Texas

D+

While Texas continues to provide a model *Medical Liability Environment* and has made great improvements in *Disaster Preparedness*, it still struggles with significant threats to *Public Health and Injury Prevention*, as well as severe financial barriers in *Access to Emergency Care*.

Strengths. Texas continues to be among the nation's leaders with its exemplary *Medical Liability Environment*. The state has the third lowest average malpractice award payments, and medical liability insurance premiums have continued to decline, especially for specialists whose premiums are on average $11,000 less than in the previous Report Card. Texas placed a $250,000 medical liability cap on non-economic damages, enacted additional liability protections for care mandated by the Emergency Medical Treatment and Labor Act, and passed apology inadmissibility legislation.

Texas has made substantial improvements in *Disaster Preparedness* since 2009. The state has instituted state or regional strike teams or medical assistance teams and has begun enrolling health care professionals in the Emergency System for Advance Registration of Volunteer Health Professionals. The state has the second highest rate of registered nurses who have received training in emergency preparedness (51.8%) and requires training in disaster management for all emergency medical services (EMS) and hospital personnel—one of only five states to do so. Texas also has strong liability protections in place to protect volunteer health care workers responding to a disaster.

Challenges. Texas continues to struggle with numerous factors in *Access to Emergency Care*, including severe financial barriers to care. The state has some of the worst rates of health insurance for adults and children (26.9% and 15.4% uninsured, respectively), for which it ranks last and second to last in the nation. Additionally, Medicaid fee levels for office visits are only 77.3% of the national average, having declined 4.9% since 2007. While hospital capacity is about average on many indicators, the state saw two hospital closures in 2011, which has likely contributed to the overall reduction in staffed inpatient beds from 319.8 to 292.7 per 100,000 people. Additionally, while Texas has been successful in attracting large numbers of emergency physicians and specialists over the past decade, performance on these indicators is overshadowed by the state's large and growing population and has resulted in very low per capita rates of many types of specialists, emergency physicians, and registered nurses. The Texas legislature recently increased graduate medical education funding, which should provide opportunity for increases in future workforce numbers.

Texas' grade in the *Quality and Patient Safety Environment* has declined, partially due to the inclusion of new indicators, but also due to a lack of funding for quality improvement of the EMS system and not having implemented important statewide policies. A multitude of EMS is necessary to cover this large state; as a result, the state has taken a regionalized approach to various EMS protocols. Nevertheless, Texas could investigate implementation of statewide practices and policies to set a standard of safe and effective care for emergency response, such as field trauma triage protocols; destination policies for stroke, ST-elevation myocardial infarction, or trauma patients; or a system for providing pre-arrival instructions.

Texas must act to increase adequate health insurance coverage and Medicaid fee levels to ensure Texans' access to care.

Texans suffer from a number of health risk factors and high rates of motor vehicle-related fatalities in the *Public Health and Injury Prevention* category. Texas has extremely high rates of obesity among adults and children (30.4% and 19.1%, respectively) and the highest cardiovascular disease disparity ratio in the nation: Non-Hispanic American Indians are 4.6 times more likely to have cardiovascular disease than the racial or ethnic group with the lowest likelihood. Texas also has high rates of bicyclist and pedestrian fatalities and the third highest rate of traffic fatalities related to alcohol (46.0%).

	2009		2014	
	Rank	Grade	Rank	Grade
Access to Emergency Care	47	F	47	F
Quality & Patient Safety Environment	17	B-	42	F
Medical Liability Environment	2	A	2	A
Public Health & Injury Prevention	34	D	49	F
Disaster Preparedness	41	D+	21	C
OVERALL	29	C	38	D+

Recommendations. Texas must work to improve *Access to Emergency Care* for its population. Of great importance is lessening the state's severe financial barriers to care by improving access to adequate health insurance for both adults and children. Texas must also act to increase Medicaid fee levels so that they are at least on par with the national average. In addition, Texas must continue to support a strong *Medical Liability Environment* and attract additional emergency care providers, specialists, and Medicare providers to meet the needs of its growing and aging population.

Texas must address racial and ethnic health disparities in cardiovascular disease rates by improving access to primary health care services. Hospitals have taken an excellent first step in addressing health disparities by collecting data on patients' race and ethnicity and taking steps to implement diversity strategies or plans, but the state must do more to encourage healthy habits and reduce cardiovascular disease risk factors among populations at highest risk. Implementing evidence-based practices to reduce adult and child obesity rates and improving traffic safety may be important first steps in improving state scores.

ACCESS TO EMERGENCY CARE	F
Board-certified emergency physicians per 100,000 pop.	6.9
Emergency physicians per 100,000 pop.	10.1
Neurosurgeons per 100,000 pop.	1.6
Orthopedists and hand surgeon specialists per 100,000 pop.	7.3
Plastic surgeons per 100,000 pop.	2.4
ENT specialists per 100,000 pop.	3.0
Registered nurses per 100,000 pop.	721.3
Additional primary care FTEs needed per 100,000 pop.	1.9
Additional mental health FTEs needed per 100,000 pop.	0.8
% of children able to see provider	94.6
Level I or II trauma centers per 1M pop.	0.9
% of population within 60 minutes of Level I or II trauma center	82.4
Accredited chest pain centers per 1M pop.	5.4
% of population with an unmet need for substance abuse treatment	8.5
Pediatric specialty centers per 1M pop.	4.2
Physicians accepting Medicare per 100 beneficiaries	2.5
Medicaid fee levels for office visits as a % of the national average	77.3
% change in Medicaid fees for office visits (2007 to 2012)	-4.9
% of adults with no health insurance	26.9
% of adults underinsured	8.1
% of children with no health insurance	15.4
% of children underinsured	18.8
% of adults with Medicaid	7.2
Emergency departments per 1M pop.	17.5
Hospital closures in 2011	2
Staffed inpatient beds per 100,000 pop.	292.7
Hospital occupancy rate per 100 staffed beds	61.0
Psychiatric care beds per 100,000 pop.	27.1
Median minutes from ED arrival to ED departure for admitted patients	274
State collects data on diversion	NR

MEDICAL LIABILITY ENVIRONMENT	A
Lawyers per 10,000 pop.	13.3
Lawyers per physician	0.6
Lawyers per emergency physician	13.1
ATRA judicial hellholes (range 2 to -6)	1
Malpractice award payments/ 100,000 pop.	1.7
Average malpractice award payments	$140,441
Databank reports per 1,000 physicians	17.3
Provider apology is inadmissible as evidence	Yes
Patient compensation fund	No
Number of insurers writing medical liability policies per 1,000 physicians	1.8
Average medical liability insurance premium for primary care physicians	$16,656
Average medical liability insurance premium for specialists	$54,176
Presence of pretrial screening panels	No
Pretrial screening panel's findings admissible as evidence	N/A
Periodic payments	Required
Medical liability cap on non-economic damages	$250,000
Additional liability protection for EMTALA-mandated emergency care	Yes
Joint and several liability abolished	Yes
Collateral source rule, provides for awards to be offset	No
State provides for case certification	Yes
Expert witness must 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	F
Funding for quality improvement within the EMS system	No
Funded state EMS medical director	No
Emergency medicine residents per 1M pop.	13.2
Adverse event reporting required	No
% of counties with E-911 capability	100.0
Uniform system for providing pre-arrival instructions	No
CDC guidelines are basis for state field triage protocols	No protocols
State has or is working on a stroke system of care	Yes
Triage and destination policy in place for stroke patients	No
State has or is working on a PCI network or a STEMI system of care	Yes
Triage and destination policy in place for STEMI patients	No
Statewide trauma registry	Yes
Triage and destination policy in place for trauma patients	No
Prescription drug monitoring program (range 0-4)	3
% of hospitals with computerized practitioner order entry	71.8
% of hospitals with electronic medical records	88.6
% of patients with AMI given PCI within 90 minutes of arrival	94
Median time to transfer to another facility for acute coronary intervention	63
% of patients with AMI who received aspirin within 24 hours	99
% of hospitals collecting data on race/ethnicity and primary language	85.5
% of hospitals having or planning to develop a diversity strategy/plan	60.6

PUBLIC HEALTH & INJURY PREVENTION	F
Traffic fatalities per 100,000 pop.	10.3
Bicyclist fatalities per 100,000 cyclists	7.9
Pedestrian fatalities per 100,000 pedestrians	9.1
% of traffic fatalities alcohol related	46
Front occupant restraint use (%)	93.7
Helmet use required for all motorcycle riders	No
Child safety seat/seat belt legislation (range 0-10)	8
Distracted driving legislation (range 0-4)	0
Graduated drivers' license legislation (range 0-5)	0
% of children immunized, aged 19-35 months	76.3
% of adults aged 65+ who received flu vaccine in past year	59.1
% of adults aged 65+ who ever received pneumococcal vaccine	70.4
Fatal occupational injuries per 1M workers	36.4
Homicides and suicides (non-motor vehicle) per 100,000 pop.	17.0
Unintentional fall-related fatal injuries per 100,000 pop.	6.1
Unintentional fire/burn-related fatal injuries per 100,000 pop.	0.9
Unintentional firearm-related fatal injuries per 100,000 pop.	0.2
Unintentional poisoning-related fatal injuries per 100,000 pop.	8.7
Total injury prevention funds per 1,000 pop.	$63.63
Dedicated child injury prevention funding	No
Dedicated elderly injury prevention funding	No
Dedicated occupational injury prevention funding	No
Gun-purchasing legislation (range 0-6)	1
Anti-smoking legislation (range 0-3)	0
Infant mortality rate per 1,000 live births	6.1
Binge alcohol drinkers, % of adults	18.9
Current smokers, % of adults	19.2
% of adults with BMI >30	30.4
% of children obese	19.1
Cardiovascular disease disparity ratio	4.6
HIV diagnoses disparity ratio	11.5
Infant mortality disparity ratio	2.7

DISASTER PREPAREDNESS	C
Per capita federal disaster preparedness funds	$5.32
State budget line item for health care surge	No
ESF-8 plan shared with all EMS and essential hospital personnel	Yes
Emergency physician input into the state planning process	Yes
Public health and emergency physician input during an ESF-8 response	Yes
Drills, exercises conducted with hospital personnel, equipment, facilities per hospital	3.2
Accredited by the Emergency Management Accreditation Program	No
Special needs patients in medical response plan	Yes
Patients on medication for chronic conditions in medical response plan	Yes
Medical response plan for supplying dialysis	Yes
Mental health patients in medical response plan	Yes
Medical response plan for supplying psychotropic medication	Yes
Mutual aid agreements with behavioral health providers	State-level
Long-term care and nursing home facilities must have written disaster plan	Yes
State able to report number of exercises with long-term care or nursing home facilities	No
"Just-in-time" training systems in place	Statewide
Statewide medical communication system with one layer of redundancy	Yes
Statewide patient tracking system	Yes
Statewide real-time or near real-time syndromic surveillance system	No
Real-time surveillance system in place for common ED presentations	Statewide
Bed surge capacity per 1M pop.	549.1
ICU beds per 1M pop.	340.5
Burn unit beds per 1M pop.	4.7
Verified burn centers per 1M pop.	0.2
Physicians in ESAR-VHP per 1M pop.	2.1
Nurses in ESAR-VHP per 1M pop.	10.1
Behavioral health professionals in ESAR-VHP per 1M pop.	0.4
Strike teams or medical assistance teams	Yes
Disaster training required for essential hospital, EMS personnel	Yes
Liability protections for health care workers during a disaster (range 0-4)	3
% of RNs received disaster training	51.8

NR = Not reported
N/A = Not applicable