it as "supervision provided by the pharmacist-in-charge and/or consultant pharmacist, and consists of on-site and telephone supervision, routine instruction, and a policy procedure manual." Discussions with the TSBP staff indicate that the requirement for continuous supervision could be met if the pharmacist-in-charge provided the clinic with the following: 1) a pharmacy procedure manual which is consistently followed; 2) basic pharmaceutical reference material; 3) two site visits per year by the pharmacist-in-charge; 4) a licensed pharmacist available by phone for technical assistance and emergencies, and most importantly; 5) adequate pre-packaging of drugs dispensed at the pharmacy. Such supervision is currently not possible in TDH clinics due to the low pharmacist to clinic ratio. The department reports that potentially 400 clinic pharmacies have to obtain class "D" pharmacy licenses to continue operation and

comply with the Texas Pharmacy Act. The department has proposed a level of staffing through which compliance with the Pharmacy Act can be achieved. This level of staffing takes into account the varied number of TDH-operated clinics in each region and also adjusts for the area that would have to be covered. The agency has requested seven additional pharmacists for the 10 regions of the state at an additional cost of $215,964 per year. This level of staffing does appear to be adequate to provide compliance with the requirements that the Texas Legislature has placed on the operation of public health clinic pharmacies in Texas. Therefore, in addition to looking to the local health departments to bear their share of the responsibility of compliance with this law, the department should seek additional funding for seven additional pharmacists in fiscal 1986 and succeeding years.

Bureau of Radiation Control

The Bureau of Radiation Control is responsible for the regulation and monitoring of the various uses of radiation to prevent the improper handling of radiation machines and radioactive materials from causing illness and death in Texans. The bureau has developed programs of regulation, compliance monitoring, specialized environmental monitoring, and public education to serve this goal. Radiation, although having many practical uses, is recognized as a potential carcinogen and mutagenic agent. Improper use, transport, or disposal can result in biological damage to humans and harm to the environment. For these reasons, active regulatory efforts have been determined by both federal and state governments to be necessary in protecting the environment and assuring the health and safety of workers and the general public.

The Texas Department of Health initially became involved in radiological health activities in 1947 with the department's initiation of industrial hygiene services. For the next nine years, the Department's activities in this area primarily consisted of performing industrial hygiene studies concerning radiation as well as toxic chemicals used in industry through the Division of Industrial Hygiene. Such studies assessed the potential radiation risks to individuals involved in the medical uses of radium and the various uses of x-rays. In 1956, the State Board of Health adopted the first set of regulations pertaining specifically to radiation exposure. The regulations were in part prompted by the federal enactment of the Atomic Energy Act of 1954.

Nuclear energy activities and regulatory authority were largely confined to the federal government prior to a 1959 amendment to the federal Atomic Energy Act of 1954 which allowed states to enter into an agreement with the federal government permitting the states to assume licensing and regulatory authority of byproduct materials and radioactive source materials. Currently 27 states, including Texas, have agreements with the United States Nuclear Regulatory Commission to assume regulatory authority over such radioactive materials.

As a result of amendments to the federal legislation in 1959, a Radiation Study Committee was created by the Texas legislature to review the state's role in nuclear energy. The committee's involvement lead to Texas becoming an Agreement State in 1963 and the subsequent enactment of the Texas Radiation Control Act that same year which authorized the Texas Department of Health "to institute and maintain a regulatory program for all sources of radiation to permit the

development and utilization of these sources of radiation for peaceful purposes consistent with the health and safety of the public and protection of the environment." At that time this responsibility was assigned to the industrial hygiene division which was renamed the Division of Occupational Health and Radiation Control. In 1971 the Texas Radiation Control Act was amended to include in the division's duties the regulation of non-ionizing radiation such as lasers and microwave devices.

Ten years later, the 67th Legislature passed two bills, S.B. 735 and S.B. 480, which greatly increased the division's responsibilities for radiation control. S.B. 735 brought the state into compliance with the Federal Uranium Mill Tailings Radiation Control Act of 1978 (P.L. 95-604). This federal act amends the Atomic Energy Act of 1954 and requires agreement states to have the authority under their own laws to regulate and license uranium mining and milling activities in the manner set out by federal law. Currently, Texas is the third largest uranium producing state in the nation with approximately 23 active uranium licenses. The Texas act provides for citizen participation in the regulation, licensing and hearing process for uranium recovery facilities. It also gives the bureau the authority to collect fees for licenses and registrations issued, and to deposit these collected fees in the General Revenue Fund.

Senate Bill 480 strengthened the regulation of low-level radioactive waste storage, processing, and disposal in the state to better protect the health and safety of workers and the public and safeguard the environment. Within Texas the volume of such waste is continually increasing however, the state has only five storage sites that can accept low-level radioactive waste on a temporary basis and none on a permanent basis. The three permanent disposal sites in the United States have little room left in which to dispose of low-level waste.

Like S.B. 735, this bill also provides for citizen participation in the regulation, licensing, and hearing process. The act expanded the department's responsibilities for keeping records of radioactive contamination in Texas, rule-making, conducting studies relating to the control of sources of radiation, and encouraging the regional and interstate cooperation in sharing the waste disposal burden. The division of occupational health and radiation control was reorganized in response to the Act and, in 1981, a new Bureau of Radiation Control was created to assume the implementation of all departmental radiation control activities.

All of the bureau's current activities are accomplished through an organizational framework consisting of four major divisions: 1) Division of Licensing, Registration, and Standards, 2) Division of Compliance and Inspection, 3) Division of Environmental Programs, and 4) Office of Information, Education, and Administration. Total fiscal year 1984 funding for the bureau is $4,224,000, which is composed of 95 percent from state sources and the rest is from federal sources. The activities of the bureau are carried out by 130 personnel. Since the bureau operates as one regulatory program the review has covered aspects of each of its divisions.

The review of the Bureau of Radiation Control involved overview discussions with the staff concerning the major functions of the bureau: 1) registration and inspection of radiation-producing machines; 2) licensing and inspection of radioactive material users; 3) statewide emergency planning; 4) staff training; and 5) the overall administration of the bureau. The review focused on the bureau's activities involving regulation of radiation machines and materials as well as the bureau's relationships with federal and state agencies in carrying out its regulatory duties. Major areas of concern resulting from the evaluation are set out below.

The Radiation Control Act should be amended to allow the Department of Health to impose administrative penalties.

One of the purposes of the Radiation Control Act is to provide a "program of effective regulation of sources of radiation for the protection of the occupational and public health and safety and the environment" (Sec. 2(1), Art. 4590f, V.A.C.S.). To accomplish this objective the Bureau of Radiation Control (BRC) within the health department, carries out an active program designed to regulate the activities of persons using radioactive machines and sources ranging from x-ray machines to uranium mining. The bureau regularly inspects the users and facilities and institutes enforcement actions when necessary. The actions taken by the bureau include the following steps. Upon discovery of a violation of the law or regulations, the inspector reports the findings to the central office. Central office staff review the facts of the violation and issue an enforcement letter. This letter informs the responsible person that a violation has been discovered and specifies what actions must be taken to achieve compliance. Should the person take no or insufficient action to remedy the situation, the bureau calls the person in for an "enforcement conference". At this conference, bureau staff discuss the problems

with the violator and the difficulties that may be present which are preventing him or her from achieving compliance. The product of this conference is an agreed upon compliance schedule which specifies what actions will be taken and outlines a schedule for achieving the desired compliance actions. If upon inspection, the violation(s) is not corrected and no good faith effort is being made by the violator, the case is referred through the department's office of general counsel for administrative hearing or to the attorney general's office to institute a court action against the violator. The Radiation Control Act also provides for the revocation of the bureau's registrations and licenses and the issuance of an emergency order if "the agency finds that an emergency exists requiring immediate action to protect the public health and safety and environment...and requiring such action be taken as it shall direct to meet the emergency" (Sec. 11(c), Art. 4590f, V.A.C.S.).

In the review of the bureau's enforcement effort, particular attention was given to determining whether the bureau had the necessary enforcement tools to help ensure compliance. The enforcement authority of the bureau was compared to that of other agencies to determine whether the range of enforcement tools was reasonably complete. Through this review, it was determined that one state agency (the Texas Railroad Commission) and two federal agencies (the Environmental Protection Agency and the Nuclear Regulatory Commission) have the authority to use administrative penalties in certain public health and environmental enforcement cases, but the Radiation Control Act does not grant this authority to the Department of Health.

An administrative penalty is different from other enforcement actions in that a fine is levied by the agency for a violation. Currently civil penalty action is taken in a court suit rather than an administrative procedure. The advantage of the administrative penalty is that it can be applied quickly, without having to go through the lengthy litigation process. This advantage makes the administrative penalty particularly suited for cases where a time delay in legal proceedings might be anticipated and where a violation might have serious and immediate consequences for human health or the environment. Staff of both the Railroad Commission and the EPA indicate that administrative penalties are effective in producing quick results and acting as a strong deterrent.

Further, discussion with staff of the Nuclear Regulatory Commission (NRC) indicate that the NRC can levy administrative fines up to $100,000 for certain

violations, and have recommended for many years, that state's gain authority to use them. The NRC also reports that of the 27 "agreement states" (including Texas) approximately 10 states can levy penalties through administrative procedures. In non-agreement states (those states which leave the regulation of radioactive materials to the NRC), the NRC is able to use administrative penalties against activities similar to those regulated by Texas. Overall, the NRC reports that the use of administrative penalties is a good tool to be able to use in efforts to regulate the uses of radiation. The improper use of radiation can significantly harm the workers involved, the public and the environment and the administrative penalty approach can provide a significant incentive to reach compliance.

The administrative penalty can also provide an alternative to lengthy litigation processes, currently the bureau's most effective regulatory tool short of registration or license revocation. A review of enforcement cases indicates that the average time to reach compliance for the bureau's registrants (primarily x-ray machine users) is a little less than one year. Three of the fifteen cases sampled were still out of compliance with an average age of 1.3 years. In the area of licensed activities (those involving the use of radioactive sources), the average time to reach compliance was a little over five months with only one out of 10 cases still out of compliance with an age of just over one year. This review indicates that overall, the enforcement actions taken by the bureau are relatively timely. The severity of the consequences of the misuse of radiation machines and particularly source materials, however, indicate that the addition of the administrative penalty would be useful as a significant deterrent to non-compliance.

The implementation of the administrative penalty process for the Bureau of Radiation Control will require a structure unlike that found in the department's traditional permitting and enforcement actions. To develop a process that is fair to the person being fined and fits into the unique board and departmental set-up, the following steps should be provided for:

1. The decision at the bureau (central office) level to take the action to fine a person and a determination of the amount of the fine to be assessed and recommended to the commissioner. The commissioner then assesses the fine upon approval of the Board of Health at its next regularly scheduled meeting.

2. If the violator protests the application of the fine, then a hearing will be held by a hearing examiner of the department's general counsel's office. The hearing examiner then makes a recommendation to the commissioner concerning the fine. The commissioner then assesses the fine upon approval of the Board of Health at its next regularly scheduled meeting.
3. If the final decision of the commissioner, approved by the Board of Health, is appealed, the appeal will be held under the Substantial Evidence Rule. Additionally, before an appeal can be made, the penalty should be paid into an escrow account.

Concerning the amount of the fine, a review of the NRC approach indicates that the fine amount varies according to the type of licensee and the severity of the violation. Although the details of the fine system should be worked out by the bureau through rulemaking it appears appropriate to provide a statutory cap of $25,000 per violation. This approach is in line with the NRC's administrative penalty system related to the types of licensees present in Texas.

Requirements of the Radiation Control Act relating to the granting of licenses and registrations should be modified.

Under the current Radiation Control Act, the bureau is required to "afford an opportunity for a hearing in accordance with...the Administrative Procedure and Texas Register Act...on written request of any person affected by the...grant, denial, suspension, revocation or amendment of any license or registration..." (Sec. 11(b)(1), Art. 4590f, V.A.C.S.). The APA provides that if the granting of a license is required to be preceded by "notice and opportunity for hearing, the provisions of this Act (the APA) concerning contested cases apply." (Sec. 18, Art. 6252-13a, V.A.C.S.). The section of the APA governing contested cases provides that "all parties must be afforded an opportunity for hearing after reasonable notice of not less than 10 days" (Sec. 13(a), Art. 6252-13a, V.A.C.S.).

The apparent intent of the Radiation Control Act provision, originally enacted in 1961, requiring the opportunity for hearing when a license or registration is granted, is to provide widespread notice to all persons that radioactive material or a radiation device has been approved for use. The notice is designed to

alert persons of these facts and then allow them to request a hearing if they feel that they will suffer from the emissions of radiation.

To comply with the provisions of the law, the bureau has chosen to publish, on a periodic basis, in the Texas Register a list of new licenses issued, amendments to licenses, renewals of licenses, and terminations of licenses. This list usually includes some 60 to 100 actions and is published twice a month. The notice includes the location and name of the licensee and the date of the action taken. To accomplish the compilation of material needed for publication, the bureau reports that the equivalent of one full-time staff member is needed. The bureau has chosen not to publish any notice of actions on registrations even though such notice is required by statute.

In discussing this situation with the bureau it has been learned that only two requests for a hearing have been made. One hearing involved the use of an instrument calibration source and the hearing examiner of the TDH General Counsel's Office ruled that the party requesting the hearing did not have sufficient standing (was not affected by the issuance of the license). The second request for a hearing has not been pursued, beyond the initial notice of intent to request a hearing by the requesting party.

In the area of "registrations" the bureau has chosen not to publish registration actions for two basic reasons: 1) the registration process provides notice to the bureau that the use of a radiation machine has already commenced, the bureau does not review and approve the use of a radiation machine as it does in a licensing application; and 2) the sheer number of registration actions (500-700 per month) is too large for the bureau to efficiently assimilate and publish in a timely manner.

Further review of the process indicates that it is unusual in the granting of a license to require such notice efforts unless it is likely that the activity of the licensed operation can result in widespread public health, economic or environmental harm. For example, the permitting of a solid waste disposal facility can result in such harm and extensive notice requirements of the application for such a permit are found in statute. Another example, found in the Radiation Control Act, is the permitting or licensing of uranium mining operations. If not operated properly, such mining and processing of uranium can have substantial harm on the environment and those persons living in proximity to it. Extensive assessment and hearing requirements are found in the statutes governing the permitting of such facilities. The licensing or registration of a person, however, to carry out a

focused activity such as x-ray machine operation or industrial weld testing does not appear to meet the caution standards found in the examples above.

A less costly alternative to the current statutory requirement that the granting process for registrations and licenses issued by the bureau afford the opportunity for hearing for all granting actions would be to remove the requirement from statute (Sec. 11(b)(1), Art. 4590f, V.A.C.S.) and require the agency, by rule, to provide notice on these actions as it deems necessary. This modification would eliminate a statutory provision that is not completely met by the bureau, is costly, and does not appear to be useful. Requiring the bureau to adopt regulations regarding any future notice and hearing opportunities on licensing and registration granting actions would allow it flexibility to determine if the actions of a regulated person could cause substantial harm. If the bureau determined that potential harm might occur then in specific cases it could provide notice of the granting action and afford an opportunity for a hearing on the action. The development of such regulations would be subject to public input and once in place would provide the bureau with a more flexible and less costly public notice approach.

Memoranda of understanding developed by the Bureau of Radiation Control with other state agencies should be processed through the APA rulemaking procedure.

The Department of Health's Bureau of Radiation Control (BRC) is the only state agency program in Texas regulating the possession and use of sources of radiation. However, radioactive materials licensees may be required to get an exemption or permit from the Texas Air Control Board for any emission other than those which are radioactive. Likewise, licensees which have discharges to the waters of the state are required to obtain permits from the Texas Department of Water Resources. Uranium recovery facilities licensed by the radiation control program must also obtain permits from the Railroad Commission of Texas (for open-pit mining) or the Texas Department of Water Resources (for in-situ mining).

As discussed in the section of the report on the Bureau of Solid Waste Management, the BRC has developed an MOU with the Department of Water Resources concerning jurisdiction questions in the regulation of in-situ uranium mining (MOU signed January 1983 and adopted as a rule February 1983). This action of adopting the MOU as a rule appears appropriate as the Administrative Procedure Act defines a rule as "...any agency statement of general applicability

that implements, interprets, or prescribes law or policy or describes the procedure or practice requirements of an agency" (Sec. 3(7), Art. 6252-13a, V.A.C.S.). By defining the jurisdiction and authority boundaries between agencies in areas of potential overlap, the MOUs do take on the character of rules. The bureau reports that similar MOUs with the Railroad Commission and the Texas Air Control Board are being developed. To ensure that future MOUs and revisions to the current MOU are adopted as rules, the Radiation Control Act should be amended to require such action.

The Radiation Control Act should be amended to clarify the definition of its registration provisions.

The bureau approaches regulation of radiation in two ways: registration and licensure. These approaches provide the agency with information regarding location of the devices or radioactive material and their intended use. There is a basic difference between the two types of regulation: registration is designed to collect this information on machines which in operation emit a "physical field of radiation". These machines, for the most part (11,743 of 12,810 registrations), are x-ray machines used by doctors, dentists and hospitals for diagnostic and therapeutic purposes. Persons who use or service these machines are required by regulation to notify the bureau within 30 days of their commencing to use or service such machines. General licenses are "issued" by statute and relate to the authorization for persons to handle certain kinds of radioactive source materials (for example, very small quantities of radioactive material used in some pharmaceuticals) and to operate machines which emit radiation from radioactive materials (not electronic sources which can be turned off). The machines covered by the general license are only those manufactured in accordance with a specific license issued by the U.S. Nuclear Regulatory Commission. These machines, unlike x-ray, are used in many different industrial calibration and measurement activities and they are not used on humans.

A specific license is issued to an individual upon review and approval of the individual's application for licensure. This type of process is used for persons engaging in activities with the greatest potential for radiation exposure to the worker(s) as well as the general public. These activities include uranium mining, low-level radioactive waste processing, industrial radiography, nuclear medicine and the like.

Although complicated, the regulatory structure does provide a reasonable framework for the agency to regulate uses of radiation in the state. As the danger to the public increases, the amount of information reviewed and sanctioned by the bureau concerning the use of radiation machines and materials also increases. For example, a dentist must "register" after he or she begins to use an x-ray machine. For a person to process low-level radioactive waste however, extensive application and hearing requirements must be met prior to beginning the processing operation. This scheme operating in conjunction with the bureau's broad authority to inspect premises to determine compliance with its Act and rules as well as enforce provisions of its act and rules, provides a good screening process as well as effective follow-up enforcement mechanisms concerning the use of radiation machines and radioactive materials in the state.

One problem, however, has been detected in the bureau's statutory framework concerning "registrations". Under current law registration is defined as:

> "notification of the agency of an activity involving the operation of radiation producing equipment or the manufacture, use, handling, or storage of radioactive material..." (Sec. 3(g), Art. 4590f, V.A.C.S.)

By regulation, however, a "certificate of registration" is issued to a person who uses a radiation machine (whose radiation emissions can be turned off) and persons providing such radiation machine installation and servicing. Those persons who manufacture, use, handle or store radioactive materials are specifically licensed, not registered. Although the bureau reports this interpretation of the statute has not been challenged, it does add confusion to an already complicated statute and regulatory structure. Further review indicates that the current language is a holdover from the original radiation regulatory act passed by the legislature in 1961. To clarify the statute and make it reflective of the bureau's current practices, it should be amended to specify that the bureau may issue a certificate of registration to persons using or servicing a product or device that has an electronic circuit which during operation can generate or emit a physical field of radiation.

The Bureau of Radiation Control should consider "size of operation" of its regulatees as it refines its fee schedule structure.

The Radiation Control Act, (Art. 4590f, V.A.C.S.) authorizes the Bureau of Radiation Control to prescribe and collect fees in an amount that does not exceed the annual actual expenses incurred for its registration and licensure approval, inspection and enforcement processes. In March 1984, the bureau finalized its fee structure approach through a process that involved six public hearings and more than two years of study. Due to uncertainties about the completeness of the bureau's data used to develop the fee schedule and a general concern that the fees imposed should not be so high as to encourage non-compliance, a 50 percent level of support for the bureau through the fees imposed was chosen as an appropriate standard. This means that approximately $2.1 million in fees will be collected in future years.

A review of the process used by the bureau to calculate its fees indicates that many factors were considered. Among the 18 factors considered were: staff time and salaries for development of standards for each category of license and registration, number of agency licensees or registrant inspectors employed and their salaries, travel time and travel costs for conducting inspections, inspection preparation time, on-site inspection time, inspection report preparation time, number of incidents needing investigation by type of license or registration, etc. The bureau reports, in most cases, exact cost figures for each item applicable to a certain fee category were unavailable and that a more detailed method of recording time by bureau staff on specific activities has been initiated. The bureau has also indicated that as it is able to more accurately determine costs per category in the future, the fees will be adjusted accordingly to ensure fair distribution of expense to bureau licensees and registrants. The fee schedule developed by the bureau is complicated and includes some 33 different fee categories. It does appear the bureau has made a good faith effort to develop a workable and equitable fee schedule, but one concern has been noted in its methodology.

In developing the fees to be paid by industrial radiographers, the bureau has established a flat fee per year to be paid by each company involved in this field. Industrial radiographers conduct testing, through the use of radioactive sources and machines to examine, for example, the integrity of welds in airplanes, high rise

buildings, pipelines, etc. One company might have one or numerous "sources" of radiation to carry out its work. During the course of testimony made concerning the fee structure, it was pointed out that the time involved to inspect one source is less than the time involved to inspect numerous sources. This appears to be accurate in that each inspection requires the review of records concerning the acquisition, use and disposal of each source as well as a physical examination of the source itself. In response to the comments made about this issue, the bureau indicates that it is following the precedent of the Nuclear Regulatory Commission and other states in its approach and that the fee should be set by category rather than "size of operation" or number of sources. In addition, the bureau points out that incident data indicates that industrial radiographers have more incidents per license than any other category of license. The investigation of these incidents is an additional cost to the agency.

Although these reasons appear valid, the approach taken in the licensing of industrial radiographers is inconsistent with the approach taken in the fees established for x-ray radiation machines. For example, an annual fee is charged for each x-ray machine used by a dentist. There is an initial fee of $40 and then an additional $10 fee charged for each additional machine, not to exceed a total annual fee of $130. This approach does take into account the increase in cost to the bureau for inspecting dentist's offices with more than one machine and appears to be a more equitable way to charge its fees. The fee is still charged on a categorical basis and the same concept can be applied to the situation regarding industrial radiographers. The fact that industrial radiography is an area of numerous incidents and generates additional costs can be built into the fee structure for this group but on a basis that does more clearly tie the fee to the time needed for inspection and overall enforcement of the activities of industrial radiographers.

The basic fee structure used by the bureau will continue to undergo examination and refinement as the bureau gathers more specific data on its costs and the time needed to regulate various aspects of its regulated populations. It appears appropriate, that specific attention should be given to the "size or number of sources" issue for all facets of its regulated community as it continues to refine a fee structure that is as equitable as possible.

Bureau of Consumer Health Protection

The Bureau of Consumer Health Protection is responsible for the implementation of programs that insure that goods produced in Texas for Texas consumers are safe, clean, wholesome, and properly labeled. To provide such protection, the bureau has developed programs designed to regulate and monitor the food and drug industries and the manufacture of certain products. In addition to the Food and Drug Division, a special program has been established to monitor the milk and dairy industry because of the special monitoring requirements this industry presents due to the perishability and potential for contamination of dairy products. Another program within the bureau has been established for the shellfish industry as it presents similar problems but requires special monitoring. Another bureau program places emphasis on overseeing the manufacture of potentially hazardous products, such as household products containing toxic substances, and the bedding industry. Each of these monitoring and regulatory programs has developed out of a particular need or risk that the type of product presents. The bureau supervises all of these industries through the four programs' various efforts of consultation, monitoring, enforcement, complaint investigation, and facility and personnel licensing.

In fiscal year 1984, the bureau operates four programs with a total budget of approximately $3,626,000 and staff of 104 budgeted full-time positions. The bureau's total budget is allocated to the four programs operated by the bureau in the following manner: Food and Drug Division - 22 percent; Milk and Dairy Division - 55 percent; Shellfish Sanitation Control Division - 11 percent; and Product Safety Division - 10 percent. The bureau allocates 2 percent of the budget for the operation of the bureau office which employs two full-time persons.

A distinct part of the bureau is the Food and Drug Division. During the review period the department's ability to respond in a timely fashion to the presence of the pesticide ethylene dibromide in food products was questioned. One of the problems cited by the department was the confusing nature of the Food and Drug Act passed in 1961. For these reasons the Food and Drug Division has been selected for specific review and a background description of the history and functions of the division follow.

Division of Food and Drug

The Division of Food and Drug was established to protect public health by ensuring that all food, drugs, medical devices, and cosmetic products purchased in Texas are safe for consumption or use. This assurance requires not only that the

products be as wholesome or effective as possible, but also that such products are properly labeled and are not falsely advertised.

Efforts to control the sale of unwholesome food and drugs in Texas have had a long history. The first law prohibiting the sale of unwholesome food and drink in Texas was enacted in 1836 while Texas was still a republic and carried a penalty of 29 lashes and a fine set by the court. The first statute was enacted in 1883 making the State Health Authority responsible for a program of surveillance and enforcement to insure the wholesomeness of both food and drugs. During the year following the passage of the federal Food and Drug Act in 1906, the legislature enacted a new Food and Drug Act which created a separate new agency, the Office of Dairy and Food Commissioner. This new agency was charged with the administration and enforcement of the new state law and established a laboratory to accomplish its duties. In 1918, during a legislative investigation of state government, a sub-committee of the Central Investigating Committee investigated the work of the Diary and Food Commissioner. The subcommittee recommended that a division be created within the Texas Department of Health to serve the functions the agency had served, the agency be abolished, and that the laboratory be consolidated with that of the Department of Health. The legislature accepted this recommendation and abolished the Office of Dairy and Food Commissioner in 1921 transferring the power and authority to the department. These duties have remained with the Texas Department of Health since that time. Within the department, separate divisions were established in 1937 and 1938 to place further emphasis on the dairy industry and the shellfish industry. The current food and drug law in operation today was passed in 1961.

For fiscal year 1984, a little more than one century after the passage of the first state food and drug statute, the division operates with a budget of $796,000 which is composed of 87 percent general revenue funding, 6 percent federal funding and seven percent is financed through fees. This division's funding represents 22 percent of the bureau's total budget. The division is authorized to employ a full time staff of 27. In fiscal year 1983, the 19 members of inspection staff focused 79 percent of their time on the regulation of food and drug manufacturers and wholesalers with 18 percent allocated for retail food establishments and 3 percent allocated for the regulation of methadone centers. This effort involved approximately 9,000 inspections. The results of similar inspection efforts in 1982 lead to the removal from distribution of over two million pounds of food that was found to

be unfit for human consumption and approximately $200,000 worth of drugs found unfit for use by both humans and animals. In addition to the inspection efforts, the division licensed approximately 4,300 distributors of drugs, manufacturers of food, and methadone centers. The division investigated over 300 complaints which were mainly from the public and, in total, initiated 212 legal actions in its enforcement efforts. The division also provides special assistance to the Texas Department of Corrections which is under a court order to make certain corrections in its operations. Included in these corrections are the division's routine sanitation inspections of TCD's food service facilities.

The Division of Food and Drug is organizationally located within the health department's Bureau of Consumer Health Protection. The division performs regulatory activities based on state and federal statute but confines its primary regulatory efforts to the review of food, drugs and cosmetics involved in intrastate commerce. Those items involved in interstate commerce are handled by the federal Food and Drug Administration. The review of the division focused on the four primary registration efforts authorized for the division: 1) food manufacturers; 2) wholesale drug distributors; 3) salvage operators or brokers (involved in selling salvaged food, drugs and cosmetics; and 4) synthetic drug (methodone) treatment programs. Since the Food and Drug Act provides the basis for the department's response to the presence of pesticides (e.g. EDB) in foods, the review also examined the department's and division's ability to respond to possible similar EDB situations in the future. Major areas of concern resulting from the evaluation are set out below.

The duties of the Food and Drug Division are numerous and aimed at ensuring that the food, drugs and cosmetics consumed by the public are safe. The facets of industry regulated by the program range from small sandwich making operations to large complex food companies such as Mrs. Baird's Bakery.

During the course of the review, the division's and the department's effectiveness at handling a crisis situation has been questioned. The focus of the criticism of the department has been the handling of the difficulties in reacting in a timely manner to the developments relating to ethylene dibromide, or EDB. The Environmental Protection Agency reports that over 20 million pounds of EDB are used as a pesticide in this country each year. The major use (90 percent) of the chemical as a pesticide is as a soil fumigant. In this use, EDB is injected directly into the soil to kill nematodes which may damage agricultural crops such as

soybeans, peanuts, cotton, tobacco, pineapples, and various fruits and vegetables. Other significant uses of EDB include its use as a quarantine fumigant for fruits and vegetables, as a fumigant for the spot treatment of grain milling equipment, and as a fumigant for grain stored in bulk.

In October of 1983, the EPA published its "Intent to Cancel Registrations of Pesticide Products Containing Ethylene Dibromide." In this report, the EPA states that based on several studies, it (the agency) concludes that "EDB poses: 1) increased risk of cancer; 2) increased risk of mutations; and 3) increased risk of adverse reproductive effects. The agency's quantitative assessments of risk have been limited, to the oncogenic risk of EDB, because these cancer risks can be estimated quantitatively, and the potential cancer risks to humans posed by this chemical are extremely high." In early December 1983, the State of Florida discovered levels of EDB varying between 1.1 parts per billion (ppb) and 75 ppb in corn products. Florida, through its state health officer, set a tolerance level of 1 ppb as the safe level of the presence of EDB in its food products. At this time, Texas increased its consideration of how to react to the EDB situation. Meetings between the Texas Department of Agriculture and the Department of Health yielded no decisions except to begin sampling food products for the presence of EDB. Throughout January 1984 public concern over the situation grew and increased attention focused on the Health Department to set tolerance levels and begin removing unacceptable food from the shelves. During late December and through January, the commissioner of health stood by his decision to wait for scientific data from EPA on what reasonable tolerance levels should be set. By early February, this information was published by EPA and on February 7, 1984 the Board of Health adopted emergency rules establishing maximum acceptable levels of EDB in foods and fruit. On February 8, the department sent recall letters to four manufacturers covering five products which had previously been identified by TDH laboratory testing as exceeding these newly established tolerance levels. By April 1984, 900 products had been tested and 30 were found to contain excessive EDB levels, and recall action had been instituted.

Throughout the EDB consideration process, complaints were lodged in public hearings and through the news media that the department had acted too slowly, that the statutes governing the department's ability to act were ineffective and that the department did not inform the public adequately of the dangers of EDB. One potential way to mitigate such problems is to develop an advisory committee

to provide a two-way information exchange between the agency, industries and consumers. The development of a committee to provide the division and board with ongoing assistance concerning their duties could be beneficial. Should the board develop such a committee, its operational guidelines should be in keeping with the advisory committee recommendation in the Policy Making Structure section of this report.

The Texas Food and Drug Act should be clarified to allow issuance of emergency rules by the commissioner and the issuance of emergency orders by the commissioner or his designee.

The Texas Food and Drug Act (Art. 4476-5, V.A.C.S.) was originally enacted in 1961. Since that time amendments have been made to it and other statutes affecting the division's operations. Many of these changes have clouded the exact authority of the commissioner to act in emergency situations as well as confused how the agency should go about adopting rules. For example, Sec. 20 of the Food and Drug Act, unchanged since originally enacted, sets out the procedure the agency must follow in adopting rules. The provisions of this section also set out how the commissioner may adopt emergency rules if conditions warrant such action. Provisions of S.B. 98 (68th Legislature), however, reserve the authority to adopt rules for the Board of Health not the commissioner.

In responding to the EDB situation, confusion apparently resulted due to these conflicting provisions. In response, the commissioner of health stated in a letter to the Senate Subcommittee on Public Health (meeting on February 2, 1984) that "legislation is needed to clearly grant and define the authority of the commissioner of health to act swiftly in emergency situations, subject to and pending the more formal rulemaking or ratification by the Texas Board of Health."

A good example of how to develop this authority in statute is found in the Solid Waste Disposal Act. This Act allows the agency to "issue an emergency order, either mandatory or prohibitory in nature, regarding any activity of solid waste management within its jurisdiction...if the state agency determines that the activity is creating or...posing an immediate and serious threat to human life or health..."(Sec. 4(e)(10), Art. 4477-7,V.A.C.S.). Providing such clear authority for the commissioner or his designee to respond to situations governed by the Food and Drug Act would be useful in responding to future EDB type incidents. To augment

this emergency order power, the statute should also be amended to clearly grant the commissioner, not the board, the ability to issue emergency rules.

To establish this clear authority, caution should be exercised by requiring that the order or the rules establish a time and place for a hearing to be held at a later date and in accordance with departmental rules to affirm, modify or set aside the emergency order or rules.

The penalty for violation of the Food and Drug Act should be increased to a Class A misdemeanor.

The Food and Drug Act (Art. 4476-5, V.A.C.S.) is the central state statute which governs the state's regulatory efforts to ensure that: 1) food is safe and wholesome; 2) drugs (human and veterinary), biologicals (e.g. vaccines), and medical devices are safe and effective; 3) cosmetics are safe; and 4) all these products are properly labeled. The Act provides for registration of certain food and drug operations and for penalties to be imposed for the violation of certain unlawful and prohibited acts.

In 1981 the legislature substantially amended the registration requirements for the wholesale distributors of drugs and made similar changes in the Act governing food manufacturers in 1983. In these changes, the penalty for not registering with the Health Department in both the food and drug areas was established as a Class A misdemeanor. The Penal Code (Sec. 12.22) defines the punishment for the commitment of a Class A misdemeanor as:

1) a fine not to exceed $2,000;
2) confinement in jail for a term not to exceed one year; or
3) both such fine and imprisonment.

In another section of the Food and Drug Act, certain acts are prohibited. These acts preclude, in part"... the manufacture, sale, or delivery ... of any food, drug, device, or cosmetic that is adulterated or misbranded; or the adulteration or misbranding of any food, drug, device or cosmetic" (Sec. 3(a), (b), Art. 4476-5, V.A.C.S.). These provisions of the section provide the basic statutory guidance as to what activities involving food, drugs and cosmetics manufacturing and distribution are prohibited in the state. The penalty for violating any of these provisions is set by statute in the following way:

> Sec. 5. (a) "Any person who violates any of the provisions of Section 3 shall be guilty of a misdemeanor and

> shall on conviction thereof be subject to a fine of not less than Twenty-five Dollars ($25.00) nor more than Two Hundred Dollars ($200.00); and for the second or subsequent offense shall be subject to a fine of not less than One Hundred Dollars ($100.00) nor more than One Thousand Dollars ($1,000.00), or imprisonment in the county jail for a period of not more than one year, or both such fine and imprisonment."

By making the first violation of the Act a Class C misdemeanor and the second violation basically a Class B misdemeanor, the regulatory framework established by the Act is inconsistent. That is, failing to register is deemed a more serious offense than actually violating the provisions of the Act.

The intent of the penalty provisions of the regulatory framework is to provide significant disincentives for violation of any of its provisions. To bring the penalties for violation of the Act's provisions into uniformity, it appears appropriate to make violation of any of its provisions a Class A misdemeanor.

Fees collected by the Food and Drug Division should be increased to offset a greater portion of its operating costs.

Currently, the Food and Drug Division collects fees for three of its four main activities. The division is authorized to collect fees for its regulation of food manufacturers, wholesale drug distributorships and salvage food brokers. It is not authorized to collect a fee for its permitting the use of synthetic narcotics.

As a general principal, some portion of the cost associated with regulating an industry or business should be borne by the regulated group. This principal is demonstrated most frequently in "licensing" agencies for professions where 100 percent of the cost of licensing is frequently paid in fees. Another example of fees supporting a significant portion of a regulatory program's cost is found in the Health Department's Bureau of Radiation Control (BRC). This program has developed a fee schedule designed to capture approximately 50 percent of its operating cost.

The review of the Food and Drug Division indicates that the fees mentioned above have been increased or authorized in the past two legislative sessions. For the current fee structure the following chart depicts the authorized fee and expected revenue.

Type	Fees	Expected Revenue (84)
Food Manufacturer		
Permit and Renewal	$ 25	$ 70,000
Wholesale Drug Distributorships		
Permit and Renewal	$ 25	
Change of Address	5	18,980
Salvage Brokers		
Permit and Renewal	$100	
Delinquent Fee	25	20,000
		$108,980

Using the current fee structure, it is projected that the fees will bring in $108,980 and will offset approximately 16 percent of its total budget allocated to regulate its registrants and permittees.

To conform to the general state approach, the program should be authorized to collect a fee for its regulatory effort concerning synthetic narcotics and its current authorized fee structure should be modified to allow the program to collect a greater amount of revenue to offset its regulatory costs. An examination of the process used by the BRC to set its fees and the nature of the industries regulated by the Food and Drug program reveals the need for consideration of at least three important factors in setting these fees.

First, the BRC has set fees at a level anticipated to recover 50 percent of the program's cost of operation. Using this amount as a rough guideline, it seems reasonable to require that fees for the regulatory efforts of the program aimed at its permittees and registrants cover between 25 and 50 percent of the state's cost. This range gives the agency the flexibility to determine an amount most appropriate for its efforts while also ensuring significant increases in dollars to offset the cost of regulation without creating a strong disincentive to compliance.

The second factor which should be considered in the development of the fee structure is that the fees charged should be reasonably related to the costs to the agency for performing the various aspects of regulation. For example, in food manufacturing the time needed to inspect a small doughnut shop is much less than the time needed to inspect a large food manufacturing plant. It appears reasonable that the fees should vary in relation to the regulatory effort the fee is designed to support. This concept is found at work in the State Banking Department.

Regulated banks are charged fees which vary with their size as measured by total assets. These fees help support the costs of state bank examinations and range from $3,500 to over $50,000 depending on the size of the bank.

The third factor which should be considered in the development of the fee structure is that all affected parties should have ample opportunity for input into the process. The information necessary to examine the impact on the entities involved and the actual costs to the agency for its permitting and enforcement activities needs to be complete. Requiring that the fee structure be adopted through the rulemaking and hearing provisions of the Administrative Procedures Act (APA) will assist in ensuring that the work will proceed with specified schedules and opportunities for those concerned with the proposal to have input.

The Food and Drug Act should be amended to allow the Department of Health to impose administrative penalties.

To protect the consuming public from unwholesome food, drugs, and cosmetics, the Food and Drug Act empowers the Department of Health with the ability to register certain types of food and drug operations and to generally enforce the provisions of the act. To accomplish these objectives the department's Food and Drug Division of the Bureau of Consumer Health Protection carries out an active program designed to regulate the activities of food manufacturers, wholesale drug companies, salvage brokers and synthetic narcotic (methodone) treatment programs. Division staff inspect these operations on a periodic basis and institute enforcement actions when necessary. Upon discovery of a violation of the law or regulations, the actions taken by the division include the following steps. Violations detected during inspections are reported to the central office and a summary report is sent to the registrant. This report includes a description of problems and the actions necessary to correct them. If upon reinspection, corrective action has not been taken, an enforcement conference is held specifically outlining when the corrections will be made. If this action does not result in improvement, court action may be pursued. The division is also empowered to "tag and detain" food and drug products that are adulterated and can also revoke the registrations of those under its regulation. The Act also allows the commissioner to issue emergency rules to meet "emergency conditions." (This authority is not clear because of additions to other Health Department statutes. A recommendation to clarify this authority is made in another section of the report).

In the review of the bureau's enforcement effort, particular attention was given to determining whether the division had the necessary enforcement tools to help ensure compliance. The enforcement authority of the division was compared to that of other agencies to determine whether the range of enforcement tools was reasonably complete. Through this review, it was determined that one state agency (the Texas Railroad Commission) and two federal agencies (the Environmental Protection Agency and the Nuclear Regulatory Commission) have the authority to use administrative penalties in certain public health and environmental enforcement cases, but the Food and Drug Act does not grant this authority to the Health Department.

An administrative penalty is different from other enforcement actions in that a fine is levied by the agency for a violation. Typically this kind of action is taken in a court suit rather than an administrative procedure. The advantage of this type of penalty is that it can be levied quickly, without having to go through the lengthy litigation process. This advantage makes the administrative penalty particularly suited for cases where a time delay in legal proceedings might be anticipated and where a violation might have serious and immediate consequences for human health or the environment. Staff of both the Railroad Commission and the EPA indicate that administrative penalties are effective in producing quick results and acting as a strong deterrent. The NRC reports that the administrative penalty is an appropriate tool in matters regarding the regulation of radioactive materials. Such a penalty can provide a significant deterrent to actions which can seriously harm workers using radioactive materials as well as the general public.

The division reports that the Food and Drug Administration (its federal counterpart) does not have authority to levy administrative penalties. In discussion with division staff however, it does appear that the administrative penalty would be useful in providing a timely penalty to stop activities which can significantly harm the consuming public. In a review of 51 sample enforcement cases pursued by the bureau, 40 (78 percent) have been resolved within $6\frac{1}{2}$ months. However, the 11 remaining cases are still unresolved with an average age of over $1\frac{1}{2}$ years. This review indicates that many of the division's enforcement actions are timely but some can stretch out for many months. Due to the severity of the consequences related to the violations of the Food and Drug Act, it appears that the addition of the administrative penalty as a deterrent to violations is appropriate.

The implementation of the administrative penalty process for the Division of Food and Drug will require a structure unlike that found in the department's traditional registration, permitting and enforcing actions. To develop a process that is fair to the person being fined and fits into the unique board and departmental set up, the following steps should be provided for:

1. The decision is made at the division (central office) level to take the action to fine a person as well as the determination of the amount of the fine to be assessed and recommended to the commissioner. The commissioner then assesses the fine upon approval of the Board of Health at its next regularly scheduled meeting.
2. If the violator protests the application of the fine then a hearing will be held by a hearing examiner of the department's General Counsel's office. The hearing examiner then makes a recommendation to the commissioner concerning the fine. The commissioner then assesses the fine upon approval of the Board of Health at its next regularly scheduled meeting.
3. If the final decision of the commissioner, approved by the Board of Health, is appealed, the appeal will be held under the Substantial Evidence Rule. Additionally, before an appeal can be made, the penalty should be paid into an escrow account.

Concerning the amount of the fine, there is no directly applicable amount used by a federal agency in this area. However, an authorized cap amount of $25,000 would appear to provide a significant deterrent as well as the flexibility for the division to establish through rulemaking lesser fines based on the situation and severity of the violation.

Bureau of Solid Waste Management

The Bureau of Solid Waste Management (BSWM) is responsible for the regulation of activities related to the handling and disposal of "municipal solid waste". The waste within the bureau's jurisdiction are those wastes incidental to municipal, commercial and institutional activities and form the bulk of wastes that are deposited in city, county and privately operated landfills. The bureau estimates that 5.2 pounds of municipal solid waste are produced by each person per day in the state. This means that over 15.8 million tons of municipal solid waste must be disposed of annually in the state of Texas. The improper handling of solid waste can provide a breeding ground for disease carrying vectors and unless properly disposed of can pollute ground and surface water supplies.

As early as 1935, field offices of the health department were involved in investigations of solid waste complaints. However, the general regulation and maintenance of these sites remained in the hands of local governments until 1969 when the legislature passed the Solid Waste Disposal Act giving the department the authority to require and issue permits for municipal solid waste disposal facilities and to adopt regulations governing the operations of disposal facilities. On the federal level, Congress amended the federal Solid Waste Disposal Act by enactment of the Resource Conservation and Recovery Act (RCRA) in 1976 providing financial assistance to the states. The federal dollars have been used to develop state plans, conduct open dump inventories and provide technical assistance for resource recovery. RCRA has also provided financial assistance to states to aid them in developing a hazardous waste program that, upon approval, can be administered by state authorities rather than the federal Environmental Protection Agency. In the state, the duties of regulating hazardous wastes are divided between the TDH (municipal wastes) and the Texas Department of Water Resources (industrial wastes).

In fiscal year 1984, the Bureau of Solid Waste Management administers permitting and enforcement activities designed to protect the public health and the environment from the potential dangers associated with municipal solid wastes. These wastes include non-hazardous and hazardous wastes disposed of in over 1,100 landfills and treated, stored or disposed of in more than 60 hazardous waste facilities. All of the bureau's activities are accomplished through an organizational framework consisting of three major divisions: 1) Permits; 2) Surveillance and Enforcement; and 3) Program Management. Total fiscal year 1984 funding for the

bureau is $2,831,000; 55 percent from state sources and 45 percent from federal sources. The activities of the bureau are carried out by 75 personnel. Since the bureau operates as one regulatory program the review has covered aspects of each of its divisions.

The review of the Bureau of Solid Waste Management included overview discussions with the staff of the bureau concerning all of the functions the bureau performs. These include: 1) regulation (e.g. permitting, inspection and enforcement actions concerning solid waste disposal sites); 2) educational and planning functions; 3) technical assistance; and 4) the overall administration of the bureau. The review focused on the bureau's activities in the regulation of solid (hazardous and non-hazardous), waste management activities in the state as well as the bureau's relationships with federal and state agencies in carrying out its regulatory duties. Major areas of concern resulting from the evaluation are set out below.

The Solid Waste Disposal Act should be amended to authorize the Department of Health to assess administrative penalties.

In carrying out its mandate to "safeguard the health, welfare, and physical property of the people, and to protect the environment, through controlling the management of solid wastes", the Bureau of Solid Waste Management has established an active enforcement program relating to solid and hazardous waste activities in the state under its jurisdiction. The bureau's activities include the periodic inspection of more than 1,100 solid waste facilities and the monitoring of more than 450 persons and some 63 facilities involved in the handling of hazardous waste. The inspection schedule for the various types and sizes of facilities and operators is established by the bureau's central office staff. Inspections are carried out according to this schedule and in conjunction with the department staff who are deployed throughout the state. Approximately 38 of the bureau's 76 staff are dedicated to the solid and hazardous waste enforcement programs.

Although somewhat different, the processes followed by the enforcement staff in responding to violations in the separate areas of solid and hazardous waste are quite similar and will be discussed as one process for the purposes of this report. Upon discovery of a violation of the law or regulations, the inspector reports the findings to the central office. Central office staff review the facts of the violation and issue an "enforcement letter." This letter informs the responsible person that a violation has been discovered and specifies what actions must be

taken to achieve compliance. Should the person take no or insufficient action to remedy the situation, a "compliance schedule" is developed again specifying what actions should be taken and outlining a schedule for bringing the operation into compliance to avoid legal action through the court system. If upon inspection the violation(s) is not corrected and no good faith effort is being made by the violator, the case is referred first to the department's general counsel, then to the commissioner's office, and then on to the attorney general's office for the consideration of court action against the violator. Although each of these steps is usually followed in enforcement actions any of them can be by-passed and the commissioner can also issue an "emergency order". Such an order can be issued if the agency determines that the violating activity "is creating or will cause extensive or severe property damage or economic loss to others or is posing an immediate and serious threat to human life or health..." (sec. 4(e)(10), Art. 4477-7 V.A.C.S.). The only additional enforcement sanctions available to the agency is the revocation of the permits it issues.

In the review of the solid waste enforcement effort, particular attention was given to determining whether the agency had the necessary enforcement tools to help ensure compliance. The enforcement authority of the Bureau of Solid Waste was compared to that of other agencies to determine whether the range of enforcement tools was reasonably complete. Through this review, it was determined that both the federal Environmental Protection Agency and the Texas Railroad Commission have the authority to use administrative penalties in certain environmental enforcement cases, but the Solid Waste Management Act does not grant this authority to the TDH.

An administrative penalty is different from other enforcement actions in that a fine is levied by the agency for a violation. Typically this kind of action is taken in a court suit rather than an administrative procedure. The advantage of this type of penalty is that it can be levied quickly, without having to go through the lengthy litigation process. This advantage makes the administrative penalty particularly suited for cases where a time delay in legal proceedings might be anticipated and where a violation might have serious and immediate consequences for human health or the environment. Staff of both the Railroad Commission and the EPA indicate that administrative penalties are effective in producing quick results and acting as a strong deterrent.

As with the Railroad Commission and the EPA, authority to levy administrative penalties could be appropriately applied to BSWM's solid waste enforcement effort. Improper disposal of non-hazardous or hazardous waste can pose a serious and immediate threat to both the environment and human health. In addition, a review of enforcement cases indicates that the time to reach compliance for all cases (hazardous and non-hazardous) averages six months to one year. Further, 35 percent of the cases sampled are still out of compliance with an average age of 1.4 years. Currently, the agency's most effective sanction is the imposition of civil penalties through the court system. Due to the heavy case load of the attorney general's office and the court system in general, this alternative can cause lengthy delays in getting violations resolved. It appears that allowing the agency to impose administrative penalties would be an effective deterrent and would avoid lengthy litigation processes.

While administrative penalties appear reasonable for the area of solid waste enforcement, another advantage to giving the agency this authority relates to "delegation" to the state of the federal hazardous waste program operated under the Resource Conservation and Recovery Act (RCRA). Delegation of this program would mean that the state is authorized to administer the federal program. In order to receive delegation, a state effort must be substantially equivalent to the federal program. The agency is currently operating the RCRA program under interim delegation for its hazardous waste program.

If the state were not to receive permanent delegation of this program, the regulated community could be under the dual jurisdiction of the Texas Department of Health and the EPA. This means that each regulated entity would have to secure a permit from each agency and make periodic reports to both of them. This duplication of regulatory effort would be costly, time consuming and confusing for permittees. The EPA has published guidelines in draft form which outline in general what is expected in a state program to qualify for delegation. These guidelines state that the assessment of an administrative penalty of up to $25,000 per day is expected within 150 days of detection of certain types of violations. It is also stated in these guidelines that when a state's authority is no longer equivalent, delegation withdrawal proceedings may be initiated. Interviews with staff members of both the EPA and the Texas Department of Health have confirmed that administrative penalties are likely to be an issue in the delegation decision.

It is therefore recommended that administrative penalties be made available to the Texas Department of Health to assist in efforts to receive RCRA delegation and to help ensure timely and effective compliance in the solid waste enforcement program.

The implementation of the administrative penalty process for the Bureau of Solid Waste Management will require a structure unlike that found in the department's traditional permitting and enforcement actions. To develop a process that is fair to the person being fined and fits into the unique board and departmental set up, the following steps should be provided for:

1) The decision is made at the bureau (central office) level to take the action to fine a person as well as the determination of the amount of the fine to be assessed and recommended to the commissioner. The commissioner then assesses the fine upon approval of the Board of Health at its next regularly scheduled meeting.
2) If the violator protests the application of the fine, then a hearing will be held by a hearing examiner of the department's general counsel's office. The hearing examiner then makes a recommendation to the commissioner concerning the fine. The commissioner then assesses the fine upon approval of the Board of Health at its next regularly scheduled meeting.
3) If the final decision of the commissioner, approved by the Board of Health, is appealed, the appeal will be held under the substantial evidence rule. Additionally, before an appeal can be made, the penalty should be paid into an escrow account.

Concerning the amount of the fine, a review of the EPA approach indicates that the fine amount varies according to the type of licensee and the severity of the violation. Although the details of the fine system should be worked out by the bureau through rulemaking it appears appropriate to provide a statutory cap of $25,000 for violation.

The Department of Health should be required to collect fees to offset the cost of regulating municipal solid waste (hazardous and nonhazardous) management activities in the state.

The Texas Department of Health is designated by statute as the state solid waste agency with respect to the management of municipal solid waste and is the coordinating agency for all municipal solid waste facilities. In general, the agency carries out its mandate to "safeguard the health, welfare, and physical property of the people, and to protect the environment" through a registration, permitting and enforcement program carried out by the department's Bureau of Solid Waste Management. The bureau regulates municipal solid and hazardous waste facilities through a permit process; it registers municipal hazardous waste generators, transporters, and owners/operators of hazardous waste treatment, storage and disposal facilities; and it attempts to ensure compliance with the law and regulations through continual monitoring and enforcement programs of the facilities and persons regulated. The program is funded through a mixture of state and federal funds totalling $2.8 million ($1.6 million from general revenue) for fiscal year 1984 and is supported by a staff of 75 persons. The bureau collects one fee associated with its program to certify "solid waste technicians". It is estimated that this fee will bring in $11,000 in fiscal year 1984. There are no fees authorized for the bureau's permitting and enforcement efforts to regulate the management of municipal solid (hazardous and non-hazardous) waste in the state.

As a general principal, some portion of the cost associated with regulating an industry or business should be borne by the regulated group. This principal is demonstrated most frequently in "Licensing" agencies for professions where 100 percent of the cost of licensing is frequently paid in fees. Another example of fees supporting a significant portion of a regulatory program's cost is found in the Health Department's Bureau of Radiation Control (BRC). This program has developed a fee schedule designed to capture approximately 50 percent of its operating cost.

To conform to this general state approach, the Solid Waste Disposal Act should be amended to allow the solid waste program to collect fees for its state supported efforts to regulate solid waste (hazardous and nonhazardous) facilities

under its jurisdiction. An examination of the process used by the BRC to set its fees and the nature of the industries it regulates reveals the need for consideration of at least three important factors in setting these fees.

First, the BRC has set fees at a level anticipated to recover 50 percent of the program's cost of operation. Using this amount as a rough guideline, it seems reasonable to require that fees for each of the regulatory efforts of the program cover between 25 and 50 percent of the state's cost. This range gives the agency the flexibility to determine an amount most appropriate for its efforts while also ensuring significant increases in dollars to offset the cost of regulation without creating a strong disincentive to compliance.

The second factor which should be considered in the development of the fee structure is that the fees charged should be reasonably related to the costs to the agency for performing the various aspects of regulation. For example, in the area of solid waste landfill disposal, the size of the landfill and the number of persons it is designed to serve bear relationships to the amount of time (and therefore dollars) needed to permit and routinely inspect the facility. It appears reasonable that the fee structure developed by the bureau should have variations in fees which correlate with measures reflective of the effort needed to carry out the regulation of the activity the fee is designed to support. This concept is found at work in the State Banking Department. Fees charged of regulated banks are "graduated" based on the size of the assets the banks may have. These fees help support the costs of state bank examinations and range from $3,500 to over $50,000 depending on the size of the bank.

The third factor which should be considered in the development of the fee structure is that all affected parties should have ample opportunity for input into the process. The information necessary to examine the impact on the industries involved and the actual costs to the agency for its permitting and enforcement activities needs to be complete. Requiring that the fee structure be adopted through the rulemaking and hearing provisions of the Administrative Procedures Act (APA) will assist in ensuring that the work will proceed with specified schedules and opportunities for those concerned with the proposal to have input.

Memoranda of understanding developed by the Bureau of Solid Waste Management with other state agencies should be processed through the APA rulemaking procedure.

Many Texas state agencies are involved in the effort to prevent adverse effects of pollution on the environment and general public health. At least four agencies, the Department of Health, the Department of Water Resources, the Air Control Board and the Railroad Commission, all play key roles in regulating various aspects of municipal and industrial activities that pose serious threats to the environment or general public health if not accomplished properly. By statute the separate duties of each of the agencies are broadly set out. For example, the "Solid Waste Disposal Act" (Art. 4477-7, V.A.C.S.) establishes that the Department of Health is responsible for regulating the management of "municipal" solid waste and the Department of Water Resources is responsible for regulating the management of "industrial" solid waste. Such statutes provide guidance as to the general jurisdiction of each agency by defining essential terms and by setting out the duties of each agency using broad language.

Such broad treatment typical of statutes does occasionally cause confusion among state agencies in regards to jurisdiction responsibilities. For instance, a statute will not provide specific instruction as to how each agency should cooperate and interact in situations when jurisdiction over a particular kind of waste is unclear.

Through either rulemaking or a joint written agreement called a "Memoranda of Understanding" (MOU), involved agencies typically have defined each other's responsibilities in order to avoid duplication of effort and to enhance cooperation between the agencies. The Health Department's Bureau of Solid Waste Management has entered into three MOUs with state agencies: 1) with the Railroad Commission and the Texas Department of Water Resources concerning pollution from oil and gas activities (MOU signed January 1982); 2) with the Texas Air Control Board to coordinate state government activity concerning incinerators used to process hazardous waste (MOU signed August 1982); and 3) with the Texas Department of Public Safety to coordinate the enforcement of motor carrier safety laws and regulations relating to the transportation of hazardous waste (MOU signed November 1982).

The review of the TDH Bureau of Radiation Control indicates that it has formally adopted an MOU with the Texas Department of Water Resources concerning jurisdiction over in situ-uranium mining as a departmental rule (MOU

signed January 1983 and adopted as a rule February 1983). The MOUs adopted by the Bureau of Solid Waste Management have not been adopted as agency rules under the Administrative Procedure Act (APA).

The APA defines a rule as "...any agency statement of general applicability that implements, interprets, or prescribes law or policy or describes the procedure or practice requirements of an agency" (Art. 6252-13a, V.A.C.S.). It could be reasonably argued that agency MOUs typically fit this definition. For example, the agency MOU with the Texas Department of Health and the Railroad Commission clarifies agency responsibilities regarding waste from oil and gas exploration in the following manner:

> The disposal of tank bottoms and stormwater runoff from storage tanks and tank-farms during the production phase, and the storage at any central crude storage area prior to entering the refinery, are under the jurisdiction of the Railroad Commission. Wastes generated from storage tanks which are part of the refinery, however, are subject to the jurisdiction of the Texas Department of Water Resources, while solid wastes resulting from the marketing of refined products are subject to the jurisdiction of the Texas Department of Health.

This language appears to "implement and interpret" the general governing statute as contemplated under the APA.

A major purpose of the APA rulemaking procedure is to provide for public comment in the agency's interpretation of general law. Under the APA the public must be given at least 30 days notice before a rulemaking action to allow all interested persons the opportunity to submit data and express their views in a public hearing.

The general character of MOUs as rules and the importance of public comment in rulemaking suggests a need to remove any question as to how these agreements should be handled in the future. The agency's statute should be amended to require that all future MOUs with state agencies, or revisions to existing agreements, be processed through the APA rulemaking procedure.

Bureau of Environmental Health

The Bureau of Environmental Health is responsible for the implementation of programs that ensure that certain conditions in the workplace and community environment which pose potential hazards to human health are monitored and that identified problems are corrected. To provide such assurances, the bureau has developed four programs. The Water Hygiene Division is established to ensure that drinking water provided by public water systems is safe and free of contamination, and that wastewater is properly treated. The bureau's Division of General Sanitation attends to the problems of improperly disposed of garbage, disease carrying insects and rodents, and the sanitation of certain public places. Guidance is provided to Texas employers in assuring that employees are not exposed to hazardous chemicals or unsafe workplaces through the Division of Occupational Safety and the Occupational Health program. The individual divisions within the bureau monitor the environment and correct identified problems through various efforts of complaint investigation, regulation, consultation, enforcement, and surveillance.

In fiscal year 1984, the bureau operates four programs with a total budget of approximately $4,395,000 and a staff of 133 budgeted full-time positions. The bureau's total budget is allocated to the four programs operated by the bureau in the following manner: water hygiene - 57 percent; general sanitation - 10 percent; occupational safety - 20 percent; and occupational health - 12 percent. The bureau allocates one percent of the total budget to the operation of the bureau office and employs two full-time persons in activities related to the administration of the bureau.

A distinct part of the bureau is the board and Division of Occupational Safety. The board has a 1985 sunset date and the Division of Occupational Safety operates at significant variance from its original 1967 statute due to legislative funding changes. For these reasons, it has been selected for specific review and a background description of the history and functions of the board and division follow.

Occupational Safety Board and Division of Occupational Safety

The Occupational Safety Board and the Division of Occupational Safety operated under the direction of the board, was established by the legislature in 1967 for the protection of working men and women in Texas from death and disability due to unsafe working conditions. However, due to the lack of state

funding since 1975, many of its statutorily authorized activities have ceased. The division currently operates through a contract with the federal Occupational Safety and Health Administration (OSHA) which provides for occupational safety and health consultation services to OSHA regulated employers, and the collection of data needed for inclusion in the nationwide occupational injury survey. The Division of Occupational Safety performs the safety activities required by the contract and collects the survey data. The occupational health program provides the health consultation required by the contract.

The Occupational Safety Board consists of three members, the commissioner of health, the commissioner of labor and standards, and a public member who serves as chairman and is appointed by the governor for a term of two years. The board is statutorily authorized to provide protection to Texas workers through the promulgation and enforcement of state occupational safety regulations, investigation of complaints from the public, publishing annual occupational injury statistics, and hiring and providing guidance to the division director in the administration of the division. The Occupational Safety Board is authorized to act independently of the department and Board of Health in the performance of these duties even though the Division of Occupational Safety which implements and enforces the policies the board establishes, is identified as a program of the Department of Health.

From 1967 until 1975, the board took an active role in the development of state occupational safety standards, hired and provided direction to the division director and published several in-depth state occupational injury surveys. The division grew from a staff of two engineers with a state funded budget of $100,000 in 1967 to 38 engineers and $1.1 million budget in 1975 at which time the division was performing approximately 8,000 inspections annually. The federal government began occupational safety and health activities at the federal level in 1970 by enacting the Occupational Safety and Health Act and creating a federal agency to implement the provisions of the Act. The Act preempted state enforcement in OSHA regulated workplaces unless the state got approval of its enforcement plan but allowed for state enforcement in non-OSHA regulated workplaces without a plan. Governmental entities (state, county, and municipal) are examples of non-OSHA regulated workplaces. The federal Act made provisions for federal matching funds for states that were willing to assume such responsibilities under an approved state plan so the Occupational Safety Board proposed to continue the enforcement

activities that were already in place. However, to be eligible for state plan approval and the matching funds, some modification of the board's statute was needed. The board was unable to obtain those amendments through either the 63rd or 64th legislative sessions. In 1975, unable to grant the provisions needed for plan approval and recognizing that some protection was being provided at the federal level, the state legislature did not continue the annual general revenue appropriation of $1.1 million for the previous state level occupational safety activities.

The various states across the nation have had mixed reactions to the introduction of federal regulation by OSHA. The Occupational Safety Board indicates that 24 of the 50 states have secured approval for their state plan and currently provide both OSHA required enforcement and state initiated occupational safety activities. OSHA provides each of these states 50 percent of the funding needed to implement the federally-mandated enforcement activities and the states fund any state mandated activities. In the 26 states without an approved state plan, OSHA provides occupational safety regulation according to the federal law and the states provide any services that are beyond the OSHA mandate. Texas and Pennsylvania are the only states in the nation that have entirely discontinued state enforcement activities concerning the areas not covered by OSHA regulation. Within Texas, the state-mandated functions which have been discontinued and are not the responsibility of any other entity include the investigation of complaints from employees and the public concerning workplace safety, the development of state occupational injury statistics, and the protection of employees in non-OSHA regulated workplaces, specifically municipal and county employees.

Apart from the enforcement activities, the federal Act also contains provisions for funding to states that agree to provide certain consultative services to OSHA regulated employers concerning their voluntary compliance with OSHA regulations. Participation in the voluntary inspection and consultation service provides the employer a one-year exemption from the usual OSHA regulatory inspection and allows the employer an option to comply with the regulations without jeopardy of fine or penalty. At present, all states in the nation with the exception of Louisiana participate in this arrangement and offer the OSHA consultation service. In those states that do not have an approved state enforcement plan, such as Texas, OSHA continues to operate the regulatory and enforcement functions and the states provide the voluntary consultation program under contract. The Texas Department of Health entered into such a contract in

1975 that continues in effect today for the provision of these services and the collection of Texas injury data necessary for inclusion in the nationwide occupational injury survey. These are the only services that are currently provided by the Occupational Safety Division.

In addition to the division's services, the state has developed a similar program for its state workers. The legislature amended the Workers Compensation Laws in 1979 to provide for a consultation service for state agencies, since they are exempt from OSHA. Such a program has been created and is operated out of the attorney general's office since the Division of Occupational Safety's contract with OSHA prohibits services under the contract being provided to governmental entities.

In fiscal year 1984, the division operates with a budget of approximately $882,000 in federal funds and a full-time staff of 21. In fiscal year 1983 the division completed 1,000 consultative inspections and assisted in the correction of 13,000 employer violations of OSHA regulations. The division estimates that this service saved Texas employers an estimated $1,300,000 in penalties that OSHA could have assessed had this consultation service not been available. That same year, the division gathered occupational injury data from 12,000 employers for OSHA. The contract which funds this activity provides only for the gathering of specific data needed for the nationwide occupational injury survey. While the method of sampling required to provide a complete nationwide survey does yield general information on the overall number of occupational accidents in Texas, it does not provide any statistically valid information concerning occupational injury rates in specific industries and workplaces in Texas.

The Occupational Safety Board has an individual sunset review date of 1985 in the Sunset Act. Since the program functions as a division within the department, not as a separate agency, it has been reviewed as a program of the department.

The review of the Occupational Safety Board and the Division of Occupational Safety within the Texas Department of Health has necessitated an examination of the board and division history, shifting federal and state mandates and the board's unusual organizational and structural relationship with the department and the Board of Health. Specifically the evaluation analyzed the current activities and responsibilities of the division and board through the following areas of study: policy-making structure, administration of the division, the continued need for the

activities, effectiveness of current activities, and the implementation of statutory mandates. Major areas of concern resulting from the evaluation are set out below.

Policy-making Structure

The evaluation of the policy-making structure was designed to determine whether the current statutory structure is still appropriate in meeting the needs of the division, and if not, what policy-making structure would be more appropriate. These concerns were identified for study because the division's activities, which originally required the current policy-making structure involving a board that acts independently of the department's Board of Health, have changed considerably over the last decade.

The Occupational Safety Board is composed of three members, the commissioner of health, the commissioner of labor and standards, and a public member. The commissioners' terms run concurrent with their tenure as commissioner and the public member is appointed by the governor for a term of two years. The primary functions that the board is authorized to accomplish include the promulgation of state occupational safety regulations for all Texas workplaces, the direction of the division in the enforcement of the regulations and policies established by the board, and the hiring and supervision of the director of the division. The board is authorized in statute to perform these duties independent of the department and Board of Health. The division and board accomplished these functions up until 1975 when the legislature did not continue the $1.1 million annual state appropriation for state occupational safety services. With this action, all state-mandated services ceased. Since that time, the division has provided limited services under a contract with the federal Occupational Safety and Health Administration (OSHA). These services currently include the provision of consultation services to OSHA regulated employers concerning their compliance with OSHA regulations and the gathering of a sample of occupational injury data for inclusion in a nationwide occupational safety survey. Most of the division's current policies, procedures, and safety standards used are prescribed by the OSHA contract. In support of the division's operations, the Occupational Safety Board states that its current role is that of administrative supervision, advice, program advocacy, and communication with professional groups and other agencies.

While specific areas of protection which were provided for in the statute have been left unattended, the review found that it has been the will of the

legislature that state funding for state occupational safety services not be provided for the activities of this board and division.

The Occupational Safety Board should be abolished.

The Occupational Safety Board discontinued the establishment and enforcement of regulations in 1975. All safety standards, procedures, and policies currently used by the division are governed by the division's contract with OSHA. Due to this, the board has not established any new regulations or official division rules of operation since 1975, even though such activity is authorized. A review of the policy-making functions of other divisions within the Department of Health indicates that a more standard method of establishing division regulations and policies when and if they are needed does not call for an independent board. Instead, the promulgation of regulations and TDH division policies is usually performed by the Texas Board of Health.

The board was also given independent authority for the selection of the division director and the supervision of the administration of the division. The director of the division and the division staff are defined as employees of the Texas Department of Health. Although the commissioner of health is a voting member of the board, the statute provides no specific authority to the department or the Board of Health to direct and oversee the activities of the division. The Department of Health has identified problems stemming from the lack of clarity in the relationship between the authority of the Board of Health and that of independent boards within the department. Such identified problems are related to personnel management, budget approval, and agency procedures relating to the adoption of rules. The usual method for the selection and supervision of a division director within the Department of Health and other similar agencies is for the commissioner to have the hiring authority and for him or her to have the option of delegating that authority when it is deemed appropriate. The current functions of the division do not present special problems or circumstances that require deviation from the standard departmental policy.

In summary, the review found that the statutorily authorized independent board, and the authority that it is given, is not only no longer needed but also presents problems within the policy-making process of the Texas Department of Health. It is recommended that the Occupational Safety Board be abolished and

that the authority for hiring and supervising the division director be transferred to the Department of Health.

An advisory committee for the division of occupational safety should be established.

Since the change in program direction in 1975, which was described previously, the division has used its board in an advisory capacity. The board advises the division director on the administration of the division, facilitates communication with professional groups and other agencies, advocates at state and federal levels for the activities of the division, and provides public and other agency input mechanisms on the administration of the division. These functions appear to be advisory in nature, within the scope of an advisory committee, and are not provided through other departmental sources.

Two significant recommendations regarding occupational safety are made in the report. One recommends the abolition of the Occupational Safety Board and the second recommends the statutes governing occupational safety be limited to consultation rather than regulation. These changes create a situation requiring some oversight to ensure that the state and the department adjust to these changes in a productive manner. A traditional way for this kind of oversight to be provided is through the establishment and operation of an advisory committee. In the Policy Making Structure of this report, it is pointed out that advisory committees are best left to be developed by the policy body within broad guidelines. However in this special situation, it appears that an Occupational Safety Advisory Committee should be established in statute to assist the department and the board in matters regarding Occupational Safety. To ensure that the committee does not outlive its usefulness, the committee should be continued in statute no longer than September of 1989. After that time, the Board of Health can continue or discontinue the committee as it sees fit.

The Division of Occupational Safety states that if the Occupational Safety Board were abolished they would then have a need for an advisory committee as a means of obtaining guidance from labor, employers, and other related agencies. Since the program states it would benefit from such a committee and this approach has been found to be a helpful advisory process, it is recommended that an advisory committee be established for the Division of Occupational Safety.

The composition of such an advisory committee appointed by the Board of Health should include all of the major interests that are affected in the deliberations of the committee. The interests that are affected by the division's activities include the general public, both the employer and the employee in OSHA regulated workplaces, professional safety engineers, and two related agencies: the Industrial Accident Board and the State Board of Insurance's Workers' Compensation Division. The two agency representatives should be included as ex officio, non-voting members, primarily for the provision of interagency coordination.

Implementation of Statutory Mandate

The evaluation of the division and board's implementation of the statutory mandate, Article 5182a (V.A.C.S.), was designed to determine: in what ways the division and board are currently fulfilling the provisions of the statutory mandate, whether that mandate adequately authorizes the activities of the program, and what if any changes need to be made in the mandate to more appropriately authorize the program's activities. These concerns were identified for study because the program's operations have changed considerably since the statute's enactment due to OSHA's preemption of previously mandated state enforcement activities, the discontinuance of state funding, and the division's establishment of an OSHA consultation service through federal funds.

The evaluation found that the division and board are not carrying out many of the provisions of the statute. It was further found that the current program functions appear to be authorized within the various provisions of the statute. While specific areas of protection authorized in the provisions of the statute have been left unattended in the current operations of the program, the review found that it has been the will of the legislature that state funding for these activities not be provided to this board and division for the provision of these state level services. The recommendation that has resulted from the previously described evaluation of the implementation of the statutory mandate is set out below.

The statute governing the Division of Occupational Safety should be amended to include only those activities currently carried out by the division.

The enabling statute for the Occupational Safety Board and Division of Occupational Safety was enacted in 1967. The provisions of that act were implemented by the board and division until three events in the 1970s changed the

operations of both the entities. The enactment of the federal Occupational Safety and Health Act (OSHA), in 1970, preempted the division's statutorily authorized enforcement activities in all OSHA regulated workplaces without the approval by OSHA of a state plan for enforcement. The approval of such a plan for Texas hinged on an amendment to the enabling statute. The department approached the legislature in 1973 and again in 1975 in an attempt to obtain the needed amendments, but was unsuccessful. In the 1975 session in which the last attempt was made, the state appropriation of $1.1 million for the occupational safety activities was not continued and all state safety activities ceased. OSHA currently provides all occupational safety regulation enforcement in Texas with the exception of a safety program for state agencies which is administered through the attorney general's office since governmental entities are exempt from OSHA regulation. Unless a state plan is approved at some future date, state enforcement concerning any OSHA regulated employer is preempted.

With the close of the legislative session in 1975, the program made plans to dismantle all state occupational safety activities performed by the program. At that point, OSHA offered the department a contract to provide the previously described voluntary occupational health and safety consultation service for OSHA regulated employers and continued collection of data needed for inclusion in the national occupational injury survey. These activities were already authorized under sections 7(b), 14, and 15(a) of the program's enabling legislation, Article 5182a (V.A.C.S.), so no legislative action was deemed necessary by the board to begin these services.

The provisions of the OSHA contract prohibit the division from performing certain functions. It requires that the consultation service only be provided to employers who request such services, thus preempting the division's mandated complaint investigation function while it operates fully funded through the contract. The publishing of the state occupational injury survey, which is also required in the statute, was discontinued by the program when state resources were no longer made available.

Based on the review, it appears that only those activities now carried out by the division should remain in statute. This approach requires the extensive modification of the current statutes as they contemplate a "regulatory" rather than "consultative" effort by the division governed by the Board of Occupational Safety. As mentioned previously, the legislature in its 64th session in 1975, ended state

funding for the regulatory program. Activities of the current program are totally funded through a federal contract which only authorizes "consultation services". It now appears timely, to modify the program's operating statutes to conform to those activities sanctioned by the legislature in its last three sessions.

In summary, the statute should be amended to delete the authorization for the following functions for the Board of Occupational Safety:

1. the authority to independently establish rules of operation;
2. the authority to promulgate safety regulations;
3. the authority to enforce safety regulations;
4. the authority to hire the division director;
5. authorization for a general advisory committee for designing regulations;
6. the authority to investigate complaints from sources other than employers; and
7. the responsibility for publishing an annual occupational injury survey for Texas.

EVALUATION OF OTHER SUNSET CRITERIA

The review of the agency's efforts to comply with overall state policies concerning the manner in which the public is able to participate in the decisions of the agency and whether the agency is fair and impartial in dealing with its employees and the general public is based on criteria contained in the Sunset Act.

The analysis made under these criteria is intended to give answers to the following questions:

1. Does the agency have and use reasonable procedures to inform the public of its activities?
2. Has the agency complied with applicable requirements of both state and federal law concerning equal employment and the rights and privacy of individuals?
3. Has the agency and its officers complied with the regulations regarding conflict of interest?
4. Has the agency complied with the provisions of the Open Meetings and Open Records Act?

EVALUATION OF OTHER SUNSET CRITERIA

The material presented in this section evaluates the agency's efforts to comply with the general state policies developed to ensure: 1) the awareness and understanding necessary to have effective participation by all persons affected by the activities of the agency; and 2) that agency personnel are fair and impartial in their dealings with persons affected by the agency and that the agency deals with its employees in a fair and impartial manner.

Open Meetings/Open Records

The review of this area indicated that the board and department has generally complied with the provisions of the Open Meetings and the Open Records Act. Timely notices of board meetings are filed with the Office of the Secretary of State. Executive sessions held by the board appear to be properly announced and are used to discuss permissible topics, such as personnel matters and litigation. While almost all of the information maintained by the agency is considered public, certain types of information held by the agency is closed in accordance with state and federal statutes. The agency has developed a centralized system through its Office of General Counsel for answering questions relating to open records requests. Further, the agency has developed an internal committee made up of representatives of its major programs and its legal division to assist in dealing with personal data requests. This committee was formed in 1982 and is available to review information requests for which there is no precedent or guideline. Although the agency appears to be operating adequately through its open meetings and open records procedures, one concern was identified in each area which needs correction.

Board of Health committee meetings should be "posted" and "open" in compliance with the Open Meetings Act.

The Board of Health currently has nine committees. They are the:

Executive Committee
Budget Committee
Crippled Children's Services Committee
Environmental Health Committee
Hospitals Committee
Legislative Committee
Nursing Home Committee
Personnel Committee
Strategic Planning Committee

The executive committee, made up of the chairman, vice-chairman and secretary is established in the rules of the board and has the power to act for the board, although its actions are subject to review and approval of the full board at its next meeting. The other committees are working groups and are appointed by the chair. These committees review recommendations coming from the staff or advisory committees concerning items to be decided by the full board. For example, the legislative committee has been active in reviewing and forwarding to the board suggested modifications or additions to current health department statutes. The budget committee has recently reviewed and forwarded to the board the department's biennial budget request. Although the committee process appears useful, one concern has been identified in the operation of the committees.

To date, the meetings of the committees have not been "posted" in accordance with the Open Meetings Act (Art. 6252-17, V.A.C.S.). The Act itself does not speak directly to the issue of whether of not committee meetings of boards should be posted and open, but two Attorney General Opinions (H-3 and H-238) do address the issue. These opinions concerned similar committees created by the board of the Texas Department of Mental Health and Mental Retardation and the Board of Managers of the Harris County Hospital District. The opinions held that meetings of these committees should be "posted and open". The reasoning for this position is laid out in H-238 as follows:

> Our ruling (in H-3) was in part based on the fear that, if the public were excluded from such committee meetings, it would be deprived of access to the actual decision-making process and the purpose of the Act would be thwarted. We recognized that when a governing board divides its membership into several committees for preliminary consideration of pending business there arises a real danger that the board itself may become merely a "rubber stamp" for the actions or recommendations of its committees... The Open Meetings Act was intended to expose the entire decision-making process of the governmental bodies it covers to the view of the interested public. It would be substantially undermined if these committee meetings were not included within its coverage.

Based on these opinions, it appears that the committee meetings of the board of health should be both posted and open in compliance with the Open Meetings Act.

The Hospital Licensing Act should be amended to remove language which closes hospital licensing information.

Currently, Section 15 of the Hospital Licensing Act (Art. 4437f, V.A.C.S.) does not allow the public access to information obtained by the agency through reports and inspections which identifies individuals or hospitals. The confidentiality requirements were put into statute 14 years before the Open Records Act of 1973. The agency has indicated that there appears to be no need for this provision. The information in the licensing files is basic information and can in fact be obtained through other divisions of the agency. For example, the health planning division of the agency receives annual surveys concerning many aspects of hospital operations. These surveys are open to the public and contain information concerning the number and type of beds operated by the hospital. This same kind of information when collected under the Hospital Licensing Act is closed to the public. It appears timely to remove the specific records provision in the Hospital Licensing Act and allow the more recent Open Records Act to control the maintenance and disclosure of documents held by the hospital licensing division of the TDH.

EEOC/Privacy

A review was made to determine the extent of compliance with applicable provisions of both state and federal statutes concerning affirmative action and the rights and privacy of individual employees. The agency is currently operating under an equal employment plan that specifies policies and procedures in recruiting, selecting, hiring and promoting employees. The plan also provides information on its development and distribution as well as the responsibilities of the agency's EEO committee, its membership and general operation. Attached to the plan are descriptions of the EEO complaint procedure, hearing and appeal processes, and other related materials. The plan and its attachments are reviewed annually and updated as needed.

The agency operated under a court ordered consent agreement relating to its employment practices from 1978 to 1983. The court order expired in December 1983. While the agency's work force continues to have a predominance of white males in professional positions, the agency has shown improvement in the area of equal employment through an increase in the number and percentage of minorities

and women employed in these and other agency-wide positions. The following exhibits (Exhibits 5 through 10) provide a breakdown of the staffing of the department and its chest hospitals for fiscal years 1980 and 1983.

A review of EEO complaints initiated during the last four years indicates that eight have been filed with the agency's Equal Employment Opportunity (EEO) committee and 26 have been filed with the federal EEO commission. The rate of filings against the agency appears to be declining from a high of 16 in calendar year 1981 to 3 in 1982 and 4 in the first eight months of 1983.

Exhibit 5

STAFF ANALYSIS FY 1980

DEPARTMENT TOTALS EXCLUDING CHEST HOSPITALS

Total Agency Employees This Classification	ANGLO		HISPANIC		BLACK		OTHER		TOTAL	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Exempt	108	13	9	1	2	0	0	0	119	14
Group 17-21	463	148	23	11	4	5	2	3	492	167
Group 12-16	358	559	37	69	6	43	1	5	402	676
Group 7-11	302	471	63	80	20	32	2	2	387	585
Group 2-6	66	653	24	231	30	120	0	7	120	1011
TOTAL	1297	1844	156	392	62	200	5	17	1520	2453

Exhibit 6

STAFF ANALYSIS FY 1983

DEPARTMENT TOTALS EXCLUDING CHEST HOSPITALS

Total Agency Employees This Classification	ANGLO		HISPANIC		BLACK		OTHER		TOTAL	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Exempt	129	16	8	0	1	0	0	1	138	17
Group 17-21	469	185	25	13	6	9	2	2	502	209
Group 12-16	336	609	41	78	8	45	3	5	388	737
Group 7-11	263	487	63	98	20	51	3	6	349	642
Group 2-6	85	559	3	292	35	143	0	4	123	998
TOTAL	1282	1856	140	481	70	248	8	18	1500	2603

Exhibit 7

STAFF ANALYSIS FY 1980

SAN ANTONIO STATE CHEST HOSPITAL

Total Agency Employees This Classification	ANGLO		HISPANIC		BLACK		OTHER		TOTAL	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Exempt	13	2	1						14	2
Group 17-21	6	9	1					1	7	10
Group 12-16	13	22	4	4	1	3			18	29
Group 7-11	6	31	19	25	1	3		1	26	60
Group 2-6	6	27	33	55		8		1	39	91
TOTAL	44	91	58	84	2	14		3	104	192

Exhibit 8

STAFF ANALYSIS FY 1983

SAN ANTONIO STATE CHEST HOSPITAL

Total Agency Employees This Classification	ANGLO		HISPANIC		BLACK		OTHER		TOTAL	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Exempt	10	1	2						12	1
Group 17-21	8	7	2						10	7
Group 12-16	13	35	6	9	2	5		1	21	50
Group 7-11	4	30	23	28	1	5		1	28	64
Group 2-6	10	22	33	53		10		1	43	86
TOTAL	45	95	66	90	3	20		3	114	208

Exhibit 9

STAFF ANALYSIS FY 1980

SOUTH TEXAS HOSPITAL

Total Agency Employees This Classification	ANGLO		HISPANIC		BLACK		OTHER		TOTAL	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Exempt	3		3				1		7	
Group 17-21	3	2	1		1				5	2
Group 12-16	2	10	3	4			1	1	6	15
Group 7-11	5	4	6	16					11	20
Group 2-6	4	2	52	68	1	1			57	71
TOTAL	17	18	65	88	2	1	2	1	86	108

Exhibit 10

STAFF ANALYSIS FY 1983

SOUTH TEXAS HOSPITAL

Total Agency Employees This Classification	ANGLO		HISPANIC		BLACK		OTHER		TOTAL	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Exempt	4		3				1		8	
Group 17-21	2	1	1		1				4	1
Group 12-16	2	7	5	7				1	7	15
Group 7-11	2	7	17	19		1			19	27
Group 2-6	4	5	48	70	1	1			53	76
TOTAL	14	20	74	96	2	2	1	1	91	119

Public Participation

The agency encourages public participation in basically two ways. First it holds numerous public hearings concerning certain regulatory and block grant allocation functions of the agency. During fiscal year 1983 the agency held some 56 hearings regarding permit applications and disciplinary actions against its regulated populations and held 10 hearings around the state regarding block grant funds. The agency also holds hearings in Austin and other parts of the state regarding the adoption of rules and regulations. Board meetings are open to the public and are held in various parts of the state with the majority of meetings occurring in Austin.

The second major effort of the department regarding public information development is the duty of its office of Public Health Promotion. This section develops literature explaining the programs' functions and services. The associated reprographics division coordinates the acquisition and distribution of health films. These films cover a multitude of topics such as cancer prevention and treatment, dental health, health careers, mental health, nursing, school health, etc. The only cost for the films is for the cost of mailing the film back to the department. These efforts in conjunction with the efforts of individual programs indicate the agency takes an active role in attempting to inform the public of its activities, provide for public input into its operations and assist the public in educating them about general health issues. Two concerns, however, have been identified in the agency's overall public participation efforts and they are discussed below.

The Public Health Promotion Division should assist in a one time assessment of agency program's public literature development and be assigned an oversight function concerning program public information on a continuing basis.

The Department of Health operates at least 42 separate programs to accomplish two distinct functions: health service and regulation. Each of the programs have separate purposes and usually a distinct population that is either served or regulated. Even though an agency like the Department of Mental Health and Mental Retardation is larger in terms of staff and budget, its focus is much more refined and its activities lend themselves to easier description. To develop an easily understood and produced document which provides the public with

information on all the TDH programs would be costly and of little use to the diverse sections of the public the agency serves. It is important however, for an agency like the TDH to make sure that each of its programs has information that is readily available to the public and covers pertinent topics concerning the program's function and services. The review indicates that the development, content and distribution of such information varies from program to program.

Under the current structure, some programs such as those involved in controlling communicable disease, have placed a high priority on informing the public about available services. For example, the Immunization Division uses volunteers in hospitals to give mothers of newborn children a packet of information on the program's immunization requirements and services that are available through TDH. In contrast, three programs selected for review were found to have no program information for dissemination to the general public. There is no system in these programs that even ensured that persons eligible for the service have access to information explaining available service (Dental Treatment Program, Dental Education Program, Children's Outreach Heart). The programs rely instead on specific segments of the medical and educational community (school nurses, teachers, public health nurses) for the referral of persons needing the service. For example, using this system of referral, the Dental Programs have focused their information dissemination effort on the school personnel and dentists involved in the delivery of the service. While professional information is important, all of the three programs not having recipient literature ultimately rely on the child or the parent to indicate to the professional their need for the service. This method delegates the state's responsibility for insuring public access to information on tax supported services to these professionals and prevents the citizen from having reasonable access to information as to the scope of services and service priorities of the department.

The legislature has taken several actions which underline the importance of public information activities. During the 68th Legislative session S.B. 117 (Article 6525-13e, V.A.C.S.) was enacted. Section 5(h) of that article requires the following of all programs funded through block grant funds:

> "the agency shall undertake public information activities necessary to ensure that recipients and intended recipients are informed of the availability of services and benefits."

One of the programs found to not have an adequate public information system is funded to some extent with block grant funds. The Sunset

Commission has also adopted an across the board approach which requires agencies to notify the public as to the activities that it undertakes. Although the department has developed the Public Health Promotion Division mentioned earlier, this division performs a technical assistance function for programs that, on their own initiative, prepare such information. It does not serve in an coordinative, oversight capacity to ensure that all programs have developed information describing their functions and services.

To correct these problems two actions appear to be needed. First, the Public Health Promotion Division should assist in a one-time review and assessment of the department's public information to ensure that each program has useful public information and that reasonable methods are followed to make the information available to the public. Second, the division should be assigned an ongoing oversight and coordination role in the area of public information to ensure that new information is developed as needed and old information is modified as the agency's programs and duties change in future years.

The department's Office of General Counsel should establish a centralized, coordinative system to ensure that program rules are adopted in compliance with state statutes.

An important aspect of any agency's operation involves the development of rules and regulations which detail the methods used by the agency to implement broad mandates established in statute. Two particular statues govern this area as it relates to the Department of Health. The Administrative Procedure Act requires agencies to "adopt rules of practice setting forth the nature and requirements of all formal and informal procedures available." (Sec. 4(a)(1), Art. 6252-13a, V.A.C.S.) Secondly, the statute governing activities of the Board of Health requires the board to "adopt rules, not inconsistent with law, for its own procedure and for the conduct and performance of every duty imposed on the board, the department, or the commissioner by law..." (Sec. 1.05(a)(4), Art 4414b, V.A.C.S.).

Of the programs reviewed, the regulatory programs were found to have adopted the necessary policies as rules. However, within the service programs, several were found to have either no rules, partial rules, or out-dated rules. For example, the Tuberculosis Services Division has no formally adopted rules nor do

the dental treatment, dental education or fluoridation programs. The SSI Disabled Children's program has out-of-date rules and the Immunization Division rule do not address how the services of the program are delivered.

Currently, the department places the responsibility for initiating rule-making with the programs responsible for policy development. Technical assistance is provided by the department's General Counsel's office on request of the program staff. Occasionally the Legal Division will initiate the rule development process but this is limited to programs responsible for implementing recently passed or amended legislation. The current structure does not appear to be adequate to ensure, department-wide, that each program has initiated and completed rule-making as required by the previously cited statutes.

The adoption of policies and procedure by rule-making for service programs is important in that it provides notice of program requirements to other agencies and contractors. It also encourages consistent, fair, and non-duplicative service. The posting requirement for rule adoption provides an important mechanism for systematically conveying policy changes to the diverse service delivery community and increases the opportunity for public participation in department policy making.

To ensure compliance with state statutes related to rule-making, it appears the Office of General Counsel should serve in an active rather than a reactive capacity. To accomplish this function in a coordinated on-going manner the office staff should initially review all the department's programs to identify those which have inadequate rules governing the programs for priority action. It should then assist in developing and adopting rules as needed for program operations.

Conflict of Interest

The review indicated that the agency has established adequate procedures for making board members and employees aware of their responsibilities under conflict-of-interest statutes. For board members, a board "resource manual" has been developed. This manual includes information concerning the board's rules and regulations, general laws affecting board procedures, the committees of the board as well as information concerning the activities of the department's many programs. The section of the manual concerning general laws contains copies of civil and criminal statutes relating to state officials and employees. Within this section are the provisions governing the conduct of state officers (Art. 6252-9b, V.A.C.S.). New members are briefed on the contents of the manual as well as their duties under the law. Each new employee is provided copies of the conflict-of-

interest statutes and required to sign an affidavit that the employee has received and read a copy of this material. Review of documents on file with the Secretary of State indicate that the proper financial disclosure forms have been filed by the commissioner and ten board members have filed disclosure of regulated business interest affidavits.

ALTERNATIVES

The analysis of whether there are practical alternatives to either the functions or the organizational structure are based on criteria contained in the Sunset Act.

The analysis of alternatives is directed toward the answers to the following questions:

1. Are there other suitable ways to perform the functions which are less restrictive or which can deliver the same type of service?
2. Are there other practical organizational approaches available through consolidation or reorganization?

ALTERNATIVES

As part of the review of the agency, the functions performed by the agency were evaluated to determine if alternatives to current practices were available. It was determined that a practical alternative to the current structure of one of the agency's functions does exist and it is discussed below.

The Health and Human Services Coordinating Council could be designated as the State Health Planning and Development Agency.

The Department of Health performs health planning functions authorized by federal (PL 93-641) and state (Art 4418h, V.A.C.S.) law. The department's Bureau of State Health Planning and Resource Development carries out the planning activities utilizing 39 staff and $1.2 million (70% federal dollars) in fiscal year 1984. The bureau is commonly referred to as the State Health Planning Development Agency or SHPDA. In an earlier section of the report, an analysis was made of changes that should be made if the structure remains in TDH. However analysis also indicated that an alternative existed which would involve transferring this function which is discussed below.

The work of SHPDA has two primary goals: 1) assist the Statewide Health Coordinating Council in developing the State Health Plan; and 2) assist the Texas Health Facilities Commission in obtaining data needed for the "certificate of need" process. The Statewide Health Coordinating Council, a multi-member policy body consisting of consumers and health service providers from various regions of the state, is required by the federal government as a part of the health planning process. It basically serves an oversight function in providing general guidance for SHPDA and in initial approval of the State Health Plan. The Texas Health Facilities Commission (THFC), a separate agency with a three-member, full-time policy body performs federally mandated "Certificate of Need" review duties for the state. The SHPDA is required by federal and state law to assist the THFC in obtaining standardized data and information to assist the commission in its determinations to approve or disapprove applications for certificates of need. Without an approved certificate of need, a proposed health care facility cannot be built.

The SHPDA does focus its efforts toward these two primary goals. Since its inception in 1975, it has produced three State Health Plans and will complete the

1985 State Health Plan by November 1984. The stated goals of the State Health Plan are two-fold: "to identify statewide health concerns, and to propose solutions whose bases are analytically derived and whose implementation will improve the health status of the citizens" (from the Texas Proposed State Health Plan, June 29, 1984). It is intended to be used as a guide by all health and health related decision makers in the development of programs and allocation of resources. The plan itself covers 13 major areas of concern which include; health protection, health promotion -education, teenage family planning, ambulatory care and EMS, short term institutional care, long term institutional care and alternatives, habilitation and rehabilitation, health care costs, data needs, health professions, drug abuse, alcohol abuse, mental health and mental retardation. The plan also includes information regarding certain health care bed need projections and a description of how the plan itself addresses certain "national health priorities" as determined by Congress.

The SHPDA also obtains and shares data with the Health Facilities Commission. As part of this activity, the SHPDA conducts an annual hospital survey which obtains information on many facets of hospital operations to assist the certificate of need (CON) process.

Considerable criticism has been leveled at the SHPDA concerning its operations in the past. The review of these criticisms and discussions with the SHPDA staff and informed persons outside the agency indicate that these criticisms are generally aimed at; 1) the State Health Plan itself, and 2) the unusual structure within which the SHPDA must operate. These two areas of concern are examined separately below.

Past criticisms of the plan relate mainly to its size and lack of focus. The 1982 plan was 704 pages long and included over 350 goals. This plan is primarily narrative and serves as a reference and survey document rather than a plan with an outline with specific needed actions. The plan is also criticized for being aimed at a very large audience rather than key policy makers. The staff of the SHPDA are well aware of these criticisms and have taken steps to correct these problems in the development of the 1985 State Health Plan. The plan is currently much smaller and does provide better focus on health issues and specific actions that should be taken to address the issues.

The review of problems associated with the structure within which the SHPDA operates indicates that some can only be solved by a major reorganization. First, the SHPDA sits inside the health department. The staff are considered

health department employees and they are hired and dismissed through TDH procedures. Theoretically, as with all TDH employees, their policy-making body is the Board of Health and the staff should follow, through various chains of command, the general policy and program directives of the Board of Health. The policy body that approves the major work products of the SHPDA, however, is the Statewide Health Coordinating Council; a body appointed by the governor with no formal or informal ties to the Board of Health. This structure leaves the staff of the SHPDA with split allegiances and creates the potential for the staff to be presented with conflicting policy directives.

Second, the major work product of the SHPDA, the State Health Plan is designed and required to analyze issues and make recommendations which affect not only the health department but also other major health related agencies. This can lead to instances of duplication of recommendations to the legislature or, if not handled carefully, can lead to conflicts between between SHPDA and individual agencies.

Third, the Statewide Health Coordinating Council (SHCC), which is the policy body looking at state health needs, is not made up of key policy-makers that are directly tied into the legislative and executive decision making processes. The current composition of the SHCC includes persons with expertise and knowledge of issues concerning health services and planning but not individuals such as legislators, that have direct ties into the process which can make the statutory or budgetary changes to implement the recommendations found in the State Health Plan.

Finally, in 1983, the 68th Legislature established the Health and Human Service Coordinating Council. This body is composed of 19 members including the governor; the lieutenant governor; the speaker of the house of representatives; the chairman of the Texas Board of Human Resources; the chairman of the Texas Board of Health; the chairman of the Texas Board of Mental Health and Mental Retardation; the chairman of the State Board of Education; two additional board chairmen of state agencies delivering health and human services, appointed by the governor; two senators appointed by the lieutenant governor; two members of the house of representatives appointed by the speaker of the house; two members of the general public appointed by the governor; two members of the general public appointed by the lieutenant governor; and two members of the general public appointed by the speaker of the house. Although new, the council is actively

carrying out its mandates which, until September 1985, are restricted to examining health and human service issues affecting children and youth. A review of the statutory mandates of the council indicates that it is to "serve as the primary state resource in coordinating and planning for health and human services" (Sec. 131.003 (a)(3), Human Resources Code). Although the functioning and role of the council will be more fully developed in coming years, this mandate concerning health planning can potentially conflict with the duties and functions of the SHPDA.

To address the problems identified above, it appears that the Health and Human Services Coordinating Council (HHSCC) could serve as the State Health Planning and Development Agency. Such a change would appear to address the concerns but would have to be handled carefully.

Designating the HHSCC as the SHPDA would remove the potential duplication of effort regarding health planning by two separate state agencies. The placement of the duties related to the development of the State Health Plan in the HHSCC would provide a direct tie to the key policy makers of the state. At the same time the policy body for the approval of the plan would be representative of the major agencies involved in the development and implementation of the plan. The planning efforts would also be provided with one policy body in contrast to the current structure where the Board of Health and the SHCC both serve in policy positions for the SHPDA. Finally, the assumptions of the SHPDA duties by the HHSCC would provide the newly formed council significant additional resources (SHPDA budget is $1.2 million is 1984). This appears particularly timely in that the council's focus is to be broadened in September 1985 to include all health and human services, not just those related to children and youth.

There are, however, certain aspects of the transfer that should be considered. First, the removal of the SHPDA from the health department would require other personnel of TDH to perform activities now carried out by SHPDA. For example, the SHPDA staff now review the Federal Register on a regular basis and notify programs of the department of any changes which might affect them. Secondly, due to federal requirements, a portion of the Statewide Health Coordinating Council membership would need to be added to the framework of the Health and Human Services Coordinating Council as an advisory committee. Allowing the SHCC membership and HHSCC membership categories to work in conjunction to meet federal requirements might present difficulties. However it does appear possible to negotiate such an arrangement and this addition would have to be

carefully thought out. Third, the HHSCC would have to add to its duties the collection of information for the Health Facilities Commission to be used in the certificate of need process. This could be done as a part of the broad planning and coordination mandates of the council. Fourth, the HHSCC would need to either develop or contract for significant data processing capabilities. The HHSCC currently has some computer capability through a contract with the Department of Human Resources and could continue to contract with TDH with little impact since the Department of Health's computer services already support SHPDA. Finally, the addition of the SHPDA's duties to the HHSCC would have to be carefully phased in so as not to "overwhelm" the new council and its small staff.

Although there could be drawbacks to designating the Health and Human Service Coordinating Council as the State Health Planning and Development Agency the benefits outweigh the disadvantages. In the long run, it appears that the council can provide an appropriate structure as well as appropriate guidance in the development and implementation of an effective health planning process in Texas.

OTHER POLICY CONSIDERATIONS

During the review of an agency under sunset, various issues were identified that involve significant changes in state policy relating to current methods of regulation or service delivery. Most of these issues have been the subject of continuing debate with no clear resolution on either side.

Arguments for and against these issues, as presented by various parties contacted during the review, are briefly summarized. For the purposes of the sunset report, these issues are identified so they can be addressed as a part of the sunset review if the Sunset Commission chooses to do so.

OTHER POLICY CONSIDERATIONS

This section covers that part of the evaluation which identifies major policy issues surrounding the agency under review. For the purpose of this report, major policy issues are given the working definition of being issues, the resolution of which, could involve substantial change in current state policy. Further, a major policy issue is one which has had strong arguments developed, both pro and con, concerning the proposed change. The material in this section structure the major question of state policy raised by the issue and identifies the major elements of the arguments for and against the proposal.

Should the department's dental service program be restricted to dental treatment services only?

The department's dental treatment services are designed to meet the emergency needs of low-income children for basic dental services for the relief of pain and infection. The program restricts such care to $75 dollars per child and only allows for basic care. Even with these restrictions the program is only able to assist 19,750 children a year. Using the program's definition of low-income family (which is based on the federal school lunch program eligibility and excluding children served by other programs) over 900,000 children in Texas are living in low-income families and have no public dental resource for emergency care. A 1983 survey by the American Dental Association of Medicaid dental service utilization rates in the 50 states indicates that, when services are available, the average utilization rate for children's dental services is 30 percent of those children that are eligible. Applying this utilization rate to the number of children eligible, and excluding those served by this and other programs currently, over 250,000 low income children in Texas have need of such service but have no available resource for emergency treatment. It is argued that emergency dental treatment should be available to all children that are in need.

The department currently has discretion in its allocation of dental health moneys between its programs of dental treatment and education. In fiscal year 1984, the budget is allocated as follows:

Dental Treatment	$ 1,373,995	70%
Dental Education	$ 593,955	30%

In addition, the department received $311,311 in federal funds to operate a fluoridation program but these funds cannot be reallocated at the discretion of the Bureau of Dental Health. Were the department directed to spend its education funds for treatment services, an estimated 8,000 additional children per year could be provided emergency treatment. Such a policy would be consistent with two riders that were adopted when state funds were first allocated to the program. A rider to the appropriation bill in the 64th session prohibited the use of state funds for education and a similar rider adopted in the 65th session limiting the program's allocation of resources for education to $98,000 for a pilot project. No subsequent riders pertaining to the program have been adopted and the programs have no statutes governing their activities.

The argument against the reallocation of all dental education funds to treatment services is that dental disease can be prevented by early training in the development of good oral hygiene habits. Dental health services of the department have included an education component since it started in 1936. The Texas dental education program is considered an innovator in the nation. The curriculum materials developed by the program are used by the state department of health in California and an adopted version is used by the Headstart programs in six major states. Further, the dental education program is seen as an important addition to the more general public school health curriculum. With the help of TDH dental hygienists, the program is implemented in 23 percent of the school districts in Texas and in 1984 reached 78,000 children.

Should the age restriction be removed from the department's Dental Treatment Services programs?

The department currently provides basic dental treatment for the relief of pain and infection to children that live in low income homes. This service is available only to children (18 and younger) that have no other dental resource and is only provided in cases of serious dental need. The program aided 19,750 children in fiscal year 1984 with a $1.4 million budget. This service is provided as an important compliment to another program of regular dental treatment which is provided to children living in lower income families, the Early and Periodic

Screening, Diagnosis and Treatment Program (EPSDT) operated by the Texas Department of Human Resources. That program provided dental treatment to 79,896 children in 1984 with a $11.7 million budget. While these two programs provide a necessary service, they are still not enough to ensure that every eligible child is free of dental pain or serious infection. However, children are not the only population at serious risk of dental disease. In fact dental disease is found at a higher rate in adults and is more serious when found in some adult age groups than in children.

Testimony was presented concerning the need for dental services to adults, especially in the elderly and disabled, both in the department's block grant public hearings and in a public hearing held by the Indigent Health Care Task Force. The testimony indicated that only extremely limited dental services are available to persons over 18 regardless of any income, circumstance, or disability level, outside of patients in major state institutions. Only emergency dental services are available, on an very limited basis, to those adults who are eligible for Medicaid (which includes primarily the disabled and single mothers living in poverty). Periodontal disease in adults can create serious health problems often leading to malnutrition. For the frail elderly, living on a fixed income with no regular dental treatment regimen, dental disease can present not only a serious financial problem but also a serious medical problem. However, no public dental resources are available for the majority of these persons.

One potential resource that could be made available to the adults in serious need is the Dental Treatment Program of TDH. This program has already established fixed community clinics in many communities, reimbursement arrangements with local dentists in communities without clinics, and mobile dental clinics for the more remote communities without dentists. A service delivery system could help meet the critical need for dental services to adults with no other resources, who are in pain and at risk of infection. Of particular value would be the mobile dental clinics in the treatment of invalid or home-bound adults, especially in summer months when schools are out and the mobile clinics are infrequently used.

There are, however, significant problems associated with lifting the age restrictions currently in place. An expansion of the age eligibility guidelines for the Dental Treatment program require a reduction of services to needy Texas children if total funding is not increased for the program. Such a lifting of the age

requirement without expansion in dollars would possibly require the program to more stringently review the applications for care of persons of all ages and select only those most critically in need. Also, the adult often requests assistance with dental care only when the dental disease has progressed to an extreme state and the cost of individual treatment would probably average higher than that of children. Although apparently needed, the state would incur significant cost increases to cover both adults and children with the program. Extending the present dental treatment program to the 400,000 adults eligible for Medicaid in 1984 would increase the cost of the program by $6 million a year based on the 20 percent average Medicaid dental utilization rate experienced in the 23 states in the nation that report providing such services.

Should the Texas Department of Health be given the authority to impose sanctions on persons who fail to provide data determined to be necessary for effective health planning and resource development?

Currently, Article 4418h (V.T.C.S.) mandates that the department (TDH) "collect and disseminate data determined to be necessary for effective health planning and resource development", and that "persons who fail to comply... are in violation of this Act". However, the Act does not specify any sanctions for persons who fail to provide the necessary data. The TDH has been obtaining a response rate to its questionnaires of approximately 90 percent. The staff states that this is primarily the result of requesting only information that health-care providers will voluntarily provide to TDH.

The proponents of authorizing TDH to utilize sanctions in the collection of health-care data argue that it is essential to the health planning process. As issues become more controversial, dependence on a totally voluntary system will mean the virtual absence of data in a number of critical areas, for example, information on the costs of obtaining health-care services in Texas. With the ability to enforce their authority in the area of data collection, TDH could receive information in a timely manner and would no longer have to limit their surveys to "non-controversial" issues in order to be able to maintain a good response rate. If sensitive data is received, it could be closed to the public to protect those submitting the data.

The opponents of this idea argue that sanctions would be detrimental to the "spirit of cooperation" which currently exists between TDH and health-care

providers. Health-care providers express concern that sanctions could be applied for any type of data that the TDH might determine to be necessary for effective health planning. In general, sanctions are reserved for violations in which a danger to the public can be proven, and there should be a range of sanctions to fix the seriousness of the violation. It is difficult to evaluate the specific "public harm" which would occur if health-care data were not submitted to TDH in a timely and complete fashion. Finally, it is argued that the health-care community has, on the whole, complied with previous TDH requests and, therefore, the need for sanctions at this time is not critical.

Should the portion of the state's hazardous waste program currently under the jurisdiction of the Department of Health be transferred to the Department of Water Resources.

Currently, the Texas Solid Waste Disposal Act (Art. 4477-7, V.A.C.S.) establishes joint jurisdiction in the regulation of solid waste between the Department of Water Resources and the Department of Health. The Department of Water Resources is charged with the responsibility of regulating "industrial solid waste", while the Department of Health regulates "municipal solid waste". These two types of waste are defined in statute as follows:

> "Municipal solid waste" means solid waste resulting from or incidental to municipal, community, commercial, institutional, and recreational activities, including garbage, rubbish, ashes, street cleanings, dead animals, abandoned automobiles, and all other solid waste other than industrial solid waste.
>
> "Industrial solid waste" means solid waste resulting from or incidental to any process of industry or manufacturing, or mining or agricultural operations.

"Hazardous waste" is seen as a subset of solid waste and is regulated under both state law and the federal Resource Conservation and Recovery Act(RCRA). In general, for a waste to be considered as hazardous, it must be toxic, corrosive, ignitable, chemically reactive, or a combination of the above.

Under RCRA, states operating a hazardous waste program substantially equivalent to the federal design are eligible to receive grant funding from EPA. In Texas, jurisdiction over hazardous waste is divided between the Health Department and TDWR according to the municipal and industrial definitions given above. In

fiscal year 1984, the total RCRA grant divided between these agencies for the regulation of hazardous waste amounted to approximately $4,478,725. To be eligible to receive the federal funds, 25 percent of the cost of the hazardous waste regulatory program must be borne by the state. Information showing how the state's hazardous waste program is divided between the Health Department and the Texas Department of Water Resources is given below:

	TDWR	TDH
Number of entities under the jurisdiction of the agency	2,600	475
Staff dedicated to permitting, registration, and enforcement	81	29
Percent of federal grant received	70%	30%
Percent of state's hazardous waste regulated by the agency	90%	10%

It has been suggested that the split of the hazardous waste program between the Health Department and the Texas Department of Water Resources is not the most appropriate way to regulate this important area. Opponents of the current split generally argue that regulation of hazardous waste should be consolidated in the TDWR. This agency already has the responsibility for most of the hazardous waste generated in the state. It could be argued that consolidation of the program in that agency would help to eliminate current confusion among the public and industry as to the specific areas of jurisdiction of each agency. Consolidation would also help to promote uniformity of regulation by giving one agency clear authority over the design and administration of the program. It is also possible that transfer of the entire program to the TDWR would help to reduce duplication of administrative personnel, thereby reducing the cost of the program.

On the other side of this issue, it could be argued that the current system of split regulation has now been worked out satisfactorily and is working adequately. It makes little sense to tear down a structure that has been recently developed to replace it with a new system of questionable superiority. In addition, the Health Department currently permits municipal disposal facilities and has control over both the non-hazardous and hazardous waste deposited at those sites. If the consolidation were to occur, two agencies instead of one would be involved in the regulation of waste at municipal facilities — the Health Department for non-hazardous waste, and TDWR for hazardous waste. This dual involvement could

confuse and complicate the permitting and enforcement systems for these municipal facilities.

Should the Food and Drug Act be amended to allow the attorney general to seek an injunction to restrain persons from violating provisions of the Act.

Currently, Sec. 4 of the Texas Food and Drug Act (Art. 4476-5, V.A.C.S.) authorizes the commissioner of health to seek an injunction in district court to restrain persons from violating the Act's provisions relating to unlawful and prohibited activities. As mentioned previously, criticism has been leveled at the department for not taking timely action in response to the EDB situation. The attorney general in a hearing held in February 1984 by the Senate Subcommittee on Public Health, requested that he be granted the authority to seek an injunction in court to stop violations of the Food and Drug Act. Although the commissioner and board of health did act quickly once the Environmental Protection Agency set EDB tolerance levels, allowing the attorney general, the chief law enforcement officer of the state, to act if he or she deems it necessary in the future might provide for quicker response to similar EDB type situations.

On the other side of this issue, it could be argued that this approach is a significant departure from other statutes which allow the attorney general to take action only upon the request of the regulatory agency. It can be argued that the TDH is the one entity with staff with sufficient medical and health backgrounds to make the initial decision to take enforcement action concerning areas under its jurisdiction. Should those in violation not respond to the agency's actions, then it is appropriate for the agency to seek the assistance of the attorney general. Another potential problem could occur if the attorney general and the regulatory agency came to different conclusions on how to react to a particular situation. In a law suit, the agency could be left without its "legal counsel" (the attorney general) if the attorney general had taken an independent action contrary to the agency's but possibly in keeping with those bringing the lawsuit.

Should the statutory requirement that the Commissioner of Health be a licensed physician be eliminated?

The position of the Commissioner of Health, which has existed under various

titles since 1879, has always been filled by a physician licensed to practice medicine in Texas. While at one point in time this may have been essential, the nature of the responsibilities of the commissioner has shifted from controlling communicable diseases. The commissioner now manages a complex organizational structure with over 500 public health clinic sites and a staff of 4,775. It has been argued that this broad administrative nature of the job does not necessarily require a physician to fill it and that this requirement unduly restricts the Board of Health in its selection of a commissioner. It is further argued that the commissioner would have sufficient medical advice through the current agency structure. Currently, physicians fill 38 percent of all key administrative positions within the department. Finally, it is argued that the commissioners of the Texas Department of Human Resources and the Texas Rehabilitation Commission are not required to be physicians even though these agencies are involved in the administration of major medical programs.

However, others argue that the mission of the Texas Department of Health is to protect and promote the health of the people of Texas and in serving such a mission, a high level of medical knowledge is required. It is argued that the TDH activities of nursing home regulation, meat inspection, solid waste management, and the compilation of vital statistics, should be guided by medical expertise to be effective. Such a base of medical knowledge, when coupled with a professional staff skilled in other specialties such as civil engineering, organizational management, law, statistics, finance, and data processing, provides the cornerstone for the effective protection of the public health for the State of Texas. In carrying out these responsibilities, the commissioner must deal with a wide variety of physicians heading up local health departments as well as members of the central office staff. It is argued that the chief administrator needs to be able to deal with medical program personnel on an equal professional footing. Finally, it is pointed out that the commissioner of TDMHMR is also required to be a physician.

ACROSS-THE-BOARD RECOMMENDATIONS

From its inception, the Sunset Commission identified common agency problems. These problems have been addressed through standard statutory provisions incorporated into the legislation developed for agencies undergoing sunset review. Since these provisions are routinely applied to all agencies under review, the specific language is not repeated throughout the reports. The application to particular agencies are denoted in abbreviated chart form.

TEXAS DEPARTMENT OF HEALTH

Applied	Modified	Not Applied	Across-the-Board Recommendations
			A. GENERAL
X			1. Require public membership on boards and commissions.
X			2. Require specific provisions relating to conflicts of interest.
X			3. Provide that a person registered as a lobbyist under Article 6252-9c, V.A.C.S., may not act as general counsel to the board or serve as a member of the board.
X			4. Require that appointment to the board shall be made without regard to race, color, handicap, sex, religion, age, or national origin of the appointee.
X			5. Specify grounds for removal of a board member.
X			6. Require the board to make annual written reports to the governor, the auditor, and the legislature accounting for all receipts and disbursements made under its statute.
X			7. Require the board to establish skill-oriented career ladders.
X			8. Require a system of merit pay based on documented employee performance.
X			9. Provide that the state auditor shall audit the financial transactions of the board at least once during each biennium.
X			10. Provide for notification and information to the public concerning board activities.
X			11. Place agency funds in the Treasury to ensure legislative review of agency expenditures through the appropriation process.
	X		12. Require files to be maintained on complaints.
	X		13. Require that all parties to formal complaints be periodically informed in writing as to the status of the complaint.
		X	14. (a) Authorize agencies to set fees. (b) Authorize agencies to set fees up to a certain limit.
X			15. Require development of an E.E.O. policy.
X			16. Require the agency to provide information on standards of conduct to board members and employees.
X			17. Provide for public testimony at agency meetings.
X			18. Require that the policy body of an agency develop and implement policies which clearly separate board and staff functions.

Texas Department of Health
(Continued)

Applied	Modified	Not Applied	Across-the-Board Recommendations
			B. LICENSING
**			1. Require standard time frames for licensees who are delinquent in renewal of licenses.
**			2. Provide for notice to a person taking an examination of the results of the exam within a reasonable time of the testing date.
**			3. Provide an analysis, on request, to individuals failing the examination.
**			4. Require licensing disqualifications to be: 1) easily determined, and 2) currently existing conditions.
**			5. (a) Provide for licensing by endorsement rather than reciprocity. (b) Provide for licensing by reciprocity rather than endorsement.
**			6. Authorize the staggered renewal of licenses.
**			7. Authorize agencies to use a full range of penalties.
**			8. Specify board hearing requirements.
**			9. Revise restrictive rules or statutes to allow advertising and competitive bidding practices which are not deceptive or misleading.
**			10. Authorize the board to adopt a system of voluntary continuing education.

*Already in statute or required.
**See Licensing ATB Summary.

LICENSING ACROSS-THE-BOARD SUMMARY

The Health Department regulates many different kinds of activities. Some of the activities are aimed at regulating individuals such as athletic trainers and others are aimed at regulating industrial operations such as solid waste landfills. The licensing ATBs adopted by the Sunset Commission have been designed to primarily cover aspects of regulation concerning individuals not facilities. Due to their design, the department has expressed concern that applying the ATBs to facility oriented regulations is not feasible. The legal staff of the department has conducted a review of the numerous regulatory activities conducted by the agency and has identified those regulatory efforts which are aimed at individuals and where the application of the ATBs is appropriate. In all, the department's staff reviewed 33 separate regulatory statutes and identified activities regarding three regulatory efforts to which the ATBs could be applied. These three include the regulation of Emergency Medical Service Personnel, Athletic Trainers, and Sanitarians. Further, the authority to stagger license renewals was identified as an appropriate addition to the regulatory functions of the Food and Drug Division in its regulation of Drug and Food Manufacturers. The application of the licensing ATBs will be confined to these areas of departmental activity.