

Texas

Despite receiving solid marks for its *Quality and Patient Safety Environment* and having one of the best *Medical Liability Environments* in the country, Texas continues to face significant problems, particularly in the area of *Access to Emergency Care*.

Strengths. Texas has the third lowest average malpractice award payment in the nation (\$148,495), reflecting the multitude of medical liability reforms that have been enacted. The state has a \$250,000 medical liability cap on non-economic damages and additional liability protections for EMTALA-mandated emergency care. The state also has expert witness rules requiring witnesses to be of the same specialty as the defendant and provides for case certification by an expert witness. Periodic payments of malpractice awards also are required by the state to alleviate the financial burden on physicians.

Texas has made numerous efforts to improve the *Quality and Patient Safety Environment* by maintaining a statewide trauma registry and providing funding for quality improvement within the EMS system. In addition, the state has or is working on a PCI network or STEMI system of care, as well as a stroke system of care.

Challenges. *Access to Emergency Care* in Texas is in crisis. The state has the highest rates of uninsured children and adults (21.2 and 25.8 percent, respectively), and ranks among the lowest states regarding access to all types of providers. Texas needs an additional 664.4 primary care providers and 139.4 mental health providers (full time equivalents) to serve the state's growing population. In addition, the state ranks among the worst 10 with regard to rates of orthopedists and hand surgeon specialists (7.3 per 100,000 people), emergency physicians (8.2 per 100,000), and registered nurses (674.4 per 100,000). Texas also faces a serious lack

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of physicians accepting Medicare (2.5 per 100 beneficiaries).

The state's grade in *Public Health and Injury Prevention* also indicates significant challenges for Texas. The state lacks adequate funding for injury prevention programs with total allocations of \$14.96 per 1,000 people, the fourth lowest in the country. Texas also lacks a law requiring all riders on all motorized cycles to wear a helmet. The percentage of traffic fatalities that are alcohol-related (48.0 percent) is the fifth highest among the states. In addition, the state ranks among the worst 10 with regard to immunizations among children aged 19–35 months (76.7 percent).

Disaster Preparedness in Texas suffers from the state's limited capacity to deploy health care workers during a disaster event. The state lacks medical assistance teams or strike teams, and has no nurses or physicians registered in a state-based Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program. Texas also lacks a statewide real-time or near real-time syndromic surveillance system. In addition, the state receives the lowest level of federal funding for disaster preparedness (\$6.24 per capita).

Recommendations. High rates of uninsured residents, combined with a shortage of providers, present a serious problem for Texas. The state needs to address the severe lack of physicians, registered nurses, and other providers in order to enhance access to medical care throughout its population. The state's comprehensive medical liability reforms are reportedly improving this situation, as the state has reported a significant influx of new physicians since those reforms were enacted. Additional efforts are needed to increase the percentage of the population with health insurance in order to increase overall access to care and reduce the number of patients




	RANK	GRADE
ACCESS TO EMERGENCY CARE	47	F
QUALITY & PATIENT SAFETY ENVIRONMENT	17	B-
MEDICAL LIABILITY ENVIRONMENT	2	A
PUBLIC HEALTH & INJURY PREVENTION	34	D
DISASTER PREPAREDNESS	41	D+
OVERALL	29	C

who delay care until they require emergency treatment.

Texas could improve its status with regard to the *Quality and Patient Safety Environment* by providing funding for a state EMS medical director position, and implementing a uniform system for providing pre-arrival instructions. The state could also benefit from increasing the number of emergency medicine residents (8.2 per 1 million people).

At the time the data were collected, Texas was in the process of implementing a state-based ESAR-VHP program. The state can expect its disaster preparedness score to improve significantly by making a strong effort to register volunteer nurses and physicians into the newly developed ESAR-VHP program. The state could take additional steps to provide specific liability protections to health care workers during a disaster event, and prepare for deployment during a disaster by developing regional strike teams or medical assistance teams.


ACCESS TO EMERGENCY CARE **F**

Board-certified emergency physicians per 100,000 pop.	 5.7
Emergency physicians per 100,000 pop.	8.2
Neurosurgeons per 100,000 pop.	1.5
Orthopedists and hand surgeon specialists per 100,000 pop.	7.3
Plastic surgeons per 100,000 pop.	2.3
ENT specialists per 100,000 pop.	2.9
Registered nurses per 100,000 pop.	 674.4
Additional primary care FTEs needed	664.4
Additional mental health FTEs needed	139.4
Level I or II trauma centers per 1M pop.	0.9
% of population within 60 minutes of Level I or II trauma center	78.6
Accredited chest pain centers per 1M pop.	2.6
% of population with an unmet need for substance abuse treatment	7.9
Pediatric specialty centers per 1M pop.	4.4
Physicians accepting Medicare per 100 beneficiaries	2.5
Medicaid fee levels for office visits as a % of the national average	NR
% change in Medicaid fees for office visits (2004-05 to 2007)	34.1
% of adults with no health insurance	25.8
% of children with no health insurance	21.2
% of adults with Medicaid	6.4
Emergency departments per 1M pop.	 17.5
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	319.8
Hospital occupancy rate per 100 staffed beds	62.3
Psychiatric care beds per 100,000 pop.	26.5
State collects data on diversion	No





MEDICAL LIABILITY ENVIRONMENT **A**

Lawyers per 10,000 pop.	14.6
Lawyers per physician	0.7
Lawyers per emergency physician	17.4
ATRA judicial hellholes (range 0 to -7)	-3
Malpractice award payments/100,000 pop.	0.4
Average malpractice award payments	\$148,495
Databank reports per 1,000 physicians	16.1
Patient compensation fund	No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	1.7
Average medical liability insurance premium for primary care physicians	\$17,596
Average medical liability insurance premiums for specialists	\$65,313
Pretrial screening panels	No
Are pretrial screening panels' findings admissible as evidence?	N/A
Periodic payments	Required by state
Medical liability cap on non-economic damages	\$250,000
Additional liability protection for EMTALA-mandated emergency care	Yes
Joint and several liability abolished	Yes
State provides for case certification	Yes
Expert witness required to be of the same specialty as the defendant	Yes
Expert witness must be licensed to practice medicine in the state	No

QUALITY & PATIENT SAFETY ENVIRONMENT **B-**




Funding for quality improvement within the EMS system	Yes
Funded state EMS medical director	No
Emergency medicine residents per 1M pop.	 8.2
Adverse event reporting required	Yes
Hospital-based infections reporting required	Yes
Mandatory quality reporting requirement	Yes
% of counties with E-911 capability	100.0
Uniform system for providing pre-arrival instructions	No
State has or is working on a stroke system of care	Yes
State has or is working on a PCI network or a STEMI system of care	Yes
Statewide trauma registry	Yes
% of hospitals with computerized practitioner order entry	20.4
% of hospitals with electronic medical records	39.4
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	51
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	16

PUBLIC HEALTH & INJURY PREVENTION **D**

Traffic fatalities per 100,000 pop.	14.8
% of traffic fatalities alcohol related	 48.0
Front occupant restraint use (%)	91.8
Helmet use required for all motorcycle riders	No
Child safety seat/seat belt legislation (10 points possible)	4
% of children immunized, aged 19-35 months	 76.7
% of adults aged 65+ who received flu vaccine in the last 12 months	 66.4
% of adults aged 65+ who ever received pneumococcal vaccine	 63.7
Fatal occupational injuries per 1M workers	46.6
Homicides and suicides (non-motor vehicle) per 100,000 pop.	17.1
Unintentional fall-related fatal injuries per 100,000 pop.	5.1
Unintentional fire/burn-related fatal injuries per 100,000 pop.	1.1
Unintentional firearm-related fatal injuries per 100,000 pop.	0.3
Gun-purchasing legislation (8 points possible)	1
% of tobacco settlement funds spent on health-related services and programs	92.6
Total injury prevention funds per 1,000 pop.	\$14.96
Unintentional injury prevention funds per 1,000 pop.	\$0.00
Intentional injury prevention funds per 1,000 pop.	\$0.00
Fall injury prevention funds per 1,000 pop.	\$0.00
Infant mortality rate per 1,000 live births	6.6
% of adults with BMI > 30	26.1
Current smokers, % of adults	17.9
Binge alcohol drinkers, % of adults	14.7

DISASTER PREPAREDNESS **D+**

Per capita federal disaster preparedness funds	\$6.24
Disaster preparedness funds used specifically for health care-related preparedness are tracked	Yes
All-hazards medical response plan or ESF-8 plan?	Yes
Plan shared with all EMS and essential hospital personnel?	Yes
Public health and emergency physician input into the state planning process	Yes, Yes
Public health and emergency physician input into the daily operations of the SEOC	Yes, No
Written plan for the coordination of the SEOC or local EMAs to provide security to hospitals in case of emergency events	Yes
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	1,026
Accredited by the Emergency Management Accreditation Program	No
Written plan specifically for special needs patients	Yes
Written plan to supply medications for chronic conditions	Yes
Written plan to supply dialysis for patients	Yes
Real-time notification system in place to notify identified health care providers of an event	Yes
"Just-in-time" training systems in place	NR
Statewide medical communication system with one layer of redundancy	Yes
Statewide patient tracking system	Yes
Statewide victim tracking system	Yes
Statewide real-time or near real-time syndromic surveillance system	No
Real-time surveillance system in place for common ED presentations	NR
Bed surge capacity per 1M pop.	NR
Burn unit beds per 1M pop.	5.4
ICU beds per 1M pop.	351.3
Verified burn centers per 1M pop.	0.2
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	No
Nurses registered in ESAR-VHP per 1M pop.	0.0
Physicians registered in ESAR-VHP per 1M pop.	0.0
Training required in disaster management and response to bio- and chem terrorism for essential hospital personnel, EMS personnel	Yes, Yes
State or regional strike teams or medical assistance teams	No
Additional liability protections for health care workers during a disaster	No
% of RNs that received any emergency training	45.8
State requires EMS and essential ED personnel to be NIMS compliant	Yes

	Improved since 2006
	Worsened since 2006
	No change since 2006
NR	Not reported
N/A	Not applicable
See Summary Statistics for State Comparisons	