ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Governor's EMS and Trauma Advisory Council (GETAC)

Number of Members: 15

Committee Status (Ongoing or Inactive): Ongoing

Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 9/1/1999 **Date to Be Abolished:** N/A

Budget Strategy (Strategies) (e.g. 1-2-4) 2.3.1 **Strategy Title (e.g. Occupational Licensing)** EMS and Trauma Care Systems

Budget Strategy (Strategies) **Strategy Title**

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Health and Safety Code, §773.012
State Authority		
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$18,125	$18,669	$18,669
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$4,500	$9,340	$9,340
Total, Committee Expenditures	$22,625	$28,009	$28,009

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$4,984	$4,984	$4,984
Personnel	$15,204	$15,508	$15,508
Number of FTEs	.35	.35	.35
Other Operating Costs	$3,000	$3,000	$6,000
Total, Committee Expenditures	$23,188	$23,492	$26,492

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
5046 - Permanent Fund for EMS & Tr	$45,813	$0	$0
512 - GR Dedicated - Bureau of Emer	$0	$42,161	$45,161
5111 - Trauma Facility and EMS Acco	$0	$9,340	$9,340
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year

Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
4	4	4

Committee Description:

This committee provides professional advice to the Emergency Medical Services (EMS) regulatory and the EMS/Trauma System programs that administer Health and Safety Code, Chapter 773 and 781, related to the certification/licensure of 5 levels of EMS personnel; licensure of EMS firms; approval of EMS Education programs; development, implementation, and evaluation of the Texas EMS/Trauma System; designation of 4 levels of trauma facilities; and dissemination of EMS/Trauma System grants. This includes, but is not limited to, advice on required basic and continuing education; standards for curricula and instructor approval; reciprocity requirements; minimum equipment, supply, and personnel standards; and regulatory rules. The committee also serves as a public forum for stakeholder input. Its purpose is to advise DSHS on rules regarding EMS and trauma systems in Texas. With ten standing committees (Air Medical, Cardiac Care, Disaster/Emergency Preparedness, Education, EMS, Injury Prevention, Pediatrics, Medical Directors, Stroke, and Trauma Systems) reporting to a 15 member council, GETAC is an active, governor-appointed advisory council with the mission of providing professional stakeholder input to DSHS on EMS regulation and overall strategies for improving trauma systems and emergency services across the state.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

Per statutory requirement, the Governor's Emergency Medical Services (EMS) and Trauma Advisory Council meets quarterly. Three of the four meetings are held in Austin, with the November meeting coinciding with the Texas EMS Conference wherever it is held.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

Provides professional advice to the department related to EMS, trauma, and stroke systems programs; serves as a forum for stakeholder input. Reviews and recommends changes to rules, assesses the need for EMS in the rural areas of the state, and develops a strategic plan for refining the educational requirements for certification and maintaining certification as EMS personnel, and developing EMS and trauma services.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

SB 8 (83R) required DSHS to submit a report on ways to reduce fraud in EMS. DSHS, through collaborative efforts with GETAC, submitted a report detailing these findings and recommendations in to the legislature 1/2014. Many of the recommendations contained in this report were made into law during the 84th legislative session. GETAC reviewed/revised the Texas Trauma System Strategic plan. Currently providing input on revisions to department rules.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ?

Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

626.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Agency staff provide administrative, technological, and logistical assistance to the committee (including, but not limited to: agenda formatting, coordination of meeting time/space, document preparation for Texas Register, documentation upload to website, additional meeting prep as necessary) and serve as resources to the committees and council during quarterly meetings.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

Public comment is accepted during each meeting. The public may also contact committee members to provide input; contact information is posted on the committee webpage. All meetings are posted in the Texas Register and the DSHS website. The Governor's Emergency Medical Services (EMS) and Trauma Advisory Council has a dedicated website at http://www.dshs.state.tx.us/emstraumasystems/governor.shtm, where additional information is available, including contacts, meeting details, and meeting documents.

7b. Do members of the public attend at least 50 percent of all committee meetings?

Yes

7c. Are there instances where no members of the public attended meetings?

No

8. Please list any external stakeholders you recommend we contact regarding this committee.

Texas EMS, Trauma, and Acute Care Foundation (TETAF), EMS for Children (EMSC), Texas Trauma Coordinators Forum (TTCF), Texas EMS Alliance, Texas Association of Air Medical Services, Texas Hospital Association (THA), American Heart Association (AHA)

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

Yes

9b. Please describe the rationale for this opinion.

The Emergency Healthcare System is ever changing as new technologies and advancements in life saving patient care interventions; the council serves as a conduit to assist the department with ongoing developments.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

Yes

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

Discontinuance of GETAC would leave the state without an important professional body to review and recommend changes to rules, and assess the need of EMS and trauma services in rural and frontier areas. It would also deprive Texans of a critical stakeholder body responsible for the development of strategic plans refining the educational requirements for certification and maintaining certification as EMS personnel and developing EMS and trauma services.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

GOVERNOR'S EMS AND TRAUMA ADVISORY COUNCIL
STANDARD OPERATING PROCEDURES

UPDATED OCTOBER 21, 2015

1 COUNCIL NAME

Governor's EMS and Trauma Advisory Council (GETAC)

2 CONDUCT OF MEETINGS

All meetings will be conducted in accordance with the state "Open Meetings" law. Agendas will include the opportunity for General Public Comment as well as specific comment before any action taken by the Council.

All documents associated with Council agenda items, will be submitted to DSHS no later than nine business days in advance of the GETAC meeting, thus allowing electronic distribution of materials to Council members, no later than five days in advance of the meeting.

The Vision and Mission will be read at the beginning of each Council and committee meeting and will be included on each Council and committee agenda.

3 VISION

A unified, comprehensive, and effective Emergency Healthcare System for a healthy and safe Texas.

4 MISSION

To promote, develop, and maintain a comprehensive data driven Emergency Healthcare System that will meet the needs of all patients and will raise the standards for high quality community health care by implementing innovative techniques and accountable systems for the delivery of emergency care for the entire population.

A quorum is a simple majority of the appointed council members that are physically present.

All Council members shall attend at least 50% of meetings in any rolling 12-month period. An attendance report will be submitted to the Governor's Appointment Office annually, after the fourth quarter meeting and prior to reappointment.

5 COMMITTEES

There will be ten standing advisory committees, as follows:
Air Medical Committee

Cardiac Care Committee
Disaster/Emergency Preparedness Committee
Education Committee
EMS Committee
Injury Prevention
Committee Medical
Directors Committee
Pediatric Committee
Stroke Committee
Trauma Systems Committee

Each committee should have a statement of purpose, as assigned by the Council.

Task Forces to address specific issues may be appointed at any time by the Council Chair. At the time of establishment of a Task Force, the Chair will appoint a leader, give the group its charge, and the Task Force will report to GETAC.

Each October of odd number years, the Council and the Committee Chairs will meet in Austin to review and revise the Council's Operational Plan and Standard Operating Procedures.
Each October of even number years, the Council and the Committee Chairs will meet to review the Strategic Plan for the Texas Emergency Healthcare System.

6 STANDING COMMITTEE STRUCTURE

The Council Chair will appoint each Standing Committee Chair- Standing Committee Chairs do not have to be GETAC members; however there must be a GETAC liaison on each Committee and GETAC members are encouraged to attend the various meetings to understand the issues that are being discussed. The Council Chair may replace a Standing Committee Chair for such issues as excessive absenteeism, misrepresentation, etc.

Executive Committee and the Standing Committee Chair will jointly appoint from a pool of applicants to serve on a specific committee. Committees shall consist of eleven members. The committee chair may ask the council chair for permission to increase the number of committee members. It is the responsibility of the Council and Committee Chairs to assure that membership appointments reflect appropriate representation on Committees/Task Forces (i.e. type of provider, geography, etc.)

The application process will be initiated at the third quarterly GETAC meeting annually, with the announcement of the;
1.) Date applications can be submitted;
2.) Deadline date for applications to be received by DSHS; 3.) And
the date by which all applicants will be notified.

Official notification of new member selections will be announced at the fourth quarter committee meetings with terms starting at the first quarterly meeting of the year.

The committee chair shall appoint a secretary who will provide written minutes of each committee meeting and will submit electronically to the Office of EMS/Trauma Systems.

DSHS, GETAC and possibly other individuals/entities will present a 2 hour orientation and educational session in conjunction with the fourth quarter GETAC meeting and EMS conference. All new committee appointees are strongly encouraged to attend the session, as well as any other interested individuals.

Committee members should have terms with expiration dates, with one third of the Committee members' terms expiring each year. When a committee member's term expires, that individual may be re-appointed, but new members should be strongly considered especially after a second term.

It is recommended that each member of the Council should serve as a committee member or liaison on at least one Standing Committee.

All committees will meet in conjunction with the quarterly GETAC meetings and as deemed necessary between the quarterly meetings to conduct the business of the committee.

Committee Chairs will:

- submit their respective committee agendas to DSHS by a specified deadline;
- ensure that minutes of the committee are kept; and
- present reports from their meetings at each Council meeting.

7 COMBINED COMMITTEE MEETINGS

Standing Committees may meet in combination. The voting composition of such meetings will include at a minimum the Chair or designee and three other members, appointed by the Chair, of each Standing Committee. Decisions made in Combined Committee meetings will be reported to GETAC.

8 EXECUTIVE COMMITTEE

The Executive Committee consists of the Council Chair, Vice-Chair and a third GETAC Council member selected by the Council Chair.

9 MEETING DAYS

Council meetings should be Fridays whenever possible, with the Standing Committees to meet prior to the Council meeting.

Standing committee meeting times are as follows:

Day 1

9:00am – 10:30am Disaster/Emergency Preparedness Committee
10:30am – 12:00pm Pediatric Committee
1:00pm – 2:30pm Injury Prevention Committee
2:30pm – 4:00pm Stroke Committee
4:00pm – 5:30pm Air Medical Committee

Day 2

9:00am – 10:30am Education Committee
10:30am – 12:00pm EMS Committee
1:00pm – 2:30pm Medical Directors Committee
2:30pm – 4:00pm Trauma Systems Committee
4:00pm – 5:30pm Cardiac Care Committee

10 CHAIR AUTHORITY TO REPRESENT GETAC'S POSITION

When critical, time-sensitive requests for GETAC input (e.g. legislative, media) are received between meetings, the chair will seek input from the Executive Committee prior to responding to the request.

When critical, but non time-sensitive requests are received between meetings; the chair may seek input from all members.

When requests regarding issues upon which GETAC has already taken action are received between meetings; the chair will respond with the GETAC's position.

In all cases, the final response will be shared with all GETAC members.

Established 412000
Revised I 11200 I Revised
9/2002 Revised 212003
Revised 212004
Revised 11 /2004 Revised
02/06 Revised *08/08*
Revised 11 /08
Revised 812009
Revised : 10/21/2015

Disclaimer: These meeting minutes will not be official until approved at the 11/20/2015 Governor's EMS and Trauma Advisory Council (GETAC) meeting.

Meeting Minutes
Governor's EMS and Trauma Advisory Council (GETAC)
August 19, 2015 9:00am

If you are unable to attend GETAC, TETAF sponsors webcasts of the quarterly meetings and can be viewed at http://www.ustream.tv/channel/getac

Council Members

Attendance	Name	Position (representing)
X	Vance Riley, LP	Fire Chief, Chair
	Nora Castañeda-Rivas	Public Member
X	Mike Click, RN	Rural Trauma Facility
	James (Mike) DeLoach	County EMS Provider
X	Linda W. Dickerson	Public Member
X	Robert D Greenberg, M.D.	Emergency Physician
	Jodie Harbert III, LP	EMS Educator
	Ryan Matthews, LP	Private EMS Provider
X	Jeffrey Beeson, D.O.	EMS Medical Director
	Karen Pickard, RN, LP	EMS Volunteer
X	Shirley Scholz, RN	EMS Air Medical Service
	James D. Williams, Lt.	Fire Department
X	Brian Eastridge, M.D.	Urban Trauma Facility
X	Alan H. Tyroch, M.D.	Trauma Surgeon
X	Robert Vezzetti, M.D.	Pediatrician

Department of State Health Services Staff

Attendance	Name	Position
X	Kathryn C. Perkins, RN	Assistant Commissioner for the Division of Regulatory Services
X	Renee Clack, LNFA	Director, Health Care Quality Section
X	Jane G. Guerrero, RN	Director, Office of EMS and Trauma Systems Coordination
X	Joseph Schmider	State EMS Director, Office of EMS and Trauma Systems
X	Colin Crocker	State Trauma Director, Office of EMS and Trauma Systems

Reading of the Vision and Mission Statement
GETAC Chair Chief Riley read the vision and mission statement.

Governor's EMS and Trauma Advisory Council (GETAC)
The meeting was called to order at 9:00 am on Wednesday, August 19, 2015, at the Crowne Plaza Hotel, Austin, Texas. A quorum of the members was present.

Approval of Minutes
No minutes were available for approval.

Chair Report and Discussion
Chief Riley announced September is committee application time for all GETAC committees. Current members should check their term expiration dates (posted on the DSHS GETAC committee web page) and if they expire 1/1/2016 and if they are interested in remaining on the committee, they should apply accordantly. Chief Riley announced that his appointment term to GETAC ends 1/1/2016 and that he does not plan to seek reappointment to the Council.

Assistant Commissioner Report, Division for Regulatory Services
Kathryn C. Perkins, Assistant Commissioner for the Division of Regulatory Services was unable to attend so Joseph Schmider reported for her. Joe encouraged everyone to sign up for Govdelivery.com to get the latest updated and meeting notices. Important dates to remember are:
September 14, 2015 – Meeting on Trauma Rules
September 21 or 23- Meeting on Rack Rules
September 22, 2015 – Meeting on Neonatal Rules
September 28, 2015- Meeting on Stroke Rules
For the doctors the medical online course has been extended for one more year so it will be up until August 1, 2016 and it will still be free after that it will cost about $400.00 to take that course. Texas has been selected to host the Nation Rural EMS conference in the spring on 2016.

State EMS/Trauma System Report, Office of EMS/Trauma Systems Coordination
No report was given

Assistant Commissioner Report, Environmental Epidemiology and Disease Registries Section
John Villanacci reported on managememt changes and staffing levels to the EMS/Trauma Registries; the status of the 2016 The TxDOT grant and planned use of the funds; and stakeholder education and training related to injury scoring, data collection and use. On July 8th 2015, the Registry was NEMSIS 3.3.4. Certified and is now avaliable.

Assistant Commissioner Report, Division for Regional and Local Health Services
No report was given

Standing Committee / Task Force Reports

Air Medical Committee
Shirley Scholz presented this report. Review and discussion included the pediatric inner facility guide lines; and the Trauma System rules; recommendations on those rules will be forthcoming.
No action was required for this agenda item.

Cardiac Care Committee

Dr. Smalling reported on the national STEMI care data from the ACTION registry and the RACs reported outcomes data to DSHS; Phase II of the STEMI Accelerator project of the American Heart Association.; and the importance of developing a RAC centered approach to STEMI outcomes reporting to the Cardiovascular Disease and Stoke Council of DSHS and the GETAC Cardiac Care Committee.

Disaster/Emergency Preparedness Committee

Eric Epley gave an update on Ebola preparedness and other high consequence diseases. The committee ask for GETAC to Support Infectious Disease Response Units as recognized components of the Emergency Medical Task Force system.

Education Committee

Jodie Harbert reported on progress in developing a curriculum for Community Health Paramedic. Committee voted to have to have mandatory stroke and stemi education added to CE topics. There will be an EMS coordinator update in Lubbock on Aug 21st and another Sept 30th in Hurst Texas.
No action was required for this agenda item.

EMS Committee

Dudley Wait reported on the continuing review of the TAC 157 dates and locations are as follows: Sept 11, 18, 25,30th. October 8, and 30th. November 6th and 13th in Tyler, Odessa, El Paso, Lerado and San Antonio, respectively.
No action was required for this agenda item.

Injury Prevention Committee

Shelly Stevens-Stidham reported on discussion regarding evaluation of Hospital-Based Injury Prevention and the importance of knowledge and science behind the layers of IP. Announcements: JPS Trauma Conference Oct 16, 2015.
No action was required for this agenda item.

Medical Directors Committee

Dr. Beeson, reported on the transport and care of patients with behavioral disorders and Pediatric Transfer and Transport Guidelines and have recommendations ready for the committee at the next council meeting; the gaps between the Texas Medical Board rules, Title 22, Texas Administrative Code (TAC), Chapter 197, and DSHS EMS rules, 25 TAC, Chapter 157.
No action was required for this agenda item.

Pediatric Committee

Sam Vance reported the committee has had a resignation that will be replaced in November. EMS for Children State Partnership update: 81% participation in reassessment results. Next week is EMS week, Wednesday is EMS for Children day.
No action was required for this agenda item.

Stroke Committee

Dr. Neal Rutledge reported on TCCVDS and RAC update by Darrel Pyle. Meeting with the education committee resulted in suggesting developing a video program that medical directors can use for stroke education.
No action was required for this agenda item.

Trauma Systems Committee

Dr. Eastridge reported the ongoing improvements to the Texas EMS and Trauma Registries including NEMSIS 3.3.4. softwear. Texas Trauma Quality Improvament program (TQIP) continues to evolve, Levels 1 and Levels 2 right now that are already apart of the TQIP program; untimate goal to involve the Level 3s and protection of statewide performance improvement process.

No action was required for this agenda item.

GETAC Liaison Summaries

Texas EMS, Trauma and Acute Care Foundation (TETAF)

The TETAF report was presented by Diana Welsh. The council chair thanked TETAF for the video streaming of the meetings .TETAF has been focused on legislative funding. There has been a lot of discussion in this session about RAC funding, and the Tobacco contracts are being delayed. Diana Welsh was able to meet with Kathy Perkins who ensured that she would not let a RAC temporally shut down. There are extraordinary funds that can be used to prevent a RAC from temporary shutting down.

EMS for Children State Partnership update

No update given

Discussion, public comment, and possible action on the following items

1. Report from the Education Committee workgroups regarding stroke-specific continuing education requirements for EMS personnel certification and recertification.

No action was taken on this issue.

2. **Update from state EMS director on Interstate CompAct (Recognition of EMS Personnel Licensure Interstate CompAct) legislation**

Joe Schmider, reported the legislation did pass approving The Replica of the EMS Compact. The real work will start in about a year or a year and half.

No action was taken on this issue.

3. Support Infectious Disease Response Units as recognized components of the Emergency Medical Task Force system

This was discussed during the Disaster/Emergency Preparedness Committee report. Please see motions

4. Information sharing for high-consequence infectious disease

No action was taken on this issue.

5. Position statement on the transport and care of patients with behavioral disorders

No update given, tabled until November meeting.

6. Freestanding emergency departments and other facilities providing emergency care and the potential categorization or designation of such entities

Dr. Greenberg advocated waiting to convene the task force in November allowing the Disaster Planning and EMS committees to contribute. There will be another meeting in November.

No action was taken on this issue.

7. How to improve the sharing of a medical facility's patient outcome data with EMS providers

No action was taken on this issue.

***8. Report on Pediatric Transfer and Transport Guidelines (*Charles Macias, MD, MPH)**
No action was taken on this issue..

***9. Child abuse and child fatality quality improvement issue (Charles Macias, MD, MPH*)**
Will be discussed at the next GETAC meeting

10. Gaps between the Medical Practice Act, Texas Medical Board (TMB) Rule 197 and Texas Administrative Code (TAC) Chapter 157 (David Persse, MD, and the Medical Directors Committee)
Will be discussed at the next GETAC meeting

11. Review and update of The Strategic Plan for the Texas EMS/Trauma System
Dr. Eastridge presented the latest draft of the strategic plan. The document was entitled: "Strategic Plan for the Texas Emergency Healthcare System."
No action was taken on this issue.

12. Renaming the Texas Trauma and EMS System strategic plan report
The original title of the 2002 document was, "A Strategic Plan for the Texas EMS/Trauma System." Discussion around the name change was approved during the July strategic planning session to be changed to Texas Emergency Healthcare Strategic plan.

Motions
***Agenda # 3* Support Infectious Disease Response Units as recognized components of the Emergency Medical Task Force system**
Motion by Dr. Greenburg 2nd by Chief Riley – to have Infectious Disease Response Units as recognized components of the Emergency Medical Task Force system.

Agenda # 8 Report on Pediatric Transfer and Transport Guidelines
Motion by Dr. Greenburg 2nd by Dr. Beeson to endorse the document but will need to have a final document along with an action plan.

Public Comment
There was one (1) public commenter related to EMS issues.
No action was taken on this issue.

Review and List Agenda Items for Next Meeting
Items will be compiled and emailed to the department for processing.

Next Meeting Date
November 20, 2015 at the Omni in Dallas, Texas.

Item 16: Adjournment
The meeting was adjourned at 1:20pm

Disclaimer: These meeting minutes will not be official until approved at the 2/18/2016 Governor's EMS and Trauma Advisory Council (GETAC) meeting.

Meeting Minutes
Governor's EMS and Trauma Advisory Council (GETAC)
November 23, 2015 4:00 pm

The GETAC quarterly meetings can be viewed at http://www.ustream.tv/channel/getac. This webcast archive service is provided by the Texas EMS, Trauma, and Acute Care Foundation (TETAF).

Council Members

Attendance	Name	Position (representing)
X	Vance Riley, LP	Fire Chief, Chair
	Nora Castañeda-Rivas	Public Member
X	Mike Click, RN	Rural Trauma Facility
	James (Mike) DeLoach	County EMS Provider
X	Linda W. Dickerson	Public Member
X	Robert D Greenberg, M.D.	Emergency Physician
X	Jodie Harbert III, LP	EMS Educator
	Ryan Matthews, LP	Private EMS Provider
X	Jeffrey Beeson, D.O.	EMS Medical Director
	Karen Pickard, RN, LP	EMS Volunteer
X	Shirley Scholz, RN	EMS Air Medical Service
	James D. Williams, Lt.	Fire Department
X	Brian Eastridge, M.D.	Urban Trauma Facility
X	Alan H. Tyroch, M.D.	Trauma Surgeon
X	Robert Vezzetti, M.D.	Pediatrician

Department of State Health Services Staff

Attendance	Name	Position
	Kathryn C. Perkins, RN	Assistant Commissioner for the Division of Regulatory Services
X	Renee Clack, LNFA	Director, Health Care Quality Section
X	Jane G. Guerrero, RN	Director, Office of EMS and Trauma Systems Coordination
X	Joseph Schmider	State EMS Director, Office of EMS and Trauma Systems
X	Colin Crocker	State Trauma Director, Office of EMS and Trauma Systems

Reading of the Vision and Mission Statement
GETAC Chair Chief Riley read the vision and mission statement.

Governor's EMS and Trauma Advisory Council (GETAC)
The meeting was called to order at 4:00 pm on Monday, November 23, 2015, at the Kay Bailey Hutchinson Convention Center, Dallas, Texas. A quorum of the members was present.

Approval of Minutes
A motion was made by Dr. Robert Greenberg, and seconded by Linda Dickerson to approve the meeting minutes from May 13, 2015 and August 19, 2015. All council members were in favor; the motion passed.

Chair Report and Discussion
Chief Riley welcomed all the new committee members. He also announced his retirement from GTEAC.

Assistant Commissioner Report, Division for Regulatory Services
Kathryn C. Perkins, Assistant Commissioner for the Division of Regulatory Services was unable to attend; no report was given.

State EMS/Trauma System Report, Office of EMS/Trauma Systems Coordination
Jane Guerrero, Director of EMS/Trauma Systems Coordination gave an update on the process of the neonatal rules, now posted in the Texas register for a 30 day comment period. They will become affective in May or June of 2016, applications will not be accepted until after the rules are effective. Staff continue to work on the TAC Chapter 157 rule revision. DSHS continues working through the transision process of HHSC. You can follow this process and sign up for alarts on Govdelivery.com. We are still going through the process of physical size up within our agency therefore, our budget has not been finalized.

Assistant Commissioner Report, Environmental Epidemiology and Disease Registries Section
John Villanacci reported on managememt changes and staffing levels to the EMS/Trauma Registries. The Registry was NEMSIS 3.3.4. Certified, tested and now has been deployed. TxDOT grant had been implamented as of October 1 2015. The funds will be used for education and training related to injury scoring, data collection and use. John Villanacci announced he will be retiering at the end of the month.

Assistant Commissioner Report, Division for Regional and Local Health Services
No report was given

Standing Committee / Task Force Reports

Air Medical Committee
Shirley Scholz presented this report. Review and discussion the rule 15711, 12 and 13; and the Trauma System rules; recommendations on those rules will be forthcoming.
No action was required for this agenda item.

Cardiac Care Committee
Dr. McCarthy is reporting for Dr. Smalling reported the progress in improving pre-hospital ST Segment Elevation Myocardial Infarction (STEMI) data collection and potential impact on improving STEMI care.
No action was required for this agenda item.

Disaster/Emergency Preparedness Committee
Eric Epley gave an update on Emergency Medical Task Force (EMTF) report and Infectious Disease Response Unit (IDRU).

No action was required for this agenda item.

Education Committee

Jodie Harbert reported on progress in developing a curriculum for Community Health Paramedic. They are working on updating the DSHS Emergency Medical Services (EMS) Education Training Manual. They will hold their second EMS summit April 15th and 15th 2016 in Corpus Christi, Texas.
No action was required for this agenda item.

EMS Committee

Dudley Wait reported that they have been reviewing TAC 157. The last date will be Dec 17th in San Antonio before they make their final recommendation to GETAC.
No action was required for this agenda item.

Injury Prevention Committee

Mary Ann Contreras reported for Shelly Stevens-Stidham on the development of a new document related to Evidence-based texting and driving prevention; planning and development of an Injury Prevention conference to be held in May 2016 in conjunction with the East Conference in San Antonio.
No action was required for this agenda item.

Medical Directors Committee

Dr. Beeson, reported on the development of the *Transport and Care of Patients with Behavioral Disorders and Pediatric Transfer and Transport Guidelines* and will have recommendations ready for the committee at the next council meeting. They welcomed two new members to the Medical Directors.
No action was required for this agenda item.

Pediatric Committee

Charles Macias reported on updating the National Pediatric Readiness Project activities, including Emergency Nurses Association demonstration project meeting.
No action was required for this agenda item.

Stroke Committee

Dr. Neal Rutledge reported on TCCVDS activities and a RAC update by Darrel Pyle; development of a report with suggestions from the Transport Bypass Workgroup, regarding severity adjusted triage criteria for hospital bypass of ambulance patients.
No action was required for this agenda item.

Trauma Systems Committee

Jorie Klein reported the ongoing improvements to the Texas EMS and Trauma Registries including NEMSIS 3.3.4. softwear. Ms. Klein presented a slide show on Texas Trauma Quality Improvement Program (TQIP) and how it continues to evolve, Levels 1 and Levels 2 trauma facilities are already apart of the TQIP program; untimate goal to involve the Level 3s, and protection of statewide performance improvement process. Ms. Klein requested the GETAC endorse the Hartford Consensus III Report.
No action was required for this agenda item.

GETAC Liaison Summaries

Texas EMS, Trauma and Acute Care Foundation (TETAF)

Diana Welsh reported due to unforeseen circumstance this GETAC is not being streamed live. TETAF has been focused on legislative funding; working our ensuring permanent dedicated funding and how our trauma funds can be rebuilt.

EMS for Children State Partnership update
Sam Vance reported that they are working on changing three performance measures. 1) To have a pediatric care coordinator for EMS. 2) To make sure that they are NEMSIS comlpliant. 3) Make sure that everyone knows how to use the recommedted pedicatric care equipment.

Discussion, public comment, and possible action on the following items

1. Update on DSHS Travel Office and Public Information Access policies as they pertain to GETAC council and committee members
Discussion deferred to February meeting.

2. Report on the Cardiac Arrest Registry to Enhance Survival (CARES)
Dr. Beeson, reported the federal funding for CARES has ended and they are moving to a subscription based for those who still want to participate. Please see motions.

3. Review GETAC Cardiovascular and Stroke Committee suggestions regarding which stroke data elements Regional Advisory Councils should consider collecting from Texas hospital.
No elements to report at this moment. They are questing if the GETAC council has any specific elements that they would like to recommend to the TCEVDS.
No action was taken on this issue.

4. Information sharing for high-consequence infectious disease
To get a better understanding of how and what is the best way to share information on high-consequences infectious disease to first responders.
No action was taken on this issue.

5. Position statement on the transport and care of patients with behavioral disorders
Dr. Beeson presented changes in the planned proposal. Please see motions.

6. Freestanding emergency departments and other facilities providing emergency care and the potential categorization or designation of such entities
Dr. Greenberg reported the overwhelming support for categorization and designation of free standing emergency departments and inclusion of free standing emergency departments in the Healthcare system. This workgroup will continue to meet for this discussion.
No action was taken on this issue.

7. How to improve the sharing of a medical facility's patient outcome data with EMS providers
Kathryn C. Perkins, Assistant Commissioner for the Division of Regulatory Services wrote an open letter to the hospitals and EMS encouraging collaboration and sharing of data. The letter will be posted on the DSHS website by December 1, 2015. Additional information will be ready in February 2016.
No action was taken on this issue.

***8. Report on Pediatric Transfer and Transport Guidelines (*Charles Macias, MD, MPH)**
San Vance presented for Charles Macias, development continues on a written action plan which is expected to be avaiable for the Febuary 2016 meeting.
No action was taken on this issue.

***9. Child abuse and child fatality quality improvement issue (Charles Macias, MD, MPH*)**
Discussion deferred to the GETAC meeting in May 2016.

10. Gaps between the Medical Practice Act, Texas Medical Board (TMB) Rule 197 and Texas Administrative Code (TAC) Chapter 157 (David Persse, MD, and the Medical Directors Committee)
Discussion deferred to February 2016 meeting.

11. Report on stroke transport bypass position paper Recommendations for Texas Emergency Medical Systems Stroke Triage and Transport.
They will continue to stay on the website so that people can continue to send comment to the Stroke committee, while they continue to work in the report.
No action was taken on this issue.

12. Review the Hartford Consensus III Report as it relates to empowering the public to serve as first responders in intentional mass-casualty and active shooter events and Stop the bleed.
Request for support of the Hartford Consensus and Stop the Bleed programs. Please see motions

13. Discussion and possible approval of revisions to the GETAC Operational Strategic Plan and GETAC Procedural Rules.
Presented the changes to the GETAC Operational Strategic Plan and GETAC Procedural Rules. This will be pushed to the GETAC meeting in February 2016.

14. Discuss and confirm date for January 2016 special called meeting of GETAC to review proposed revisions to DSHS Emergency Medical Care rules in 25 TAC 157.
Date will be January 27th, 2016 in Austin, Texas

Motions
Agenda #2 Report on the Cardiac Arrest Registry to Enhance Survival (CARES)
Dr Beeson motioned 2nd by Dr. Greenbug- GETAC to support the state in starting a state registry for CARES. Motion Passed

Agenda # 5 Position statement on the transport and care of patients with behavioral disorders
Motion by Dr. Beeson 2nd by Dr. Greenburg- To allow this statement to be posted on the Medical Directors webpage. Motion passed

Agenda # 12 Review the Hartford Consensus III Report as it relates to empowering the public to serve as first responders in intentional mass-casualty and active shooter events and Stop the bleed.
Motion by Jodie Harbert 2nd by Dr. Greenburg - To support the Hartford Consensus and Stop the Bleed as it's relates to first responders. Motion passed

Public Comment
There was one (1) public commenter related to Trauma issues.
No action was taken on this issue.

Review and List Agenda Items for Next Meeting
Items will be compiled and emailed to the department for processing.

Next Meeting Date
February 10-12, 2016 at the Wyndam Garden in Austin Texas

Item 16: Adjournment
The meeting was adjourned at 6:20pm

Disclaimer: These meeting minutes will not be official until approved at the 5/11/2016 Governor's EMS and Trauma Advisory Council (GETAC) meeting.

Meeting Minutes
Governor's EMS and Trauma Advisory Council (GETAC)
February 12, 2016 9:00 am

The GETAC quarterly meetings can be viewed at http://www.ustream.tv/channel/getac. This webcast archive service is provided by the Texas EMS, Trauma, and Acute Care Foundation (TETAF).

Council Members

Attendance	Name	Position (representing)
	Nora Castañeda-Rivas	Public Member
X	Mike Click, RN	Rural Trauma Facility
X	James (Mike) DeLoach	County EMS Provider
X	Linda W. Dickerson	Public Member
X	Robert D Greenberg, M.D.	Emergency Physician
X	Jodie Harbert III, LP	EMS Educator
X	Ryan Matthews, LP	Private EMS Provider
X	Jeffrey Beeson, D.O.	EMS Medical Director
X	Karen Pickard, RN, LP	EMS Volunteer
X	Shirley Scholz, RN	EMS Air Medical Service
	James D. Williams, Lt.	Fire Department
X	Brian Eastridge, M.D.	Urban Trauma Facility
X	Alan H. Tyroch, M.D.	Trauma Surgeon
X	Robert Vezzetti, M.D.	Pediatrician

Department of State Health Services Staff

Attendance	Name	Position
X	Kathryn C. Perkins, RN	Assistant Commissioner for the Division of Regulatory Services
	Renee Clack, LNFA	Director, Health Care Quality Section
X	Jane G. Guerrero, RN	Director, Office of EMS and Trauma Systems Coordination
X	Joseph Schmider	State EMS Director, Office of EMS and Trauma Systems
X	Colin Crocker	State Trauma Director, Office of EMS and Trauma Systems

Reading of the Vision and Mission Statement
GETAC Interim Chair Dr. Robert Greenberg read the vision and mission statement.

Governor's EMS and Trauma Advisory Council (GETAC)
The meeting was called to order at 9:00 am on Friday, February 12, 2016 at the Wyndam Garden in Austin, Texas. A quorum of the members was present.

Approval of Minutes
A motion was made by Dr. Robert Greenberg, and seconded by Linda Dickerson to approve the meeting minutes from November 2015 and January 27th rules meeting. All council members were in favor; the motion passed.

Chair Report and Discussion
No report was given.

Assistant Commissioner Report, Division for Regulatory Services
Kathryn C. Perkins, Assistant Commissioner reported that Senate bill 202 and 200 passed. The recommendations propose eliminating or consolidating 72 agencies, boards, commissions, councils, and programs, and would result in a positive fiscal impact to State. Follow the transformation on the HHSC website. Tobacco Endowment funds amount is 1.4 million for this year. They will continue to work on contracts. Texas Legislature will give you notices.

State EMS/Trauma System Report, Office of EMS/Trauma Systems Coordination
Elzabeth Stevenson gave an update for Jane Guerrero, Director of EMS/Trauma Systems Coordination. Update on Title 25 of the Texas Administrative Code (TAC), Chapter 157. At the the Febuary meeting for the Health Services Council work session, DSHS will them notice that the 16 sections related to EMS are going to be presented at the May meeting. Our gaol is to have these 16 sections to be effective by the end of the caldander year. We are expecting the Nenonatial rules to be adopted by May of this year.

Assistant Commissioner Report, Division for Disease Control and Prevention Services
Heidi Boyce reported for Commissioner Zumbrun. She reported on managememt changes and staffing levels to the EMS/Trauma Registries. They will contine to support the Trauma systems. They will contine to hold webinars for trainings
Assistant Commissioner Report, Division for Regional and Local Health Services
No report was given

Standing Committee / Task Force Reports

Air Medical Committee
Shirley Scholz reported reviewed the revisions to Texas Department of State Health Services (DSHS) Emergency Medical Services (EMS) rules in Title 25 of the Texas Administrative Code (TAC), Chapter 157. They reviewed recommendations of Pediatric Recognition Program and consider combining workgroup recommendations for Advanced Life Support/Basic Life Support into one list.
No action was required for this agenda item.

Cardiac Care Committee
Dr. Smalling introduced the new committee members Lisa Rovedo and Jeff Mincy. Dr. Smalling reported the continuing progress in improving pre-hospital ST Segment Elevation Myocardial Infarction (STEMI) data collection and potential impact on improving STEMI care. Review and approve proposed pre-hospital data collection elements for the Heart Attack and Stroke Data

Collection Initiative.
No action was required for this agenda item.

Disaster/Emergency Preparedness Committee

Joe Palfini gave an update on the Texas Disaster Medical System (TDMS), Emergency Medical Task Force (EMTF) and Infectious Disease Response Unit (IDRU) workgroups.
No action was required for this agenda item.

Education Committee

Jodie Harbert reviewed the progress on Texas effort (based on the Hartford Consensus III and the Stop the Bleed projects); Title 25 of the Texas Administrative Code (TAC), Chapter 157.
No action was required for this agenda item.

EMS Committee

Dudley Wait reported completed committee review of revisions to Title 25 of the Texas Administrative Code (TAC), Chapter 157. Updates were given on EMS for Children, EMS and Trauma Registry and 911 Commission's telemedicine project. They would like to get approval from GETAC to develop a work group on how to rehabilitate EMS personnel with substance abuse problems and reintegrate them into the EMS workforce.
No action was required for this agenda item.

Injury Prevention Committee

Shelly Stevens-Stidham gave an update on the League of Women's Voters request for more comprehensive firearm injury data collection in Texas. Sam Vance provide an update on Emergency Medical Services for Children. The Evidence-Based Texting/Driving Prevention fact sheet is almost complete. The Texas Injury Prevention Leadership Symposium is May2-3, 2016.
No action was required for this agenda item.

Medical Directors Committee

Dr. Beeson, reported on the gaps and/or differences between the Texas Medical Practice Act in the Texas Occupations Code and the Texas Medical Board rules in Title 22 of the Texas Administrative Code (TAC), Chapter 197, entitled: "Emergency Medical Service", and Title 25 of the Texas Administrative Code (TAC), Chapter 157. They discussed the guidelines of Interfacilty transport of patients with behavioral disorders. Updates were given on the Trauma Systems Committee Registry Workgroup and the Community Para medicine Taskforce.
No action was required for this agenda item.

Pediatric Committee

Charles Macias reported on Child Fatality Review Teams, including project description of the Abusive Head Injury initiative. Sally Snow gave an update on Child Fatality Review Teams, including project description of the Abusive Head Injury initiative. Updates were given on pediatric data from Cardiac Arrest Registry to Enhance Survival (CAREs).
No action was required for this agenda item.

Stroke Committee

Dr. Neal Rutledge reported on Texas Council on Cardiovascular Disease and Stroke (TCCVDS) / Regional Advisory Councils (RACs) stroke data collection and Stroke/ST Segment Elevation Myocardial Infarction (STEMI) data collection as funded by the Appropriations Act, Rider 97 of the 83rd Texas Legislature, 2013. H.T.Fillingim reported on Stroke Education Program Workgroup

activities.
No action was required for this agenda item.

Trauma Systems Committee
Elizabeth reported DSHS EMS and Trauma System Rules in Title 25 of the Texas Administrative Code (TAC), Chapter 157, including the process for applying for trauma facility designation. Review the Hartford Consensus III Report as it relates to empowering the public to serve as first responders in intentional mass-casualty and active shooter events.
No action was required for this agenda item.

GETAC Liaison Summaries
Texas EMS, Trauma and Acute Care Foundation (TETAF)
Diana Welsh reported they want to keep the Driver Responsibility program around to help pay for the Trauma system. She challenges every council member to talk to the legislature and explain the challenges about the Trauma and Emergency Health Care System.

EMS for Children State Partnership update
No report was given.

Discussion, public comment, and possible action on the following items

1. Assignment of GETAC committee members to serve as ex officio liaisons for each GETAC committee
Each council member was assigned to a committee.

2. Assignment regarding the development of a position statement addressing privately operated vehicle transports for patients being transferred between facilities to EMS and Medical Directors Committees, for report back at May 2016 council meeting

***3.* Review of revisions to Texas Department of State Health Services (DSHS) Emergency Medical Services (EMS) rules in Title 25 of the Texas Administrative Code (TAC), Chapter 157**
Recommended changes for sections 2, 5, 11 & 12.

4. Information sharing for high-consequence infectious disease
To get a better understanding of how and what is the best way to share information on high-consequences infectious disease to first responders. Three high-consequence infectious disease conferences have been held. Texas need to have a state wide system where local information is kept private with local entities.
No action was taken on this issue.

5. **Update from task force on freestanding emergency departments (ED) [Freestanding Emergency centers (FEC)]; other facilities providing emergency care; and the potential for categorization or designation of such entities.**
Dr. Kidd reported on the discussions related to FECs related to categorization and/or designation by the state of Texas.
No action was taken on this issue.

6. **How to improve the sharing of a medical facility's patient outcome data with Emergency Medical Services providers**
Kathryn C. Perkins, Assistant Commissioner for the Division of Regulatory Services wrote an open letter to the hospitals and EMS encouraging collaboration and sharing of data. The letter will be posted on the DSHS website by December 1, 2015.
No action was taken on this issue.

7. **Review the final edited version of the Pediatric Committee's report titled Pediatric Transfer and Transport Guidelines and accompanying plan of action**
No action was taken on this issue.

8. **Gaps and/or differences between the Texas Medical Practice Act in the Texas Occupations Code and the Texas Medical Board rules in Title 22 of the Texas Administrative Code (TAC), Chapter 197, entitled: "Emergency Medical Service", and**
Title 25 of the Texas Administrative Code (TAC), Chapter 157.
Recommended edits to §§157.2 and .5.

9. **Update on Texas effort to develop a coalition relating to the empowering of the public to serve as first responders in intentional mass-casualty and active shooter events**

10. **Discussion and possible approval of revisions to the GETAC Operational Strategic Plan and GETAC Procedural Rules**
Every even year they will review the GETAC Operational Strategic Plan. Every odd year they will review the GETAC Procedural Rules. See motions

Motions
Agenda #3 & 8 **Title 25 of the Texas Administrative Code (TAC), Chapter 157.**
Motion: to change 2 and 3 By Ryan Matthews 2nd by Mike Deloach; remove the work in service as a definition and add the word vehicle where it needs to be added. Motion passed
Motion to change: 11 & 12 by Shirley and 2nd by Ryan Matthews; remove the words: not routinely carried by the provider. Motion passed

Agenda# 10 Motion by Mike Click 2nd by Dr. Eastridge. Every even year, review of the GETAC Operational Strategic Plan. Every odd year, review the GETAC Procedural Rules.

Public Comment
There was one (1) public commenter related to Air Medical issues.
No action was taken on this issue.

Review and List Agenda Items for Next Meeting
Items will be compiled and emailed to the department for processing.

Next Meeting Date
May 11-13, 2016 at the Wyndam Garden in Austin Texas

Item 16: Adjournment
The meeting was adjourned at 12:20pm

GOVERNOR'S EMS AND TRAUMA ADVISORY COUNCIL
EMERGENCY MEDICAL SERVICES SUB-COMMITTEE

FINAL REPORT -

SOLICITATION OF STAKEHOLDER INPUT ON - CHANGES TO LAWS AND POLICIES RELATED TO - THE LICENSURE OF NON-EMERGENCY - TRANSPORTATION PROVIDERS -

REPORT DELIVERED
NOVEMBER 25, 2013

GETAC EMS SUB-COMMITTEE -

FINAL REPORT ON THE SOLICITATION OF STAKEHOLDER INPUT REGARDING - CHANGES TO LAWS AND POLICIES RELATED TO THE LICENSURE OF NON-EMERGENCY TRANSPORTATION PROVIDERS -

The 83rd Legislature of Texas passed Senate Bill 8 which had a wide range of changes to the current laws regulating EMS. This was done to address and lower the instances of fraud throughout the Texas medical assistance program (Medicaid) including the ambulance industry. In addition, there were several directives to study different areas of health care provision to identify additional methods of reducing fraud, waste and abuse. Included in Section 14 was a directive to the Department of State Health Services (DSHS), in cooperation with the Health and Human Services Commission and the Texas Medical Board to conduct a thorough review including the solicitation of stakeholder input regarding the laws and policies related to the licensure of nonemergency transportation providers. DSHS was then tasked to make recommendations to the legislature regarding needed changes to the law and to implement identified policy changes.

DSHS asked the Governor's EMS and Trauma Advisory Council to utilize its available resources to solicit stakeholder input on behalf of DSHS. GETAC's EMS Committee took on this task at the August meetings. To accomplish this charge, the EMS Committee held meetings in the following locations:

- Houston
- Harlingen
- Amarillo
- Dallas
- Austin
- San Angelo

These meetings had attendance from approximately 400 licensed EMS Providers and had a wide variety of organizational types represented. Three to five hours were spent in each meeting both reviewing all the changes being implemented to Chapter 157.11 as a result of SB 8 and HB 3556 as well as taking stakeholder input as directed above. The new State EMS Director attended all of these meetings and was a tremendous asset to the EMS Committee and the stakeholders.

Although each location had differing primary concerns with this charge, throughout them all there emerged five recurring themes in which all stakeholder suggestions could be placed. This report is broken down into these five themes with specific ideas for new rules or laws listed under each topic.

I. Increased education and accountability on EMS personnel, healthcare facility personnel (i.e. hospitals and nursing homes), Medicaid managed care personnel and patients:

In every location the EMS Committee met, this group of suggestions was repeated and refined by all providers of all types. No one excused the behavior of fraudulent EMS Providers across the State, but there was strong consensus that all of the parties involved in the request for or the provision of non-emergency ambulance transportation should be provided increased education and be held to a higher level of accountability where appropriate.

- **EMS Personnel**
  - Education on the laws and regulations related to EMS billing practices, medical necessity and proper use of the State's medical assistance program should be required in all initial EMS certification programs from EMT through Paramedic.
  - An EMS jurisprudence exam should be developed and implemented for all EMS certified personnel at their initial certification.
  - Regulations should be put into place so that EMS personnel are held accountable when they violate DSHS rules if their employing agency can prove that the violation rested upon the crew member or if the employee knew that they were violating a rule and chose to do so anyway. This would include policies in place that require the employee to abide by the rule and a system in place to inspect and insure that employees are following the established policies. This input was offered by many stakeholders who felt that employees who have no personal risk to their certification will not stand up or leave an employer who regularly expects them to violate DSHS rules and regulations.
  - Laws should be developed to provide increased whistle-blower protections for EMS personnel.
  - Laws should be developed to protect EMS Providers from inappropriate whistle-blower allegations.

- **Healthcare facilities, Medicaid managed care organizations and their personnel**
  - EMS Providers who commit fraud are responsible for their own actions. Those agencies make choices that result in violations of the law without coercion or deception.
  - The first bullet notwithstanding, one of the suggestions voiced most adamantly and most commonly for improvement in non-emergency ambulance transportation was to require training for nursing home and hospital personnel who request ambulances, mandate increased accountability for facilities and Medicaid

managed care organizations who are a party to inappropriate ambulance transports and the implementation of new methods to track these inappropriate transports prior to them being paid.

- Nursing home and hospital personnel whose job requires them to arrange for non-emergency ambulance transportation should be required to undergo training on ambulance medical necessity to help guide them on using the proper mode of transportation when an ambulance is not required.
- When a healthcare facility requests an ambulance for a patient that does not meet medical necessity or requests a transport at a rate that is not legal and the agency denies their request; the facility will then call around to other agencies until they find an ambulance to perform the transport fraudulently. The healthcare facility should be held accountable for this practice.
- If a Medicaid managed care organization refuses to utilize the normal or local transport agency for an ambulance transport out of a healthcare facility due to the rate they quote and calls multiple agencies until they find one that is willing to do the transport at a rate significantly below the Medicaid fee schedule, they should be held accountable for this practice.
- Regulations should be enacted by DSHS-Hospital Licensing, the Department of Aging and Disability Services and the Health and Human Services Commission that requires healthcare facilities and Medicaid managed care organizations be held accountable if they use an inappropriately licensed EMS Provider (licensed below the level of care required by the patient, an unlicensed or expired Provider, etc). When this is discovered, DSHS should be required to report that organization to their specific regulatory organization for enforcement and discipline.

- If an EMS Provider refuses to transport a patient from a facility due to the lack of medical necessity, that refusal must be documented within a tracking system to be developed by the Health and Human Services Commission that would allow other providers to discover the refusal prior to accepting the call. This HHSC "refusal system" would also be used for enforcement of EMS Providers, healthcare facilities and Medicaid managed care organizations.

- **Patients**
    - The State medical assistance program should work with ambulance stakeholders to develop new and updated education for patients regarding the proper utilization of ambulances in the non-emergency environment.

II. Increase the number, ability and processes of DSHS EMS Regulatory Personnel

A large amount of input was received on the inability of DSHS to appropriately regulate EMS Providers and a multitude of ideas were provided on how to improve this.

- More regulatory personnel are needed to enforce the current rules and regulations effectively across the State of Texas.
    - All EMS regulatory personnel should be dedicated to enforcing the EMS rules and regulations and not used in other regulatory strategies.
    - EMS regulatory personnel should be used for investigations, inspections, licensing, regulating and providing technical assistance to EMS Providers, First Responders and education providers.

- DSHS should develop and publish a discipline manual so that all EMS Providers and personnel will understand how the discipline and regulatory process works for both agencies and individuals.

- DSHS should work with stakeholders to develop a process to utilize EMS stakeholders in the regulatory and enforcement process. The development of a peer process involved in the regulatory process will bring credibility to the process with all providers, increase the level of accountability and provide a more consistent process like other healthcare providers regulation.

- DSHS should task GETAC with developing a “deadly sin” list of EMS Provider rule violations. Then when EMS providers violate one or more of these, their licensing reverts back to all the requirements placed on new applicants as a result of HB 3556 and SB 8. The reversion back to “New Applicant” status would apply to all providers regardless of their business type or longevity.

- If an EMS Provider has multiple enforcement actions in a specific amount of time (i.e. 3 violations in two years), their Provider license should be revoked or the Provider should be required to revert back to all the

requirements placed on new applicants as a result of HB 3556 and SB 8. The reversion back to "New Applicant" status would apply to all providers regardless of their business type or longevity.

- DSHS should work with GETAC, RAC's and EMS stakeholders to find appropriate ways to require higher levels of participation with RAC's, Emergency Medical Task Forces and other regional organizations by all EMS Providers, not just 911 providers. More local and regional participation with other EMS Providers will lead to higher levels of integration and peer pressure to perform appropriately in their business practices.

- With additional regulatory personnel, DSHS should implement mandatory unannounced visits to new providers within their first six-months of operation.

- With additional regulatory personnel, DSHS should initiate routine "blitz" inspections where they inspect a majority of Providers for critical patient care equipment such as oxygen, suction, defibrillators/monitors, etc.

- When a new applicant submits their initial license packet, they should only be given two additional attempts to submit any missing or incorrect pieces of that license packet. If this cannot be done in these two additional attempts, their application process and fees are forfeited and the applicant has to begin the process again.

- DSHS should put into rule the timelines for the initial licensing process and the re-licensing process. These timelines should include the amount of time agencies have to correct deficiencies in their licensing or re-licensing packets before the process is stopped for lack of response.

- Stakeholders across the State agreed that intent cannot be regulated. If people intend to violate the law, they will regardless of the regulations. The key is to provide more regulators with the tools to effectively and efficiently enforce the rules and regulations that are currently in place.

III. There should be one type of license for ALL ambulance providers, regardless of their primary service type:

- Across the State, all stakeholders agreed that there should be one type of EMS Provider license.

- The general public does not know one ambulance from another. A different license may impact the provider or the regulatory agency, but will not make any difference in how that agency performs and will only confuse the consumers.
- If there was a desire to regulate ambulance transport by emergency or non-emergency, determining what definition of emergency and non-emergency would be the deciding factor:
  - How the vehicle responds to the call
  - How the transport is billed
  - The reason for the request for transport
- The largest area of fraud is in the provision of non-emergency ambulance services. There was overwhelming consensus among stakeholders that if that part of the industry were segregated, the focus of DSHS with limited enforcement staff would still be on the emergency providers because of the perceived impact to public safety. As a result, the "non-emergency" provider would become less and less regulated just exacerbating the fraud issue.

- Several stakeholders suggested that all types of medical transport be regulated including wheelchair and non-medical stretcher transport
  - Wheelchair transportation is used to move individuals who do not meet medical necessity for ambulance.
    - This saves money for facilities and 3rd party payers such as the State's medical assistance program. Unfortunately this can also be abused by providers who offer wheelchair transport at very low rates in exchange for getting all of the ambulance transports out of a facility or the facility can entice the ambulance provider to do this.
    - This mode of transport routinely moves medically fragile patients with no requirements on equipment, training or safety for the patient placed upon the provider. Things like operating wheelchair lifts, properly securing patients in their wheelchair and their wheelchair into the vehicle and recognizing a patient who is having a medical emergency should be required for wheelchair transport providers.
  - Several years ago, non-medical stretcher transport (gurney car) was outlawed in Texas. This was done because individuals who were medical patients were being inappropriately transported via this type of service to achieve cost savings for facilities that were responsible for the cost of the transport. There was no medical oversight or regulation on what type of individual could appropriately be moved by non-medical stretcher transport.
    - Today, no agency has responsibility for enforcing the ban on non-medical stretcher transport. As a result, these services

are still being offered but being an illegal mode of transport, the patient is at risk as the service is offered below the radar.
        - As the healthcare system continues to look for better efficiencies, stakeholders believe there is a role for non-medical stretcher transport if it is regulated by DSHS and by local healthcare systems. This would ensure that stretcher bound individuals who are "patients" (needing medical care or monitoring) are moved via ambulance while those who are not "patients" are moved by lower cost methods.
    - Stakeholders have asked that the State consider additional regulatory personnel for EMS transportation regulation and that laws and rules be passed to regulate wheelchair and non-medical stretcher transport.

IV. **Updates, enhancements and refinements to changes resulting from HB 3556 and SB 8 from the 83rd Legislature:**

These two pieces of legislation are making large changes and improvements to the ambulance industry, but now that the dust is settling, there are areas that stakeholders feel need to be adjusted to further address fraud while removing some possible unintended consequences of these new laws.

- Exemptions to providers that are "directly operated by a governmental entity" should be expanded to include not-for-profit corporations whose primary purpose is the provision of 9-1-1 EMS services utilizing volunteers or a combination of paid and volunteer personnel.
    - Stakeholders understand the exemption, but believe the same reasoning can be applied to these not-for-profit agencies that primarily provide 9-1-1 EMS services to governmental entities.
    - If exempting these agencies is not deemed feasible, rural and frontier stakeholders suggested applying these new items based upon county population.

- The requirement for new providers to only operate in the jurisdiction where they have a letter of approval from the local governmental entity for their first two years should be expanded to require this for several more years if not permanently.

- The new Administrator of Record requirements of an initial education course, continuing education hours and the ability to only serve as the Administrator of Record for one agency should apply to **all** EMS Providers including governmental entities and should not have an exemption for tenure in the industry.

- These requirements have the potential to increase the level of education and sophistication of EMS leadership and stakeholders strongly felt these should apply to all provider types to assist in moving the entire industry forward.

- As laws and regulations continue to increase, there should be a tie between compliance with DSHS regulations to incentives in the State's medical assistance program, the Medicaid managed care program and the child health plan program. This would provide higher reimbursement rates to those agencies that are strongly compliant through announced and unannounced DSHS inspections.

- Provide an up-to-date listing of Administrators of Record for all agencies readily available on the website so that local governments who implement ordinances or provide letters of approval to new providers can contact agencies they see in their jurisdiction to advise them of their ordinances and laws.

- DSHS should approve all providers of Administrator of Record Continuing Education.

V. Increase the requirements on legitimate business practices

This type of increased regulation will, theoretically, not impact Providers who are working to be compliant, but it may increase the level of effort required of fraudulent providers to a level that could preclude some of them from entering the field.

- Require all providers to supply proof of ownership or lease of a legitimate place of business in their licensing packet. This must be the same as the agency's primary place of business.

- Rules should be put in place that only allows one EMS Provider at one specific address.

- Require Providers to show proof of ownership or lease of all capital inventory items such as ambulances, EKG monitors, defibrillators, and stretchers necessary for operation under their protocols and equipment lists.

- Develop a five year plan to require all EMS Providers to have electronic Patient Care Reports that integrate into the State EMS Data Registry,

their regional registry and the receiving hospital's electronic medical record.

The EMS Sub-Committee of GETAC respectfully submits this report on behalf of EMS stakeholders across the State of Texas. The Committee deems that this document represents the best consensus of ideas presented by EMS Providers of all types (private, public, fire, non-fire, hospital, for-profit, not-for-profit, paid and volunteer) from across the State. The stakeholders all agreed that the ambulance industry has been through a dark period over the last several years, but it is recovering. The ideas presented here along with the willingness and diligence of EMS Providers from across the State to continue improving themselves and their agency will further the recovery of the EMS industry. After completing this journey, the EMS Committee believes brighter days are ahead for our industry. We thank you for the opportunity to have seen this first hand from EMS Providers all across the great State of Texas.

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name:	Healthcare Safety Advisory Committee		
Number of Members:	13		
Committee Status (Ongoing or Inactive):	Ongoing	Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.	
Date Created:	9/1/2007	**Date to Be Abolished:**	N/A
Budget Strategy (Strategies) (e.g. 1-2-4)	A.1.2.6	**Strategy Title (e.g. Occupational Licensing)**	GR/HAI INT
Budget Strategy (Strategies)		**Strategy Title**	HAI/PAE

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Admin Code	Rule under development, to be adopted by 7/01/2016; 25 TAC, Sec. 200.40
State Authority		
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$413	$350	$350
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$413	$350	$350

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$68,345	$68,345	$41,007
Number of FTEs	1.0	1.0	1.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$68,345	$68,345	$41,007

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	$68,758	$68,695	$41,357
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year	3	3	3

Committee Description: Provides stakeholder input on program initiatives and proposals related to emerging and acute infectious diseases, including healthcare-associated infections and preventable adverse events. Without this committee, stakeholder feedback would not be as readily attainable. This committee was previously named the Advisory Panel on Healthcare-Associated Infections and Preventable Adverse Events.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?
The committee typically meets four times a year at the Brown Heatly Building in Austin. There is no requirement on the frequency of committee meetings.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

The committee is not required to produce any documents. The committee has provided consistent stakeholder input on how to implement legislatively mandated reporting of healthcare associated infections and preventable adverse events. They have also assisted in the prioritization of activities related to healthcare safety surrounding the conditions.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

Recommendations for defining preventable adverse event reporting guidelines, recommendations for displaying healthcare associated infection information to stakeholders and the public via the program website.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ? Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees? No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015? 45.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Tasks include identification of meeting space and time, preparation of reports and agenda items for discussion and conducting the meeting.

6. Have there been instances where the committee was unable to meet because a quorum was not present? No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

All meetings are public. Meeting dates are posted on the program website as well as distributed to external stakeholders for publication.

7b. Do members of the public attend at least 50 percent of all committee meetings? Yes

7c. Are there instances where no members of the public attended meetings? No

8. Please list any external stakeholders you recommend we contact regarding this committee.

Texas hospital association

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals? Yes

9b. Please describe the rationale for this opinion.

Healthcare associated infections reporting is now totally functional and two of three phases of preventable adverse events reporting have been implemented.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute? No

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area? No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)? Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission? Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

The committee provides the perspective of stakeholders who must comply with the legislation. Their input allows DSHS to elicit greater cooperation from these stakeholders.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

Minutes recorded by K. Nevers
Last updated 01/14/2015

Minutes
Texas Department of State Health Services (DSHS)
Healthcare-Associated Infections (HAI) and
Preventable Adverse Events (PAE) Advisory Panel Meeting
Brown Healy Room 1410-1420
January 6th, 2015 10:00 am

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1. **Welcome and introductions**
   Panelists attending: Jane Siegel, Charles Lerner, Debora Simmons, Susan Mellott, Linda Scribner, John James, Richard Bays, Allison Hughes, Bruce Burns, Susan Sebazco

   Staff members attending: Marilyn Felkner, Shawn Tupy, Jennifer Vinyard, Jessica Ross, BobbieJean Garcia, Kelly Brossard, Vickie Gillespie, Emily Engelhardt, Kenzie Nevers, Arminta Forrer,

   Telephone attendance: no panelists

   Panelist not attending: Ed Septimus

   Chairperson Jane Siegel led the meeting

   Meeting was called to order at 10:03 AM

   Chairperson Jane Siegel welcomed attendees. Attendees made introductions.

2. Announcements
   a. DSHS has received approval to hire 6 auditors.

3. Review of May 29, 2014 meeting minutes

   John James requested to have his name removed as he was not in attendance.

4. HAI/PAE program
   a. Staffing update
      i. Kenzie Nevers
      ii. Kelly Broussard
   b. HAI/PAE rule changes/amendments
      i. The PAE rules are currently moving through the registrar and will be effective January 18, 2015.
   c. PAE reporting status update
      i. Received PAE contacts from 69% or 692 of 923 facilities.
      ii. Logins for PAE reporting will be sent out mid-January 2015.

iii. Subproject with a possible intern to contact facilities that have not submitted PAE contacts. The subproject will utilize DSHS resources to determine the best way to contact facilities in regards to PAE reporting. This is of importance as there is a subset of facilities that do not receive the
iv. There was discussion for adding a section to each PAE Report that indicates lessons learned.

d. HAI reporting data summary
    i. Graphs indicating the overall Texas SIR for 2014 were handed out
    ii. The panel discussed providing clarification on future graphs to indicate the source of benchmarks for SIRs.
e. Facility HAI data audit report
    i. All but 2 of the facilities with a statistically high SIR have been contacted in regards to audits. The number of facilities with statistically high SIRs is lower than the previous year. The previous half-year had 34 facilities with a statistically high SIR.
f. Status report on MDROs and CRE reporting
    i. Jessica and BobbieJean responded to an outbreak of over 962 cases of MDROs.
g. Status report on *Clostridium difficle* and exception item activities
    i. DSHS has been successful in spending the majority of the budget allocated to C. diff
    ii. The collaborations with University of Texas Health Science Center, UH, and Texas A&M have submitted all of their reports.

5. Update on Website activities
    a. DSHS has sought to have their communication department approve a Twitter account for communicating the website to the public
    b. John James recommended a TV advertisement or a news story. John James indicated that he would speak with a news source.
    c. Richard Bays recommended using Facebook or contacting other facilities to put out Facebook, Twitter or newsletter notifications
    d. Susan Mellott recommended sending Texas Rural Health Association a notification to put in its newsletter.
6. Report on recent training/educational activities
    a. There is an upcoming collaboration with DADS for infection control training in LTACs
7. Review of items from the last meeting
8. Agenda items for next meeting
    a. Jane Siegel
        i. Send letter supporting resources for validation to Commissioner
        ii. Contact Lisa McGiffert on how to get public informed about website
        iii. Send letter to communications about need for publicity
    b. Shawn

i. Send *C. diff* presentations from 8.29.2014 mtg. to new members
ii. Check w communications
iii. Send Panel info. on the other advisory panel looking fro a member from our panel
iv. Obtain information from regulatory about outcome of communication with facilities that are reporting HAIs.

c. Jennifer
    i. Include a comment section for HAI and PAE to include useful information.
d. BobbieJean
    i. Request to report on the findings of the most recent audit, including the number of facilities that repeatedly have high SIR rates.
e. Jessica Ross
    i. Summarize information on CRE and MDROs with the goal of identifying clusters and areas where interventions can be focused with special attention given to LTC facilities.
f. John James
    i. Work with Consumer's Union to determine methods to inform the public regarding data on website
    ii. Contact potential news stations/reporters to contact DSHS Communications Department, to increase public awareness of data on website
g. Vickie Gillespie
    i. Send website links for 2-3 different states version of PAE Reporting
h. Deborah Simmons
    i. Develop a brief summary of what is known about the most effective method to report PAEs with key references
i. Charles Lerner
    i. Work with Therese Connor on a template for VAE data collection and feedback that can be used in facilities
j. Therese Connor
    i. Work with Charles Lerner on a template for VAE data collection and feedback that can be used in facilities

9. Adjournment
    a. The next panel meeting will be in June 2015.

Minutes recorded by K. Nevers
Last updated 10/05/2015

Minutes
Texas Department of State Health Services (DSHS)
Healthcare-Associated Infections (HAI) and
Preventable Adverse Events (PAE) Advisory Panel Meeting
Brown Healy Room 1410-1420
Tuesday June 23rd, 2015 10:00 am

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1. **Welcome and introductions**

   Panelists attending: Jane Siegel, Susan Mellott, John James, Patricia Jackson, Susan Sebazco, Ed Septimus, Isaiah Gordon, Barbara Hodo

   Staff members attending: Marilyn Felkner, Shawn Tupy, Jennifer Vinyard, Jessica Ross, Kelly Broussard, Vickie Gillespie, Emily Engelhardt, Kenzie Nevers, Arminta Forrer, Allison Hughes, Bruce Burns, and David Bastis

   Telephone attendance: no panelists

   Panelist not attending: Darleen Adams, Amy Beasley, Debora Simmons, Linda Scribner, and Susan Purcell.

   Chairperson Jane Siegel led the meeting

   Meeting was called to order at 10:05 AM

   Chairperson Jane Siegel welcomed attendees. Attendees made introductions.

2. Announcements
   a. DSHS has received approval and funding to hire 3 regional HAI epidemiologists.
3. Review of January 6, 2015 meeting minutes
   a. Jane Siegel asked about number of reported MDRO cases.
   b. Patricia Jackson asked that her name be included as an attendee of the January 6, 2015 Advisory Panel
   c. Meeting minutes from January 6, 2015 were approved with suggested revisions.
4. Status report on *Clostridium difficile* and ELC Ebola exception item activities
   a. ELC supplement grant for Ebola $1.9 million dollars was received by Texas that will allow for the hire of 3 regional epidemiologists.
   b. Texas Society for Infection Control worked with Texas to provide 16 trainings across Texas.
   c. University of Houston, University of Texas Health Science Center will be invited in the fall to provide insights into their work on *C. diff*.
   d. Harris County will receive a subcontract to work on a study with C. diff, to review active surveillance and contact isolation precautions at Ben Taub Hospital.

5. HAI/PAE program
    a. Staffing Updates
        i. Sunset Committee resolution passed, however the advisory panel will continue to meet due to a mandate for updating the state HAI/PAE reporting plan and no funding required.
        ii. Neil Pascoe has been hired as an HAI epidemiologist
        iii. Jennifer Vinyard has taken the lead role of the auditors
        iv. Emerging and Acute Infectious Disease Branch(EAIDB) has requested approval for hire of 3 auditors
        v. DSHS has hired 1 new auditor who will start 06/29/2015.
    b. HAI reporting
        i. A formal program of HAI Auditing of CLABSI will begin in the fall of 2015.
        ii. H1(First Half of the Year) of 2014, 34 total facilities with a statistically significantly high SIR: 25 of those were facilities had their first time High SIR, 9 facilities were repeat facilities with High SIRs. For the 25 first-time high SIRS: 286 records/events reviewed. Of those, 274 met definition during auditors' review. 12 did not meet definition (5 SSI, 7 CAUTI). This is an accuracy rate of 95.8%. Of the 274 that met definition, there were 16 that had variations in the documentation that did not affect the definition, (e.g. different days for admission, date of event, type of SSI).
        iii. H2 of 2014, there were 23 first time and 8 repeat facilities on the High SIR. So far only 2 first time SIR audits have been completed. All records reviewed met NHSN surveillance criteria. The remaining facilities with a high SIR (first time) have been contacted and site visits are being scheduled. Hope to complete all audits/site visits by August 2015.
        iv. The panel discussed concern with HAI under reporting. Auditing of CLABSI should review for possible under reporting with facilities, by reviewing results from facilities with consistently low HAIs reported.
6. Update on Website activities
    a. DSHS has sought to have their communication department approve a Twitter account for communicating the website to the public.
    b. Kenzie Nevers recommended having a Twitter Account follow other relevant agencies' Twitter Accounts.
    c. John James suggested a Public Service Announcement in AARP regarding HAI and PAE reporting.
    d. PAE reporting status
        i. The PAE reporting started in January 2015. Hospitals and Ambulatory Surgery centers are required to report adverse events as outlined in the Texas Administrative Code.
        ii. PAE contacts have been sent an email asking contacts to login to TxHSN and review their facility's reports.

iii. Preliminary results of 145 PAEs reported as of 06/23/2015. Predominant PAEs are falls.
iv. 8 webinars for a second PAE Training are scheduled to be held during June and July, 2015. .
v. Subcommittee to provide assistance with PAE definitions and questions.
vi. Subproject with an intern to contact facilities that have not submitted PAE contacts. 75% of Health Care Facilities have provided PAE contacts.

7. Status report on MDR-A and CRE reporting
    i. 1,401 cases of MDRO since beginning reporting in April 2014. 860 were MDR-*Acinetobacter*, 541 were CREs (*E.coli* & *Klebsiella* species).
    ii. Panel raised questions regarding geographic distribution of CREs.
    iii. Laboratory does not have the capability to run PCR testing, or whole genome sequencing for MDROs at this time. Panel expressed concern that there is no ability to do whole genome sequencing. DSHS lab does have the capability to run PFGE at this time which is a molecular test that helps HAI/ MDRO epidemiologists to determine trends and likeness of the organisms during outbreaks. According to the literature, detection of the specific enzyme responsible for the resistance of CRE is a critical component of such surveillance and control programs.
    iv. Jane Siegel indicated that she would write a letter to the commissioner about expanding laboratory capability to include whole genome sequencing.
    v. Jessica Ross discussed an outbreak of MDR-Acinetobacter she has been following in an LTAC, with continuous infection control violations; specifically, variations in PPE donning and doffing, hand hygiene, and environmental cleaning. Of note, she reported a substantial decrease in *Acinetobact*er infections after the training she gave the HCP in that facility.
        1. Panel suggested that Jessica Ross consider publishing these findings as the information could further drive the point that basic infection control is a critical component of any antimicrobial stewardship program.
    vi. The Panel has requested a more detailed analysis of the CRE/MDR *Acinetobacter* data for the next meeting.
8. ELC Funding and Ebola Assessment Facilities.
    a. CDC requires that Texas DSHS evaluate facilities that designate themselves as Ebola Assessment Facilities.
    b. Ebola Assessment facilities need to be able to care for a possible Ebola patient for up to 96 hours until the patient is released or transported to an Ebola Treatment Facility
    c. DSHS Preparedness has asked facilities to declare whether or not they want to be Ebola Assessment Facilities. Approximately 35 facilities in the state of Texas

have indicated that they would like to be Ebola Assessment Facilities. Texas Children's Hospital in Houston is the only pediatric treatment center in Texas.

d. DSHS Epidemiologists will conduct onsite visits to these health care facilities in collaboration with the preparedness and laboratory teams.

9. Report on recent training/educational activities
    a. There is an upcoming Texas DSHS Health Care Safety Conference in Houston on August 20-21, 2015.
    b. The conference will be held at Hilton NASA Clear Lake, Houston
10. Review of items from the last meeting.
    a. All items addressed in prior discussion during the meeting.
11. Agenda items for next meeting
    a. Jane Siegel
        i. Send letter to Commissioner regarding the need for molecular studies of CRE and MDR-A
    b. Program Staff
        i. Send links to 9/2014 PCAST report and 3/2015 PCAST Action Plan to Advisory Panel members
        ii. Explore other methods of informing public of HAI and PAE data with the public
        iii. Include pie charts of major groups of pathogens and share with panel members for comments.
        iv. Separate out top 4 SSIs from total SSIs
        v. Send announcement about the Patient Safety meeting on 8/20/2015
        vi. Summarize best practices that have resulted from Houston *C. diff* studies
        vii. Share new proposals with Advisory Panel
        viii. Share number of individuals trained

    c. John James
        i. Talk w Lisa McGiffert re: communicating to the public

12. Adjournment
    a. The next panel meeting will be in October 2015.

Minutes
Texas Department of State Health Services (DSHS)
Healthcare-Associated Infections (HAI) and
Preventable Adverse Events (PAE) Advisory Panel Meeting
Brown-Heatly Building Room 1410-1420
Thursday October 29th, 2015 10:00am

1. Welcome and introductions

Panelists attending*:* Jane Siegel, Edward Septimus, Charles Lerner, Susan Sebazco, Patricia Jackson, Darlene Adams, Susan Mellott, Linda Scribner, Therese Conner, Laurence Donovan, Debora Simmons

Staff members attending: Marilyn Felkner, Shawn Tupy, Jennifer Vinyard, Jessica Ross, Neil Pascoe, Kelly Broussard, Vickie Gillespie, Emily Engelhardt, Arminta Forrer, Lisa Peers, Bruce Burns, Bobbiejean Garcia, David Bastis, Candace Campbell, Nesreen Gusbi, Thi Dang, Sandi Henley, Linda Gaul, Sherri Richardson, Susan Tanksley, Elizabeth Delamater, Chun Wang

Telephone attendance: no panelists

Other Attendees: Karen Degtoff, Elizabeth Showberg

Panelists not attending: Barbara Hodo, Richard Bays, John James

Chairperson Jane Siegel led the meeting

Meeting was called to order at 10:02 AM

Chairperson Jane Siegel welcomed attendees. Attendees made introductions.

2. Review and approval of June 23rd, 2015 meeting minutes

a. No changes to minutes and were approved.

3. Program staffing update

a. Lisa Peers, with regulatory division of DSHS, is taking over for Allison Hughes.
b. New Staff: Candace Campbell, Epidemiologist for central line associated blood stream infection (CLABSI) validation. She will be auditing facilities that are selected using the NHSN targeted facility selection approach which identifies facilities with a high number of expected infections (highest risk). The new validation method will be able to identify facilities that may be under-reporting.

c. New Staff: Nesreen Gusbi, program specialist for HAI and PAE users. She is helping to answer TxHSN helpdesk questions from users and assists facilities in maintaining their compliance with reporting mandates.
d. New Staff: Thi Dang is a regional HAI Epidemiologist for region 2 and 3, which is the Arlington, Dallas Fort Worth area.
e. New Staff: Sandi Henley is a regional HAI Epidemiologist for region 7, which is the Austin, Temple area. She will be starting in November.
f. Neil Pascoe will be retiring at the end of this calendar year.

4. Presentation of Society for Healthcare Epidemiology of America (SHEA) healthcare epidemiologist skillset report

a. The report: Guidance for Infection Prevention and Healthcare Epidemiology Programs: Healthcare Epidemiologist Skills and Competencies

b. There appears to be a trend toward dismissal of Health Care epidemiologist in hospitals. This is concerning and can be detrimental to the facility.

c. Anyone in infectious diseases that is interested in health care epidemiology should be aware of the required skill set for this position. Infection preventionists are ahead of health care epidemiologists (usually physicians) in that there is a defined skillset and certification for infection preventionists.

d. The panel concluded that this document is a great resource and is especially useful to explain the differences between infection prevention and control and infectious diseases. It is also useful in developing a job description.

e. Dr. Edward Septimus stated that the number of fellowships filled in this field is down to 60%, which is concerning for the next generation. There is also a shortage in infection preventionists.

f. Dr. Jane Siegel stated that Infection prevention and quality improvement each have unique functions and skillset requirements that the facility administrators should be aware of.

5. HAI reporting and auditing data summary

a. Summary of audit findings and 2014 annual report.
    i. The definition change for catheter associated urinary tract infections (CAUTI) affected the state SIR in 2015 and showed a decrease in the ratio. There will be a new national SIR in 2017 that is expected to change the current trends for most health care associated infections, especially affecting the CAUTIs.

ii. It was stated that it is important to try to alert people of the recalculating SIR and what to expect. DSHS plans to appropriately communicate this change to the facilities in order to highlight the changes in the baseline in late-2016.

iii. It was suggested to add the new HHS 2020 goals with the new baseline. Original HHS goal was to reduce CLABSI by 50% by 2013. DSHS will have to realign the goals with the new baseline data.

iv. There were no major differences between HAI-associated organisms in Texas and the national distribution of organisms.

v. The panel discussed their concerns and suggestions around incorporating a pie chart and/or table displayed in the final report. The panelists will submit their suggestions prior to the next meeting and the topic will be discussed further at the next meeting.

b. CLABSI protocol implementation.

i. There were a total of 31 facilities that appeared to have a statistically significant high SIR. 23 were first time (non-consecutive) high SIRs. Of those 23, 16 were for CAUTI, 2 were for CLABSI and 5 were for Surgical Site Infections (SSI). According to the audit summary, 99% of the records reported were accurate. This was the highest percentage so far. There were 3 consecutive high SIR facilities and one was selected for follow up.

ii. TMF Health Quality Institute is consulting with some facilities with high rates. TMF just finished recruiting due to a 5 year contract with the Center for Medicaid and Medicare Services (CMS). CMS required that TMF increase their consultation to 20% of Texas hospitals. They currently work with both large and small hospitals.

iii. The panel discussed ways to improve communication of the results of audits from the state epidemiologists and perceptions by the facilities, especially for consecutive high SIR facility identified during audits. It was suggested that a physician could be present for the audit and that a physician to physician discussion may increase impact. It was also suggested to engage the governing board of the facility if it appears that the staff are not responding adequately to the data presented. Sometimes things don't get high enough in the hierarchy to get the funds to make a difference. It was recommended that when the post-audit report is shared with the facility that the auditors recommend with whom the information should be shared, for example the medical executive committee or quality performance council.

c. CAUTI and SSI upcoming protocols

i. For 2014, there were 20 facilities with statistically significant high SIR for either CAUTI or SSI. Seventeen were first time high SIR and 15 of the high SIR were for SSI while 3 were for CAUTI. There were consecutive high SIR for 3 facilities.

ii. CLABSI validation started in the 2015.
iii. There were 11 facilities chosen for the CLABSI validation pilot.
    1. Six from upper third of facilities with highest expected number of infections (2 significantly high SIR, 2 about the same, 2 significantly low SIR).
    2. 2 (with no SIR calculated) selected based on highest delta count (greatest difference between reported and expected number of infections)
    3. 3 selected randomly.
iv. One of the facilities selected for the CLABSI audit was also undergoing an inspection from CMS. The staff decided that if CMS was going into a facility that the state planned to audit then the state would take CMS validation and not audit the facility unless deemed necessary. If there are concerns, the state will request the facility's action plan.
v. The HAI Auditor asks for a line list of positive cultures for 6 months and often the number is less than 200. From this line list, up to 60 candidate CLABSI medical records are selected for review.
vi. Once CLABSI validation is off the ground, next will be SSI and CAUTI validation. CAUTI validation will be similar to CLABSI validation. SSI will be different because the denominator will be number of procedures within the specified time interval instead that is reported to NHSN. DSHS hopes to be able to validate the first half year of 2016 data.

d. Training and Educational Activities
    i. Jennifer held 2 webinars recently to explain how the validation process works. Both of these are available online. One is targeted towards local and regional health departments. The other goes into more detail about what is reported and how the validation process is transitioning.

e. HAI website activity chart: HAI Web Stats
    i. Spike in activity in October 2014 could be due to the timing of facility reports coming out and due to Ebola.
    ii. Jane Siegel asked if there are ways of increasing awareness and bringing people to the website.
    iii. Shawn Tupy responded that the staff is still pursuing social media options and Public Service Announcement as opportunities to raise awareness. Restructuring in the agency has created some challenges. The staff should have some feedback by the next meeting

f. Jane Siegel suggested some more information for future meetings.
    i. The antibiogram was missing Region 6: oxacillin.
    ii. Proportion of infections that lead to death.
    iii. Want to know what kind of HAIs contribute to death.
        1. How many and what type of infection and the proportion

iv. Temporal and geographic clusters of infections have not been identified yet. DSHS hasn't analyzed cluster data since the year before. More focus was established in attaining regional resources. Before starting with validation, DSHS developed a cluster report that would identify facilities that had the same pathogen growing, same unit or same time. However, this wasn't fruitful. The results were always delayed by months and were not available in real time. The same facilities also had high SIRs. DSHS feels it is better to develop the relationship with facilities at the regional level so that they can reach out.

6. HAI investigation team topics

a. Multi-Drug Resistant Organism-Acinetobacter (MDR-A) and Carbapenem Resistance enterococcus (CRE) reporting.
   i. There was an MDR-A outbreak in Amarillo, Texas. It took place at a long term acute care facility between July 2014 and April 2015. There were 25 cases of MDR-A identified, with 18 of those cases having the same pulsed-field gel electrophoresis (PFGE) pattern representing on-going transmission. The majority of cases were from wound and respiratory cultures. Findings and recommendations were given to the facility. The facility was visited on three instances by the state for an outbreak investigation and were followed up by a regulatory visit.
   ii. The initial source of the outbreak was not found. Many of the patients bounced back and forth between the Long Term Acute Care (LTAC) facility and other facilities.
   iii. The MDR-A and CRE incidence rate was represented on a county and regional map for both the residence of the individual and the health care facility location.
   iv. There were 860 cases of MDR-A in 2014 and most of the clustering of cases by residence was in region 1, region 11, regions 2/3 and region 6/5 south.
   v. The clustering of MDR-a cases by the location of admittance into a health care facility was similar. There were a total of 622 cases in 2014 with clustering in region 1, regions 2/3, region 11 and region 6/5 south.
   vi. DSHS has been working closely with region 11 since 2008 and part of the reason for high incidence rates is thought to be due to accessibility of antibiotics across the border. However, not many cases are seen in El Paso. Region 11 has infectious disease resources as well as some universities but could always use more public health resources.
   vii. There were 541 CRE cases in 2014 and most of the clustering by residence was in region 6/5 South and region 11.
   viii. The clustering of CRE cases by the location of admittance into a health care facility was similar. There were 420 CRE cases in 2014 and most of the clustering by admittance location was in region 6/5South and region 11.

ix. DSHS does not have the polymerase chain reaction (PCR) lab capability to verify the CRE cases, which is a critical piece of the surveillance. All states do not report CRE or use PCR to verify CRE cases. The Council of State and Territorial Epidemiologists just came out with a new definition for CRE.
x. The panel discussed the communication plan. Once the data is cleaned up, the reports will be posted online. Kelly was working this year to keep the data clean and organized so future reports will be easier. DSHS is planning an antibiotic stewardship program to launch in 2016. The program plan will be shared with the board.
xi. For future reports the panel would like to see:
    1. Incidence overtime every 6 months
    2. Data displayed in Graph or a table along with the map to show trends
    3. For trending, start with total overall and then look at hotspots and see if they've changed
    4. Organize data by regions and do the rate over time
    5. Have an overlay of education to see how it correlates
    6. Look at red spots (higher incidence) and see the counties overtime to see if they stay red or progress over time.
    7. Use sentinel reporting. Do the trends for the frequently occurring regions then the one time occurrence for places that have high incidence at one point in time and not throughout the year.

b. Vital Sign Report Review
    i. There is a National Action Plan for Vital Statistics.
    ii. There are 2 CDC work groups that work to reduce inappropriate antimicrobial use in acute care by 20% and by 50% in outpatient care by 2020. They are trying to define what is inappropriate. The Standard Antibiotic Administration Ratio (SAAR) (days of therapy) is a new measure that is going to be endorsed by the National Quality Forum (NQF) patient safety committee. The future reports will be risk adjusted.
    iii. Vital sign reporting is to track where the patients are going within and between facilities. We need to track where the organisms go. The question is: How can we assist the community wide coordination?
    iv. People in Houston are working on this specifically with c-diff and asymptomatic bacteria projects.
    v. NQF, has a special group on antimicrobial stewardship. CMS is going to do make antimicrobial stewardship guidance and specify some requirements.
    vi. There are challenges with facilities sharing data. After the President's Council of Advisors on Science and Technology (PCAST) report came out there could be some more energy and possibly more willingness to share collaboratively. Another challenge is determining where the local Health Department will get funding to do this. Many people are donating their time. It doesn't take a large amount of money to do this work. You can rely on donations.
    vii. Shawn stated that the legislature is putting some resources at the local Health Departments with around 30 epidemiologists. CDC does have an antibiotic stewardship grant. DSHS needs to determine what the state role is.

viii. Jane suggested meeting attendees watch the CDC webinar from August because it had some great ideas. Their registry for Multi Drug Resistant Organisms in Chicago, Illinois was a good example.

c. Antibiotic Stewardship discussion
   i. There is a Get SMART week for this subject.
   ii. DSHS should phrase it as antimicrobial resistance not stewardship.
   iii. The plan for 2016 will be discussed at the next meeting.

7. PAE reporting update

a. As of September 2015, for January through June 2015 there were 894 total facilities including hospitals and Ambulatory Surgery Centers (ASC). The hospitals had a higher compliance rate (73.7%) compared to the ASCs (56.2%). There were two groups of non-compliant facilities. The first group that was non-compliant did not report or confirm PAEs but did have designated facility contacts. That group includes 20.6% of all hospitals and 36.8% of ASCs. The second non-compliant group failed to report as well and did not designate facility contacts. This includes 5.7% of hospitals and 7% of ASCs.

b. There are about 22 facilities that are not reporting HAI and haven't conferred rights to the state. Program staff informs regulatory, and then regulatory follows up with the facility. DSHS and both THA and TASCS have contacted facilities that are have not provided PAE contact information. DSHS will continue this effort. Facilities that remain non-compliant with PAE reporting will be reported to regulatory after the next reporting cycle.

c. DSHS provided updated Frequently Asked Questions documents, Definitions and Guidance for facility users, which are posted at www.paetexas.org. This update includes the next set of PAE reportable events scheduled for implementation on January 1, 2016.

d. August 20-21st, 2015 was DSHSs first health care safety conference. The conference had 212 attendees, 20 speakers and 15 sessions. The speaker evaluations for each speaker for "very good ratings" ranged from 44%-83%. The attendees that were surveyed were almost all (99%) interested in attending a future healthcare safety conference. The overall quality was rated very good (79%).

e. DSHS is now planning a conference for 2016. DSHS sent out a survey to see where the future conference should be.

f. The PAE first half year data for 2015 showed a total of 270 events with the highest incidence for patient death or severe harm associated with a fall resulting in a fracture (109 events). The second highest category was foreign object retained after surgery or invasive procedure (69 events). The third highest category was wrong site surgery or invasive procedure (27 events).

g. Completion of a root cause analysis (RCA) and corrective action plan (CAP) following an adverse event are required in Texas but submission is not. Some states do require submission of a RCA and/or CAP.

h. It would be good to have facilities learn from each other including degradation of equipment, pieces breaking off etc. but DSHS does not have a formal process to facilitate this.

i. There are some challenges to reporting. The interpretation by providers can be subjective. Currently we are not auditing for underreporting. We strive to provide clear and consistent guidance and directions for appropriate reporting via trainings, presentations, posted documents and responses to email questions.
j. There have been questions around perinatal events. For example, how do you define a low risk vs higher risk pregnancy? Texas Hospital Association (THA) has provided names of obstetricians and neonatologists that can give input in determining this.

8. Electronic Laboratory Capacity (ELC)

a. Funding is provided from CDC to establish Ebola self-designated assessment facilities. There were 70 facilities initially, but now there are 20 facilities.
b. There appears to be communication challenges within the facilities between preparedness, infection prevention and the corporate level.
c. DSHS has completed 2 assessments of these systems. CDC has an Ebola assessment readiness tool that is about 150-155 questions. The questions cover 12 different domains, from pre-transport to hospital, worker safety, lab and personal protective equipment. The assessment is done by a group of three: DSHS HAI Epidemiologist, lab and hospital/emergency preparedness individuals. There are between 4 and 6 representatives from the assessment team that go to the site. The hospital conducts their own self-assessment prior to the visit. The team has a tour and then assesses the facility by going over the tool. After the questions are answered there is a discussion with recommendations at the end. DSHS follows up with an in depth feedback report. This ends with a yes/no answer per question.
d. So far, the self-assessments match the DSHS assessment at around 75-80%. The 20 facilities right now are located throughout the state. There is a pediatric assessment facility included and a pediatric treatment facility.

9. Lab Whole genome sequencing

a. Through the genome tracker program, the US Food and Drug Administration (FDA) has provided loaner instrumentation, training, reagents/supplies and bioinformatics capability.
b. DSHS must sequence 400 bacterial/clinical isolates annually from food or environmental sources for 3 years. DSHS is looking at Salmonella, Shigella, Listeria, Campylobacter, E. coli 0157 and non-0157 STEC.
c. The lab recently requested funding for reagents/supplies to sequence an additional 250 clinical outbreak specimens and received part of the funding from the ELC with supplemental funding from the Association of Public Health Labs (APHL). CDC is able to help with data analysis. APHL has also provided BioNumerics 7.5 upgrade to support whole genome sequencing.

d. The lab is running about 16 samples a week. They are currently training staff. There is 1 fully trained by FDA and CDC and 5 others that are cross trained. The staff is planning to sequence around 650-800 isolates per grant year.
e. It is very likely that WGS will replace PFGE. The cost is still unknown for WGS.
f. Current testing for Health care associated infections (HAI) includes bacterial isolation and culturing, biochemical and serological tests for Acinetobacter, Klebsiella pneumoniae, E.coli O-157 and non O-157 and Klebsiella spp. For PFGE the organisms are Acinetobacter, Klebsiella pneumoniae, E.coli O-157 and non O-157.
g. There are limitations specifically in capacity since there is only one instrument, limited staff, limited knowledge specifically in data analysis and limited resources.
h. WGS is becoming more important and desired but there is a lack in DSHS lab expertise to analyze and interpret the findings.
i. Many other states only do foodborne related WGS and many don't have HAI.
j. There is currently no CRE confirmation testing in the lab due to lack in funding.

10. *Clostridium difficile* (CD)

a. In the US there is an excess of 1 million dollars in medical costs per year, 500,000 infections per year and 29,000 deaths per year due to *Clostridium difficile* (CD). There has been a steady increase in incidence and mortality rates for C. diff in Texas.
b. The major issues in C. diff is with diagnosis and treatment.
c. To diagnose, only unformed stool is tested. The stool is tested for toxins A and B using cell cytotoxicity, enzyme immunoassay or polymerase chain reaction (PCR). There are positives and negatives to each. PCR can over-diagnose because it appears to be picking up colonization.
d. Studies by Jardin 2013 and Johnson 2014 support oral vancomycin to be preferred treatment with better outcomes over Metronidazole. Metronidazole is drastically going to be used less to treat C. diff.
e. Fidaxomicin has equal efficacy as vancomycin to cure patients and lessens the risk of recurrence when compared to Metronidazole. Fidaxomicin can reduce reoccurrence by half but is very expensive. However a study by Gallanghe, 2015 shows that over time Fidaxomicin is more cost effective than vancomycin.
f. The study funded by DSHS asked where C. diff was coming from. The objective of the study was to assess community environmental contamination of toxigenic CD. Samples were collected around Houston to assess C. diff prevalence in public areas including parks, chain stores, fast-food restaurants, homes and hospitals.

g. There were over a thousand isolates obtained from the environment and hospitals including 1173 from homes, 230 from chain stores, 125 from fast-food restaurants, 540 from public areas and 613 from hospitals.
h. The isolates were then tested for CD contamination. The environmental samples were 17-61% positive for CD *C. diff* the percent positive for CD for each were:
    i. 61% of public areas (n=540)
    ii. 3.9% of homes (n=1173)
    iii. 17.8% of chain stores (n=230)
    iv. 20.8% of fast-food restaurants (n=125)
i. In the home environment, the areas that had a higher percent positive included shoe soles (45.3%), restrooms (35.6%), cleaning supplies (38.6%) and kitchens (45.8%). Only risk factor found in homes was a pet being in the home.
j. The ribotype distribution of clinical and environmental isolates were similar in pattern for both except for the 027 strain, which was more common in a clinical setting.
k. Environmental isolates are capable of causing disease based on early experience with animal model.

l. Hospital Transmission of *C. diff*

    i. C. diff typically develops when an elderly person receives antibiotics and has contact with contaminated environments in hospitals or nursing homes. The environment of a hospital has been shown to be contaminated with C. diff spores, especially in rooms housing patients with C. diff Infection (C. diff) or a patients colonized by C. diff. Disinfection of the hospital is complicated by: the number of patients with comorbidity housed, frequency of antibiotic use and difficulty in removing patient rooms sufficiently long enough for thorough cleaning.

    ii. This study examined the nature of C. diff to determine if infection was caused by single or multiple strains of C. diff. The study looked at 18 patients with active C. diff. Ten colonies of C. diff were taken from each of the 18 patients with C. diff and were individually tested by ribotype for similarity.

iii. A majority of the colonies had multiple strains present.

1. 12 patients at 4-5 strains

2. 4 patients had 2-3 strains

3. 1 patient had 1 strain

iv. A study funded by the MacDonald Fund and Baylor St. Luke's Medical Center was conducted on the environmental contamination by C. Diff spores. It was a one year study that collected C. diff spores from patients diagnosed with C. diff and from the adjacent rooms as a control. There was a higher percentage of C. diff in the patients with CD diarrhea as compared to patients without C. diff diarrhea in both patient bathroom and patient room. Rooms housing patients with C. diff were frequently positive for C. diff despite daily cleaning and showed short time persistence. Five ribotypes of C. diff caused the hospital cases of C. diff. Ribotype O27 is commonly found at Baylor St. Luke's Medical Center.

v. A disinfection study was done on the environmental contamination by C. diff spores on hospital floors. The cleaning methods included H_2O_2 & peracetic acid (OxiCide), Quaternary Ammonium (QA), Ultra Violet (UV) plus QA, 10% Bleach. The study concluded that there was not a 100% effective disinfection method. UV light plus QA was the most effective method of decontamination. OxyCide was no more effective than standard QA.

vi. Another study looked at 29 patients with C. diff and their rooms and tested for C. diff spores. They identified if there were identical clones in patients and rooms. By using Multilocus sequence typing they found 4 clusters of C. diff strains that were common throughout the hospital. They concluded that there were a limited number of clones suggesting that there is in hospital transmission or the presence of a pool of hospital strains in the community

vii. A new study funded by DSHS aims to develop a gold standard for diagnosing C. diff and to translate research into actual changes in the infection control practice.

m. C. diff Summary Remarks

i. Currently we over diagnose C. diff. Hospital transmission is where we need to concentrate our efforts with the majority of 4 stains in the hospital. There are many other strains in the environment. Current challenges include turning around beds too quickly for C. diff patients. C. diff should be treated like AIDS patients, where we assume everyone in the hospital coming in has it. 25% of patients with C. diff recur. Fecal microbiome implementation is helping people who lack the necessary flora needed to fight C. diff and continue to have reoccurrence of C. diff. This so far has been 95% successful.

11.Review of items from the last meeting and Concluding Remarks

a. All items addressed from the last meeting.

b. May need someone with pharmacology in the panel.

c. Dr. Jane Siegel did not receive a response to her WGS letter.

12.Public comments

a. None

13.Agenda items for next meeting

a. Board Members:

i. Provide feedback around incorporating a pie chart and/or table to be displayed in the final report for HAI.

ii. Dr. Edward Septimus will send out his CRE presentation to Shawn

b. Program Staff

i. Provide status update on the changes to the board due to the sunset review.

ii. Share plan of antimicrobial stewardship once it's available

14.Adjournment

a. Meeting adjourned at 3:26pm

b. The next panel meeting will be in February 2016.

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name:	HIV (Human Immunodeficiency Virus) Medication Advisory Committee		
Number of Members:	12		
Committee Status (Ongoing or Inactive):	Ongoing	Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.	
Date Created:	1/1/1991	**Date to Be Abolished:**	8/1/2016 (per rule; expected to be continued)
Budget Strategy (Strategies) (e.g. 1-2-4)	A.1.2.2	**Strategy Title (e.g. Occupational Licensing)**	HIV Prevention and Care
Budget Strategy (Strategies)		**Strategy Title**	

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Health & Safety Code, Sec. 85.271-85.282
State Authority	Admin Code	25 TAC 98.121 (c)
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$1,102	$2,200	$2,200
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$1,102	$2,200	$2,200

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	$1,102	$2,200	$2,200
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year	2	3	3

Committee Description: Advises in the development of procedures and guidelines for the Texas HIV Medication Program (THMP). Reviews THMP's goals and aims, evaluates ongoing efforts, and recommends short-range and long-range goals and objectives. Recommends medications for addition or deletion to the THMP formulary. Advisory committees are recommended by the Health Recourses Services Administration (HRSA) as a best practice for AIDS Drug Assistance Programs (ADAP).

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?
Per statute, the committee is required to meet only as necessary. The committee typically meets 2-4 times annually in Austin, Texas.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

Committee advises addition of medications to the Texas HIV Medication Program formulary. No required documents.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

Committee recommended addition of Daraprim to Texas HIV Medication Program formulary and it was added. Committee recommended program research potential addition of Hepatitis C treatments for program participants, this is currently being investigated.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ? Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees? No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015? 12.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Staff create presentations, coordinate meetings, schedule and set up meeting room, produce and distribute meeting packets, attend meetings, take notes, and produce minutes.

6. Have there been instances where the committee was unable to meet because a quorum was not present? No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

Notices are posted in the Texas Register and emails notifying of event time and date are provided to parties who have expressed interest.

7b. Do members of the public attend at least 50 percent of all committee meetings? Yes

7c. Are there instances where no members of the public attended meetings? No

8. Please list any external stakeholders you recommend we contact regarding this committee.

Consumers (persons with HIV/AIDS), medical professionals (doctors, nurses, pharmacists), social workers/case managers, drug company representatives.

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals? Yes

9b. Please describe the rationale for this opinion.

As required, the committee advises in the development of procedures and guidelines for the Texas HIV Medication Program (THMP). Reviews THMP's goals and aims, evaluates ongoing efforts, and recommends short-range and long-range goals and objectives. Recommends medications for addition or deletion to the THMP formulary.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute? Yes

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area? No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

N/A

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

While HRSA does not mandate that ADAP programs have an advisory committee, it is strongly recommended as a best practice and allows for a process through which new medications are recommended and approved to be added to the Texas HIV Medication Program formulary.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

TEXAS
Department of State Health Services

OFFICIAL MINUTES
Texas HIV Medication Advisory Committee Meeting
December 5, 2014

The December 5, 2014 meeting of the Texas HIV Medication Advisory Committee (MAC) was held at 4110 Guadalupe Street, Building 626 in Austin, Texas.

MAC Members in Attendance: Philip Keiser, M.D., Chair, Natalie Vanek, M.D., Vice-Chair, Mary Paul, M.D., Nancy Miertschin, M.P.H., Raul Castaneda, R.Ph., David Huse, Bruce Turner, Frank Rosas

DSHS Staff in Attendance: Shelley Lucas, Imelda Garcia, Felipe Rocha, Rachel Sanor, John Allen, Mary Richards, Heather Nagy, Lisa Cornelius, M.D., David Gross, Paul Bell

Registered Guests: Erin Smith, Mark Vane, Michelle Flores, Becky Gonzales, Sara Deppe, Jay Dee Fredericksen, Mike McBride, Januari Leo, John Carlo, Roger Grotzinger, Suzanne Erickson, Roberto Perraza, Victoria Ford, Jack McClure, Sheldon Skinner

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Action and Discussion Items Covered:

I. The meeting was called to order by Dr. Keiser at 12:03 pm, December 5, 2014.

II. The committee reviewed and unanimously approved the February 21, 2014 meeting minutes.

III. Imelda Garcia, Section Chief for Infectious Disease Prevention, gave a brief update on recent developments that staff has been addressing concerning a tuberculosis exposure case in El Paso that required the identification and screening of over 900 infants in addition to household members and community contacts, as well as a section wide response to the discovery of the first US Ebola virus diagnosis in Dallas. In regards to ongoing bill analysis, the Section is awaiting the outcome of the recent Sunset Committee recommendation to consolidate the agencies under the enterprise umbrella within HHSC into one single agency. Registered guest Januari Leo expressed concerns that the existing advisory committees would all be disbanded and potentially reinstated by approval of a rule; Ms. Garcia stated that the topic was currently being reconsidered by the Sunset Committee, and some modifications to the report are expected to be released as early as next week.

IV. Felipe Rocha, Manager of the TB/HIV/STD Viral Hepatitis Unit, presented an update on the THMP Budget.

V. Rachel Sanor presented ADAP/SPAP update reports detailing first time enrollment by month and program, clients served by month, monthly medication expenditures, number of prescriptions filled by month, the top ten drugs dispensed and race and gender demographics for State FY 2014. Raul Castaneda requested additional data on the numbers of clients served versus eligible to be served each month. Shelly Lucas stated that she would have Margaret Vaaler from the HIV/STD Planning and Evaluation Group give a presentation at the next meeting covering both the HIV Cascade in Texas and the unmet need statistics for Texas, with specific data pertaining to the ADAP population where applicable. Dr. Paul had some specific questions regarding the accessibility of pediatric HIV medication formulations for program recipients; John Allen explained some of the processes in place for monitoring of inventory on hand and purchasing of infrequently utilized medications, and requested that drug manufacturers contact our Program Manager when new formulations are made available to purchase. Mr. Allen also stated that he is available to work with addressing any specific

formulation needs that prescribers encounter to ensure greater access to medications for all recipients. Nancy Miertschin also expressed interest in opening up discussions as to any potential ablility of the THMP to assist Harris Health with dispensing partial bottle fills to the homeless population.

VI. The recommendation to add the drug cobicistat (Tybost) to the THMP formulary was approved unanimously by the Committee. Cobicistat had previously been added to the formulary as a component of the combination therapy drug Stribild, and is now being marketed as a coadministered agent with the drugs atazanavir 300mg and darunavir 800mg. Dr. Keiser explained that a combination drug containing cobicistat, atazanavir and darunavir is likely to be presented for FDA approval in the near future, and stated that the Committee is anticipating that the price associated with such an item be equivalent to the individual components rather than an increase in cost to ADAPs. Dr. Keiser also explained that the other unique component of Stribild, the integrase inhibitor elvitegravir (Vitekta), was also approved by the FDA on its own, but is not yet ready for consideration as the wholesale acquisition price (WAC) has yet to be established. Rachel Sanor stated that the ADAP task force anticipates pricing negotiations to begin with the manufacturer in early 2015.

VII. The next MAC meeting was tentatively scheduled for Friday, May 15, 2015.

VIII. There was one public comment. Januari Leo with Legacy Community Health Services in Houston requested an update on the ability of the agency to begin purchasing Affordable Care Act insurance plans from the marketplace for eligible ADAP recipients, as a majority of ADAP programs are now doing for their population. Imelda Garcia stated that conversations are ongoing within the agency and recent communication with our leadership team has appeared positive, but no decisions have been made as of yet. Shelly Lucas stated that a $3.5 million Ryan White Supplemental Services Grant was received this year, and she was hopeful that the Administrative Agencies would use some of the increased funding to purchase plans on the local level while the Department continued to pursue the possibility of doing so on a statewide level. John Carlo from AIDS Arms in Dallas recommended that local programs be handled on a pilot project level, as they had found that tobacco use from recipients were leading to increased premium costs by as much as 300%. Ms. Garcia stated that such cost factors were being factored into our modeling projections, based on the known rate of tobacco use amongst Ryan White recipients.

IX. The meeting was adjourned by Dr. Keiser at 1:43 pm.

Approved by: _____

Phillip H. Keiser, M.D. – Chairman, Texas HIV Medication Advisory Committee

_____

Date

TEXAS Department of State Health Services

OFFICIAL MINUTES
Texas HIV Medication Advisory Committee Meeting
July 17, 2015

The July 17, 2015 meeting of the Texas HIV Medication Advisory Committee (MAC) was held at 4110 Guadalupe Street, West Auditorium, Building 582 in Austin, Texas.

MAC Members in Attendance: Philip Keiser, M.D., Chair, Natalie Vanek, M.D., Vice-Chair, Mary Paul, M.D., Fernando Garcia, M.D., Nancy Miertschin, M.P.H., Raul Castaneda, R.Ph., David Huse, Frank Rosas, Demetra Tennison, Bruce Turner

DSHS Staff in Attendance: Janna Zumbrun, Felipe Rocha, Shelley Lucas, Rachel Sanor, Margaret Vaaler, John Allen, Mary Richards, Heather Nagy, Lester Mattson, R.Ph., William Ayres

Registered Guests: Becky Gonzales, Jay Dee Fredericksen, Jack McClure, Suzanne Erickson, Jami Durham, Michelle Flores, Sunnye Simmons, Sheldon Skinner, Karen Petties, Michelle Puyear, Tyler Hunter, Venita Ray, Myra Leo, Armando Chavez, Mark Vane, Roger Grotzinger, Sylvia Moreno, Bruce McLaughlin, Mary Pasley, Quynh Chau Doan

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Action and Discussion Items Covered:

I. The meeting was called to order by Dr. Keiser at 12:15 pm, July 17, 2015.

II. The committee reviewed and unanimously approved the December 5, 2014 meeting minutes.

III. Felipe Rocha, Manager of the TB/HIV/STD/Viral Hepatitis Unit, presented an update on the THMP Budget and a snapshot of current ADAP projections.

IV. Rachel Sanor presented ADAP/SPAP update reports detailing first time enrollment by month and program, clients served by month and over the past four quarters, monthly medication order costs over the past four quarters, clients served by EMA during the first half of Fiscal Year (FY) 2015 as well as all of FY 2014, clients served by county during the first half of FY 2015, medication order costs by EMA for the first half of FY 2015, comparison graphs of ADAP clients and persons living with HIV in Texas by sex and by race, ADAP client demographics for the first half of FY 2015 by gender, by race and by age group, the average monthly cost per client over time, the top ten drug prescription expenditures for the first half of FY 2015 and a comparison of increases and decreases in bottles dispensed for drugs between the first half of FY 2014 versus the first half of FY 2015.

V. Felipe Rocha informed the MAC that the DSHS Pharmacy Branch was now incorporated into the TB/HIV/STD/Viral Hepatitis Unit and introduced Lester Mattson, R.Ph. as a new employee within the Pharmacy Branch.

VI. Margaret Vaaler, data team lead from the Care Services Group within the HIV/STD Prevention and Care Branch give a presentation covering the HIV Treatment Cascade and unmet need statistics for Texas. The report covered 2013 data; Ms. Vaaler explained that the 2014 data was currently being compiled and not yet finalized. The data indicated 80% of ADAP clients in Texas had achieved viral suppression, which was a higher level than those patients receiving their HIV care through other resources in Texas including Medicare or Medicaid.

VII. Assistant Commissioner Janna Zumbrun presented an update on the Division for Disease Control and Prevention Services, including the legislative session that had recently wrapped up and the proposed changes to agencies within HHSC in response to the Sunset Review process.

VIII. The recommendation to add the drug elvitegravir (Vitekta) to the THMP formulary was approved unanimously by the Committee pending successful national ADAP Task Force negotiations with the manufacturer to secure an ADAP contract pricing agreement. It was explained that Vitekta was already approved as a component of the combination therapy drug Stribild, much like the other unique component of Stribild known as cobicistat (Tybost) had been added to the formulary per the recommendation made at the previous MAC meeting.

IX. Mary Pasley with Abbvie regarding the Viekira Pak as a treatment for Hepatitis C and its efficacy for those patients co-infected with HIV. After discussion amongst the MAC members, a request was made to have Margaret Vaaler present data on coinfection rates amongst the Texas ADAP population. The request to add the Viekria Pak to the ADAP formulary was tabled awaiting feasibility information on financial impact; in the meantime the doctors on the MAC would also take time to consider potential clinical criteria for that class of drug.

X. Texas ADAP Manager Rachel Sanor provided an explanation of Modified Adjusted Gross Income (MAGI) and the recommendation by HRSA to begin using it as a primary component of the financial criteria for greater uniformity in the eligibility process between state ADAPs and local Ryan White Care Services. The MAC members expressed concerns about the MAGI requirements for IRS documentation presenting a barrier to care in light of recent restrictions to online accessibility of transcripts and non-filing verifications. Felipe Rocha said that the Unit would present an update at the next Committee meeting concerning issues encountered by staff and Part A agencies in getting the MAGI process rolled out statewide.

XI. Rachel Sanor updated the MAC on the HMS contract for third party health insurance verification that began in January 2015. HMS is providing monthly data matching reports to the Texas ADAP for clients who appear to have active health insurance coverage for prescription drugs, and those clients are being dropped from standard ADAP eligibility unless the client can provide proof of coverage termination or they work in cooperation with ADAP staff to contact the insurer directly for specific policy details. Each of the data mangers at the Administrative Agencies are being notified via the confidential Public Health Information Network of the ADAP clients in their respective areas that are being flagged for insurance coverage.

XII. The next MAC meeting was tentatively scheduled for Friday, November 20, 2015.

XIII. There were no public comments.

XIV. The meeting was adjourned by Dr. Keiser at 2:53 pm.

Approved by: _____

Phillip H. Keiser, M.D. – Chairman, Texas HIV Medication Advisory Committee

_____

Date

TEXAS Department of State Health Services

OFFICIAL MINUTES
Texas HIV Medication Advisory Committee Meeting
November 20, 2015

The November 20, 2015 meeting of the Texas HIV Medication Advisory Committee (MAC) was held at 4110 Guadalupe Street, West Auditorium, Building 582 in Austin, Texas.

MAC Members in Attendance: Philip Keiser, M.D., Chair, Natalie Vanek, M.D., Vice-Chair, Mary Paul, M.D., Fernando Garcia, M.D., Raul Castaneda, R.Ph., Yolanda Rodriguez-Escobar, David Huse, Frank Rosas, Bruce Turner

DSHS Staff in Attendance: Janna Zumbrun, Felipe Rocha, Shelley Lucas, Lisa Cornelius, M.D., Rachel Sanor, John Allen, Becky Ruiz, Juliet Garcia, Janina Vasquez, Justin Irving, Laura Potter, Lester Mattson, R.Ph.

Registered Guests: Steve Nettles, Jesse Jones, Tom Valentine, Suzanne Erickson, Sunnye Simmons, Michelle Puyear, Tyler Hunter, Karin Petties, Becky Gonzales, Brandon Wollerson, Alexandra Zingg, Victoria Ford, Mark Vance, Mary Helen Gloria, Allen Murray, Isis Torrente, Alex C. Moses, Eunice Marshall, Kalvin Marshall, Tana Pradia, Barry Kountz, Rodney Mills, Denis Kelly, Venita Ray, Holly Turner, Armando Chavez, Chris Tubbs, JayDee Fredricksen

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Action and Discussion Items Covered:

I. The meeting was called to order by Dr. Keiser at 12:35 pm, November 20, 2015.

II. The committee reviewed and unanimously approved the July 17, 2015 meeting minutes.

III. Janna Zumbrun provided an update on the Division for Disease Control and Prevention and the selection of the new DSHS Commissioner, Dr. John Hellerstedt effective January 1, 2016. Ms. Zumbrun gave assurance that the Medication Advisory Committee would remain intact during the transitions taking place within HHSC based on the Sunset Committee report.

IV. Felipe Rocha, Manager of the TB/HIV/STD/Viral Hepatitis Unit, presented an update on the THMP Budget and a snapshot of current ADAP projections.

V. Rachel Sanor presented ADAP/SPAP update reports detailing first time enrollment by month and program, clients served by month and over the past four quarters, monthly medication order costs over the past four quarters, clients served by EMA during the last half of Fiscal Year (FY) 2015, medication order costs by EMA for the last half of FY 2015, the top ten drug prescription expenditures the last half of FY 2015, comparison graphs of ADAP clients and persons living with HIV in Texas by sex and by race, ADAP client demographics for FY 2015 by gender, by race and by age group, and HMS findings on outcomes for insured clients.

VI. Dr. Keiser and Shelley Lucas led a discussion regarding Hepatitis C Virus (HCV) coinfections amongst the HIV population in Texas and the potential for adding HCV medications to the ADAP formulary in a manner that meets the mission guidelines given to ADAPs per HRSA and the Ryan White Care Act. Motions were approved to table the discussion for now and for additional review to be performed by DSHS for presentation at the next MAC meeting.

VII. The committee discussed adding Daraprim to the THMP formulary, and a motion was unanimously approved to recommend doing do. Representatives from Turing Pharmaceuticals gave assurances to the MAC and DSHS staff that the current distribution method for Daraprim would be adjusted to meet THMP procedures, with Amerisource setting up third-party distribution through contracted wholesaler Morris & Dickson for drop shipments.

VIII. Rachel Sanor updated the committee on the ongoing process of Part B Modified Adjusted Gross Income (MAGI) implementation throughout the state.

IX. Rachel Sanor updated the committee on findings for THMP third-party health insurance verification conducted through the agreement with HMS (Health Management Systems). The first data match report in January 2015 flagged 1,500 THMP recipients for review by THMP staff. About 800 patients were ultimately dropped from the program due to insurance plans that needed to be utilized; from those originally dropped, 11% had their THMP enrollment reinstated with proof the plans had been terminated and 4% more were enrolled in to the TIAP or SPAP programs as appropriate. Currently 46% of the clients are under current review for coverage determination, with their ability to order THMP medications on hold while staff determines current eligibility for coverage. Ms. Sanor explained that the administrative agencies are notified each month that persons within their coverage area are being dropped for insurance. She also stated that HRSA is very pleased to see this system being implemented by Texas as part of the payer of last resort requirements.

X. Shelley Lucas presented information on the KPMG audit recommendations, explaining how thoroughly the auditors scrutinize program policies, procedures and processes. She gave the example of how strongly the auditors recommend the collection of primary source documentation such as tax transcripts versus personal copies of tax returns, which the auditors equate to self-attestation of income. The THMP staff have to ensure the program is in compliance with recommendations set forth by HRSA, the Office of Inspector General, and designated auditors for the State of Texas and the Ryan White Grant.

XI. The next MAC meeting was tentatively scheduled for Friday, March 4, 2016.

XII. There were no public comments.

XIII. The meeting was adjourned by Dr. Keiser at 3:03 pm.

Approved by: _____

Phillip H. Keiser, M.D. – Chairman, Texas HIV Medication Advisory Committee

_____

Date

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Interagency Obesity Council

Number of Members: 3

Committee Status (Ongoing or Inactive): Ongoing — Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 9/1/2007 **Date to Be Abolished:** N/A

Budget Strategy (Strategies) (e.g. 1-2-4): 1.3.1 **Strategy Title (e.g. Occupational Licensing):** Chronic Disease Prevention

Budget Strategy (Strategies): **Strategy Title:**

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Health & Safety Code, Chapter 114
State Authority		
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$3,489	$3,489	$3,489
Total, Committee Expenditures	$3,489	$3,489	$3,489

Method of Financing

Method of Finance	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
1 - General Revenue Fund	$3,489	$3,489	$3,489
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year

Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
1	1	1

Committee Description: Monitor and evaluate obesity prevention efforts in the Department of State Health Services, Department of Agriculture and the Texas Education Agency; develop recommendations for improving obesity prevention efforts.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission.

No bylaws. The commiitte meetings are not open meetings and so no minutes are available.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

The Interagency Obesity Council (IOC) is required to meet at least once per year. The Committee current meets as needed. Meeting location rotates among the member agencies as space is available.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

The IOC produces a biennial report to the Legislature.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

The IOC recommendations are made to the Legislature. DSHS has adopted recommendations from the IOC that are within the agencies scope of authority to implement, such as a continued focus on worksite wellness initiatives and supporting locally decided/developed obesity prevention initiatives. Recommendations that were not adopted, DSHS felt was beyond the agency's authority to act on.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ?

Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

160 hours

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Agency staff support the IOC by providing logistical support and participating at meetings, developing report content related to agency obesity prevention efforts, and drafting reviewing and distributing the IOC report.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes. - Representatives of all three agencies attend each meeting.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

The committee takes public input at its meetings, as well as through public comment periods associated with agency obesity prevention activities. Meetings of the IOC are not required to be posted as open meetings.

7b. Do members of the public attend at least 50 percent of all committee meetings?

No

7c. Are there instances where no members of the public attended meetings?

Yes

8. Please list any external stakeholders you recommend we contact regarding this committee.

Texas Department of Agriculture, Texas Education Agency

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

Yes

9b. Please describe the rationale for this opinion.

Activities within DSHS, TDA, and TEA that relate to nutrition, physical activity and obesity prevention are well coordinated with each other and employees of these three agencies are very aware of the activities of the other agencies due to the communication facilitated by the IOC and the biennial report.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

Yes

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

This committee requires significant participation by staff of three separate agencies. The required participation for the council to be successful would be difficult to attain through agency rule or on an ad-hoc basis.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission? No

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

A Report to the Texas Legislature from the Interagency Obesity Council

2015

A collaborative effort among these commissioners and their agencies:

Todd Staples
Commissioner of Agriculture

David Lakey, M.D.
Commissioner of State Health Services

Michael Williams
Commissioner of Education

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Introduction

This is an update of the 2011 Report to the Legislature from the Interagency Obesity Council, as mandated by Chapter 114 of the Health and Safety Code (Senate Bill 556, 80th Regular Session of the Texas Legislature) and revised per Senate Bill 870 passed during the 81st Regular Session.

Obesity is a critical health problem in Texas. According to the Center for Disease Control's (CDC) 2013 Behavioral Risk Factor Surveillance System, 66.2 percent of Texas adults were classified as overweight or obese; in 2012 that percentage was similar at 65.1 percent[1]. The problem of overweight and obesity is not limited to the adult population, however. The CDC's 2011 Youth Risk Behavior Survey of Texas found that approximately 31.6 percent of adolescents in grades 9 through 12 were overweight or obese; in 2013 that prevalence stayed the same at 31.3 percent[2].

Additionally, in 2014, 15 percent of low-income children (ages 2-5) enrolled in the Texas Women Infants and Children (WIC) Program were overweight or obese; this is a significant decline from 30 percent in 2008[3]. Obese adults and children have a much higher risk of developing high cholesterol, high blood pressure, heart disease, stroke, Type 2 diabetes, pulmonary disease, arthritis, and many other chronic conditions that reduce quality of life and cause premature disability and death. Obese children and adolescents are likely to remain obese as adults. Although many variables can affect weight status, retrospective studies show that 50 to 80 percent of overweight children remain overweight as adults, and if children are overweight before the age of 8, obesity in adulthood is likely to be more severe[4 5 6].

According to the 2011 Texas Comptroller's Report, updated estimates indicate the obesity related costs for Texas businesses were $9.5 billion in 2009. Without action, obesity could cost employers $32.5 billion annually by 2030[7]. Additionally, the Trust for America's Health estimates that 57 percent of Texans will be obese by the year 2030[8].

Without support for obesity prevention efforts Texas will face an unprecedented deadly and expensive healthcare crisis. The obesity prevention initiative will continue through funding from the Center of Disease Control (CDC). The Department of State Health Services (DSHS) Health Promotion and Chronic Disease Prevention Section was awarded funds through the CDC's State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health from 2013 to 2018. In addition, the DSHS Community Transformation Grant (CTG): Transforming Texas program, which was awarded $10 million per year from CDC, concluded after three years (2011-2014). The Texas Department of Agriculture (TDA) received funds to start the Nutrition Education Grant Program to increase and expand the nutrition education provided in schools. In 2012 TDA awarded approximately $810,000 in Nutrition Education Grant Program funds to 143 school campuses.
The commissioners of TDA, DSHS, and the Texas Education Agency (TEA) remain committed to reversing the trend and to continue making obesity prevention a top priority for their agencies. The

[1] Texas BRFSS, Center for Health Statistics, Texas Department of State Health Services
[2] U.S. Centers for Disease Control and Prevention "Youth Risk Behavior Survey" http://www.cdc.gov/healthyyouth/npao/data.htm, custom queries
[3] Texas Department of State Health Services, WIC Certification Data, 2014
[4] Mossberg, H.O.: 40-year follow-up of overweight children. Lancet, 2, 491-493 (1989).
[5] Whitaker RC, Wright JA, Pepe MS, Seidel KD, Dietz WH. Predicting obesity in young adulthood from childhood and parental obesity. N Engl J Med 1997; 37(13):869– 873.
[6] Serdula MK, Ivery D, Coates RJ, Freedman DS. Williamson DF. Byers T. Do obese children become obese adults? A review of the literature. Prev Med 1993;22:167–177.
[7] Susan Combs, State Comptroller of Public Accounts, Gaining Cost, Losing Time: The Obesity Crisis in Texas, 2011
[8] Trust for America's Health, F as in Fat: How Obesity Threatens America's Future, 2012

Interagency Obesity Council (IOC) was codified in Health and Safety Code, Chapter 114, during the 80th Legislative Session (2007) to address nutrition and obesity prevention among children and adults. The IOC charge was then updated per the passing of S.B. 870 during the 81st Legislative Session. The IOC is comprised of the commissioners of the Texas Department of Agriculture (TDA), the Texas Department of State Health Services (DSHS), and the Texas Education Agency (TEA), or their designees. The IOC is required to meet at least once a year to:

- Discuss the status of each agency's programs that promote better health and nutrition and prevent obesity among children and adults in this state; and

- Submit a report by January 15 of each odd-numbered year to the governor, the lieutenant governor, and the speaker of the House of Representatives on the activities of the council during the preceding two calendar years.

Agency Programs and Activities to Promote Better Health and Nutrition

TEXAS DEPARTMENT OF AGRICULTURE

Since taking office in January 2007, Agriculture Commissioner Todd Staples has made education and awareness top priorities for all Texas Department of Agriculture (TDA) nutrition programs. Early on, Commissioner Staples established the 3E's of Healthy Living — Education, Exercise and Eating Right to encourage and empower Texans to embrace healthy choices for themselves and their families. He continues to promote this strategic campaign in school, community, business and government forums across the state. TDA has continued to support community partners in their efforts to promote healthy lifestyles at the local level.

In 2009, TDA initiated the Mayors Challenge by calling for Texas mayors to improve outcomes in local Summer Nutrition Programs for children in need of assistance. Based on the success of this initiative, in 2012 TDA expanded its partnership with mayors to help accomplish a broader goal that arms communities with resources to combat obesity and food insecurity year-round. This initiative is called the Healthy Community Network and it empowers mayors to unite their efforts to reduce hunger and prevent obesity by promoting the 3E's of Healthy Living – Education, Exercise and Eating Right and building bridges to success in communities across the state.

Coupled with this strategy is a concentrated effort to convert access to nutrition assistance programs into a more self-sufficient, independently healthy population. The 3E's encourage participants in these assistance programs to employ them as bridges to success — not endless highways of dependency.

NUTRITION PROGRAMS

TDA has administered the United States Department of Agriculture (USDA) child nutrition programs for Texas since 2003. These programs include the National School Lunch Program, the School Breakfast Program, Special Milk Program, Fresh Fruit and Vegetable Program and the Summer Food Service Program.

In 2007, TDA became the administering agency for several special nutrition programs when they were transferred by the Texas Legislature from the Health and Human Services Commission. These programs, including Child and Adult Care Food Program, Commodity Supplemental Food Program, Emergency Food Assistance Program, Food Distribution Program, Senior's Farmers Market Nutrition Program,

Summer Electronic Benefits Transfer Card demonstration project, and the Farmers Market Nutrition Program provide nutritious food through various delivery methods to Texans in need- including children, the elderly, people with disabilities and low-income adults.

- **National School Lunch Program (NSLP)**: Serves nutritious, low-cost or free lunches to students in public and non-profit private schools in Texas. Lunches must meet federal nutrition guidelines and are reimbursable to schools based on number of meals served.

- **School Breakfast Program (SBP)**: Serves nutritious, low-cost or free breakfasts to students in public and non-profit private schools in Texas. This program operates in a similar manner to the National School Lunch Program. Texas state law requires that a school district must participate in the School Breakfast Program if at least 10 percent of its students are eligible to receive free or reduced-price meals. Senate Bill 376 passed in the 83rd Legislative session requires that public and charter school campuses with 80 percent or more free and reduced students provided breakfast at no charge to all students or seek a waiver opting out of the requirement.

- **Summer Nutrition Programs**
    - **Summer Food Service Program (SFSP)**: Provides nutritious and free meals to children under 18 during the summer months. School districts and other sponsors (non-profit youth programs such as Boys and Girls Clubs, YMCAs, summer camps, etc.) may serve as a summer feeding program site. School districts are currently required to operate a SFSP if 50 percent or more of their students are eligible for free or reduced-priced meals.
    - **Seamless Summer Option (SSO):** SSO was created by the federal government as a summer feeding alternative for schools that already participate in school meal programs and wish to continue meal service into the summer.

- **Fresh Fruit and Vegetable Program (FFVP):** The Fresh Fruit and Vegetable Program (FFVP) is a federally assisted invitation-only program providing free fresh fruits and vegetables to students in participating elementary schools during the school day. The FFVP helps schools create healthier school environments by providing healthier food choices, expanding the variety of fruits and vegetables children experience, and increasing children's fruit and vegetable consumption.

- **Special Milk Program**: Provides reimbursable milk to preschool and school-aged children who do not participate in a federal child nutrition meal program.

- **Child and Adult Care Food Program (CACFP)**: Provides reimbursable meals and snacks to day care centers, day care homes and adult day care centers (elderly or disabled). For program year 2013, the number of contracting entities totaled 1,607, including 14,518 sites. The average daily participation in lunch for program year 2013 was 212,326.

- **At-Risk Afterschool Meals in the CACFP:** Public or private nonprofit organizations, or eligible for-profit organizations operating an afterschool program. Programs must be located in an attendance area of a public school where at least 50 percent of the enrolled students are certified as eligible for free or reduced-priced meals. Programs must provide educational or enrichment activities in an organized structured, and supervised environment after the end of the school day, on weekends, or on holidays during the school year. Afterschool programs do not need to be licensed in order to participate unless there is a state or local requirement of licensing. All programs must meet state or local health and safety standards. Provides all children who are 18 and under at the start of the school year a free meal, a snack, or both. There are no age limits for children with disabilities.

- **Commodity Supplemental Food Program (CSFP):** Provides USDA Foods for food packages that are used for home consumption. Local organizations distribute food packages and provide nutrition education to nearly 34,000 eligible participants. Eligible participants include persons 60 and over. Participants must be income-eligible 130 percent of the federal poverty level for the elderly) and reside within a CSFP contractor's service area.

  The CSFP provides nutritionally balanced food packages consisting of USDA donated food. USDA has replaced regular canned vegetables with low-sodium canned vegetables, and is offering more whole grains and low-fat choices. These improved food choices will reach all participating organizations. At the time of distribution, CSFP contractors provide information on nutrition and healthy lifestyle choices as well as recipes for wholesome meals using the contents of the package.

- **The Emergency Food Assistance Program (TEFAP)**: Provides USDA Foods for food packages used for home consumption distributed by local non-profit organizations (usually called food pantries) and in prepared meals at emergency shelters (usually called soup kitchens). For home consumption, eligibility is based on income and residential location. A household's gross income may not exceed 185 percent of the federal poverty level. If undergoing a crisis, a household with income exceeding the poverty level may be eligible for emergency food assistance for a maximum of six months. There are no means-testing for receiving a prepared meal at an emergency shelter.

  The food is initially ordered, received and stored by contractors (food banks) and is then distributed to the local agencies. Additional eligible participants include homeless people and low-income senior citizens. Similar to CSFP, USDA has replaced regular canned vegetables with low-sodium canned vegetables, and is offering more whole grains and low-fat choices.

- **Food Distribution Program (FDP)**: Provides USDA Foods to public and private nonprofit schools, public and private nonprofit residential child care institutions and nonprofit organizations (contracting entities or CEs). The value of USDA Foods that are allocated to a CE is based on the number of meals the CE provides to program participants. CEs that can receive, store and distribute USDA Foods in truckload quantities (e.g., large, independent school districts or school cooperatives), may receive direct delivery from USDA. TDA contracts with commercial distributors to receive, store and distribute USDA Foods on behalf of CEs that do not have this capacity. Contracts are awarded through a competitive procurement process and TDA negotiates the distribution rates paid by CEs. CEs may use commercial food processors to convert USDA Foods into more usable end products. The FDP enters into agreements with processors and coordinates the ordering of the CEs' requests for USDA Foods with USDA. Similar to CSFP and TEFAP, USDA has replaced regular canned vegetables with low-sodium canned vegetables and is offering more whole grain and low fat choices to help CEs meet nutritional standards. The programs support the US agriculture market.

- **Senior's Farmers Market Nutrition Program (SFMNP)**: TDA administers this program in select areas of the state for low-income seniors 60 years of age or older. Seniors receive vouchers to use at TDA certified farmer's markets to purchase fresh fruits and vegetables, increasing their access to healthier, locally grown foods.

- **Farmer's Market Nutrition Program:** TDA began administrating the Farmers' Market Nutrition Program (FMNP) in 2012. FMNP is associated with the Special Supplemental Nutrition Program for Women, Infants and Children, popularly known as WIC. The FMNP provides fresh, unprepared, locally grown fruits and vegetables to WIC participants, and expands the

awareness, use of, and sales at farmers' markets. TDA partners with Texas food banks and other entities to ensure eligible participants are aware of this program and receive benefits as needed.

- **Summer Electronic Benefits Transfer Card (SEBTC) demonstration project**: In an effort to better target summer feeding program assistance to those children most in need, TDA initiated a Summer Electronic Benefits Transfer Card (SEBTC) pilot program related to the SFSP. The program, using a WIC-like electronic benefits card to provide families extra funds for National School Lunch Program-eligible children's meals during the time of summer recess, had up to a 70 percent monthly redemption rate. The demonstration project was conducted in 2011, 2012, and 2013 was the most effective method ever demonstrated for ensuring child nutrition over the summer.

During the 2012-2013 school year, 8,534 schools participated in the National School Lunch Program/School Breakfast Program in Texas and 890,471,994 meals were served.

As part of CACFP, to improve the health and nutrition of Texas children in child care settings, TDA released a policy notice in August 2009 recommending that child care facilities:

- Serve lower fat milk;
- Serve only 100-percent juice and no more than once daily;
- Increase the availability of fresh and frozen fruits and vegetables;
- Increase whole grains;
- Lower sugar in ready-to-eat cereals; and
- Provide a variety of fruits and vegetables to increase vitamins A and C.

To support the recommendations, TDA provides training and resources to contractors statewide. Training tools and resources include cycle menus, seasonal produce and The Adventures of Zobey DVD programs. TDA also provides training - *Feeding Infants the First Year of Life* - that promotes breast milk through the age of 12 months. The training also emphasizes proper introduction of solid foods and how to understand the infant's cues for hunger.

Update on Healthy Hunger Free Kids Act of 2010

As of July 1, 2012 Texas schools participating in the National School Lunch and Breakfast Program are required to follow new federally mandated school meal patterns, as required by the Healthy Hunger Free Kids Act of 2010. Key changes include:

- Increasing the amount of fruits and vegetables available;
- Increasing the amount of whole grain-rich foods;
- Reducing trans fats to zero grams per serving;
- Offering only fat-free or low-fat milk varieties; and
- Decreasing sodium amounts.

TDA continues to monitor compliance with the new meal standards and offers training and guidance to schools to assist schools with the new federal requirements.

School Meals Nutrition Standards

In addition to the school meal patterns, USDA has implemented new strict federal standards for all foods and beverages sold in school. Previously, the Texas Public School Nutrition Policy (TPSNP) covered these items. To ensure overlap did not exist and to reduce confusion by having two competing standards, TDA repealed the majority of the TPSNP policy.

The exceptions to this repeal include maintaining or adjusting the following provisions:

- Maintaining existing ban of cooking with deep fryers;
- Maintaining the prohibition of providing diet or regular sodas; and
- Maintaining the time and place provision as it relates to sold items and allowing a school to create a different standard if they so choose.

GRANTS ADMINISTERED BY TDA

- **Texas Feeding Texans – Home-Delivered Meals Grant Program**: The Texans Feeding Texans Home-Delivered Meal Grant Program was created during the 80th Texas Legislative Session (Texas Administrative Code (TAC) §12.042, HB 407), which established a statewide grant program to help supplement and extend the applicant's current home-delivered meal program for seniors and/or disabled Texans. Governmental and non-profit agencies are eligible for this grant program.

- **Texans Feeding Texans - Agricultural Surplus Grant Program**: The Agricultural Surplus Grant Program continues to partner with Texas food banks and agriculture producers to help hungry Texans. Funds are used to offset the costs of harvesting, cleaning and transporting agricultural products to Texas food banks.

- **3E's Grant Programs:** As TDA continues to promote the 3E's of Healthy Living-Education, Exercise and Eating Right, TDA provides grants through the 3E's Grant Program to promote better health and nutrition programs and prevent obesity among children in this state and increase awareness of the importance of good nutrition. TDA is authorized by §12.0027 of the Texas Agriculture Code to administer this grant program.

- **Urban Schools Agricultural Grant Program:** The Urban Schools Agricultural Grant Program is an agricultural-related program for urban elementary and middle public school pupils enrolled in districts with populations of 49,000 or more. The program not only helps improve students' understanding of agriculture through projects but many projects also teach importance of water conservation and nutrition.

SPECIAL PROJECTS

TDA currently has the following special projects underway for school-aged children. These projects are designed to complement the Child Nutrition Programs.

- **Healthier US School Challenge (HUSSC):** TDA is actively promoting this USDA initiative in which schools voluntarily commit to re-shaping their environments to promote healthy nutrition, physical education and physical activity. HUSSC criteria reflect NSLP meal pattern requirements, while continuing to encourage schools to offer a variety of vegetables, fruits (including fresh fruit) and whole grain-rich grains. Schools that have achieved the Healthier US School Challenge Award have demonstrated strong efforts to produce an environment in which the healthy choice is the easy choice. TDA has provided multiple training sessions around the state and offered technical assistance with the application process. For detailed information on the initiative visit: **www.teamnutrition.usda.gov/**

- **NUTRIGRAM®:** TDA has partnered with The Cooper Institute (TCI) to administer a student nutrition assessment and educational service called NUTRIGRAM®. The online survey is geared toward children grades 3-5. The survey provides an individual snapshot

of each participating student's nutrition knowledge and behavior. Additionally, NUTRIGRAM® empowers students to take ownership of their food choices through online learning opportunities and provides critical information to raise the bar for school nutrition. Approximately seventy Texas elementary schools are currently participating in NUTRIGRAM.

- **Farm to School:** Farm to School is the practice of sourcing local food for schools as well as providing agriculture, health and nutrition educational opportunities to students. Farm to school includes activities such as school gardens, farm field trips, and cooking lessons. Farm to school improves the health of children and communities while supporting local and regional agricultural producers. Key initiative activities include marketing farm-to-school opportunities to producers and schools, connecting farmers to interested schools, providing technical assistance, training and resources for schools and farmers, and assisting with coordination of special events.

TRAINING ACTIVITIES

TDA administers standardized program and nutrition training for CEs participating in USDA child nutrition programs administered by the agency. Training is designed to ensure program compliance according to USDA/state/other requirements and regulations, and to improve the nutrition and well-being of the customers (children and adults) served.

TDA currently oversees more than 100 training classes for agency staff and contractors who participate in the Child and Adult Care Food Program; National School Lunch Program/School Breakfast Program; and Summer Food Service Program. Training is primarily provided by TDA trainers or through the contracted training services of Education Service Centers. Training is provided to staff, contractors, and statewide organizations using multiple media including: facilitator led instruction, online training, and other distance learning options.

STATEWIDE COMMUNICATION

TDA works to educate individuals regarding food and nutrition program requirements and benefits. The primary focus is to connect Texans in need with the nutrition resources they need to reach independence.

In 2013-2014, outreach efforts focused on the following:

- Providing nutrition guideline education;
- Partnering with schools during National School Lunch Week and School Breakfast Week to promote healthy meal options available in campus cafeterias;
- Distributing CACFP videos and materials to improve nutrition and increase physical activity in children ages 2-5;
- Attending events and engaging with stakeholders;
- Providing information on programs for distribution; and
- Event attendance and public engagement.

EXHIBITS AND CONFERENCES

Communities, CEs, partners, children and parents have direct access to nutrition education and program information through TDA exhibits and conference attendance. Exhibits and conferences provide TDA the opportunity to distribute program information, provide nutrition education and communicate about federal policy change. Exhibits and/or conferences attended included but were not limited to:

- NSLP, SBP, and Commodities: School Nutrition Association

- NSLP, SBP, and Commodities: Texas Association for School Nutrition
- NSLP, SBP, and Commodities: Texas Association of School Boards
- NSLP, SBP, and Commodities: Texas Association of School Business Officials
- NSLP, SBP, and Commodities: Texas Association of School Administrators
- NSLP, SBP: Parent Teacher Association
- NSLP, SBP: Texas Association of Health, PE, Recreation and Dance
- CACFP: Texas Association for the Education of Young Children
- CACFP: Society for Nutrition Education
- CACFP: Obesity Prevention in Public Health Course University of North Carolina Chapel Hill
- CACFP: Texas Professional Home Child Care Association
- NSLP & CACFP: American Dietetic Association
- CACFP: CACFP Roundtable
- CACFP: National CACFP Leadership Conference
- CACFP: Southern Obesity Summit
- Farm to School: Farm to Cafeteria Conference

TDA WELLNESS PROGRAM

The TDA Wellness Program has been in place since 2003. The program, also called "**T**ake **D**aily **A**ction," includes:

- Employee challenges, such as the Annual Governor's Texas Round-Up. (Four hours administrative leave are granted to employees who complete the program and/or participate in the 5K fun run.)
- Employee Health Interest Survey
- Access to organized wellness activities established through various state agencies such as Yoga, Weight Watchers (offered at a nearby external site), Fitness Center Discounts
- Employee Training (outsourced) provided in CPR (cardiopulmonary resuscitation), AED (automated external defibrillator), First Aid, Defensive Driving, and Safety
- Lunch 'n' Learns
- Detailed wellness program intranet page with announcements, calendar of events, insurance carrier wellness information, employee achievements, walking trails, helpful links, recipes, policy, forms, training, etc.
- Partnership and coordination with other Capitol Complex wellness liaisons
- Participation in the Farm to Work Program

LEGISLATIVE COMMITTEES

TDA is participating in several legislatively established committees targeting obesity prevention and food policy. The agency leads in facilitating many of these. This section outlines the status of the legislated committees.

Report from the Healthy Foods Advisory Committee created through SB 343 (81st Legislative Session)

SB 343 by Sen. Jane Nelson called for the creation of the Healthy Food Advisory Committee, an advisory committee to study the retail availability of healthy food in Texas. The report was submitted to the Texas Legislature in January 2011 and recommended the following:

- Maximize existing grant, loan and other financing programs available in the state to ensure appropriate distribution levels to the most underserved urban and rural areas across Texas, and to

create innovative public-private partnerships to provide incentives for the redevelopment and expansion of fresh and healthy food retail outlets that are sustainably self-sufficient.

- Encourage and enable the temporary use of existing food assistance tools as mechanisms to close the gaps between time periods of individual food insecurity or as primers to enable privately sustainable healthy foods retail investment into communities.

Farm-to-School Task Force Report created by SB 1027 (81st Legislative Session)
SB 1027 by Sen. Kirk Watson authorized an interagency farm-to-school coordination task force. TDA took the lead facilitating this committee. The task force's report recommended the creation of a Farm-To-School Coordinator position at TDA which was filled in November 2011. The Farm-To-School Coordinator continues to focus on:

- Marketing the Farm-to-School program to producers and schools
- Connecting farmers and schools wanting to implement a farm-to-school program
- Providing technical assistance, training and resources for schools and farmers
- Managing Farm-to-School grants
- Assisting in the development, implementation and coordination of Farm-to-School special events

Six-Year Plan for the Early Childhood Health and Nutrition Interagency Council created by SB 395 (81st Legislative Session)
SB 395 by Sen. Eddie Lucio authorized TDA to establish the Early Childhood Health and Nutrition Interagency Council. TDA has taken the lead facilitating this committee and has published a six year plan to improve the health in children under six and improve nutrition and physical activity practices in early childcare settings, which work towards:

- Centralizing efforts among Texas state agencies to combat childhood obesity, address malnutrition and undernourishment involving children, parents, families, caretakers and communities to improve the health of children under the age of six;
- Promoting awareness among parents, families, caretakers and communities about the benefits of breastfeeding and facilitate the consumption of breast milk in early childcare settings;
- Increasing consumption of fruits and vegetables and moderate to vigorous physical activity by promoting educational, recreational, and hands-on opportunities that encourage healthy eating and physical activity in early childcare settings for children under the age of six;
- Promoting raising nutrition standards and minutes of structured and unstructured physical activity in licensed day care facilities for children under the age of six by recommending policies to improve the childcare minimum standards guidelines.

Plan to Increase Outcomes in Summer Food Service Program created by HB 749 (83rd Legislative Session)
HB 749 by Rep. Richard Raymond required TDA to establish a five-year plan in collaboration with Baylor University's Texas Hunger Initiative and implement no-cost provisions to increase outcomes in the summer food service program. The plan was submitted to the Legislature in November 2014.

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

The mission of the Texas Department of State Health Services (DSHS), an agency of the Texas Health and Human Services System, is to improve health and wellbeing in Texas. Obesity has severely affected the health and quality of life of the Texas population and has placed an enormous burden on the state's healthcare resources. Dr. David L. Lakey, M.D., Commissioner of DSHS, has made obesity prevention a high priority for the agency.

DSHS' obesity prevention efforts are evidence-based and coordinated across agency programs and with external partners at the national, state, and community levels. Within DSHS, the Community and Worksite Wellness (CWW) Program is responsible for coordinating obesity prevention activities with the Texas Title V Program, WIC (the Special Supplemental Nutrition Program for Women, Infants and Children), worksite wellness, school health, and chronic disease programs that address diabetes, heart disease and stroke, kidney disease, and other related health conditions. The CWW Program was created in October 2013 by merging the Nutrition, Physical Activity and Obesity Prevention (NPAOP) and Worksite Wellness Programs.

COMMUNITY AND WORKSITE WELLNESS (CWW) PROGRAM

This program supports and promotes projects that focus on increasing physical activity, increasing consumption of fruits and vegetables, decreasing consumption of sugar-sweetened beverages, reducing consumption of high-calorie foods, reducing screen time, and increasing breastfeeding initiation, duration and exclusivity. The program targets large segments of the population by promoting:

(1) Strategies to reduce environmental barriers to healthy living, and
(2) Administrative policies that facilitate healthy choices.

For example,

- Grocery stores in low-income neighborhoods often carry a less-than-optimal selection of fresh produce. This is an environmental barrier for families that want to eat healthy foods but do not have or cannot afford transportation to other areas to buy them. One successful strategy that helps eliminate this barrier is the creation of farmers markets in low-income neighborhoods.
- Areas of low socio-economic status may have less access to safe places for children to be physically active. Mothers are less likely to allow their children to play outside in low-income areas due to safety issues. These areas often have less access to sidewalks and safe routes" to schools. Another strategy that helps to increase physical activity is increasing and improving trail systems that connect families to schools and businesses.
- A business worksite wellness policy that lowers the price of healthful beverages (e.g., water) and increases the costs of sugar-sweetened beverages, promotes the affordability of healthier choices among employees.

The CWW Program, in its attempt to reduce the burden of disease related to obesity, oversaw the implementation of the following projects:

CDC Cooperative Agreement

Fiscal year 2012-2013 was the fifth year of a five-year obesity prevention grant from the CDC. Texas was one of 23 states and territories that received this grant funding. The CDC grant was used to fund specific program-related activities in six communities in Texas:

- **The Texas Tech University Health Sciences Center, Garrison Institute on Aging** in Region 1 is actively engaged in programs that promote health and wellness in West Texas. As part of the

Healthy Lubbock initiative, the Institute supports and encourages improved nutrition, increased physical activity, and promotion of wellness. During this time, the institute established a community garden at Dunbar College Preparatory Academy in Lubbock to increase access to fresh fruits and vegetables. They created a comprehensive plan to work on menu labeling, menu improvement, and pricing strategies in public service venues. To increase access to physical activity, the institute is expanded a walking trail at a softball quad.

- **The Community Council of Greater Dallas** in Region 2/3 led a collaborative partnership with faith-based organizations, human services programs, parents, and the school system to create a natural playscape for preschool children at Jack Lowe Sr. Elementary School to increase physical activity in the Vickery Meadow neighborhood of Dallas, an area with high economic need. A joint use agreement between Jack Lowe Sr. Elementary School and the Community Council of Greater Dallas was also created to ensure sustainability of the natural playscape.

- **Tarrant County Public Health (TCPH)** in Region 2/3 implemented a campaign called Live a More Colorful Life. As part of this campaign, TCPH enhanced four and started one community garden in the Fort Worth area. TCPH enacted physical activity policies at two worksites and physical activity resolutions for Tarrant County and the City of Arlington. Nutrition policies were enacted at two worksites. TCPH evaluated the results from their WIC program's electronic benefit transfer (EBT) pilot program, which allows farmers market vendors to accept credit, SNAP, and WIC transactions as payment for fresh produce in addition to cash. TCPH also conducted a nutrition environment assessment in food deserts using the Texas Nutrition Environment Assessment in Stores (TxNEA-S) tool. Results from the assessment were presented to the Tarrant County Food Policy Council.

- The **City of El Paso Department of Public Health** in Region 9/10 identified thirteen walkable trails with green spaces and public sites to encourage walking in neighborhoods and communities through their Move! El Paso project. A comprehensive communication campaign and University of Texas at El Paso students promoted awareness of the trails and encourage people to incorporate walking into their daily lives as a form of transportation. The Mayor and City Council of El Paso declared 2013 the Move! El Paso year.

- **Hidalgo County WIC** in Region 11 increased community support of breastfeeding to reduce childhood obesity. This project opened a second Baby Café in Hidalgo County at the Women's Hospital at Renaissance, Edinburg, Texas, where about half the county's babies are born. During the grant period, Baby Café staff provided information and problem-solving advice to 81 pregnant and breastfeeding women in a supportive environment. A referral system for the café was established among WIC and healthcare providers. The project also recruited 182 businesses to be established as Breastfeeding Friendly Establishments. The City of Edinburg became designated as a Mother-Friendly Worksite, one of three municipalities in Texas at the time.

- **The Edinburg Consolidated Independent School District (ECISD)** in Region 11 is implementing a project to promote safe cycling through the Safe Cycling for Edinburg Schools project. The school district is working to reduce childhood obesity by improving infrastructure for children to ride bicycles and walk to schoolby installing a 0.9 mile bikeway separated from pedestrians and cars by a raised barrier (e.g., a curb with a planted barrier strip) that connects to South Middle School. The project increased safety through several measures, including crossing and stop signs, and volunteers along routes to school, as well as police-led training in safe travel. An interlocal cooperation

agreement was created in March 2013 between the ECISD and the City of Edinburg to outline their participation in the project.

Farm to Work

Farm to Work is an employee wellness program that provides employees with the opportunity to receive a basket of fresh locally-grown produce delivered to the worksite on a weekly basis. Since the program was launched at the DSHS' main campus in 2007, it has expanded to serve 38 worksites including state agencies and private companies in Austin, San Antonio, and Houston. Similar programs have been launched in Lubbock and Fort Worth. Worksites interested in learning more about Farm To Work can participate in the Sustainable Food Center's Program Replication Training or download the Farm To Work Toolkit (and also the Farm To Work Toolkit Supplement), which compiles all the tools, sample documents, and other resources that were developed to successfully implement Farm To Work at DSHS.

Healthy Community Food Systems Module

The CWW Program is working in collaboration with the Austin-based Sustainable Food Center to develop an online educational module. The aim of this project is to educate consumers on the concept of sustainable agriculture and to increase awareness of the food system's role in the prevention of obesity. The module will highlight changes needed in communities to increase access and availability of fruits and vegetables.

Ten Steps to Successful Breastfeeding Module

The CWW Program is working in collaboration with DSHS' breastfeeding subject matter experts to provide and promote a new online breastfeeding training module for healthcare professionals. The module has been designed to fulfill staff training requirements, step 2 of the Ten Steps to Successful Breastfeeding, and to provide Texas hospitals with an accessible tool to attain Baby-Friendly designation. The free online training module will provide comprehensive, professional, continuing education in a self-paced format. The module will be available on the Texas Health Steps site in the spring of 2015.

Your Health Matters: Growing Active Communities and Growing Healthy Communities

The CWW Program partnered with the University of Texas School of Public Health (UTSPH), Brownsville for the production of "Your Health Matters: Growing Active Communities" and "Your Health Matters: Growing Healthy Communities." The purpose of this project is to provide a continuing education curriculum in English and Spanish to train *promotores* and community health workers (CHWs) throughout Texas how to promote physical activity and nutrition in their communities. The curriculum incorporates administrative policy and environmental change approaches or strategies for healthy living.

Both Your Health Matters curricula has been tested in both English and Spanish, using participatory methods that include the target audience (promotores or CHWs), focus groups and expert consultation from local professional health educators and evaluators. Both curricula have been developed within the core principles, goals, and competency areas of the DSHS-certified training program's curriculum framework. DSHS, in collaboration with UTSPH, has trained 309 CHWs and 47 CHW instructors.

Childhood Obesity Research Demonstration

The CWW Program provides support to the Childhood Obesity Research Demonstration (CORD) project in coordination with the Michael & Susan Dell Center for Healthy Living and The University of Texas School of Public Health, Austin Regional Campus to develop, deliver, and evaluate an integrated model of primary health care and public health strategies in the community. CORD is a CDC-funded project designed to evaluate community-based obesity prevention and treatment programs in Austin and Houston. CORD connects families, pediatricians, schools, early childhood education centers, local youth organizations, and the community to support children's healthy eating and active living. If successful,

CORD will become a national model for medical and community practice. The model incorporates policy, systems, and environmental support approaches for nutrition and physical activity. The purpose of the CORD project is to prevent and reduce overweight/obesity in underserved, ethnically-diverse children, ages 2-12 years.

Texas! Bringing Healthy Back – Growing Community Video Series

This DSHS initiative was implemented to educate and inspire communities into action. The CWW Program developed a communications initiative called "Growing Community" which highlights successful community-based improvement strategies across the state through short, documentary-style video clips. The videos were initially distributed to the 2009 Statewide Obesity Summit attendees, where recipients were charged to be "catalysts for change" by hosting video screenings. The video series is available online and in DVD format. In FY 2013 and FY 2014, the online videos have been accessed 4,471 times and 40 requested DVDs have been sent to partners.

Tex Plate: Eat Between the Lines

The Tex Plate: Eat Between the Lines project was created as a restaurant-based, portion-control initiative by the DSHS and included the CWW Program, WIC Program, Steps to a Healthier Austin, Austin Dietetic Association, and The University of Texas Department of Kinesiology and Health Education. Inspired by a diabetes portion control plate, Tex Plate serving plates are designed with visual cues for recommended portion sizes consistent with current healthy eating guidelines. To participate, restaurants incur no costs, nor do they have to change any food offering or recipe. Tex Plate is currently being modified for worksite cafeterias. Pilot restaurant and cafeteria locations are to be determined.

Texas Nutrition Environment Assessment in Stores (TxNEA-S) Tool

The Texas Nutrition Environment Assessment in Stores (TxNEA-S) tool assesses the availability, price, and quality of healthy foods in the retail food setting which includes grocery and corner stores. This tool has been used by Texas communities to conduct nutrition environment assessments.

Texas Nutrition Environment Assessment in Restaurants (TxNEA-R) Tool

The Texas Nutrition Environment Assessment in Restaurants (TxNEA-R) tool is being developed to assess the availability of healthy and less healthy foods and beverages, as well as barriers and facilitators to healthy eating in the prepared foods setting. It is a Texas adaptation of the Nutrition Environment Measures Survey in Restaurants (NEMS-R) tool. TxNEA-R was tested for reliability and is currently being tested for validity.

TRANSFORMING TEXAS

Transforming Texas (TT) is a $10 million per year federally funded initiative with a project period of September 30, 2011 to September 29, 2014. The initiative supports communities, workplaces, schools and health care providers as they work together to reduce chronic disease, lower the cost of care, and promote a lifetime of health for every Texan through the power of prevention. This grant focuses on funding communities with populations of less than 500,000, and focuses on rural, border, and frontier communities. Its purpose is to create healthier communities by:

- Building capacity to implement evidence- and other practice-based policy, environmental, programmatic, and infrastructure changes aligning with Healthy People 2020 focus areas
- Supporting implementation of interventions to prevent heart attacks, strokes, cancer, and other leading causes of death or disability

Transforming Texas seeks to:

- Reduce death and disability due to tobacco use
- Reduce the rate of obesity through nutrition and physical activity interventions
- Reduce death and disability due to heart disease and stroke

Transforming Texas initiated 18 community contracts on February 15, 2012, which awarded a total of $6.5 million among 30 counties. Seventeen community contracts were renewed in September 2013, awarding at total of $6.15 million among 28 counties. The program also initiated contracts for health disparities training, clinical systems training and media/communications initiatives. Community funding has been awarded in counties with less than 500,000 residents, with an emphasis on rural counties. Within funded communities, Transforming Texas has implemented broad-evidence and practice-based policy, environmental, programmatic, and infrastructure change interventions in three Strategic Directions:

- Tobacco-free living with a focus on secondhand smoke
- Healthy eating and active living
- Utilization of high impact evidence-based clinical and other preventive services with a focus on high blood pressure and high cholesterol

Specifically, TT creates new practices, programs, policies, and environmental and system changes to reduce cardiovascular disease, decrease exposure to secondhand smoke, increase opportunities for healthy eating and active living, and decrease the burden of obesity and diabetes in their communities.

All community contractors are working to increase smoke-free environments through administrative policies in community and worksite settings such as local businesses, colleges and universities, restaurants and bars, local government agencies, public property, and multi-unit housing.

See the funded communities' physical activity and healthy eating initiatives below:

- In Regions 1, 2, and 3 (in the Parker, Hood, Lubbock, Hale, and Wichita Counties), TT funded two contractors to implement activities to increase opportunities for physical activity in communities and workplaces. This includes community-wide campaigns, access to facilities and places, joint use agreements, flextime, and stairwell modifications. They are also working to establish community design standards and environmental enhancements to make streets safe for all users, including pedestrians, bicyclists, and public transit users.

- In addition, two contractors are implementing activities to increase accessibility, availability, affordability, and identification of healthful foods in communities. This includes community gardens, farmers markets, small-store initiatives, farm to work/school initiatives, mobile vending carts, and restaurant initiatives.

- In Regions 4, 5, and 6 (Angelina, Polk, Waller, Wood, Smith, Van Zandt, Lamar, Hopkins, and Nueces Galveston Counties) TT funded five contractors to implement activities to increase opportunities for physical activity in communities and workplaces. This includes community-wide campaigns, access to facilities and places, joint use agreements, flextime, and stairwell modifications. They are also working to establish community design standards and environmental enhancements to make streets safe for all users, including pedestrians, bicyclists, and public transit users.

Two contractors are implementing activities to increase accessibility, availability, affordability, and identification of healthful foods in communities, including community gardens, farmer's markets, small-store initiatives, farm to work/school initiatives, mobile vending carts, and restaurant initiatives.

- In Regions 7 and 8 (Bastrop, Caldwell, Comal, Guadalupe, McLennan, Williamson, and Burnet Counties), TT funded three contractors, to implement activities to increase opportunities for physical activity in communities and workplaces. This includes community-wide campaigns, access to facilities and places, joint use agreements, flextime, and stairwell modifications. They are also working to establish community design standards and environmental enhancements to make streets safe for all users, including pedestrians, bicyclists, and public transit users.

  One contractor is implementing activities to increase the number of designated Baby Friendly hospitals, clinics, and health care offices in counties where hospitals are not present.

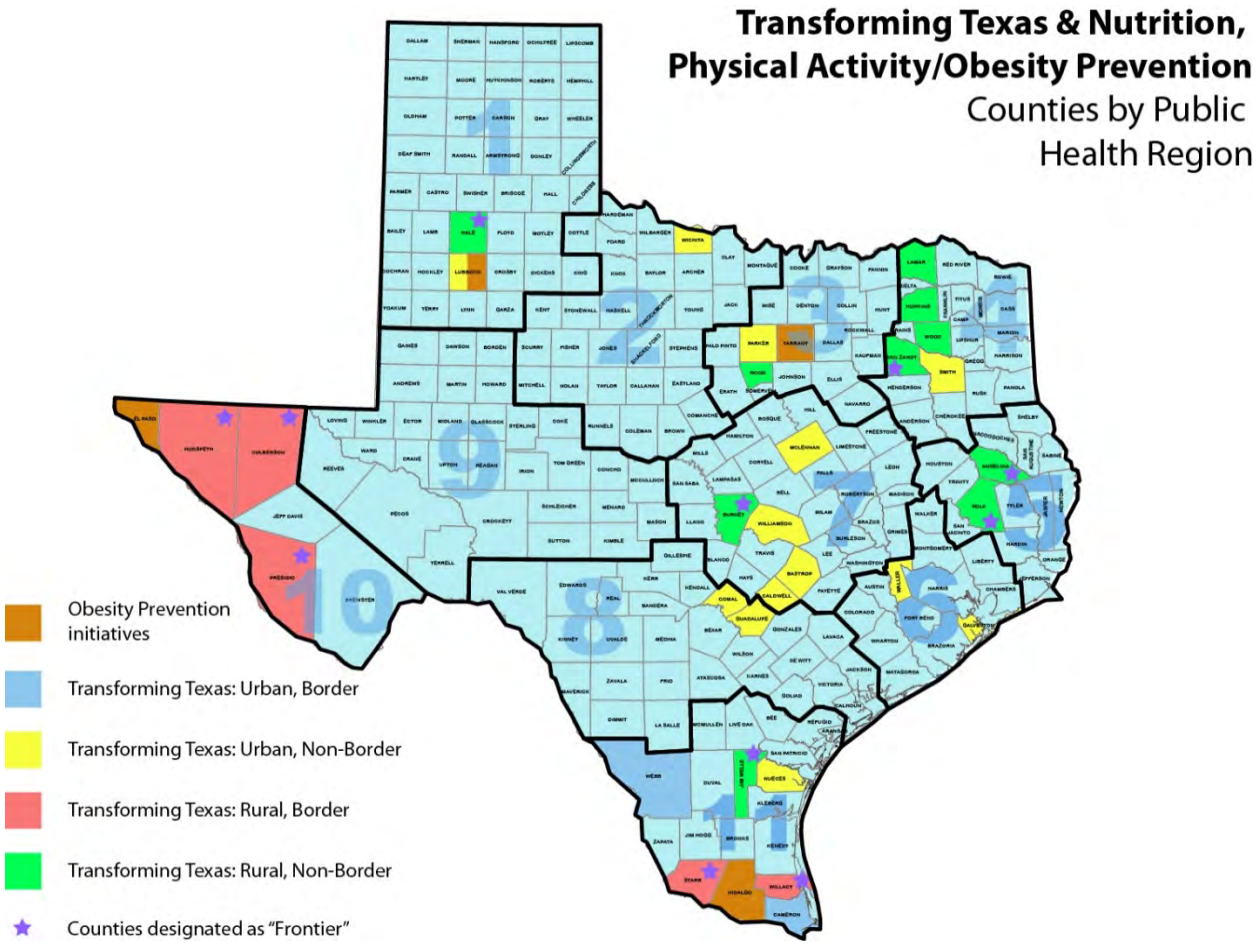
  In addition, two contractors are implementing activities to increase accessibility, availability, affordability, and identification of healthful foods in communities. This includes community gardens, farmer's markets, small-store initiatives, farm to work/school initiatives, mobile vending carts, and restaurant initiatives.

- In Regions 9, 10, and 11 (Willacy, Jim Wells, Presidio, Culberson, Hudspeth, Webb, Starr, Galveston Nueces, and Cameron Counties), TT funded five contractors, to implement activities to increase opportunities for physical activity in communities and workplaces. This includes community-wide campaigns, access to facilities and places, joint use agreements, flextime, and stairwell modifications. They are also working to establish community design standards and environmental enhancements to make streets safe for all users, including pedestrians, bicyclists, and public transit users.

  One contractor is implementing activities to increase the number of designated Baby Friendly hospitals, clinics, and health care offices in counties where hospitals are not present.

  Three contractors are implementing activities to increase accessibility, availability, affordability, and identification of healthful foods in communities, including community gardens, farmers markets, small-store initiatives, farm to work/school initiatives, mobile vending carts, and restaurant initiatives.

The following map demonstrates a geographic distribution of the Transforming Texas funded communities.



SCHOOL HEALTH PROGRAM

The DSHS School Health Program coordinates with Texas Education Agency (TEA) and Texas Department of Agriculture (TDA) as members of the Texas School Health Advisory Council (TSHAC). The TSHAC develops tools and resources to assist local school health advisory councils and school district personnel in making policy recommendations to local school boards. In addition, the three agencies work closely together each year to ensure consistency in their technical assistance to schools on coordinated school health program issues.

The DSHS School Health Program serves as a resource to local school districts by providing technical assistance, developing resources such as the School Health Advisory Council Guide and the Coordinated School Health Guide and coordinating school health efforts with a variety of partnerships, including Texas Action for Healthy Kids, Texas School Nurse Organization, Texans Care for Children, and many others.

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS and CHILDREN (WIC)

WIC is a nutrition program that helps pregnant women, new mothers, and young children up to age five eat well, learn about nutrition, and stay healthy. To enroll, they must have a household income at or below 185 percent of the federal poverty level, and they must have a qualifying nutrition or medical condition.

WIC services, which are available to residents of every Texas county, are provided by local health departments, community health clinics, hospitals and hospital districts, and other non-profit organizations.

WIC families routinely receive education through classroom education, on-line education, and one-on-one counseling that emphasizes healthful eating and physical activity – key behaviors for preventing obesity and related chronic diseases. In recent years, WIC has devoted considerable resources to obesity prevention through: (1) breastfeeding promotion and support; (2) a physical activity initiative for children that includes popular take-home DVDs to guide preschoolers through a series of fun physical activities; (3) obesity-prevention education for families; and (4) obesity-prevention grants for local WIC agencies to cover activities like grocery store tours, community gardens, food demonstrations, walking groups, and other staff programs.

To help WIC employees in local WIC agencies throughout the state become better role models for the families they serve, WIC has an ongoing employee wellness program called WIC Wellness Works (WWW) that focuses on nutrition, physical activity, and stress reduction. WWW materials are not limited to WIC employees; they are also being used to successfully educate and motivate women enrolled in WIC.

Breastfeeding is another obesity-prevention strategy extensively promoted by WIC. Most people are familiar with the immediate health benefits of breastfeeding for the infant – improved immunity; lower rates of ear infections, gastrointestinal disturbances, and atopic dermatitis, as well as reduced risk of sudden infant death syndrome. But few people realize that the long-term benefits include reduced obesity and diabetes. In fact, the longer an infant breastfeeds, the less likely he or she is to be overweight, and exclusive breastfeeding appears to have a stronger protective effect than when breastfeeding is combined with formula-feeding.

Many barriers make it difficult for mothers to meet their breastfeeding goals. Routine practices in hospitals often interfere with the early establishment of breastfeeding. When women experience early breastfeeding problems, they often do not have access to healthcare professionals who are knowledgeable about breastfeeding, and they often experience social disapproval when they breastfeed in public places. When they work outside the home, rigid schedules and lack of employer support make it difficult for them to express milk and continue breastfeeding.

Increasingly, Texas women are choosing to breastfeed. Greater than 83 percent of Texas mothers, including mothers in the Texas WIC population, initiate breastfeeding, exceeding the target for the Healthy People 2010 objective for breastfeeding in the early postpartum period. However, breastfeeding duration and exclusivity rates continue to fall well below Healthy People 2020 targets and we continue to see disparately low rates of breastfeeding among low-income and minority women. State and national data indicate that women face significant barriers to breastfeeding, with greater than half of women who initiate breastfeeding reporting that they did not breastfeed for as long as they wanted.

The Texas WIC Program has activities in place that address all of these barriers, and it leads the nation with its comprehensive breastfeeding promotion and support activities. These include:

- A “Breast Milk, Every Ounce Counts” media campaign advertising the benefits to breastfeeding for moms and babies and the Texas right to breastfeed in public law;

- A breastmilkcounts.com and lechematernacuenta.com website for WIC participants;
- Breastfeeding education for pregnant women in WIC;
- Support for new moms who experience breastfeeding problems or need assistance after they return to work;
- High-quality breast pumps for women in WIC who are separated from their infants and need to establish their milk supply or maintain their milk supply;
- Four lactation support and training centers where WIC moms receive personal breastfeeding assistance, healthcare professionals receive advanced lactation training, and hotlines that provide statewide assistance and referral;
- Peer-training for WIC mothers who have successfully breastfed their infants and are willing to offer encouragement and support to other WIC moms;
- Numerous breastfeeding courses designed to train medical, hospital and WIC staff; and
- The Texas Ten Step Program that provides technical assistance and recognition to hospital and birthing facilities that are addressing 85 percent of the WHO/UNICEF Ten Steps to Successful Breastfeeding;
- The Texas Ten Step Star Achiever Breastfeeding Learning Collaborative, to accelerate integration of the Ten Steps and readiness for Baby-Friendly designation, and to support continuity of care from the hospital to the community

Texas WIC had numerous accomplishments in FY 2013 and FY 2014. Over 900,000 women, infants and children received nutrition and health education. More than 24,000 WIC employees in 57 of the 76 local WIC agencies participated in the WWW activities. Four hospital collaborative learning sessions and more than 200 DSHS health professional trainings were held, providing continuing education to more than 7,000 health professionals. Approximately 361 peer counselors were employed and 115,150 breastfeeding education bags were delivered to WIC clinics to distribute to pregnant participants. WIC ran a Breastmilk: Every Ounce Counts campaign from June through August 2014 which consisted of TV, radio, outdoor and interactive ads touting the benefits of breastfeeding and directing listeners to visit www.breastmilkcounts.com. Prior to the start of the campaign, breastmilkcounts.com was receiving approximately 22,000 visits per month. The website received 21,819 visits during the first week of the campaign with a total of 78,862 users in July 2014 and 69,817 users in August 1-24, 2014.

Texas WIC oversees the Texas Ten Step program and Texas Ten Step Star Achiever Initiative, which are described in the Maternity Services section of this report below.

In October 2009, WIC implemented new food rules that were developed to:

- Align the WIC food packages with the 2005 Dietary Guidelines for Americans and current infant feeding practice guidelines of the American Academy of Pediatrics;
- Better promote and support the establishment of successful long-term breastfeeding;
- Provide WIC participants with a wider variety of food;
- Provide WIC state agencies with greater flexibility in accommodating participants with cultural food preferences; and
- Serve participants with certain qualifying conditions under one food package to facilitate efficient management of medically fragile participants.

Thirty-seven WIC agencies were funded through the Obesity Prevention Mini Grants (OPMG) project in FY 2013. The activities varied and ranged from group classes, cooking demonstrations, community gardens, and health carnivals to walking clubs. In FY 2013 and FY 2014, Texas WIC continued its outreach efforts to enroll eligible women, infants and children and will continue providing high quality nutrition education and obesity-prevention education.

WIC Wellness Works will continue to recruit more WIC staff into the program, and its materials will continue to be adapted for use with WIC participants. Through the OPMG project, approximately $650,000 will be disseminated to 40 agencies to conduct obesity prevention activities for both participants and staff.

In addition, the DSHS Office of Title V and Family Health, the Texas WIC program, the Nutrition, Physical Activity and Obesity Prevention Program, the Building Healthy Texans Statewide Agency Wellness Program, Transforming Texas-Healthy People in Healthy Communities Initiative, Texas' Coordinated Chronic Disease Initiative, and the Heart and Stroke Healthy City Initiative each include activities related to programmatic objectives to promote support for breastfeeding mothers. DSHS has multiple breastfeeding promotion initiatives that cut across program areas and target maternity services, worksites, and communities. These initiatives are aimed toward increasing breastfeeding initiation, duration, and exclusivity. DSHS's breastfeeding activities are coordinated through the DSHS Infant Feeding Workgroup.

WORKSITE WELLNESS

Since June of 2008, DSHS has implemented the requirements of H.B. 1297, which was passed in the 80th Legislative Session (2007) and amended the State Employees Health Fitness and Education Act of 1983, Chapter 664, Health and Safety Code. As a result of H.B. 1297, the statewide wellness coordinator was hired by DSHS to oversee the development of a model worksite wellness program for state agencies.

Obesity prevention is a high priority within the model worksite wellness program and continues to be a cornerstone of worksite wellness programs throughout the state. Through the worksite wellness program, DSHS provides state agency wellness coordinators with resources to implement the latest evidence-based worksite wellness strategies to support obesity prevention.

The priority objectives of the model wellness program are:

- Increase Usage of Preventive Services and Screenings
- Improve Tobacco Cessation and Prevention
- Improve Healthy Eating Choices
- Increase Physical Activity
- Improve Stress Management (including Employee Assistance Programs)
- Improve Support for Nursing Mothers

For additional information about the objectives and strategies of the DSHS worksite wellness program, visit www.wellness.state.tx.us.

The following initiatives have been implemented at the statewide level for all state employees and within DSHS in FY 2013 and FY 2014 to support the priority objectives and strategies of the Building Healthy Texans Model Wellness Program.

STATEWIDE WELLNESS INITIATIVES

- **Health Risk Assessment and Physical Exam Leave Incentive.** Since 2008, the Health and Human Services Enterprise wellness policy has enabled employees to earn an additional eight hours of leave per year by completing a health risk assessment (HRA) and seeing their physician for a physical exam. Between September 2012 and August 2013, more than 6,100 state employees completed the HRA, and from September 2013 to August 2014, the number was 5,990. Survey data indicate staff awareness of the benefit may be a barrier to greater utilization, which will be a focal point for wellness staff in FY 2015.

- **Farm To Work.** This initiative provides state employees with access to healthy, farm-fresh produce at their worksite. Employees order a basket of produce online by Monday and it is delivered to their worksite on Wednesday of the same week. Each basket costs the employee $20 and contains 12-17 pounds of vegetables and fruit grown by local Texas farmers. Between September 1, 2012 and August 31, 2014, the program reached 5,881 unique customers and sold a total of 21,686 baskets.

- **Get Fit Texas.** In 2013 and 2014, DSHS and Department of Aging and Disability Services (DADS) staff collaborated to offer the Get Fit Texas physical activity challenge to state employees. In 2013, almost 21,000 state employees participated, while 2014 saw more than 16,000 state staff join the challenge. Get Fit is driven by a strong collaborative effort between DSHS and DADS, featuring an interactive website that enables staff (and teams) to enter and track minutes of physical activity. The challenge culminates in an awards lunch recognizing state agencies with the highest levels of staff participation, led by DSHS Commissioner Dr. David Lakey.

MATERNITY SERVICES

Healthy People 2020 set targets for maternity services to improve practices related to care of the breastfed newborn. Targets include:

- Reducing the proportion of breastfed newborns who receive formula supplementation within the first two days of life
- Increasing the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies, as measured by proportion of births that occur in Baby-Friendly-designated facilities

The Baby-Friendly Hospital Initiative, administered in the United States by a national non-profit organization, Baby-Friendly USA, recognizes hospitals that have fully implemented an evidence-based bundle of maternity practices known as the Ten Steps to Successful Breastfeeding (the Ten Steps). The Ten Steps, originally developed by UNICEF and the World Health Organization, are internationally recognized best practices in infant nutrition and care that are demonstrated to improve short- and long-term infant feeding outcomes as well as other aspects of infant health. Currently, only about 40 percent of

Texas infants are exclusively breastfed during their neonatal hospital stay. However, infants who are born in hospitals implement the Ten Steps are more likely to be exclusively breastfed and to breastfeed for longer. DSHS offers the following initiatives to support implementation of the Ten Steps in Texas:

- The Right from the Start campaign aims to increase awareness among key decision-makers in Texas birthing facilities about their role in improving breastfeeding outcomes. Materials illustrate the impact that hospital policies and practices have on breastfeeding outcomes, and include an informational booklet including state and national data related to hospital practices, information on the Texas Ten Step and Baby-Friendly USA programs, a self-assessment guide, resource list, and a hospital-specific one-page report. The campaign, released in November 2011, encourages hospitals to assess their current practices and consider opportunities for improvement. A second stage of the campaign is currently in development.

- The Texas Ten Step (TTS) Program recognizes hospitals that have adopted policies that address 85 percent of the Ten Steps to Successful Breastfeeding, and encourages facilities to pursue Baby-Friendly Hospital designation. The program itself is free and allows for total support throughout the application process. Technical assistance provided includes free on-site training with contracting entities, policy writing assistance, and identification and assistance with areas of needed improvement. Hospitals and birthing facilities that fully adopt the "Ten Steps to Successful Breastfeeding" are well-poised to achieve the Baby-Friendly designation, the gold standard for maternity care. However, any hospital is eligible to apply for Baby-Friendly and does not have to complete TTS first. There are currently 107 facilities with Texas Ten Step designation. There are currently seven facilities in the state that have been designated through Baby-Friendly USA. At least 26 facilities have officially started the Baby-Friendly designation process. The TTS facilities recertify annually, and DSHS provides on-going guidance on areas for improvement to integrate the Ten Steps.

- The TTS Star Achiever Breastfeeding Learning Collaborative with National Institute for Children's Health Quality (NICHQ) launched in December 2012 and will run through June 2017. It assists Texas birthing facilities to more fully integrate the Ten Steps. The initiative includes the Texas Breastfeeding Learning Collaborative, which provides technical assistance, training, collaborative opportunities, and tools to assist participating facilities to implement rapid-cycle quality improvement processes to assure delivery of recommended care for lactating mothers and infants. Supporting activities include communication with local community partners to encourage systems development for continuity of care throughout the prenatal to postpartum continuum. The aim of the collaborative is to increase the average aggregate performance for exclusive breastfeeding throughout the hospital stay to more than or equal to 65 percent by June 2017 among participating facilities. Data from the first cohort of hospital teams demonstrate increased adherence across each of the Ten Steps as well as increased rates of any- and exclusive breastfeeding and decreased rates of formula supplementation. Participating facilities are encouraged to seek the Baby-Friendly designation through Baby-Friendly USA. More information about the TTS Star Achiever Initiative is available from the TTS Star Achiever web page (http://texastenstep.org/starachiever-texastenstep/index.html) and from the National

Initiative for Children's Healthcare Quality (NICHQ) Texas Breastfeeding Learning Collaborative web page (http://breastfeeding.nichq.org).

- Breastfeeding Trainings are designed to prepare health-care providers to appropriately and adequately support breastfeeding women and their infants. Continuing education credits are provided. The material is presented at a level to fill the gaps in professional education. Available two-day courses include Principles of Lactation Management and Lactation Counseling and Problem Solving. One-day courses may be scheduled on request. A Peer Counselor Trainer Workshop is available to prepare participants to initiate a breastfeeding peer counselor program in their community. A one-hour breastfeeding module for healthcare professionals is available on the Texas Health Steps Online Provider Education portal. An eighteen-hour online training is currently under development by DSHS Nutrition, Physical Activity, and Obesity Prevention Program.

BREASTFEEDING IN WORKSITES AND CHILDCARE

Lack of support for breastfeeding in the workplace remains a barrier for breastfeeding initiation, duration, and exclusivity. The Texas WIC Infant Feeding Practices Survey (2011) found that mothers who returned to work after the birth of their children reported that returning to work or school was the leading reason for introducing formula, discontinuing breastfeeding, or not initiating breastfeeding. Further, survey findings indicate that working mothers are significantly less likely to meet their personal breastfeeding goals than mothers of infants who do not work outside of the home. Many women lose their milk supply or are unable to express and store breast milk for later feedings when they face barriers at the workplace. Worksite lactation support policies and programs have been shown to significantly improve breastfeeding outcomes and result in a three-dollar return for every one-dollar invested for employers. Healthy People 2020 set a national objective to increase the proportion of employers that have worksite lactation support programs. DSHS provides technical assistance, tools, resources, and recognition to encourage and support employers to establish and maintain high-quality lactation support programs for their employees who are separated from their infants during the workday. Training resources prepare providers to support breastfeeding in the child care setting to further support successful breastfeeding among working mothers. DSHS offers the following activities to promote breastfeeding support for mothers who wish to continue to breastfeed after returning to work:

- The Texas Mother-Friendly Worksite Program is a worksite recognition program that DSHS developed to fulfill requirements of Texas Health and Safety Code 165. The statute directed DSHS to establish recommendations supporting the practice of worksite breastfeeding and to maintain a registry of businesses that have a written breastfeeding policy addressing the recommendations, including provision of: work schedule flexibility for expression of milk, accessible locations allowing privacy, access to clean running water, and access to hygienic storage alternatives for storing mother's breast milk. This initiative includes a social marketing campaign to disseminate breastfeeding support strategies to a broad variety of employment sectors. The initiative has contributed to a 630 percent increase in the number of designated Mother-Friendly Worksites—from 233 worksites in February 2010 to over 1,700 in August 2014. Three municipalities, including Cities of San Antonio, Austin, and Edinburg, have received the designation. More information about the program is available at http://texasmotherfriendly.org/.

The program was recently recognized as a Practice-Tested Intervention by the Center for Training and Research Translation. More information is available at http://www.centertrt.org/?p=intervention&id=1182.

- A child-care training curriculum, *How to Support a Breastfeeding Mother: A Guide for the Childcare Center*, is available at http://www.dshs.state.tx.us/wichd/bf/childcare.shtm. The curriculum is featured as an implementation resource for the national *Let's Move!* Child Care Goal for Infant Feeding: http://www.healthykidshealthyfuture.org/content/hkhf/home/nutrition/infantfeeding.html.
- *Supporting Breastfeeding in the Child Care Setting* is an online continuing education module for child care professionals hosted by Agrilife Extension's distance learning portal. The course is available in both English and Spanish from: http://extensiononline.tamu.edu/courses/child_care.php.

BREASTFEEDING IN COMMUNITIES

A mother's ability to begin and to continue breastfeeding can be influenced by a host of community factors including the education and information she receives about infant feeding and the quality of support that she receives from her family, friends, service providers, and other community members in the places where she lives, works, and plays. DSHS activities related to supporting breastfeeding in communities include the following:

- The Statewide Lactation Support Lines are a "hotline" referral system for Texans in need of breastfeeding information and support. Lactation specialists provide answers for breastfeeding questions to health care professionals and to consumers. They also provide contact information for lactation specialists located near the Texas caller. More information is available at http://www.dshs.state.tx.us/wichd/bf/hotline.shtm.
- The Expanded Primary Health Care Program provides primary, preventive and screening services to women age 18 and above whose incomes are at or below 200 percent of the federal poverty level. The program also supports the integration of International Board Certified Lactation Consultants in primary health care settings. More information is available at http://www.dshs.state.tx.us/ephc/Expanded-Primary-Health-Care.aspx.
- WIC Lactation Resource and Training Centers in three Texas cities provide lactation support services to WIC families and provides information and training to WIC staff and health professionals. More information may be accessed at http://dshs.state.tx.us/wichd/data11/11013-acc.pdf
- The Baby Café is a model for community-based drop-in breastfeeding centers for pregnant women and breastfeeding moms, dads, and families. Breastfeeding peer counselors, as well as International Board Certified Lactation Consultant(s), are available on site to answer questions and assist with breastfeeding concerns. Cafés provide a comfortable atmosphere and mother-to-mother support in addition to professional lactation services and referrals. The idea is predicated on evidence that children who are breastfed as babies have significantly lower risk of becoming obese later in life. Currently, there are 11 Baby Cafés in Texas, including Baby Cafés established with past funding from the DSHS Nutrition, Physical Activity and Obesity Program and through the Texas WIC program.
- Texas WIC Breastmilk. Every Ounce Counts campaign is a statewide awareness campaign to encourage moms to breastfeed. The campaign includes TV, radio and outdoor public service announcements and 60-second news spots on radio news channels aired during National Breastfeeding Awareness Month in August. The campaign also includes breastfeeding promotion

materials such as Breastfeeding Friendly Establishment decals, WIC Peer Counselor program and Texas Ten Step promotional materials, Right to Breastfeed cards, and a website (breastmilkcounts.com). These materials prepare new moms on what to expect, help current breastfeeding moms continue breastfeeding, give working moms tips on how to continue breastfeeding once they've gone back to the workplace, and provide other resources.

- The Support from Day One website is a new component of the Breastmilk. Every Ounce Counts Campaign targeting public health professionals and others involved in breastfeeding promotion and support activities. The website provides information and resources to assist interested organizations and individuals with their activities to strengthen breastfeeding support in their local communities.

DSHS INFANT FEEDING WORKGROUP

The DSHS Infant Feeding Workgroup, coordinated by the Maternal and Child Nurse Consultant in the Office of Program Decision Support, was formed to coordinate breastfeeding activities across DSHS areas, including Texas WIC, Office of Program Decision Support, and the Nutrition, Physical Activity, and Obesity Prevention Program. The workgroup has developed a (draft) DSHS strategic plan for breastfeeding promotion that includes strategies for increasing breastfeeding assessment, promotion support, and evaluation in health services, the community, and worksites, and for more fully integrating breastfeeding promotion into relevant DSHS programs and initiatives across the agency. Breastfeeding promotion activities are addressed in more detail elsewhere in this document.

TEXAS HEALTHY COMMUNITIES

The Cardiovascular and Stroke Program oversees the Texas Healthy Communities (TXHC) Program, which recognizes Texas communities with policies and environments that promote health to reduce risk factors for chronic diseases. Participating communities are assessed on eight health indicators that impact chronic disease, including: physical activity, healthy foods, healthy schools, healthy worksites, breastfeeding, tobacco control and prevention, cardiac and stroke care, and health care quality improvement.

The assessment allows for a better understanding of a community's capacity to become healthier, motivating stakeholders to develop and implement a strategic plan for system and environmental changes to support healthy behaviors.

Since 2004, 34 cities have participated in the Program:

- Ten cities have earned Gold Level recognition: Abilene, Austin, Beaumont, Corpus Christi, El Paso, Houston, Laredo, Marshall, Nacogdoches, and Tyler.
- Thirteen cities have earned Silver Level recognition: Cedar Park, Amarillo, Brownsville, Bryan, Denton, Fort Worth, Georgetown, Longview, Lubbock, Lufkin, Temple, Waco, and Wichita Falls.
- Seven cities have earned Bronze Level recognition: Katy, Rusk County, Harlingen, McAllen, Odessa, San Antonio and Texarkana.
- Dallas, Galveston, Huntsville, Midland, and Victoria have been recognized with Honorable Mention.

TEXAS HEALTH STEPS ONLINE PROVIDER EDUCATION MODULES

Texas Health Steps provides regular medical and dental checkups and case management services to babies, children, teens, and young adults enrolled in Medicaid at no cost. DSHS also provides online provider education modules and continuing education credits to healthcare providers, including doctors, social workers, nurses and others. Texas-licensed physicians and subject matter experts from DSHS and HHSC partnered with Texas Health Steps staff to lend their expertise on over 50 modules. These modules are available for free and are accredited by nine separate accrediting bodies at www.txhealthsteps.com.

Three modules specifically address general nutrition and weight management issues for children from birth through age 20. Additional modules include information on weight management and healthy lifestyle issues. Additionally, Texas Health Steps (THSteps) and Online Provider Education staff present and exhibit at several conferences throughout the year. The purpose of this educational outreach is to promote the THSteps program, provider education, and other related DSHS and HHSC programs. Educational tools including BMI calculators, parent guides, and periodicity schedules are distributed to providers at these events.

The Nutrition module covers the following information and more: tools for pediatric screening related to height, weight, quality and quantity of food habits; methods for pediatric screening for obesity; methods for gathering nutritional information during routine checkups; and identifying risk factors for obesity and other nutrition-related diseases.

The Management of Overweight and Obesity in Children and Adolescents module was created with a goal to introduce Texas Health Steps providers and others to best practices in the prevention of overweight and obese children from birth through age 20. The increasing numbers of overweight and obese children is a medical crisis in our country. It is imperative for healthcare providers to assess the weight of all children in their care and develop weight management protocols and prevention strategies. This module describes methods of assessment and practices for correction and prevention.

The Breastfeeding module was written in collaboration with the State Breastfeeding Coordinator and DSHS WIC staff in addition to other subject matter experts. This module offers Texas Health Steps providers and others best practices in providing support to mothers who breastfeed their infants. The course provides information about the benefits of breastfeeding, cultural and legal aspects of breastfeeding, public health recommendations, and potential problems for clinicians to assess, and signs that breastfeeding is successful.

Additional modules that address obesity-related issues are: Identifying and Treating Children with Diabetes; Identifying and Treating Young People with High Risk Behaviors; and Behavioral Health: Screening and Intervention.

SCHOOL PHYSICAL ACTIVITY AND NUTRITION (SPAN) SURVEY

The School Physical Activity and Nutrition (SPAN) survey is a partnership between the University of Texas School of Public Health's Michael & Susan Dell Center for Healthy Living and the Department of State Health Services. The purpose of the questionnaire is to identify factors that may underlie childhood obesity including dietary behaviors, nutrition knowledge and attitudes, physical activity, and social and environmental factors. The survey includes questions on bullying, body image, depression, and other psychosocial issues that impact health behaviors in children and adolescents.

A representative sample of school children in grades 4, 8, and 11 were assessed as part of the third SPAN survey in Texas. Schools were selected with a probability-based sample that was represented at grade

level, health service region, and Texas-Mexico border/non-border region. The most recent iteration included a matched 4th grade parent survey to assess parental perceptions, attitudes and knowledge of factors associated with childhood obesity.

Data have been analyzed and indicate that the prevalence of obesity in children in grades 4, 8 and 11 was 23.8, 23.0, and 21.6 percent respectively. Since 2000 to 2002, there were decreases in the prevalence of obesity among 4th grade students, and increases in obesity prevalence for 8th and 11th grade students, but these changes were not significant. The prevalence of obesity was significantly greater among students in schools with low socioeconomic status. Plans to further analyze and disseminate these findings are currently being developed. More information may be accessed at https://sph.uth.edu/research/centers/dell/span/.

TEXAS EDUCATION AGENCY

The Texas Education Agency (TEA) is comprised of the commissioner of education and agency staff. The TEA and the State Board of Education guide activities and programs related to public education in Texas. The mission of the TEA is to provide leadership, guidance, and resources to help schools meet the educational needs of all students. The policies and programs that impact the health and well-being of Texas school children are administered in part by the Curriculum Division. The Curriculum Division provides state-level support, information, and non-regulatory guidance to school administrators, teachers, counselors, parents, and students regarding general curriculum laws and rules, including those related to the health and well-being of Texas school children as described below.

COORDINATED SCHOOL HEALTH

Studies have shown that healthy students are better learners. Addressing childhood obesity is a key step in creating healthier, more successful students in Texas. The Texas Education Code (TEC), §38.013, requires the TEA to make available to each school district one or more coordinated health programs designed to prevent obesity, cardiovascular disease, oral diseases, and Type 2 diabetes in elementary, middle, and junior high schools. House Bill (HB) 2483, 83rd Texas Legislature, Regular Session 2013, amended TEC §38.013 by adding oral diseases to the list of diseases to be addressed by coordinated health programs and to add oral health education to the health education component of coordinated school health programs.

The TEC §38.014 requires that all school districts implement coordinated school health programs in elementary, middle, and junior high schools. They do so following the Centers for Disease Control and Prevention (CDC) Coordinated School Health Model. The TEA assists school district implementation of effective coordinated school health programs by providing technical assistance and facilitating the review and approval of the required programs. The four components of the programs--health education, physical education and physical activity, nutrition services, and parental involvement support the reduction of obesity in Texas youth.

A review of coordinated school health programs was conducted in October 2013 and August 2014. Programs approved by the review committee are approved for the 2014-2015, 2015-2016, 2016-2017 academic years. For more information about programs that are approved please visit the Approved Coordinated School Health Programs web page.

SCHOOL HEALTH ADVISORY COUNCILS

The TEC, §28.004, requires the board of trustees of each school district to establish a local school health advisory council (SHAC) to assist the school district in ensuring that local community values are reflected

in the district's health education instruction. A SHAC is a group of individuals, primarily parents of students in the school district, appointed by school district officials to represent the community. The members of the SHAC provide advice on coordinated school health programming and its impact on student health and learning. SHACs provide an efficient, effective structure for creating and implementing age-appropriate, sequential health education programs and early intervention and prevention strategies that can be supported by local families and community stakeholders. The benefits of SHACs include:

- Developing relevant district policies for improving student health
- Communicating to school administrators, parents, and community stakeholders the connection between health and learning
- Reinforcing the health knowledge and skills children need to be healthy for a lifetime

To further strengthen the development of SHACs at the local level, the TEA facilitates quarterly videoconferences and webinars focusing on improving the health and educational outcomes of young people throughout Texas. These videoconferences and webinars provide school staff, parents, community members, and school health organizations with helpful resources, tools, data, ideas, and strategies. Legislation passed by the 83rd Texas Legislature, impacted SHACs in the 2014-2015 biennium. House Bill (HB) 1018 amended TEC §28.004 by requiring each local SHAC to establish a physical activity and fitness planning subcommittee. The subcommittee is charged with considering issues related to student physical activity and fitness and making policy recommendations to increase physical activity and improve fitness among students. HB 1018 also requires each local SHAC to include in its annual written report to the local board of trustees any recommendations made by the physical activity and fitness planning subcommittee.

PHYSICAL EDUCATION AND PHYSICAL ACTIVITY

Physical activity programs can improve the health of children and help motivate them to make healthy decisions throughout life. TEC §28.002(l) requires students enrolled in full-day prekindergarten or kindergarten to grade 5 to participate in moderate or vigorous daily physical activity for at least 30 minutes throughout the school year as part of the district's physical education curriculum or through structured activity during a campus's daily recess. If a school district determines, for any particular grade level below grade six, that requiring moderate or vigorous daily physical activity is impractical due to scheduling concerns or other factors, the district may as an alternative require a student in that grade level to participate in moderate or vigorous physical activity for at least 135 minutes during each school week. The law further requires students enrolled in grades six to eight to participate in at least 30 minutes of moderate or vigorous daily physical activity for at least four semesters during those grade levels as part of the district's physical education curriculum., As an alternative, a school district may require a student enrolled in a grade level for which the district uses block scheduling to participate in moderate or vigorous physical activity for at least 225 minutes during each period of two school weeks.

It is essential that children in Texas receive quality programming in each required grade level. The Texas Essential Knowledge and Skills (TEKS) for physical education strengthen the quality of physical activity provided in physical education. The TEKS provide the standards for what students must know and be able to do by the end of each grade level and course in order to exhibit a physically-active lifestyle and understand the relationship between physical activity and health.

Additional information related to obesity prevention and health programs is available on the TEA website.

PHYSICAL FITNESS ASSESSMENT INITIATIVE

The Texas Education Code (TEC), §38.101, requires all students, in grades three or higher who are enrolled in a course that satisfies the curriculum requirements for physical education to be assessed once a year using a fitness assessment instrument identified by the commissioner of education. A request for offer (RFO) process was conducted in 2007, and FITNESSGRAM®, created by The Cooper Institute of Dallas, was selected as the state fitness assessment instrument.

FITNESSGRAM uses criterion-referenced standards called the Healthy Fitness Zones, which are based on age and gender and represent the basic levels for good health and fitness in children ages 5 - 17 years. The assessment includes a variety of health-related physical fitness tests that assess aerobic capacity, muscular strength, muscular endurance, flexibility, and body composition. Scores from these assessments are compared to Healthy Fitness Zone standards to determine a student's overall physical fitness and to suggest areas for improvement when appropriate.

In 2007-2008, private funds were used to pay for all software and training to support schools in implementing the fitness assessment. Regional education service centers (ESCs) and TEA staff provided training on the program to districts throughout the state. Additional training on software installation and use, data collection, and data reporting has been provided through webinars, professional conferences, and the Texas Education Telecommunications Network (TETN).

In 2013, the 83rd Texas Legislature appropriated $5,000,000 for the 2014-2015 biennium for the physical fitness assessment and related analysis. The TEA entered into agreements with Human Kinetics and The Cooper Institute to provide a statewide license to FITNESSGRAM 10 at no cost to schools and to conduct an analysis of physical fitness assessment data to assess the relationship among physical fitness and student academic achievement, attendance, obesity, disciplinary problems, and school meal programs. In addition, the funds provided professional development opportunities for physical educators as well as education materials for those campuses that participated in training.

TEC §38.103 requires schools to report their results to TEA. Approximately 650 districts currently use FITNESSGRAM 10, which automatically reports the required data for schools. The remainder of districts continue to report their data using the Physical Fitness Assessment Initiative (PFAI) application developed by TEA. PFAI users submit their data through the TEA's Secure Environment known as TEASE.

Aggregated physical fitness assessment information can be accessed by district, campus, grade-level, and gender for the entire state for the last six consecutive school years (2007-2008 to 2012-2013). To view this data, please visit the Fitness Data web page. The fitness assessment data for the 2013-2014 academic year are expected to be available in early 2015.

Each year, the Texas Comptroller of Public Accounts requests FITNESSGRAM data to map the results of the assessment. These maps are posted to the Reshaping Texas website. Additionally, the TEA reports the FITNESSGRAM results to the Texas School Health Advisory Committee for use by the committee in assessing the effectiveness of coordinated health programs provided by school districts and to develop recommendations for modifications to coordinated health program requirements or related curriculum. Texas was the first state to order a comprehensive physical assessment of its students. During the program's first year, 2.6 million of the almost 3.4 million students in grades 3-12 were tested. Results in year one showed that 33 percent of third-grade girls and 29 percent of third-grade boys reached the "Healthy Fitness Zone." By seventh grade, 21 percent of girls and 17 percent of boys still met this achievement level. By 12th grade, 8 percent of the girls and 9 percent of the boys met the health standards in all six tests. Data remained somewhat consistent in years two and three of the assessment's

implementation although significant improvements have been seen in the number of students tested and the number of school districts and campuses collecting and reporting data. In the 2009-2010 school year, 2.9 million students were tested and 92 percent of school districts submitted data. The FITNESSGRAM data has been analyzed to identify relationships between healthy fitness zones and student academic indicators and has revealed a link among cardiovascular fitness, student achievement, and attendance. Results of this analysis can be found at Our Kids Health website.

During the 2011-2012 school year, the TEA collected data from 1,064 districts and charter schools, encompassing 2,296,200 students in grades 3-12. The 2012-2013 school year collection of data included 1,080 districts and charter schools on 2,253,652 students in grades 3-12.

The TEA has contracted with The Cooper Institute for an analysis of the physical fitness assessment data for 2012-2013 and 2013-2014. The study is expected to identify any relationships between student fitness and academic achievement, school attendance, obesity, disciplinary problems, and school meal programs (TEC §38.104).

With continued focus at the local level in the implementation of evidence-based physical activity and nutrition programs, schools can expect to see improvements in student health outcomes each year. School districts are encouraged to review their own data using the FITNESSGRAM software reporting systems, as well as other evaluation methods. Students, school personnel, parents, and community members are encouraged to use this locally collected data to motivate the implementation of new programs and practices as well as nurture existing best practices that will continue to improve the health and well-being of their students.

SCHOOL HEALTH SURVEY

To enhance implementation of school health requirements and improve the quality of fitness data, the TEA developed an annual survey to collect additional data from school districts on student health and physical activity programs (TEC §38.0141). Results from the survey help identify district needs and guide technical support and training related to effective implementation of coordinated school health programs and SHACs. The results also help other organizations and agencies throughout the state in efforts to improve policies and practices that affect health behavior in their districts and communities.

CAMPUS IMPROVEMENT PLANS

Under TEC §11.253(d)(10), campus improvement plans (CIPs) must establish goals and objectives for the coordinated school health program on each elementary, middle, and junior high school campus. The goals and objectives must be based on the following:

- student fitness data,
- student academic performance,
- attendance rates,
- the percentage of students who are educationally disadvantaged,
- the success of any methods used to ensure that students participate in moderate to vigorous physical activity, and
- any other indicators recommended by the local school health advisory council (SHAC).

During the 2012-2013 and 2013-2014 school years, district school health personnel received information about the statutory requirements through the ESCs via TETN.

Conclusions and Recommendations

The Interagency Obesity Council appreciates the opportunity to communicate with the Legislature about its respective agencies' obesity prevention activities. It is clear that these three agencies are continuing to provide valuable leadership on obesity prevention to schools, communities, health care providers, and the public through a variety of programs and initiatives. Texas has taken many bold steps to improve the health status of its schoolchildren through policy and legislation that require better nutrition and more physical activity in schools. However, the obesity epidemic persists, and there is much more to be done. The council respectfully offers the following recommendations:

- Continue the collaboration between the three agencies and other state agencies on obesity prevention efforts, including communication between program staff, management, and commissioners.

- Continue to emphasize workplace wellness programs that incorporate a broad array of interventions and activities that focus on the prevention and control of the most common and costly employee health problems (e.g. improved nutrition, increased physical activity, smoking cessation, routine health screening, stress reduction, substance abuse, etc.). While obesity does have a tremendous impact on employee health and productivity, and healthcare costs, other modifiable behaviors and treatable conditions, for example – tobacco use, alcohol abuse, depression and sleep problems – also have a tremendous impact on health care costs and productivity.

- Encourage the creation of locally developed interventions to address obesity at the community level and to improve opportunities for physical activity and healthful eating within the entire community. These interventions should complement the substantial progress toward healthful eating and increased physical activity in schools.

- Strengthen existing state-level systems to support obesity prevention interventions in various settings at the community level through cross-systems collaboration.

- Strengthen nutrition education in kindergarten through grade 12, delivered through a variety of curricula and activities.

- Strengthen the quality of nutrition education and physical activities in early childhood and after-school programs.

- Examine ways to increase the availability of fresh produce for disadvantaged and low-income populations.

- Develop mechanisms or strategies to use the results of FITNESSGRAM and NUTRIGRAM data.

- Track obesity for all age groups, including preschool age children.

- Involve parents and community members in school-based and/or youth-focused physical activity and nutrition programming, especially through local School Health Advisory Councils.

- Increase the availability of resources, technical assistance, training, and support for schools and community-based organizations to enhance the implementation of evidence-based programs to prevent obesity.

- Identify effective programming throughout the state as a means for referrals and modeling and establish criteria and measurement systems to identify such programs.

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Joint Committee on Access and Forensic Services

Number of Members: 25

Committee Status (Ongoing or Inactive): Ongoing

Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 11/1/2015

Date to Be Abolished: 11/1/2019

Budget Strategy (Strategies) (e.g. 1-2-4): 3.1.3

Strategy Title (e.g. Occupational Licensing): Mental Health State Hospitals

Budget Strategy (Strategies):

Strategy Title:

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Texas Health and Safety Code §532.0131
State Authority	Statute	Texas Health and Safety Code §533.0515
State Authority	Admin Code	Rules under development, to be adopted by 7/01/2016; 25 TAC
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$3,680	$1,840
Personnel	$0	$39,178	$34,228
Number of FTEs	0.0	0.5	0.5
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$42,858	$36,068

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	$0	$42,858	$36,068
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year

Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
0	4	4

Committee Description: Duties: Makes recommendations for a comprehensive plan for effective coordination of forensic services; makes recommendations and monitors implementation of updates to a bed day allocation methodology and an utilization review protocol for state funded beds in hospitals and other inpatient mental health facilities

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings? Statutory requirement to meet at least quarterly. Meetings are held in Austin with some members participating via teleconference.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

Deliverables required by statute include: Recommendations to Executive Commissioner for an updated allocation methodology and utilization review protocol; report to state leadership with recommendations for creation of comprehensive plan for coordination of forensic services. The committee will also be making annual reports with policy recommendations. Initial set of recommendations sent to Executive Commissioner regarding allocation methodology and utilization review protocol

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

The committee's first deliverable was the initial set of recommendations to the Executive Commissioner regarding allocation methodology and utilization review protocol (March 2016). The decision of the Executive Commissioner is pending.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ? Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees? No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015? 0 (new committee)

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Activities specific to support of the committee include scheduling and logistics, preparing presentations, drafting documents, gathering information per committee request.

6. Have there been instances where the committee was unable to meet because a quorum was not present? No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

Meeting notices made available through Texas Register and DSHS website; public comment taken throughout the meeting on all but routine agenda items.

7b. Do members of the public attend at least 50 percent of all committee meetings? Yes

7c. Are there instances where no members of the public attended meetings? No

8. Please list any external stakeholders you recommend we contact regarding this committee.

Don Lee, Executive Director for the Conference of Urban Counties (Chair)

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals? Yes

9b. Please describe the rationale for this opinion.

The committee is new, and faced very tight deadlines established by statute for initial deliverables. The committee scheduled extra meetings and subcommittee work to achieve objectives within the required timeframes.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute? Yes

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area? No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

The statute ensures the activity and deliverables of the committee are aligned with legislative intent.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

Committee provides valuable stakeholder input to inform state policies and processes. If abolished, agency would lose a valuable source of input from a diverse group of experts and other stakeholders on priority issues.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

Joint Committee on Access and Forensic Services
Meeting #4 Minutes
Monday, March 21, 2016
9:00 a.m. to 3:00 p.m.

Austin State Hospital Campus
Building 552
Training Room 125
909 West 45th Street
Austin, Texas 78714

Agenda Item 1: Opening remarks and introductions

The Joint Committee on Access and Forensic Services (JCAFS) meeting commenced at 9:10 a.m. Committee Chair Donald Lee welcomed everyone to the meeting.

Ms. Cassandra Marx, Enterprise Facilitation Services Office, Health and Human Services Commission (HHSC) announced that the meeting was being conducted in accordance with the Texas Open Meetings Act, and noted that a quorum was not present at that time. Table 1 notes Committee member attendance.

Table 1: The Joint Committee on Access and Forensic Services member attendance at the Monday, March 21, 2016 meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Allison, Jim	X		Lewis, Kathryn	P	
Burkeen, Honorable Daniel	P		McLaughlin, Darlene MD	X	
Cusumano, Sherry	X		Oncken, Denise	X	
Davis, Lorie	X		Schnee, Steven PhD	P	
Davis, Mike	X		Smith, Shelley	X	
Desai, Tushar MD		X	Smith, James	X	
Faubion, Matthew MD	X		Suiter, Honorable Wes	P	
Gentry, Michael		X	Switzer, Gyl	X	
Hall, Jerry		X	Taylor, Sally MD		X
Holcomb, Valerie	X		Wilson, Sheriff Dennis		X
Holstein, Nicholas		X	Wilson, Stacy JD		X
Lee, Donald	X		Zamora, April		X

Yes: Indicates attended the meeting
No: Indicates did not attend the meeting
P: Indicates phone conference call

Agenda Item 2: DSHS Committee Updates

Dr. Erin Foley, Forensic Director, Department of State Health Services (DSHS) updated members about collaboration between DSHS staff and Judge Hervey, Court of Criminal Appeals, on a two-day mental health summit to be held in mid-August. It is in the planning process and topics of interest include working with forensic patients and the continuum of doing forensic services.

Ms. Lauren Lacefield-Lewis asked members to utilize their networks to spread the word about this upcoming summit.

Agenda Item 4: Public Comment

No public comment was heard at this time.

DRAFT

Agenda Item 5: Review of March 4, 2016 Hogg Foundation summit and forensic subcommittee meeting

Dr. Foley provided a recap of the Hogg Foundation summit held March 4, 2016.

Panel discussion included various aspects of forensic services and conditional release, competency evaluations and the quality and oversight of evaluations, as well as how to approach services in a large and varying state such as Texas.
Ms. Frost led an activity for rank ordering of ideas for forensic services that summit participants would like to see in the state. The top three ideas included: aligning the drug formulary with the local jails, better discharge planning and not guilty by reason of insanity (NGRI) placements in the community, and establishing a review board to evaluate the release for long-term patients.

Action Item:

- Dr. Foley will share more details about the Hogg Foundation summit activity to members upon their request.
- Ms. Boyd will send the electronic document of the summit activity to members.

Agenda Item 3: Approval of minutes from February 22, 2016 joint committee meeting

Mr. Lee noted that a quorum was present at that time and asked for a motion to approve minutes from the previous meeting.

MOTION 1:

Mr. Jim Smith motioned to approve the minutes from the February 22, 2016 meeting. Honorable Jim Allison seconded the motion. The Committee members unanimously approved the minutes by voice vote, with no nays and no abstentions.

Agenda Item 6: Discussion of a framework and recommendations for forensic services*

Dr. Foley reviewed the handout entitled *Recommendations for a Comprehensive Plan for the Coordination of Forensic Services* and presented on the recommendations for forensic services.

Highlights of member discussion included:

- Revise language regarding the need for increased access to services from "mental health" to "behavioral health" to include substance abuse.
- The Dangerousness Review Board should include someone from the community. Rural jails need support and services to address the needs of individuals with mental health issues, particularly in the period before a determination of competency is made. Collaboration between LMHAs and jails can have a real impact in this area.
- There are a number of issues involved in getting individuals stabilized on medication as soon as possible consistent with physician recommendations. Education is important for advocacy groups, sheriffs, judges, criminal defense attorneys, and rural prosecutors so they have a better understanding of applicable statutes and procedures.
- The sheriff plays a critical role initiating an assessment in the jails to begin the mental health process for an individual. Utilizing best practices and procedures as a framework in conjunction with regional training would assist in moving individuals to the right placement.
- The alternatives to hospitalization document published by DSHS is available online for review.

DRAFT

- In addressing the maximum security unit (MSU) backlog, specific focus should be given to individuals with intellectual and developmental disabilities (IDD). All of these patients are currently referred to Vernon, and many are then transferred to Mexia State Supported Living Center (SSLC). This is a population where transitions can be more challenging. Admitting appropriate patients directly to Mexia could avoid unnecessary hospitalization, but such an approach would need to be thoroughly explored. Mexia operates under the intermediate care facility (ICF) umbrella and has aging, juvenile, and medically-fragile populations. Accepting direct admission from the MSU waiting list could create a challenge because it is an open campus and currently does not have segregated units and other security features
- Workforce shortages include peer specialists and family partners, and recommendations should include adequate training for peers at all levels.
- Members agreed to change number 2, item a. to read: "Increase the availability of community services to reduce the need for inpatient care for individuals."
- Members agreed to change number 2, item b. to read: "Increase resources and access to community services including access to medications to reduce the need for inpatient care for individuals charged with misdemeanors." This may involve strengthening community resources and providing services that may not exist yet.It is unclear why existing statutes related to court-ordered medication and outpatient commitments are not being used more extensively. Members expressed a desire to learn more about the issues and barriers that might be inhibiting use, particularly from those serving on the bench.
- Under the education/training bullet of the Diversion section, a suggestion was made to add legal ethics education and training for reentry peer support specialists.
- Diversion encompasses effective crisis intervention and stabilization services, which can include peer respite services. Furthermore, easy access to robust community services can reduce crises and forensic involvement.
- Members expressed the desire to recommend a review of the mental health codes in Texas. While the Legislature would initiate and comprehensive review, the Committee could identify areas of focus to improve coordination and improve services, to be followed by more specific recommendations. The Forensic subcommittee can begin looking at relevant sections of the Code of Criminal Procedure and Health and Safety Codes, with a goal of including recommendations in the document to go to the Legislature later this year.
- Members discussed the establishment of an Advisory Psychiatric Review Board to make decisions about movement of individuals within the forensic system.
- A suggestion was made to split the recommendation regarding the housing and employment needs of patients in outpatient competency restoration programs and patients reentering the community post-discharge

PUBLIC COMMENT:
Ms. Candace Aylor, a children's mental health advocate and a parent representative to the Behavioral Health Advisory Committee (BHAC), spoke to the Committee's focus on diversion and client-based services, and the discussion around compelling medication and beds for forced treatment for individuals. Ms. Aylor acknowledged that both have their place but noted that there are better ways to provide help and if implemented, beds are less of an issue and would result in less need for legal strategies to compel. Ms. Aylor noted that a bigger focus on recovery throughout the system would address all of the concerns she mentioned.

Additional member discussion:
Mr. Lee stated that this document is not the final document and that a draft will be provided to the Committee for further discussion and approval during a conference call. Following the same process for approval that the Committee utilized for the Allocation Methodology

and Utilization Review Protocol recommendations, the members agreed to allow Mr. Lee as chairperson to make a final approval if quorum was not reached for voting during the upcoming conference call.

MOTION:
Mr. Jim Smith moved to accept the proposed framework for a comprehensive plan for the coordination of forensic services as proposed by the Forensic subcommittee as reviewed and revised by the Committee. The motion also stated to allow Mr. Lee to approve the document on behalf of the full Committee, pending review by Committee members. Ms. Shelley Smith seconded the motion. The Committee members unanimously approved the motion by voice vote, with no nays and no abstentions.

Action Item:
- Ms. Kat Lewis will research how courts in other states address the challenges of funneling misdemeanors away from inpatient care to share it with the Committee.

Agenda Item 7: Adjourn
Mr. Lee adjourned the meeting at 11:55 a.m.

DRAFT

Joint Committee on Access and Forensic Services: Attendance Records January – March, 2016

MEMBER NAME	Jan	Feb	Mar	MEMBER NAME	Jan	Feb	Mar
Allison, Jim			X	Lewis, Kathryn	X	X	X
Burkeen, Honorable Daniel	X		X	McLaughlin, Darlene MD	X		X
Cusumano, Sherry	X	X	X	Oncken, Denise	X	X	X
Davis, Lorie		X	X	Schnee, Steven PhD	X	X	X
Davis, Mike	X		X	Smith, Shelley		X	X
Desai, Tushar MD	X			Smith, James	X	X	X
Faubion, Matthew MD	X	X	X	Suiter, Honorable Wes	X		X
Gentry, Michael	X			Switzer, Gyl			X
Hall, Jerry				Taylor, Sally MD	X	X	
Holcomb, Valerie		X	X	Wilson, Sheriff Dennis	X		
Gray, Anna/Holstein, Nicholas	X	X		Wilson, Stacy JD		X	
Lee, Donald	X	X	X	Zamora, April	X		

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

JOHN HELLERSTEDT, M.D.
COMMISSIONER

February 15, 2016

ACTION

MEMORANDUM FOR THE EXECUTIVE COMMISSIONER

THROUGH: Mary Katherine Stout – Special Advisor to the Executive Commissioner

FROM: John Hellerstedt, M.D.
Commissioner

SUBJECT: Recommendations for a Bed Day Allocation Methodology and Utilization Review Protocol

Purpose

To convey the report and recommendations of the Joint Committee on Access and Forensic Services regarding an updated bed day allocation methodology and utilization review protocol, as required by Section 2, S.B. 1507, 84th Legislature, Regular Session, 2015. S.B. 1507 requires the Executive Commissioner to adopt an updated bed day allocation methodology and utilization review protocol by June 1, 2016.

Background/Summary

S.B. 1507 requires the Commission to divide the state into regions for the purpose of allocating state-funded hospital beds to each region, with input from local mental health authorities (LMHAs), local behavioral health authorities (LBHAs), stakeholders, and the Department of State Health Services (DSHS) Forensic Director.

It further requires the Executive Commissioner to adopt a bed day allocation methodology and a utilization review protocol. The Joint Committee on Access and Forensic Services (JCAFS) was established under the provisions of the bill and is charged with submitting a proposal for an updated bed day allocation methodology and utilization review protocol for the Executive Commissioner's consideration.

The utilization review protocol is an alternative to prior policy of potentially assessing financial penalties on a LMHA from which more patients come into the state hospital system than are

allocated to that LMHA.

This report documents recommendations by the JCAFS to the Executive Commissioner regarding an updated bed day allocation methodology and utilization review protocol.

These recommendations are narrowly drawn to respond to the immediate task defined by S.B. 1507. The allocation methodology and utilization review protocol are based on current resources and do not address the underlying capacity challenges facing the mental health service system. Such challenges undermine the efficacy of these recommendations. As the committee continues its work, it will consider recommendations to ensure an appropriate array of services with adequate capacity to serve the state's growing population.

Discussion

Regions

The JCAFS considered the division of the state into regions in conjunction with the bed day allocation methodology. The committee includes representation from local authorities and a diverse group of other stakeholders.

Historically, DSHS has allocated bed days to LMHAs and LBHAs. Because the local authorities retain responsibility for authorizing hospital admissions, the JCAFS recommends that the LMHA/LBHA local service areas continue to serve as the regions used for the bed day allocation methodology.

Bed Day Allocation Methodology

S.B. 1507 requires the bed day allocation methodology to be based on the identification and evaluation of factors that impact utilization, including:

- Clinical acuity;
- Prevalence of serious mental illness; and
- Availability of resources in the region.

The current methodology allocates available beds among local service areas based on the total population; a local authority with ten percent of the state's population would be allocated ten percent of the available beds. Available beds include all beds in the state hospital system, excluding maximum security beds and residential adolescent beds. Beds in the state hospital system include state hospital beds, contracted community beds, and contracted private psychiatric beds.

Recommendations

The committee has five recommendations regarding the bed day allocation methodology:

1. Maintain the current exclusions for maximum security beds and residential adolescent beds.
2. Update the current bed day allocation methodology to allocate beds based on the poverty-weighted population, which gives double weight to the population with incomes at or below 200 percent of the Federal Poverty Level (FPL):

   Poverty-weighted Population = Total Population + Population ≤ 200% FPL

3. Continue to evaluate the utility and potential impact of incorporating factors related to acuity and the availability of local resources.
4. Use the bed day allocation as a metric for analyzing bed day utilization, but do not consider imposing a sanction, penalty, or fine on a local authority for using more than the allocated number of hospital bed days since such financial penalties would require further legislative action to authorize.
5. Modify existing funding contracts with local authorities to clarify that provisions allowing for penalties for contract violations do not include using more bed days than is allocated to the local authority under the bed day allocation.

Rationale

The committee is mindful of the possibility that making major changes to the bed day allocation methodology could disrupt the system and result in unintended consequences. Therefore, the committee acknowledges the following issues continue to affect the development of a new bed day allocation methodology:

- Data is not available to directly measure the prevalence of serious mental illness or the acuity of the population within each local service area.
- More time is needed to assess the utility and potential impact of incorporating available indirect indicators of acuity and the availability of local resources.

Accordingly, the committee bases its recommendation to use of the poverty-weighted population on the following reasons:

- Research has indicated a correlation between poverty and serious mental illness, suggesting that poverty might serve as a proxy indicator for prevalence.
- The overwhelming majority of individuals receiving DSHS-funded services have incomes at or below 200% FPL.
- The 84th Legislature used the poverty-weighted population rather than the general population as the basis for comparing per capita funding among local authorities and appropriating funds to those below the statewide level of per capita funding. Using the same metric for allocating funding and hospital beds establishes a consistent approach to resource allocation. In addition, the proposal to move to the poverty-weighted population was supported by a broad group of stakeholders during the legislative session.
- The proposed methodology allocates more bed days to local service areas with higher rates of poverty, but does not result in a dramatic redistribution of beds. Compared with the 2016 bed day allocation using the current methodology, only one local service area

will have a bed day reduction of more than 10 percent (Denton County, 11.85%). Only two local services areas will have an increase of more than 10 percent (Tropical Texas, 16.30% and Border Region, 15.73%).

A table detailing the potential indicators evaluated by the JCAFS is included as Attachment 1, and a table showing the impact of the proposed methodology is included as Attachment 2.

Utilization Review Protocol

S.B. 1507 calls for a utilization review protocol that includes a peer review process to:

- Evaluate the use of state-funded beds, alternatives to hospitalization, readmission rates, and the average length of admission; and
- Review diagnostic and acuity profiles to assist in making informed decisions and using available resources efficiently and effectively.

The goal of the utilization review protocol is to bring key decision makers and stakeholders together to:

- Identify factors driving the demand for hospital beds;
- Ensure individuals are served in the most appropriate level of care;
- Develop strategies to address identified local and regional issues; and
- Identify systemic issues and resource needs to inform state policy makers.

Together with the metric established using the bed day allocation methodology, the utilization review protocol presents a problem-solving approach to support efficient and effective utilization of available beds.

<u>Recommendations</u>

The JCAFS submits the following recommendations pertaining to the proposed utilization review protocol:

1. Adopt a flexible framework that allows for refinement as the process is implemented.
2. Incorporate three levels of peer review:
    a. Statewide and regional data analysis;
    b. Analysis of outliers focused on local service areas; and
    c. Individual case review.
3. Revise the current monthly State Hospital Allocation Methodology (SHAM) report to provide local authorities a detailed set of data regarding bed day utilization, length of stay, readmission rates, and other key indicators.
4. Assign responsibility for statewide and regional data analysis to the JCAFS Subcommittee on Allocation and Utilization Review.
5. Establish an expert panel that includes representatives from key stakeholder groups to conduct the local analysis of outliers and individual case reviews with DSHS staff assistance.

6. Provide a mechanism for evaluating whether a regional roundtable may be needed to identify and address regional issues.
7. Develop simple, checklist-style templates for local authorities and state hospitals to use in the peer review process.
8. Establish a tracking system to monitor results and provide feedback to the expert panel and the JCAFS.
9. Pilot the initial protocol in one or two local service areas before implementing on a statewide basis, with the initial pilot beginning in September 2016.

A high-level flow chart of the proposed utilization review protocol is provided in Attachment 3, and explanatory notes are provided in Attachment 4.

The JCAFS will work with DSHS and stakeholders to define the details of the utilization review protocol. Major tasks to be completed include:

1. Revise the monthly utilization report to include an expanded set of data.
2. Develop procedures and forms for the utilization review and individual case review processes, including follow-up.
3. Create templates for the local and regional inventories, including an initial list of recommended practices to address specific issues and barriers.
4. Recruit and train individuals to serve on the Utilization Review Panel.
5. Identify a pool of specialized experts to participate in the local utilization review meetings and Individual case reviews as needed.
6. Develop procedures for initiating and conducting regional roundtables.
7. Establish reporting formats and timeframes.

Recommendation

Accept the JCAFS recommendations for an updated bed day allocation methodology and utilization review protocol.

Executive Commissioner's Decision

Approve _____ Disapprove _____

Modify _____ Schedule Briefing _____

Comments/Acknowledgment _____

Information for Scheduling Briefing (If Requested by the Executive Commissioner)

Meeting Priority and Explanation of Time-Sensitive Factors

S.B. 1507 requires the Executive Commissioner to adopt an updated bed day allocation methodology and utilization review protocol by June 1, 2016.

Possible Date(s) and Time(s)

As your schedule permits.

Participants

Lauren Lacefield Lewis
Assistant Commissioner, Mental Health and Substance Abuse Services

cc: Cecile Young, Chief of Staff

Attachment 1: Indicators Considered for the Bed Day Allocation Methodology
Attachment 2: Impact of Proposed Methodology
Attachment 3: Overview of Utilization Review Processes
Attachment 4: Description of the Proposed Utilization Review Protocol

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Maternal Mortality and Morbidity Task Force

Number of Members: 15

Committee Status (Ongoing or Inactive): Ongoing

Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 9/1/2013

Date to Be Abolished: Unless continued in existence as provided by Chapter 325 - Government Code, the task force is abolished 9/1/2019.

Budget Strategy (Strategies) (e.g. 1-2-4): 2.1.2

Strategy Title (e.g. Occupational Licensing): Strategy - Women and Children's Health Services

Budget Strategy (Strategies):

Strategy Title:

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Health and Safety Code, Chapter 34
State Authority	Admin Code	rules under development, to be adopted by 7/01/2016; 25 TAC 37.401
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$71,851	$127,440	$127,440
Number of FTEs	2.0	2.0	2.0
Other Operating Costs	$2,378	$3,000	$3,000
Total, Committee Expenditures	$74,229	$130,440	$130,440

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	$72,604	$130,440	$130,440
555 - Federal Funds	$1,625	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year

	4	4	4

Committee Description:

The Maternal Mortality and Morbidity Task Force (M3TF) is a statutorily-defined multidisciplinary task force within the department. Texas Health and Safety Code, Sections 34, directs this task force to study and review cases of pregnancy-related deaths and trends in severe maternal morbidity, determine the feasibility of the task force studying cases of severe maternal morbidity, and make recommendations to help reduce the incidence of pregnancy-related deaths and severe maternal morbidity in Texas. If this committee were abolished, DSHS would not have authority to request the records that are essential to conduct death reviews and discern recommendations to prevent severe maternal morbidity and mortality in Texas.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

Per proposed rules, the committee is required to meet quarterly. Meetings are in Austin.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

DSHS completed a report to the legislature in September 2014 on the progress of establishing the M3TF. DSHS and the M3TF are in the process of completing the joint report due September 2016.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

The task force is making its first set of recommendations in the upcoming report to the legislature due September 2016.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ?

Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

6536.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Tasks include requesting of records (such as vital records, autopsies, investigative reports, medical records), redacting, abstracting, data analysis, data management, meeting planning, coordination, liaising with external stakeholders.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

Due to the confidential nature of the work of this task force, there is no opportunity for public attendance or participation. The findings and recommendations of the task force will be made public in the report to the legislature due September 2016.

7b. Do members of the public attend at least 50 percent of all committee meetings?

No

7c. Are there instances where no members of the public attended meetings?

Yes

8. Please list any external stakeholders you recommend we contact regarding this committee.

Dr. Lisa Hollier, Dr. Gary Hankins

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

Yes

9b. Please describe the rationale for this opinion.

The task force has met every quarter since its inception and has started reviewing data and case of maternal morbidity and mortality in Texas. The task force successfully produced its first report and is on schedule to delivering its second report this fall.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

Yes

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

No

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

Maternal Mortality and Morbidity Task Force Quarterly Meeting
October 16, 2015
Meeting Notes and Action Items

Meeting Attendees

Task Force Members					
Name	**Present**	**Absent**	**Name**	**Present**	**Absent**
Dr. Lisa Hollier	X		Dr. James Maher	X	
Dr. Gary Hankins		X	Dr. D. Kimberley Molina	X	
Evelyn Delgado	X		Dr. Carla Ortique	X	
Dr. Meitra Doty		X	Dr. Ronald Peron	X	
Dr. Linda Gaul	X		Dr. Amy Raines-Milenkov	X	
Dr. Kidada Gilbert-Lewis		X	Nancy Jo Reedy	X	
June Hanke	X		Nancy Sheppard		X
Pamala Gessling		X			

Department of State Health Services (DSHS) Staff	Tammy Sajak, Sonia Baeva, Dorothy Mandell, Tonia Mancuso, Julie Stagg, Patricia Lightsey

1. Welcome and Review of Agenda	
Presenters	Dr. Lisa Hollier, Evelyn Delgado and Tammy Sajak

Dr. Hollier called the meeting to order, welcomed Task Force (TF) members and thanked everyone for the work they do to improve maternal health in Texas. The opening remarks were closed by a moment of silence for families impacted by maternal mortality. Dr. Hollier reminded all in attendance of the importance of the confidentiality of the meetings discussions.

Tammy covered logistical information and briefly reviewed the agenda.

2. DSHS Update	
Presenters	Evelyn Delgado

Evelyn Delgado explained that the redaction and abstraction of records is a larger amount of work than the current amount of staff can handle in a timely fashion and help is needed. There is a possibility of contracting this out with the UT System via Dr. Lakey. The TF expressed interest. Nancy Jo Reedy shared that without solicitation academic/practicing Certified Nurse Midwives had approached her and expressed interest in abstracting for the TF. Some of them are familiar with the CA mode. This would allow for flexibility, experience and expertise.

Evelyn shared that the Texas Collaborative for Healthy Mothers and Babies (TCHMB) which consists of 3 standing committees now has a membership of 200 people including some of our TF members. What

has been needed for growth in our endeavors is the support of other entities that complement each other and create leverage across agencies much like a Health Improvement Network. Dr. Lakey from the UT System has approached DSHS about entering into an interagency agreement. This has not only logistical but epidemiology, research and publishing implications for the two groups. The annual TCHMB conference will be held in Austin on November 6, 2015 and everyone was encouraged to attend.

It was reported that Sonia Baeva, DSHS, shared non-confidential (TF) information with AMCHP as they are working to create a portal to share data and promote collaboration amongst states. She will provide the web site information so that the members can review its contents.

Action Items:

- Sonia will share link to the AMCHP portal with the TF.
- Pat will provide membership list of the DSHS staff (Dr. Peron requested this)

3. Procedural **Updates**	
Presenters	Dr. Dorothy Mandell and Sonia Baeva

Sonia passed out an excel form with all of the 2012 cases listed and their records requested/received status. Since our last meeting all delivery hospital records have been requested for 2012 cases and they are coming in. Barriers identified were misspelled names that resulted in the record having to be re-requested. Sonia is keeping a list of fax numbers for the agencies. Education is still needed for the agencies receiving these requests. For example one hospital said that they need to get the patients permission to release records. PDF is the preferred format.

Dorothy discussed the Task Force case workflow related to the subcommittees and review teams. Currently a subcommittee triages a case and if they cannot closed it they report why, make requests and then that case goes to a new team at a later date while the subcommittee is given a new case and starts all over. Then when the first case is ready to be looked at again they would go to a brand new team. The efficiency of this was discussed and the Task Force agreed that the case should remain with the same teams until case closure. All cases would still be presented to the entire TF at case closure. Dorothy will adapt the flow chart for this change.

Action Items:

- Dorothy will update the TF work flow chart to reflect the changes discussed
- Look for opportunities to educate providers regarding medical records release

4. Natural Death Subcommittee #1 Case Review	
Presenters	Dr. James Maher, Dr. Lisa Hollier and Julie Stagg

Julie introduced this section by reviewing the plan for the review with the TF. It was explained that the first page of the report is a high level summary of the prenatal course and case. The remaining pages

provide information from specific records, so some information is redundant. There is a section that describes issues with the records as well as highlights about the case from the abstractor that are not captured elsewhere on the form.

The review of Case 059 was led by Dr. Maher and the Case 002 review was led by Dr. Hollier. A report was presented about each case and the determinations on the Contributing Factors and Consensus forms (TF1) were recorded for each case by Dr. Hollier and received by Sonia.

Case 002 remains open. Needed: Postpartum care and emergency department records. Questions left unanswered include: who was managing this care, what was her pregnancy health coverage, were there social services, case management notes, what was the Hgb on the day of discharge? It was suggested that the team might consider a systems problem related to timing of discharge (4 days) in this case.

Case 059 is closed: Toxicology analysis would be needed, but it does not exist since hospital autopsies do not include toxicology screens. Information needed but not available: did she have preeclampsia and it was missed, how were blood pressures taken, would better postpartum follow up have prevented death?

Dr. Molina explained that medical examiners (ME) perform autopsies on unknown or suspicious deaths, so manner reported influences if an ME autopsy is performed. When a death certificate is signed by a Justice of the Peace (JP) but the autopsy is done by a ME, this is a non-jurisdiction autopsy and the ME only gets information provided by the JP, not the medical record. Only MEs have access to toxicology screening.

Dr. Molina said that the normal heart weight for woman is 300 g.

Dr. Peron asked about how definitive a ME assigned cause of death is and is it ever fallible or can we assume that they are always right? Dr. Molina explained that when compared to physician SOAP notes, an investigative report is subjective, an autopsy is objective and the cause of death is the assessment.

The group had some recommendations to improve identification of maternal deaths and completeness of autopsies (i.e. assurance that the ME has access to medical records when determining cause of death and indicators when a toxicology screening is to be completed) to improve the system:

- Regional ME System
- Mechanism to reimburse the ME (autopsies cost $3000+) when autopsy is mandated and family has not consented to it.
- Discussion re: public backlash regarding mandated autopsies. MEs and JPs do not need consent to conduct autopsy. As long as deaths are reported appropriately, then the ME has the opportunity to consider the case. The problem is that only metropolitan counties have ME jurisdiction.
- Consider general autopsy education for the task force. Medical Providers and hospital risk management personal may benefit from general autopsy education and the importance of completing the required paper work correctly. Education with contact hours or CME would be the preference.
- Dr. Hollier suggested a 2-3 page report to inform the medical community on what happens after death and what is needed.

Julie solicited feedback on TF1:

- #1: Add check box agree with/disagree with death certificate
- #3: Add unable to determine
- #6: Need discrete categories for scheduled/unscheduled/planned/unplanned/in labor/not in labor
- #7: Break question in to two parts – autopsy and investigative report
- #8: Add an 8d and make it "contributing factors." Add clear choice for when more information is needed. Add preventability to the question, more information needed and not possible to obtain information.
- #9: Add option for "Yes, but record not available. Specify record:"
- Change "labor, delivery, postpartum records to "delivery hospitalization".
- Possible new item: Patient discharged prematurely? Reason: [TF members' reasoning for why they thought patient was discharged too soon]

Action Items:

- Pat will work with Dr. Molina to seek resources regarding autopsies.
- Add check box to TF1 that denotes agree with or disagree with death certificate.
- Make discrete categories for scheduled/unscheduled; planned/unplanned; in labor/not in labor.
- On 8d make "contributing factors". Clarify that "no" should be selected if more information is needed. Add preventability to the question. Add a check box that says: "yes more information is needed, but it is not possible to obtain the information.
- Consider changing "labor, delivery, recovery and postpartum records to "delivery hospitalization"
- Pat – change Dr. Peron's organization to Community Health Services Agency remove the s at the end of services to roster and name tents
- Add to initial summary: what type of jurisdiction was it – ME vs. non ME, NICU level of care
- Break Preventability down in groups i.e. patient, family, system
- Consider project of Identify counties with MEs
- Make changes to TF1 items listed above
- Note date postpartum/follow-up visit scheduled on Form A3
- Standardize labs collected on Form A3, and how they are presented on Case Report

5. Natural Death Subcommittee #2 Case Review

Presenters	Dr. Carla Ortique, Dr. Ronald Peron and Pat Lightsey

Pat reminded the presenters of the organization of the Case Reviews and each of the presenters went over their case. Dr. Ortique had Case 088 and Dr. Peron had 003.

Case 003 remains open. Needed: postpartum/follow-up care, prenatal records and emergency department records

Case 088 remains open. Needed: prenatal, emergency department records.

Process feedback:

The phone calls (pre and post) were helpful.

Forms feedback:

- The shorter form was a preference with the ability to ask specific information
- Liked: Information about discrepancies between records
- Disliked: redundancies and a copy of a long report was marked to indicate them – Sonia received
- The longer form was preferred for its detail and many questions were left with the short form. The long form supported better understanding that Dr. Ortique said changed her conclusions. It was recognized that the long form could be shortened to reduce redundancies (keep the clinical impressions without repeating details of assessments, unless there was a change of condition).
- Another opinion: redundancy was not liked but it could be skimmed through and sometimes the details addressed questions that arose. The ideal form would be footnoted when additional information is needed when high level information only is presented. This way everyone on the team could see what has been requested.
- There were concerns about losing too much information with the short form.
- One suggestion was to have a color coded case time line of key events at the beginning of the form.
- It was requested that patient and patient family quotes be recorded as they are very useful to the TF.

Action Items:

- Define prenatal visits and what constitutes one. Suggested that it should only count as a PNC visit if they see the primary care/OB care provider.
- Dorothy suggested reorganization so that the teams follow a case to completion since so much work goes into each case. This would mean that the task force would be divided into review teams but from there the process would not change much. It was agreed that the cases did need to stay with the same team and this would start with the next cases. It was discussed that we would revisit the workgroups and make sure they are divided to have balanced expertise for full case reviews. It was suggested that Dr. Molina not be on a group, but to serve as a consultant for all groups.
- Create a triage form as it is anticipated that the TF will want more records to inform causation and preventability.
- DSHS staff were requested to record time spent on case work. Consider creating a time sheet for this.

6. Texas Legislative Report

Presenters	Dorothy Mandell and Pat Lightsey

Pat informed the group that the next legislative report is due September 1, 2016 and that a time-line would be presented at the next meeting. At this time our Share Point should be up and will aide DSHS and TF members in sharing information related to the report.

Sonia will be studying morbidity stats on a woman by woman case instead of encounter to encounter. Data such as hospital level of care, geography, race, ethnic disparities can be pulled from linked data

sources. A Medicaid-only study could indicate whether care was occurring and how soon a sick woman was receiving care.

Evelyn Delgado shared that the Better Birth Outcomes work group desires a more comprehensive inter-conception care plan including health screening and contraception care with treatment of some chronic conditions.

Action Items:

- Provide an outline of legislative report steps to completion and discussion by the next meeting.

7. DSHS Update

Presenters	Julie S., Tonia M, Pat L. and Tammy S.

Tonia updated the TF on the progress of the SharePoint site. Soon the TF will receive login instructions and an invite to join their SharePoint site. Once the TF has had an opportunity to use SharePoint, they can submit suggestions for how they'd like for it to be utilized and formatting. SharePoint will not be replacing Basecamp.

Julie presented the "Life Change Index Scale" and it was well received.

Pat shared several abbreviation lists including a "do not use list provided by the Joint Commission. The group suggested that we create our own specialty list for the TF to use.

Pat shared next year's meeting dates: March 4, 2016, June 17, 2016, September 16, 2016 and December 9, 2016.

Next meeting is 12/4/2016 – Dr. Gaul, Evelyn D. and Nancy Jo Reedy said they will not be in attendance.

Action Items:

- Consider how to incorporate Life Change Index into forms.
- Make list of abbreviations.
- Poll group and see if there is a better date for the December meeting.

8. Meeting Closing

Presenters	Dr. Hollier and Evelyn Delgado

Brief closing remarks and thanks to attendees was provided.

Maternal Mortality and Morbidity Meeting Attendance

February 20, 2015

Task Force Members					
Name	**Present**	**Absent**	**Name**	**Present**	**Absent**
Dr. Lisa Hollier	X		Dr. James Maher	X	
Dr. Gary Hankins	X		Dr. D. Kimberley Molina	X	
Evelyn Delgado	X		Dr. Carla Ortique	X	
Dr. Meitra Doty	X		Dr. Ronald Peron	X	
Dr. Linda Gaul		X	Dr. Amy Raines-Milenkov		X
Dr. Kidada Gilbert-Lewis	X		Nancy Jo Reedy	X	
June Hanke	X		Nancy Sheppard		X
Pamala Gessling	X				

June 19, 2015

Task Force Members					
Name	**Present**	**Absent**	**Name**	**Present**	**Absent**
Dr. Lisa Hollier	X		Dr. James Maher	X	
Dr. Gary Hankins		X	Dr. D. Kimberley Molina		X
Evelyn Delgado	X		Dr. Carla Ortique	X	
Dr. Meitra Doty	X		Dr. Ronald Peron	X	
Dr. Linda Gaul	X		Dr. Amy Raines-Milenkov	X	
Dr. Kidada Gilbert-Lewis		X	Nancy Jo Reedy	X	
June Hanke	X		Nancy Sheppard	X	
Pamala Gessling	X				

October 16, 2015

Task Force Members					
Name	**Present**	**Absent**	**Name**	**Present**	**Absent**
Dr. Lisa Hollier	X		Dr. James Maher	X	
Dr. Gary Hankins		X	Dr. D. Kimberley Molina	X	
Evelyn Delgado	X		Dr. Carla Ortique	X	
Dr. Meitra Doty		X	Dr. Ronald Peron	X	
Dr. Linda Gaul	X		Dr. Amy Raines-Milenkov	X	
Dr. Kidada Gilbert-Lewis		X	Nancy Jo Reedy	X	
June Hanke	X		Nancy Sheppard		X
Pamala Gessling		X			

December 4, 2015

Task Force Members					
Name	**Present**	**Absent**	**Name**	**Present**	**Absent**
Dr. Lisa Hollier	X		Dr. James Maher	X	
Dr. Gary Hankins	X		Dr. D. Kimberley Molina		X
Evelyn Delgado		X	Dr. Carla Ortique	X	
Dr. Meitra Doty	X		Dr. Ronald Peron	X	
Dr. Linda Gaul		X	Dr. Amy Raines-Milenkov	X	
Dr. Kidada Gilbert-Lewis	X		Nancy Jo Reedy		X
June Hanke	X		Nancy Sheppard		X
Pamala Gessling	X				

March 4, 2016

Task Force Members					
Name	**Present**	**Absent**	**Name**	**Present**	**Absent**
Dr. Lisa Hollier	X		Dr. James Maher	X	
Dr. Gary Hankins	X		Dr. D. Kimberley Molina	X	
Evelyn Delgado	X		Dr. Carla Ortique	X	
Dr. Meitra Doty	X		Dr. Ronald Peron	X	
Dr. Linda Gaul	X		Dr. Amy Raines-Milenkov	X	
Dr. Kidada Gilbert-Lewis	X		Nancy Jo Reedy	X	
June Hanke	X		Nancy Sheppard	X	
Pamala Gessling	X				

Maternal Mortality and Morbidity Task Force Report

As Required By
Senate Bill 495, 83rd Legislature, Regular Session, 2013

Department of State Health Services
September 2014

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Executive Summary

In accordance with Section 2(a) of S.B. 495, 83rd Legislature, Regular Session, 2013, the Department of State Health Services (DSHS) presents this 2014 progress report in establishing the Maternal Mortality and Morbidity Task Force. The DSHS Commissioner has appointed the 15-member task force, including a chair and vice chair. Task force members have been oriented to their roles and duties. DSHS has convened two task force meetings and two additional meetings are planned during 2014. The task force has made considerable progress toward developing the structures, policies, and processes necessary to review maternal death cases and to make recommendations to help reduce the incidence of pregnancy-related deaths and severe maternal morbidity in Texas.

At this time, DSHS has no recommendations for legislation. DSHS appears to have an appropriate statutory framework to assist in studying pregnancy-related deaths and severe maternal morbidity.

Introduction

The Maternal Mortality and Morbidity Task Force (MMMTF) was created to study cases of pregnancy-related deaths and trends in severe maternal morbidity and make recommendations to reduce the incidence of pregnancy-related deaths and severe maternal morbidity in Texas.

S.B. 495, Section 2(a), requires DSHS to submit a report to the Governor, Lieutenant Governor, Speaker of the House of Representatives, and appropriate committees of the Legislature outlining:

(1) DSHS' progress in establishing the MMMTF required by Chapter 34, Health and Safety Code; and
(2) Any recommendations for legislation to assist DSHS in studying pregnancy-related deaths and severe maternal morbidity.

Background

Both nationally and in Texas, there has been a rise in maternal mortality during the past 10 years. Although improvements in health care facilitated a dramatic decline in maternal mortality in the U.S. during the 20th century, women still die from complications of pregnancy. Nationally as well as in Texas, Black women have a maternal mortality rate more than twice as high as White women and this disparity gap has increased since 2007 (See Figure 1, page 6), but the causes of this increase are unclear.

Research indicates between 20 percent and 50 percent of maternal deaths in the U.S. are preventable. Initiatives such as state-based maternal death reviews are known to have the potential to identify deaths, review the factors associated with them, and take action on the findings.[1]

Related National Initiatives

The Centers for Disease Control and Prevention Maternal Mortality Initiative (MMI) documented the maternal death review processes and the capacity to translate the findings into action to prevent maternal death.

The Health Resource and Services Administration's (HRSA) Maternal and Child Health Bureau launched the National Maternal Health Initiative (NMHI) in 2013. The goal of the NMHI is to reduce maternal morbidity and mortality by improving women's health across the life course. A national maternal health strategy is anticipated for release in 2014.

The Association of Maternal and Child Health Programs launched the Every Mother Initiative project in 2013 to strengthen and enhance state maternal morbidity and mortality surveillance systems to inform maternal death prevention and maternal health improvement strategies.

[1] Berg CJ, Callaghan WM, Syverson C, Henderson Z. Pregnancy-related mortality in the United States, 1998 to 2005.Obstet Gynecol. 2010;116(6):1302-9.

Related Texas State Initiatives

The Healthy Texas Babies (HTB) initiative was developed to help Texas communities decrease infant mortality using evidence-based interventions. Framed in the Life Course Perspective, its programs aim to enhance protective factors for those affected by disparities that impact a woman's and her family's health. The initiative is led by the Office of Title V and Family Health in the Family and Community Health Services Division of DSHS in collaboration with the Health and Human Services Commission (HHSC) and the Texas Chapter of the March of Dimes.

DSHS has been an active participant in the Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality sponsored by HRSA. The CoIIN establishes cross-state collaborations and exchanges that support rapid-cycle quality improvement activities and collaborative learning to improve maternal and infant outcomes. Priority objectives of the CoIIN include the following: reduced elective delivery at less than 39 weeks of pregnancy; expanded access to interconception care (between pregnancies); increased smoking cessation among pregnant women; improved infant safe sleep practices; and improved perinatal regionalization (a geographically-targeted approach to assure risk-appropriate care for mothers and infants).

The Perinatal Advisory Council, created by H.B. 15, 83rd Legislature, Regular Session, 2013, develops and recommends criteria for designating levels of neonatal and maternal care, makes recommendations for dividing the state into maternal and neonatal care regions, examines utilization trends in maternal and neonatal care, and recommends ways to improve maternal and neonatal outcomes. The council must submit a report with its recommendations to HHSC and DSHS by September 1, 2015.

The Texas Maternal Mortality and Morbidity Task Force

The MMMTF was created by S.B. 495, 83rd Legislature, Regular Session, 2013, to study maternal mortality and morbidity in Texas. The task force is charged to:

- Study and review cases of pregnancy-related deaths and trends in severe maternal morbidity;
- Determine the feasibility of the task force studying cases of severe maternal morbidity; and
- Make recommendations to help reduce the incidence of pregnancy-related deaths and severe maternal morbidity in this state.

S.B. 495 prescribed the requirements for task force membership and terms, and directed the DSHS Commissioner to appoint task force members. The statute specifies that the task force must meet quarterly and due to the confidential nature of the work, the meetings are not open to the public.

DSHS MMMTF must submit its first biennial joint report on its findings, including recommendations to reduce the incidence of pregnancy-related deaths and severe maternal morbidity in Texas by September 1, 2016. Reports are to be submitted to the Governor, Lieutenant Governor, Speaker of the House of Representatives, the Senate Committee on Health and Human Services Commission and the House Committee on Public Health.

Progress in Establishing the Maternal Mortality and Morbidity Task Force

Solicitation of Task Force Positions

DSHS posted a standardized task force application and information on the DSHS website. DSHS requested nominations from a broad cross section of stakeholder groups, including professional organizations, medical associations, hospital districts, university health care systems, local coalitions, licensing boards, social service entities, and other DSHS and HHSC stakeholders.

DSHS assembled a multidisciplinary application review team comprised of DSHS and HHSC staff. The review team evaluated a total of 51 applications. In considering members to serve on the task force, DSHS prioritized individuals working in and representing communities that are diverse with regard to race, ethnicity, immigration status, and English proficiency; and are from different geographic regions of the state. In addition, the review team recommended individuals who are working in and representing communities that are affected by pregnancy-related deaths and severe maternal morbidity, and by a lack of access to relevant perinatal and intrapartum care. In December 2013, the DSHS Commissioner appointed the 15-member multidisciplinary task force. A task force roster is included in Appendix A of this report.

Task Force Activities to Date

DSHS formed a workgroup, the DSHS Core Team, to manage planning and logistics for the task force meetings and communications. A conference call was held with the DSHS Core Team, the task force chair, and the task force vice chair on January 17, 2014, to orient the chairs to new roles and responsibilities; outline key milestones for the establishment of MMMTF's structure; establish shared expectations about the initial task force meeting; and review and solicit feedback on developed materials.

The inaugural meeting of the MMMTF was held February 28, 2014, in Austin. DSHS staff outlined confidentiality and legal considerations for task force members; presented data relevant to maternal mortality and morbidity in Texas; facilitated a discussion on the task force members' perspectives on analytic approach; and received requests for additional analyses of population level data. DSHS also reviewed task force members' duties, roles and responsibilities, and staffing considerations. The chair and vice chair led task force members in a discussion regarding factors impacting the structure of the task force in Texas; opportunities and resources available for the task force; and components of a logistical action plan for short-term actions.

Work continued after the first meeting to develop the necessary infrastructure including developing drafts of task force policies and of tools to record pertinent data from medical, vital statistic, and other records about the events surrounding a mother's death.

The second meeting of MMMTF was held on June 27, 2014, in Austin. Meeting objectives were to:

- Provide an updated overview of Texas maternal mortality and morbidity data;
- Provide MMMTF with technical assistance from a national leader in maternal mortality and morbidity review; and
- Facilitate future task force planning and direction.

Current Status and Next Steps

The DSHS Core Team continues to:

- Coordinate meeting and communications logistics;
- Develop the internal infrastructure necessary to collect, compile, and disseminate de-identified cases of maternal deaths to the task force for review;
- Review legal considerations to ensure maintenance of full confidentiality of information acquired by DSHS pertaining to a pregnancy-related death or severe maternal morbidity, including identifying information of an individual or health care provider; and
- Provide technical assistance and subject matter expertise to support the activities of the task force members.

The task force continues to develop its structure and processes to support comprehensive review of maternal deaths and development of recommendations to help reduce the incidence of pregnancy-related deaths and severe maternal morbidity in this state. Next steps include refining and finalizing rules of operation, and establishing clear processes to review cases.

Task force members will participate in a technical assistance webinar on severe maternal morbidity in August 2014 and will continue to meet quarterly; meetings are currently scheduled in Austin in October and December 2014.

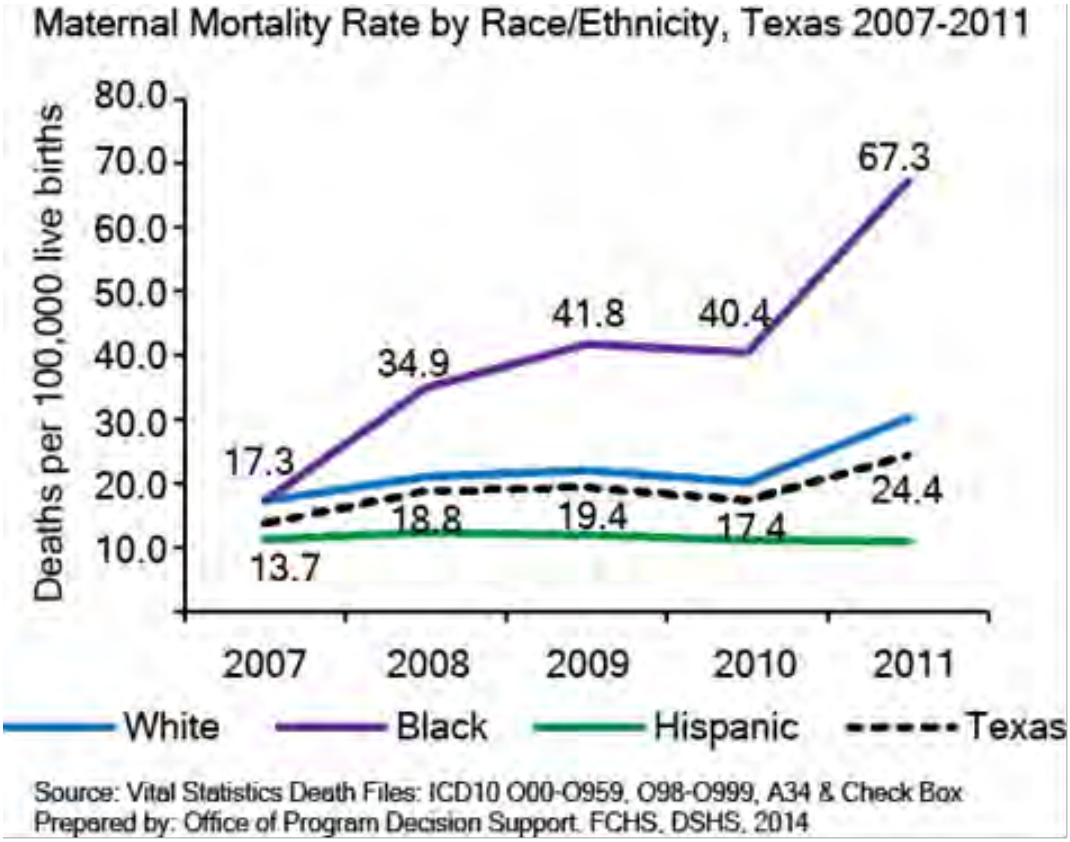
Recommendations for Legislation to Assist the Department in Studying Pregnancy-Related Deaths and Severe Maternal Morbidity

At this time, DSHS has no recommendations for legislation. DSHS appears to have an appropriate statutory framework to study pregnancy-related deaths and severe maternal morbidity.

Conclusion

Since S.B. 495, 83rd Legislature, Regular Session, 2013, went into effect in September 2013, considerable progress has been made toward establishing MMMTF. The DSHS Commissioner appointed a 15-member task force, including a chair and a vice chair. DSHS assembled a team to support the establishment of the task force. Task force members have been oriented to their roles and duties and maternal mortality and morbidity review processes. The task force has held two meetings and has planned for two additional meetings and a webinar during 2014. With support from DSHS, the task force has begun to review state trends in maternal death and severe morbidity and is working to develop rules of operation and the structures and processes necessary to begin case reviews of maternal deaths.

Figure 1: Maternal Mortality Rate by Race/Ethnicity, Texas 2007-2011



Appendix A—Current Task Force Membership

Name	Task Force Position	City
Lisa Hollier, MD, MPH* Chair	Physician specializing in Obstetrics	Houston
Gary Hankins, MD* Vice-Chair	Physician specializing in Obstetrics	Galveston
James Maher, MD*	Physician specializing in Obstetrics	Odessa
Carla Ortique, MD	Physician specializing in Obstetrics	Houston
Ronald Peron, MD	Physician specializing in Family Practice	Greenville
Meitra Leigh Doty, MD	Physician specializing in Psychiatry	Dallas
Kidada Gilbert-Lewis, MD	Physician specializing in Pathology	Houston
Kimberley Molina, MD	Medical Examiner or Coroner responsible for recording deaths	San Antonio
Amy Milenkov, DrPH, MPH	Epidemiologist, Biostatistician, or Researcher of Pregnancy-related Deaths	Fort Worth
Nancy Jo Reedy, CNM, MPH, FACNM	Certified Nurse-Midwife	Arlington
June Hanke, RN, MSN, MPH	Community Advocate	Houston
Armilla Henry, MSN, MEd	Registered Nurse	Houston
Nancy Sheppard, LCSW	Social Worker or Social Services Provider	Austin
Linda Gaul, PhD, MPH	DSHS Representative - State Epidemiologist	Austin
Evelyn Delgado, BS	DSHS Representative – Family and Community Health Services Division	Austin

**indicates maternal fetal medicine specialist*

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Medical Advisory Board

Number of Members: 10

Committee Status (Ongoing or Inactive): Ongoing

Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 1971 **Date to Be Abolished:** NA

Budget Strategy (Strategies) (e.g. 1-2-4): 4.1.4. **Strategy Title (e.g. Occupational Licensing):** Health Care Professionals

Budget Strategy (Strategies): **Strategy Title:**

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Health & Safety Code 12.092 - 12.098
State Authority	Admin Code	25 TAC 1.151 - 1.152
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$108,907	$114,476	$0
Number of FTEs	2.4	2.4	0.0
Other Operating Costs	$8,694	$6,000	$0
Total, Committee Expenditures	$117,601	$120,476	$0

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	$117,601	$114,476	$0
512 - GR Dedicated - Bureau of Emergen	$0	$6,000	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year

	22	22	22

Committee Description: Assist the Department of Public Safety (DPS) in determining whether an applicant for a driver's license or a license holder is capable of safely operating a motor vehicle; or an applicant or holder of a private security commission or a license to carry a concealed handgun is capable of exercising sound judgment with respect to the proper use and storage of a handgun.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

Meetings are held at 8407 Wall Street, Exchange Building, Austin, TX 78754. The MAB meets twice monthly to review DPS referrals, except in November and December when they meet monthly. They must have a quorum of 3 to process referrals. Per rule, the committee is required to meeting upon request by DPS.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

Opinion Sheets are provided to DPS. There are no required documents.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

None to DSHS. Recommendations are given to DPS.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ? Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees? No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015? 4000.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Reviews medical history forms and prepares cases for presentation to the MAB. Identifies medical form or case file deficiencies, consults with private physicians regarding completion of medical history form entries, law enforcement, or the individual to ensure that case file contents are clear and complete. Schedules physicians, coordinates and facilitates MAB meetings. Reviews physician opinion documents after MAB meetings and enters or facilitates entry of opinions into MAB database. Provides technical assistance and support for the MAB.

6. Have there been instances where the committee was unable to meet because a quorum was not present? No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes. **3 members were in attendance during the last meeting, 3 prior to that, and 2 prior to that. No attendance rosters are available. This is not an open meeting.**

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

None.

7b. Do members of the public attend at least 50 percent of all committee meetings? No

7c. Are there instances where no members of the public attended meetings? Yes

8. Please list any external stakeholders you recommend we contact regarding this committee.

Department of Public Safety

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals? Yes

9b. Please describe the rationale for this opinion.

The MAB provides medical opinions to DPS regarding applicant licensure for drivers licenses and concealed hand guns.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute? Yes

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area? No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

Needed to provide guidance to DPS in determining whether an applicant for a driver's license or a license holder is capable of safely operating a motor vehicle; or an applicant or holder of a private security commission or a license to carry a concealed handgun is capable of exercising sound judgment with respect to the proper use and storage of a handgun.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

Increasing their compensation and/or reimbursement of travel expenses would help to attract a wider variety of physician types.

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Newborn Screening Advisory Committee

Number of Members: 10 minimum

Committee Status (Ongoing or Inactive): Ongoing

Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 9/1/2009

Date to Be Abolished: Not specified

Budget Strategy (Strategies) (e.g. 1-2-4)	2.1	**Strategy Title (e.g. Occupational Licensing)**	Strategy - Women and Children's Health Services
Budget Strategy (Strategies)	2.1.2.3	**Strategy Title**	Sub-strategy - Population Based Services

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Health & Safety Code, Chapter 33, Sec. 33.017
State Authority	Admin Code	25 TAC, Sec. 37.64
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$968	$1,000	$1,000
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$968	$1,000	$1,000

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	$968	$1,000	$1,000
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year

Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
3	3	3

Committee Description: Purpose and Duties: a) advise DSHS regarding strategic planning, policy, rules, and services related to newborn screening and additional newborn screening tests for each disorder included in the list described by Section 33.011 (a-1); b) adopt bylaws governing the committee's operation; and c) meet at least three times per year or at other times at the call of the Commissioner of the Department of State Health Services.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

Per statute, the Committee meets at least three times per year: two are held via conference call, and one is held as an in-person meeting in Austin.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

This committee is not subject to Chapter 2110, Government code and not required to submit deliverables.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

The Committee recommended implementation of the Secondary Panel of the Recommended Uniform Screening Panel (RUSP) of disorders in 2014. The Newborn Screening program implemented screening of the Secondary Panel in May 2015.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ?

Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

700.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

(1) Meeting Dates: Set and confirm meeting dates with Chairperson; secure meeting room(s).
(2) Agenda: assist Chairperson with soliciting agenda items from committee members; finalize agenda and submit to OGC for submission to TX Register; confirm presenters and time slots.
(3) Meeting Packet: prepare meeting packets and distribute to members prior to meetings.
(4) Meetings: Ensure equipment is available for conference calls and in-person meetings; coordinate with Chairperson; Post-meeting: provide follow-up information and/or action items as necessary; coordinate travel reimbursement; transcribe meeting minutes.
(5) Perform tasks related to soliciting and filling vacant committee positions. Includes notification to stakeholders of vacancies, collecting, compiling application evaluations, and preparing memo to the commissioner for new member approvals. Ensure new members receive training and committee processes. Coordinate and post committee website information. Respond to all inquiries and assignments related to committee activities.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes. This information is captured in the meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

This committee is subject to Government Code, Chapter 551, Open Meetings, and includes a time slot for Public Comment at the end of each meeting. The details of the meeting (time, location, topics/discussion items) are included on the agenda which is posted on the Texas Register, the Newborn Screening Advisory Committee business page, and via gov delivery email. The Minutes are also posted on the Newborn Screening Advisory Committee business page.

7b. Do members of the public attend at least 50 percent of all committee meetings?

No

7c. Are there instances where no members of the public attended meetings?

No

8. Please list any external stakeholders you recommend we contact regarding this committee.

Texas Hospital Association, Texas Medical Association, Texas Pediatric Society, March of Dimes

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

Yes

9b. Please describe the rationale for this opinion.

Recommendation to implement Secondary Panel of the Recommended Uniform Screening Panel (RUSP) of disorders in the Spring of 2015

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

No

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

The committee provides valuable advice regarding policies and services related to newborn screening and additional tests to be included.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

Suggest modification to include a term limit for Chairperson of the Committee.

Newborn Screening Advisory Committee
Bylaws

I. Bylaws. These bylaws govern the proceedings of the Newborn Screening Advisory Committee established by Health and Safety Code, §33.017.

II. Duties. The Newborn Screening Advisory Committee shall:
- A. Advise the Department of State Health Services (DSHS) regarding strategic planning, policy, rules, and services related to newborn screening, and additional newborn screening tests;
- B. Adopt bylaws governing the committee's operation; and
- C. Meet at least three (3) times each year or at other times at the call of the commissioner of state health services.

III. Composition of, Appointment of, and Terms of Appointment for Members.
- A. *Members*. The Newborn Screening Advisory Committee should be composed of the following members:
  1. at least four physicians licensed to practice medicine in this state, including at least two physicians specializing in neonatal-perinatal medicine.
  2. at least two hospital representatives.
  3. at least two persons who have family members affected by a condition for which newborn screening is or may be required under this subchapter; and
  4. at least two health care providers [persons] who are involved in the delivery of newborn screening services, follow-up, or treatment in this state.
- B. *Appointment of members.* All members shall be appointed by the Commissioner of the DSHS in accordance with DSHS policy for the appointment of advisory committee members.
- C. *Terms of membership.* The Commissioner of DSHS shall appoint members for three-year terms. Members may be reappointed.
- D. *Resignation of Member*s. Members of the committee shall tender their resignations in writing to the chairperson, with a copy to the assigned DSHS staff member.
- E. *Vacancie*s. DSHS shall fill vacancies on the committee in the same manner as original appointments to serve for the remainder of the unexpired term and in accordance with DSHS policy.

IV. Compensation. A member of the committee is not entitled to compensation, but is entitled to reimbursement for travel or other expenses incurred by the member while conducting the business of the committee, as provided by the General Appropriations Act.

V. Responsibilities of Members. Members shall:

A. Attend committee meetings and/or participate in meetings conducted by conference call;
B. Give prior notice to the assigned DSHS staff member if they are unable to attend or participate in a committee meeting or in a conference call;
C. Keep their organizations and/or networks informed of the committee's activities; and
D. Review committee agenda items and the supporting documentation before meetings and participate in discussions.

VI. Officers.

A. The committee shall elect a chairperson from its members who shall preside over each committee meeting.
B. The committee may select from its members a vice chairperson or other officers.
C. The chairperson shall preside at all committee meetings at which he or she is present, call meetings in accordance with Health and Safety Code, §33.017, and appoint subcommittees of the committee as necessary. The chairperson may serve as an ex-officio member of any subcommittee of the committee.

VII. Meetings, Quorums and Voting**.** The committee shall meet at least three times each calendar year.

A. DSHS staff shall make meeting arrangements. DSHS staff shall contact committee members to determine their availability for a meeting date.
B. Meetings will be held during regular DSHS business hours and will be open to the public.
C. The committee is not a "governmental body" as defined in the Open Meetings Act, Texas Government Code, Chapter 551. However, in order to promote public participation, an agenda for each meeting will be posted.
D. Meetings may be conducted by telephone conference call.
E. Each member of the committee shall be informed of a committee meeting at least ten business days before the scheduled meeting date.
F. The quorum for a meeting of the committee is six members. Six members shall constitute a quorum for the purpose of transacting official business. Actions taken by the committee must be approved by a majority of the members present.
G. Each member shall have one vote, and the member may not authorize another individual to represent the member by proxy.
H. The committee shall make decisions in the discharge of its duties without discrimination based on any person's race, creed, gender, religion, national origin, age, physical condition, sexual orientation, or economic status.
I. The committee is authorized to transact official business only when in a legally constituted meeting with a quorum present.

J. The agenda for each meeting shall include an opportunity for any person to address the committee on matters related to committee business. The chairperson may establish procedures for such public comment, including a time limit on each comment.

K. DSHS staff shall record, via written meeting notes, the proceedings of each meeting.
    1. A draft of the minutes approved by the chairperson shall be provided to each committee member within 30 calendar days of the meeting; and
    2. After approval by the committee at the next meeting, the chairperson shall sign the minutes.

L. Meetings shall be conducted according to *Roberts' Rules of Order, Newly Revised.*

VIII. Staff. The Department of State Health Services shall provide staff support for the committee and its subcommittees.

IX. Subcommittees. The committee may establish subcommittees as necessary to assist the committee in carrying out its duties.

A. The chairperson shall appoint members of the committee to serve on subcommittees and to act as subcommittee chairpersons.

B. Subcommittees shall meet at the call of the subcommittee chairpersons, as the subcommittees' workloads require.

C. A subcommittee chairperson shall make regular reports to the committee at each committee meeting or in interim written reports as needed. The reports shall include an executive summary or minutes of each subcommittee meeting.

X. Statement by members**.**

A. DSHS and the committee shall not be bound in any way by any statement or action on the part of any committee member except when a statement or action is made in response to specific instructions from DSHS or the committee.

B. The committee and its members may not participate in legislative activity in the name of the committee or DSHS. Committee members may represent themselves or other entities in the legislative process.

C. A committee member shall not accept or solicit any benefit that might reasonably tend to influence the member in the discharge of the member's official duties.

D. A committee member shall not disclose confidential information acquired through his or her committee membership.

E. A committee member shall not knowingly solicit accept, or agree to accept any benefit for having exercised the member's official powers or duties in favor of or against another person.

F. A committee member who has a personal or private interest in a matter pending before the committee shall publicly disclose the fact in a

committee meeting and may not vote or otherwise participate in the matter. The phrase "personal or private interest" means the committee member has a direct financial interest in the matter but does not include the committee member's engagement in a profession, trade, or occupation.

XI. Revisions to Bylaws. The committee may revise these bylaws by majority vote at any meeting.

Texas Department of State Health Services
1100 W. 49th, Austin, Texas 78756
Moreton Building, M2-204
February 27, 2015 via conference call
Minutes

Members via Conference Call:

William Morris, LVN
Kelly McDonald
Nancy L. Beck, MD
Charleta Guillory, MD
Michael E. Speer, MD
Mark E. Lawson, MD
Scott D. McLean, MD
Felicia M. Adams, MSN

Staff

David R. Martinez, Department of State Health Services (DSHS), Newborn Screening Unit Manager
Debra Freedenberg, MD, PhD, DSHS Newborn Screening Unit
Beth Rider, DSHS, Newborn Screening Unit, Ombudsman, Committee Support
Brendan Reilly, Program Specialist, DSHS Laboratory, Biochemistry & Genetics Branch
Rachel Lee, PhD, Branch Manager, DSHS Laboratory, Biochemistry & Genetics Branch
Patricia Hunt, DSHS Laboratory, Metabolic Screening Group
Karen Hess, DSHS, Newborn Screening Genetics Branch Manager
Sam Cooper, DSHS, Director, Specialized Health Services Section

Guests

Jennifer Needham via conference call with Dr. Guillory
Sarah Kingsberry, Hays County

Call to Order and Roll Call of Committee Members, Staff and Guests

Chairman Morris called to order the February 27, 2015 meeting of the Newborn Screening Advisory Committee at 10:07 am. Introductions were made and Chairman Morris welcomed everyone. Members, staff and guests attending are listed at the beginning of these minutes. A GoToMeeting link was provided for the benefit of Committee members to allow them to visually follow along with each agenda topic and PowerPoint presentation.

Review and Approval of Minutes

Chairman Morris asked if everyone had a chance to review and approve the minutes from the October 2, 2014 meeting. He stated that he took a quick look and did not see anything that needed to be changed. Dr. Guillory seconded the motion to approve the minutes. Motion passed.

Newborn Screening Program Updates-Debra Freedenberg, Rachel Lee

Debra Freedenberg and Rachel Lee gave updates on the newborn screening programs. The PowerPoint presentation included the Newborn Screening System; information on courier services; and electronic data transfer. Information was provided on the efforts to increase web-based demo

entry and expand HL7 electronic data transfer. Updates to the technology/instrumentation upgrades and developments were given. Potential new screening conditions are Pompe; Mucopolysaccaridosis Type I (MPS1); and X-linked Adrenoleukodystrophy (X-ALD). Potential issues include the proposed Senate Bill (SB) 475; and the "Newborn Screening Saves Lives" reauthorization. The Updates included NBS educational efforts, including DSHS Grand Rounds, webinars, and THSteps modules. There are also NBS Hearing Grant activities which were provided in the presentation.

Secondary Panel Updates-David R. Martinez

David R Martinez gave an update on the secondary panel. Mr. Martinez informed the Committee that a metabolic workgroup meeting was held where metabolic specialists were invited to a working meeting to review information being prepared to get ready to roll out the secondary panel. Mr. Martinez informed the Committee that the needed hardware and software upgrades mentioned at the last meeting had been done. At the metabolic meeting, the metabolic specialists helped review the data collected for metabolic conditions and looked at the ACT and FACT sheets that were prepared for the secondary conditions. Mr. Martinez stated that the edits received from Committee members on the brochure that the Committee had reviewed at the previous meeting in October, 2014, were incorporated and shared with the metabolic specialists. Mr. Martinez stated input was received from the metabolic specialists on many ACT and FACT sheets, including lab cutoffs, and algorithms. There is educational information on our website which was shared with the specialists. We have other brochures that mention the number of conditions that we are screening for. In anticipation that we may add more conditions, we are going to a more generic terminology. Mr. Martinez stated that we were fortunate to get the metabolic specialists' input and the workgroup meeting was very productive. Mr. Martinez stated that we are still preparing some of the software changes that need to be made. He stated that we still do not have a firm implementation date, but the Committee would be notified.

Critical Congenital Heart Defect (CCHD) Updates-Karen Hess

Karen Hess gave the Committee a PowerPoint presentation update on CCHD.

- CCHD reporting began September 1, 2014
- Only cases that have been diagnosed are reported
- To date we have received 64 reports from 18 different sites
- The data is fairly new so the statistics may not be reflective across the state
- Of the facilities reporting, 33% of babies get ECHO within 24-48 hours

Dr. Guillory and Dr. Gong are both involved in the TxPOP project and work with the facilities diagnosing and reporting CCHD. The Newborn Screening Algorithm includes screening for CCHD based on pulse oximetry of the right hand and foot after 24 hours.

Timeliness of Newborn Screening-Rachel Lee, Brendan Reilly

Rachel Lee and Brendan Reilly discussed timeliness of newborn screening. A PowerPoint presentation was presented to the Committee.

Texas Department of State Health Services
1100 W. 49th, Austin, Texas 78756
Moreton Building, M2-204
February 27, 2015 via conference call
Minutes

- Discretionary Advisory Committee on Heritable Disorders in Newborns and Children (DACHDNC) recommendations related to timeframe for first newborn screen, including the presumptive positive results for time-critical conditions should be communicated to the newborn's healthcare provider within five days of life; all other presumptive positive results should be communicated to the newborn's healthcare provider within seven days of life; all NBS tests should be completed within seven days of life; and encouraging states to have 95% or more of newborns meeting the timeliness goals by 2017.
- Pre-analytical measures in Texas – 96.2% of first screens collected within 48 hours after birth and 23.8% first screens received within 24 hours of collection. Many ongoing activities to improve transit time have been conducted and are effective (~90% of specimens are received within 72 hours of collection). Additional considerations and requirements are needed to achieve further improvement.
- Analytical and post-analytical measures in Texas – 30.7% of presumptive positive results for time-critical conditions were reported within five days of life, 79% of all other presumptive positive results were reported within seven days of life, and 67% of all NBS tests were reported within seven days of life.
- Potential requirements and considerations to improve analytical and post-analytical measures, including Check-in / Punching (Ch-IP) Workflow redesign and update testing platform.
- Discussion during and following the presentation included Committee members' and DSHS staff commenting on any potential impact to timeliness after the secondary conditions are required. The rules currently only require the initial screen to be collected between 24 and 48 hours, but have no requirement on transit time. However, the national goal is to receive the initial specimen within 24 hours of collection. Certain other states, such as Iowa and North Dakota have couriers seven days a week; courier cost is included in their newborn screening fee. Iowa appears to be a model state as they receive 94% of their specimens within 24 hours. The question was asked whether Iowa regulates the costs through legislation, and whether that would be feasible for Texas (cost-effective). Texas DSHS currently publishes the top performers on the website, and discussion included whether the poor performers should also be posted online. It was recommended that the timeliness issue specific to poor performing facilities be brought to the applicable facility CEO's attention. Reportedly, a comparison between Texas and other states shows Texas to rank in the lowest quartile based on percentage of specimens meeting recommended timeframes. The discussion concluded with a suggestion that we gather high-level benchmark data to provide a fiscal impact statement with regards to taking measures for improvement of transit time to 24 hours.

NBS Follow-up Activities-Specialist Perspective-Debra Freedenberg

Dr. Freedenberg informed the Committee that Newborn Screening is a system, and we are collaborative partners with clinical care providers (the specialists as well as the primary care providers)

and the families. Questions and some concerns related to both short-term and long-term follow-up activities have been received. Dr. Freedenberg stated that what was wanted was an open discussion with the Committee about what concerns or issues specialists have related to short-term and long-term follow-up. Short-term follow-up is defined as immediate follow-up of an abnormal screen until the case is cleared or diagnosed, and long term follow-up is periodic contact with specialists after a child is diagnosed with a condition. Follow-up for the long-term is challenging because the data is not captured easily and consistently. It would be helpful to find a way to share the data electronically or web-based. Dr. Guillory mentioned providers may also explore collaborating with the March of Dimes. Dr. Lawson mentioned that for geographically large and/or more rural areas, such as west Texas, follow-up is particularly difficult because there are fewer specialists available. It is also difficult to know who the newborn's primary care provider may be, and whether the family is enrolled with a Medicaid Managed Care Organization (MCO). The ACT and FACT sheets should be available to MCOs and providers. Sam Cooper informed the Committee that someone from the Health and Human Services Commission could talk about the case management responsibilities of the MCOs with the Committee if that would be of interest to them at the June meeting. David Martinez advised the NBS Unit webpage includes a list of the Texas Newborn Screening Specialists and the link to that webpage will be provided via email following the meeting. The map of the Regional Public Health Coverage across the state of Texas will be included in that email and as an additional resource.

Legislative Session/Sunset Review-David R. Martinez

David R. Martinez gave the Committee an update on the 84th Legislative Session and the Sunset Review. Mr. Martinez stated that on January 13, 2015, the Regular Legislative Session began. The Legislature is working on the state budget and the bills that will affect the Texas Department of State Health Services (DSHS). Last week, the Senate and the House had a Finance Hearing where DSHS presented the budget in Senate Bill 1 and House Bill 1 in hearings that have already begun. More bills will be forthcoming. As the Committee is aware, the Legislators will review the recommendations that were submitted by the Sunset Advisory Commission regarding DSHS and Health and Human Services (HHS) agencies, and the recommendation to consolidate the five agencies under the Health and Human Services Commission. The deadline for filing a bill is March 13, 2015. Mr. Martinez stated that as we get closer to the deadline, we will see bills being filed. Some of the major milestones are:

- March 13, 2015 – Deadline for filing bills
- May 26, 2015 – Last day for House and Senate to adopt conference committee reports
- May 27, 2015 – Last day of session; only corrections permitted
- June 21, 2015 – Date by which the Governor must approve or veto bills
- August 31, 2015 – September 1, 2015 – Dates on which most bills are effective

Mr. Martinez stated that throughout this time frame, we are responding to inquiries from Legislators as they seek the information they need to make informed decisions. Department staff will serve as resource witnesses and provide bill analysis and fiscal notes throughout the session. The Newborn

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Screening Program monitors any filed bills that relate to blood spot screening and point of service screening that includes Hearing and Critical Congenital Heart disease. Mr. Martinez advised that the information on the proposed bills that are of importance to our Committee: Senate bill (SB) 219, Senate Bill (SB) 475, Senate bill (SB) 791, and Senate Bill (SB) 628, will be provided via email.

Public Comments

None

Agenda Items

1) Secondary Panel Updates
2) Follow-up activities
3) Follow-up on biliary atresia
4) Bench mark data related to the timeliness piece maybe with high level fiscal impact kind of estimate
5) Have someone from HHS to discuss the case management responsibilities of MCOs

Adjournment

The next meeting will be held on Thursday, June 18, 2015 at 10:00 am via conference call. There being no further business, the meeting was adjourned at approximately 1:00 p.m.

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10:00 a.m. – 2:00 p.m.
Minutes

Members via Conference Call
William Morris, LVN
Alice K. Gong, MD
Charleta Guillory, MD
Thomas M. Zellars, MD
Scott D. McLean, MD
Felicia M. Adams, MSN
Aida Gonzalez, RN

Staff
Beth Rider, Department of State Health Services (DSHS), Ombudsman, Committee Support
Karen Hess, DSHS, Newborn Screening Genetics Branch Manager
Patricia Hunt, DSHS Laboratory, Metabolic Screening Group
Brendan Reilly, Program Specialist, DSHS Laboratory, Biochemistry & Genetics Branch
Debra Freedenberg, MD, PhD, DSHS Newborn Screening Unit
Rachel Lee, PhD, Branch Manager, DSHS Laboratory, Biochemistry & Genetics Branch
Susan Tanksley, PhD, DSHS, Laboratory Operations Unit Manager
Eugenia Dunham, DSHS, Newborn Screening Support Group Manager
Lynette Borgfeld, DSHS, Laboratory, Endocrine, Hemoglobinopathies
D'Andra Luna, DSHS Laboratory, DNA Analysis Group
Michelle Shaffer, DSHS, Newborn Screening Endocrine Group
Sam Cooper, DSHS, Specialized Health Services Section

Guests
Shannon Lucas, March of Dimes
Daniela De Luna Olivares, Health and Human Services Commission (HHSC)
Sanjiv Harpavat, MD, PhD via conference call

Call to Order and Roll Call of Committee Members, Staff and Guests
Chairman Morris called to order the June 18, 2015 meeting of the Newborn Screening Advisory Committee at approximately 10:15 a.m. Introductions were made and Chairman Morris welcomed everyone. Members, staff and guests attending are listed at the beginning of these minutes. A GoToMeeting link was provided for the benefit of Committee members to allow them to visually follow along with each agenda topic and PowerPoint presentation.

Review and Approval of Minutes
Chairman Morris asked if everyone had received a copy of the minutes from the February 27, 2015 meeting. He asked the Committee if there were any concerns or changes that needed to be made. No changes or concerns were noted and Chairman Morris requested that a motion be made to accept the minutes. Dr. Guillory made a motion to approve the minutes as is. Motion passed.

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Minutes

Timeliness of Newborn Screening – Rachel Lee, PhD, Brendan Reilly

Rachel Lee and Brendan Reilly provided updates on the timeliness of newborn screening. A PowerPoint presentation was presented, which included an Overview that focused on Pre and Post-analytical Measures, (including a national comparison, a current status, and cost estimates)

- Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC) provided recommendations earlier this year. In the recommendations, they specified that the presumptive positive results for time-critical conditions should be communicated to the healthcare providers within five days of life. All abnormal results of the other conditions should be reported to the healthcare providers within seven days of life. All results should be reported within seven days of life. In order to meet these standards, the ACHDNC also recommends that specimens should be collected within 48 hours after birth and specimens should be received in the laboratory within 24 hours after collection. The recommendations also include a goal to achieve compliance of more than 95% by the end of 2017.
- The Association of Public Health Laboratories (APHL) conducted a national survey to gather data regarding timeliness for all 50 states. Data gathered between January and May 2014 revealed 87.5% of first screen specimens were collected within 24-48 hours of life, which was above the national median (82.2%). However, during this timeframe, only 20.5% of specimens were received at the DSHS Laboratory within 24 hours of collection (national median = 25%). More recent data (July to December 2014) show that 96.2% of first screens were collected within 48 hours after birth (meeting the 95% goal), and 23.8% of first screens were received within 24 hours of collection.
- A Transit Time Project was initiated in 2013 to decrease time from collection to receipt in the DSHS Laboratory. Transit time decreased during 2014, from approximately 70% of first screens received within three days of collection to about 90% of first screens received within three days of collection. Since late 2014, however, the results have plateaued.
- Receipt within 3 days of collection is still the goal being used in Texas.
- Gaps and Barriers to improvement?
    - Submitters –
        - Consistent poor performers
        - Inefficient use of courier service
        - Delayed delivery of specimens to lab from nurseries
        - Inadequate/weekend staffing
    - DSHS Couriers
        - Current couriers do not cover all submitters
        - Courier operating hours
        - Weather and holiday delays
        - Geographic size of state

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    - Laboratory
        - No receiving on Sundays or major holidays
        - Lack of resources to provide education to low volume problem sites
        - Lack of resources to monitor efficient use of courier service
        - Inefficient/incomplete escalation system to monitor worst performers
- New initiatives
    - Escalation team for persistent poor performers
    - Identify top 10 based on percentage delayed as opposed to volume delayed
    - Courier cost analysis
    - Investigate needs for additional staff to provide onsite education
- DSHS Courier
    - Study was conducted based on two Tiers of courier service [Lone Star Delivery and Processing (full-service courier) and FedEx]
- Analytical and post-analytical measures in Texas for July to December 2014 – 30.7% of presumptive positive results for time-critical conditions were reported within five days of life, 79% of all other presumptive positive results for non-critical conditions were released within seven days of life and 25.4% were reported within seven days of life.

Secondary Panel Implementation – Debra Freedenberg, MD, Rachel Lee, PhD

Dr. Debra Freedenberg informed the Committee of the screening for the secondary conditions as implemented on May 26, 2015. The Texas Newborn Screening statute requires newborn screening for disorders listed on the Recommended Uniform Screening Panel (RUSP) to the extent that funding allows. It exempts screening for galactokinase and galactose epimerase deficiencies. The DSHS Newborn Screening Laboratory performs testing for all laboratory-based, core disorders on the RUSP except for Pompe disease which was added to the RUSP in March 2015. Hearing and Critical Congenital Heart Disease (CCHD) screening are point-of-service tests typically performed at the birthing facility. There are 24 additional secondary conditions that were added. Some of the secondary conditions may have an unclear natural history or lack appropriate medical therapy that affects long-term outcome. They are detected during screening for core conditions and no additional blood spots will need to be collected. The additional conditions will be detected from the same specimen using existing assays. Of the 24 conditions, we detected 18 of them and so we are really only adding six new conditions. There were three new Fatty Acid Oxidation Disorders, two Organic Acid Disorders and one Amino Acid Disorder added. ACT/FACT sheets for each condition on the secondary panel have been created and are available on line. At this time, there will not be a change in the newborn screening fee. However, we plan to conduct a work load unit study to re-evaluate the newborn screening fee after finalizing a new newborn screening IT contract in 2015.

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Dr. Lee informed the Committee that everything went pretty well during the implementation. There were a few bumps as expected, but the Laboratory staff are working through them. In the first three weeks of testing, there were about 30 actual specimens that were reported out as presumptive positive for the new secondary disorders.

X-ALD Public Health Impact Assessment – Debra Freedenberg, MD, Susan Tanksley, PhD

Dr. Freedenberg gave a summary of X-ALD from a clinical perspective to the Committee. X-ALD stands for X-Linked Adrenoleukodystrophy. X-Linked means the gene is located on the X chromosome. It is a metabolic disorder that affects the central nervous system and adrenal glands. It is due to a mutation in the ABCD1 gene. ABCD1 stands for ATP Binding Cassette, sub-family D, first member 1. It is the only gene in that particular sub-family that has been identified. It affects metabolism with very long-chain fatty acids, and it is a peroxisomal disorder. It can present as spectrum of disease, typically with progressive neurological decline which is the cerebral ALD. Seventy percent of boys affected also have an adrenal insufficiency, called Addison's disease. It can present across a life span. Neurologic involvement can also occur later in adolescence or adulthood. Females can be identified as being carriers or heterozygous for this mutation, and up to 20% can present neurologic symptoms in later adulthood. The typical onset of this condition in terms of clinical symptoms would not be during the neonatal period. The treatment is stem cell transplantation. Usually that is not done until there is MRI evidence of some brain damage that occurs with the continued lack of ABCD1 gene expression. Estimates are about 1 per 20,000 male births. There are some states that are screening. Clinically, about 35% to 40% of patients have adult onset of cerebral adrenoleukodystrophy. There has also been a gene trial that is ongoing and/or has been concluded, but hasn't been thought to be the answer. This condition is currently undergoing evidence review for the Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC) as part of the assessment to determine if the condition should be added to the Recommended Uniform Screening Panel (RUSP).

A public health system impact assessment is now conducted for all conditions that are under consideration for addition to the RUSP. All states are asked to provide feedback on the impact to their state if the condition is added as well as barriers to implementation and timing for implementation. A summary of the nationwide data is shared with the ACHDNC as part of the evidence review. Texas Newborn Screening Advisory Committee members and metabolic specialists were asked to provide input from their perspectives. The public health system impact assessment to the Association of Public Health Laboratories was due June 17, 2015. Dr. Tanksley gave a summary of the Texas responses to the survey. It would take less than one year to receive authorization as we have authorization once a condition is on the RUSP. We would need more staff. To get funding, we estimated that it would take one to three years after it was added to the RUSP. Our primary challenges would be to provide the screening tests and then clinical coordination for X-ALD as well as long term follow-up for carriers and individuals with

peroxisomal disorders. By adding a new condition, it impacts other improvement activities and other things that we are trying to do. The cost per specimen to conduct the screening is unknown right now, as is the cost of treatment for newborns diagnosed with X-ALD. This is a public health system impact assessment - not a newborn screening program assessment. So when you think about the cost of treatment from a system perspective, it would be very high.

Parental Consent Form Changes for Newborn Screening – Susan Tanksley, PhD

In 2009, new legislation required DSHS to provide disclosure that the newborn screening specimen would be saved and could be used for research. If parents wanted to have the specimens destroyed, they could fill out a form and send it to us or have the physician send it to us, and then we would destroy that specimen within 60 days. In the next legislative session, HB 411 changed the law to require consent for retention and external research use of the specimens. The form was changed to reflect this change. In June 2012, the language was changed to reflect this opt-in process and is currently part of the existing newborn screening collection kits. In December, 2014, a federal law passed which essentially makes any federally-funded research using newborn screening specimens into human subject research, thus requiring informed consent in order to utilize the specimens for research. We have determined that our existing forms do not meet the requirements of informed consent. National discussions suggest that broad consent will be allowed in the next revision of the Common Rule. We are trying to reach a level we feel meets the elements of broad consent. Dr. Tanksley asked the Committee to email Beth Rider if they have any feedback regarding the forms.

Medicaid Managed Care (MCO) Case Management – Daniela De Luna Olivares

Daniela De Luna Olivares from HHSC Program Operations gave an overview of Medicaid Managed Care (MMC) to the Committee. In addition to explaining the concept of managed care, Ms. De Luna Olivares gave a PowerPoint presentation with some of the components she thought would be of interest with regards to newborn screening, such as:

- Provider Network
- Prior authorization requirements
- MSHCN and service management coordination
- Challenges, barriers and recommendations

Ms. De Luna Olivares reported that approximately 85% of Medicaid recipients are enrolled in Managed Care Organizations (MCOs). She discussed the different programs in MMC, such as STAR, STAR+PLUS, and STAR Health. Currently, the STAR MCOs are required to identify Members with Special Health Care Needs (MSHCN). All STAR+PLUS members are considered MSHCN. Members with STAR MCOs receive service management, which is the same as case management. An individualized plan is developed by the MCO which includes access to specialty care providers with experience serving MSHCN. Service coordination is provided by STAR+PLUS and STAR Health MCOs for all members enrolled.

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TxPOP2 Project Update – Charleta Guillory, MD, Alice Gong, MD

Dr. Guillory and Dr. Gong gave updates to the Committee on the TxPOP2 Project. Dr. Guillory stated that TxPOP1 was a joint regional, educational, and quality improvement project initiative of the University of Texas Health Science Center of San Antonio, Baylor College of Medicine, and DSHS. The project was initiated to provide screening for apparently healthy newborns to identify Critical Congenital Heart Disease (CCHD). The topics discussed with the Committee were presented in a PowerPoint presentation.

- Quality improvement – February to July
  - 12,946 births in the 13 facilities
  - 96% of babies admitted received a CCHD screening in the recommended time frame
  - 11 positive screens
    - One had severe CCHD from secondary target
    - Two were in the <90% group
    - Seven were the indeterminate of 90-95%
    - One had > greater 3% difference
- HB 740 mandated that all Texas babies be screened for CCHD, not just apparently healthy babies in newborn nurseries
- CCHD screening using pulse oximetry

Dr. Guillory and Dr. Gong discussed several cases of interest.

Biliary Atresia Follow-up – Sanjiv Harpavat, MD

Dr. Harpavat gave the Committee an update on biliary atresia. He gave a PowerPoint presentation which will not be repeated in the minutes. Dr. Harpavat reported that early intervention results in better outcomes. The statistics show the procedure Kasai Hepatoportoenterostomy performed earlier following diagnosis improves the patient's outcome. However, the Biliary Atresia is being diagnosed later, negatively affecting patient outcome. The studies are ongoing to determine ways to make screening for Biliary Atresia more acceptable.

Legislative Session Summary – Karen Hess

Karen Hess gave the Committee an update on the Legislative session. The Committee was provided a hand-out with the summary. Ms. Hess discussed SB 791 which will require DSHS to develop materials for Cytomegalovirus (CMV) education in conjunction with the Texas Medical Board. The provision that was removed by the House from this bill was the provision for CMV testing for newborns who are deaf at birth. The reason for testing is so that CMV diagnosis can be made early and babies and their families can be educated through appropriate case management.

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The Sunset bills initially recommended the consolidation of all five agencies. The legislature decided to take a more graduated approach to consolidation and passed bills that would restructure the agencies over a longer period of time. Ms. Hess pointed out that the Department of Family and Protective Services (DFPS) and DSHS would remain as independent agencies with a 2023 Sunset review. Dr. Freedenberg informed the Committee that the Interagency Council for Genetic Services (IACGS) was abolished by SB 219, 84th Regular Legislative Session.

Public Comments
None

Future Agenda Items
1) Celebration of Secondary Panel
2) Pompe
3) CCHD NICU screening

Adjournment
The next meeting will be in October, 2015; however, the final date has not been determined. This will be a meeting to be held at DSHS in the Moreton Building. There being no further business, the meeting was adjourned.

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October 9, 2015
10:00 a.m. – 4:00 p.m.
Minutes

Members Present
William Morris, LVN
Felicia M. Adams, MSN
Alice K. Gong, MD
Charleta Guillory, MD
Benna Timperlake
Scott D. McLean, MD
Michael Speer, MD

Member via conference call
Nancy Beck, MD
Thomas M. Zellars, MD
Aida Gonzalez, RN

Staff Present
David R. Martinez, Department of State Health Services (DSHS), Newborn Screening Unit Manager
Michelle Shaffer, DSHS, Newborn Screening Endocrine Group
Gwen Hanley, DSHS, Newborn Screening Metabolic Group
Patricia Hunt, DSHS Laboratory, Metabolic Screening Group
Lynette Borgfeld, DSHS Laboratory, Endocrine, Hemoglobinopathies
D'Andra Luna, DSHS Laboratory, DNA Analysis Group
Susan Tanksley, PhD, DSHS, Laboratory Operations Unit Manager
Rachel Lee, PhD, Branch Manager, DSHS Laboratory, Biochemistry & Genetics Branch
Brendan Reilly, Program Specialist, DSHS Laboratory, Biochemistry & Genetics Branch
Laura Blanke, Health & Human Services Commission (HHSC)
Beth Rider, DSHS, Ombudsman, Committee Support
Debra Freedenberg, MD, PhD, DSHS Newborn Screening Unit
Sam Cooper, DSHS, Specialized Health Services Section, Director

Guests
Elizabeth Sjoberg, Texas Hospital Association (THA)
Janet Berg, San Antonio Military Medical Center (SAMMC)
Jennifer Lemons, University of Texas Health Science Center at Houston (UTHSC)
Shannon Lucas, March of Dimes (MOD)
Heather Schraeder, Grey's Gift
Pat Parks, Grey's Gift
Nicole Morris, Grey's Gift
Antonio B. Gonzales, Sr.
Chad Schraeder, Grey's Gift
David Attenhoff, Grey's Gift
James B. Gibson, MD, Seton Family of Hospitals
Rachel Jew, Texas Pediatric Society (TPS)
Kim Flanagan, Texas Medicaid & Healthcare Partnership (TMHP)
Sharon Livingston, MOD Honey Child

DRAFT

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October 9, 2015
10:00 a.m. – 4:00 p.m.
Minutes

Call to Order

Chairman Morris called to order the October 9, 2015 meeting of the Newborn Screening Advisory Committee at 10:06 am.

Review and Approval of Minutes

Chairman Morris requested a motion be made to approve the June 18, 2015 minutes. Dr. Alice Gong made the motion, and Dr. Charleta Guillory seconded.

Recording of Meeting

There were technical difficulties and discussions during portions of the meeting were not captured by an audio recording.

Medicaid Provider (Re) Enrollment-Update-Kim Flanagan

Kim Flanagan spoke to the Committee on Federally Mandated Provider Enrollment and provided a PowerPoint presentation.

- Federal mandate-Affordable Care Act (ACA)
  - Provides procedures under which screening activities are performed for providers
  - Beginning January 1, 2013, Texas Medicaid adopted this and enacted new provider enrollment and screening requirements
- Provider screening
  - Texas Medicaid & Healthcare Partnership (TMHP) and Texas Health and Human Services Commission (HHSC) have always performed screening activities that include license verification and criminal history checks
  - Beginning January 1, 2013, all Texas Medicaid providers will screening according to their risk category in order to fulfill additional requirements for enrollment as federally mandated
- Risk category
  - Providers must be screened based on a categorical risk of limited, moderate or high
  - Risk level categorization is established by the Centers for Medicare and Medicaid Services (CMS) based on assessment of risk of fraud, waste and abuse
  - For Medicaid provider types not recognized under Medicare, HHSC has assessed the risk using similar criteria to those used by CMS
- Re-enrollment
  - Submission of a new Texas Medicaid provider enrollment application, a new HHSC Texas Medicaid Provider Agreement and any additional required documentation including submission of an application fee

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  - Purpose of re-enrollment is not only to comply with federal regulation, but it is also to ensure State provider enrollment systems contain valid active provider enrollment data
  - CMS directed States to complete the first cycle of the re-enrollment process for all provider types by March 24, 2016
- Re-enrollment requirements
  - Applies to those providers that render services through Medicaid managed care organizations (MCOs) or through traditional fee-for-serviced Medicaid
  - In order for providers to maintain credentialing with their Medicaid MCO or dental plan, providers must be sure they are fully re-enrolled in Texas Medicaid before the March 24, 2016 deadline.
- Frequency of re-enrollment
  - Beginning January 1, 2013, all providers must re-enroll at least every 5 years
  - Suppliers of durable medical equipment, prosthetics, orthotics and medical supplies are required to re-enroll at least every 3 years
  - HHSC may require certain providers to re-enroll more frequently
  - Each TPIU or each practice location must re-enroll
- Application fee
  - An application fee is required for any newly enrolling or re-enrolling institutional provider, including for the addition of a new practice location
  - TMHP will collect an application fee as a condition for enrollment in Texas Medicaid for designated providers
  - Helps defray the costs of program integrity efforts
  - Subject to change every calendar year
  - Approved Medicare, CHIP or another state's Medicaid program enrollees are exempt
  - Hardship exceptions available
- Ordering, referring and prescribing only providers
  - Individual providers who are not currently enrolled in Texas Medicaid and whose only relationship with Texas Medicaid is to order, ref or prescribe supplieds or services for Texas Medicaid-eligible clients must enroll in Texas Medicaid as participating providers in accordance with provisions of ACA
  - A condensed application is available using PEP or paper. No application fee required
- Site visits, moratoria, surety bonds
  - Providers in moderate and high risk categories are subject to unscheduled and unannounced pre and post-enrollment site visits
  - A temporary moratorium may be imposed on the enrollment of new providers and suppliers of a particular provider type under certain conditions as directed by CMS or HHSC

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    - A surety bond is required
- Provider enrollment on the portal
    - Enhancements to the Providers Enrollment on the Portal (PEP) include:
        - Brower compatibility
        - Pre-population of already filed information
        - Ability to electronically sign required documents
        - Ability to electronically attach required documents
        - Expanded error messages to provide guidance
- Disenrollment
    - Expired or inactive enrollments result in
        - Disruption to reimbursement
        - Disruption as Medicaid MCO provider
        - Reduced access to care for Medicaid clients
- DADS LTC and VDP providers
    - Long term care (LTC) providers must re-enroll through the Department of Againg and Disability Services (DADS)
    - LTC providers that also provide Medicaid acute care services must re-enroll through TMHP
    - Vendor Drug Program (VDP) pharmacy providers must re-enroll through VDP
- VDP pharmacy / DME providers must re-enroll through TMHP
- TMHP website-Federal re-enrollment resource

Newborn Screening Follow-up Support-Jennifer Lemons

Jennifer Lemons, a genetic counselor with the UTHSC at Houston, works with Dr. Hope Northrup in the Department of Pediatrics. They had a summer scholars student, Albert Heo, come and work with them over the summer, funded by DSHS. As his project, he chose to put together information on the clinical follow-up services for metabolic disorders in Texas. Ms. Lemons presented the Committee a PowerPoint presentation with his findings.

- Objective and methods used for project
    - Assess the need for funding support of NBS follow-up services by Texas metabolic centers
        - Online survey distributed to 8 metabolic centers in Texas
    - How the need is met in other states
        - Telephone calls and e-mail correspondence with states with more than 80,000 births/year
    - Birth data from the 2013 National Vital Statistics Reports by the Center for Disease Control and Prevention (CDC)

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Timeliness of Newborn Screening-Rachel Lee, Brendan Reilly

Rachel Lee and Brendan Reilly gave updates on the timeliness of newborn screening. A PowerPoint presentation, which focused on pre-analytical measures, national comparisons data, what the current status is and analytical and post-analytical measures in Texas, was presented to the Committee.

Other Business

A motion was made by Chairman Morris to request a fiscal analysis to determine if we can increase the fee per blood spot kit, whether those funds can be used to potentially offset the gap in diagnosis and follow up resources in the clinics/specialists' offices. Dr. Gong seconded. The motion was approved.

Public Comments

None

Agenda Items

1) Fee schedule
2) Pompe
3) CCHD
4) Newborn Hearing ECI

Adjournment

The next meeting will be in January or February, 2016; however, the final date has not been determined. There being no further business, the meeting was adjourned.

DRAFT

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Preparedness Coordinating Council (PCC)

Number of Members: 14

Committee Status (Ongoing or Inactive): Ongoing — Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 5/1/2003 **Date to Be Abolished:** NA

Budget Strategy (Strategies) (e.g. 1-2-4): 1.1.1 **Strategy Title (e.g. Occupational Licensing):** Public Health Preparedness and Coordination Services

Budget Strategy (Strategies): **Strategy Title:**

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Admin Code	25 TAC, Sec. 2.1
State Authority		
State Authority		
Federal Authority	Public Law	No. 109-417
Federal Authority	Other	42 USC, 247d-3a
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$20,223	$68,000	$68,000
Total, Committee Expenditures	$20,223	$68,000	$68,000

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
555 - Federal Funds	$20,223	$68,000	$68,000
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year

Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
4	4	4

Committee Description: The Preparedness Coordinating Council (PCC) is an advisory committee of diverse members who's purpose is to provide strategic guidance and advice to the Department of State Health Services pertaining to Emergency Support Function (ESF) 8: Public Health and Medical Services, preparedness and response. Title 42 United States Code 247d-3a requires an advisory committee to obtain input on public health emergency preparedness programs.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

The PCC typically meets 4 times per year in the State Medical Operations Center (SMOC). As indicated in the Texas Administrative Code, "The PCC shall meet as necessary as determined by the department, but no less than quarterly, to conduct business".

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

The goal of the PCC is to advise DSHS concerning public health and medical preparedness, response, recovery, and mitigation activities in Texas. Some examples of deliverables include planning and promoting the eight high consequence infectious disease workshops being presented throughout Texas and providing program input for on various arboviruses such as Zika, West Nile, Chikungunya, and Dengue. There are no required reports.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

The PCC recommended a greater awareness for high consequence infectious diseases, hurricane preparedness activities, arboviruses, and avian influenza.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ? Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees? No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015? 300.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Prior to each quarterly meeting the Director of the Health Emergency Preparedness and Response Section (HEPRS) and the HEPRS project manager meet with the PCC presiding officer, the assistant presiding officer, and an external planning member to discuss the upcoming meeting agenda. The project manager contacts those individuals who are identified as meeting contributors and presenters and coordinates meeting agenda items and logistics.

6. Have there been instances where the committee was unable to meet because a quorum was not present? No

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

As stated in the Texas Administrative Code, "The PCC is not a "governmental body" as defined in the Open Meetings Act".

7b. Do members of the public attend at least 50 percent of all committee meetings? No

7c. Are there instances where no members of the public attended meetings? Yes

8. Please list any external stakeholders you recommend we contact regarding this committee.

Local Health Departments, Regional Advisory Councils, Volunteer Organizations Active in Disasters, Texas Disaster Medical Systems

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals? Yes

9b. Please describe the rationale for this opinion.

The PCC has offered guidance and strategic direction for both the Public Health Emergency Preparedness and the Hospital Preparedness Programs as well as for supplemental high consequence infectious disease funding.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute? No

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area? No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

Public Law 109-417, 109th Congress, Pandemic and All-Hazards Preparedness Act, Title II-Public Health Security Preparedness, Sec. 201. Improving State and Local Public Health Security. Section 319C-1 of the Public Health Service Act (42 U.S.C. 247d-3a) (2) "State shall prepare and submit to the Secretary an application at such time, and in such manner, and containing such information as the Secretary may require, including (G) a description of the means by which to obtain public comment and input on the plan described in subparagraph (A) and on the implementation of such plan, that shall include an advisory committee or other similar mechanism for obtaining comment from the public and from other State, local, and tribal stakeholders"

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

TEXAS Department of State Health Services

Approved:_____
PCC Presiding Officer

Date:

MINUTES

Preparedness Coordinating Council
3rd Quarter Meeting

July 20, 2015 from 10:00 AM – 3:00 PM
State Medical Operation Center
1100 West 49th Street, Laboratory Services Building, 7th Floor
Austin, TX 78756

Meeting Goals:

- Build awareness of ongoing public health and medical preparedness, response, recovery, and mitigation activities in Texas
- Identify strategic recommendations for consideration by DSHS

PCC Members in Attendance:

Member Name	Represented Entity	Yes	No	Alt
Cuellar Rojas, Adriana	United Ways of Texas		X	
Epley, Eric	Governor's EMS and Trauma Advisory Council (GETAC)		X	
Manifold, Col. Craig	Texas Military Forces (TMF)		X	
Mendez, Margaret	Texas Medical Association (TMA)	X		
Nisenbaum, Miriam	National Association of Social Workers/Texas Chapter	X		
Olivarez, Eddie	Urban Local Health Department	X		
Parisi, James	Texas Hospital Association (THA)	X		
Patterson, David	Texas Funeral Commission	X		
Phinney, Chuck	Governor's Division of Emergency Management (GDEM)	X		
Quiram, Dr. Barbara	University or Health Science Center	X		
Redington, Penny	Texas Association of Regional Councils (TARC)	X		
Shine, Larry	Voluntary Organizations Active in Disaster (VOAD)		X	
Zolnierek, Dr. Cindy	Texas Nurses Association (TNA)			X

Others in Attendance:

Name	Name
Alejandre, Julia (DSHS)	Ladd, Clint (Witt O'Brien's)
Adams, Barbara (DSHS)	Lassberg, Hil (DSHS)
Badke, Megan (Witt O'Brien's)	Neisen, Michelle (DSHS)
Birnberg, Dana (DSHS)	Poole, Michael (DSHS)
Brannan, Lesley (DSHS)	Romano, Alison (DSHS)
Clements, Bruce (DSHS)	Schmider, Joseph (DSHS)
Cole, Kirk (DSHS)	Schultz, Lisa (DSHS)
Hilliard, Ron (TNA; proxy)	Sheahan, Donald (DSHS)
Hodgson, Wes (DSHS)	Sidwa, Tom (DSHS)
Kroll, Carrie (THA)	Zumbrun, Janna (DSHS)

Meeting Notes:

I. Welcome and Introductions (E.Olivarez and C.Ladd)

a. 10:10 AM – Meeting start and introductions
b. 10:13 AM – Quorum established (7 PCC members + 1 proxy)
c. 10:14 AM – The PCC reviewed the minutes from the Q2 meeting. **Recommendations were made to correct the name of the interim DSHS Commissioner of Health and to add page numbers**. At 10:17 M.Nisenbaum motioned to approve the minutes with corrections. The motion was seconded and passed.
d. C.Ladd: A year-end report summarizing all PCC meetings in the 2015 calendar year will be produced. Additionally, minutes and a summary report will be developed after each individual PCC meeting. These products will document meeting participants, presentations, discussions, and most importantly, PCC recommendations for reference by DSHS. Witt O'Brien's is producing these deliverables.
e. Review of Action Items:
    i. PCC Members Advocate for Public Health and Medical Preparedness: Several PCC members testified on behalf of public health and medical preparedness during the 84th Texas State Legislative Session. For instance, M.Mendez (TMA) testified on broad public health issues. M. Nisenbaum testified on the critical mental health worker shortage and worked with Representative Schwertner on a loan repayment pilot project for physicians, counselors, social workers, etc. working in rural areas. M.Nisenbaum also worked on initiatives to indemnify social workers to work as volunteers and recruit mental health workers

to help in disasters. The importance of this work was further underscored by E.Olivarez and M.Nisenbaum, who indicated that out-of-state recruitment efforts are being explored, due to the lack of qualified mental health professionals in Texas (48 counties have no licensed social workers).

ii. Suggested Agenda Items: **All suggested meeting agenda items were incorporated into the Q3 meeting, except for the topic on syncing communications. This should be addressed at a future meeting. E.Olivarez recommended that the PCC discuss crisis standards of care at the next meeting.**

iii. Incorporation of DSHS RVI Plan: PCC members had nothing to report. E.Olivarez suggested that PCC members could provide briefings to stakeholders at the regional level regarding the plan.

iv. PCC Meeting Reminders: **PCC members requested meeting reminders 1 month prior, earlier minutes, frequent reminders, and a list of future meeting dates.**

II. DSHS Health Emergency Preparedness and Response Section (HEPRS) Update (B.Clements)

a. B. Clements represented Texas at a Public Health and Emergency Preparedness (PHEP) impact stakeholder workshop (which was also applicable for Hospital Preparedness Program [HPP] stakeholders) hosted by the Association of State and Territorial Health Officials (ASTHO). Topics included: a public health preparedness elevator speech, impact statements, Congressional cuts to public health budgets, and how to promote public health.

b. The new Director of the U.S. Office of Management and Budget (OMB) wants to combine the PHEP and HPP programs and close the Office of the Assistant Secretary for Preparedness and Response (ASPR). The workshop attendees felt that the programs should remain separate. The question was raised as to whether the PCC should draft a letter supporting the continued separation of the PHEP and HPP programs. PCC members expressed that the public health and medical fields are very distinct and need to be funded separately. B.Clements recommended that the discussion be tabled until after a meeting in September, which will provide more information on the situation. **AGENDA ITEM: review updates on the OMB issue and discuss whether a recommendation is needed from the PCC.** However, if the situation becomes urgent, PCC leadership will draft a letter and distribute it to other PCC members for review and approval.

c. During the workshop, attendees separated into groups and developed impact statements. These were consolidated into the following 5 statements:
    i. PHEP resources have built state and local public health emergency management expertise that has improved coordination.
    ii. PHEP-established public health emergency management expertise is now an integral and credible component of emergency responses to public health threats.
    iii. PHEP made it possible to build and maintain effective public health response systems, such as the Strategic National Stockpile Program.
    iv. Public health laboratory and epidemiological capacities and capabilities have significantly improved due to the PHEP.
    v. Public health emergency response capabilities are now scalable from the local to federal levels based on PHEP.
d. The overall impact of PHEP is to improve health outcomes and minimize public health consequences of emergencies. A major theme identified was that public health is now part of the larger emergency management team. An elevator statement is now in development. Also, the working group is starting to develop a toolkit and final report. Feedback will be compiled and discussed in September. **B.Clements indicated that he will provide impact statements to the PCC and will solicit feedback, which will then be given to ASTHO.** E.Olivarez recommended that the PCC discuss the final results of the working group with stakeholders.
e. Ebola Funding: Approximately $13 million in Ebola funding was awarded. DSHS has notified selected local health departments regarding the funding they will receive. Over $8 million of the funding is allocated to build epidemiological capacity. Also, money was allocated for building laboratory capacity and for developing a new communications platform ($1.2 million). The communications platform will be designed as a real-time, web-based tool that will improve situational awareness by connecting to, consolidating, and summarizing social media data from sources such as Facebook and Twitter. Currently, PHEP contracts have been distributed to health departments and HPP contracts have been sent to the RACs. Part A of the Ebola projects has been initiated, but Part B requirements have not been met yet. Funding will be/has been spent on personal protective equipment, training, and exercises. Additionally, two contract personnel were recently hired by DSHS to coordinate Ebola preparedness activities: Julia Alejandre and Alison Romano.

f. Regarding Ebola Treatment Centers: Hospitals do not have to transfer patients to designated facilities (UTMB in our region). The federal government will transfer patients to approved hospitals via Phoenix Air. UTMB will receive $3 million dollars of Part B funding and $1 million of Part A funding. Also, $1 million will be provided to Texas Children's Hospital. UT Southwestern Medical Center in Dallas currently is declining funding. They have the required capacity for Ebola treatment but are not sure it is within their best interest to participate in the grant program.
g. B.Adams: DSHS recently updated its hurricane annex. Medical shelter sites and kits still need to be reviewed this year, though it is not anticipated that significant changes will be needed. DSHS also worked with Texas Department of Emergency Management (TDEM) partners to update Annex H. The document is in review. Additionally, there was a June coordination meeting with San Antonio partners for resource planning in anticipation of potential hurricanes. An upcoming project will be to categorize and align DSHS planning documents (based on TDEM concepts). The planning requirements, organizational structures, and naming conventions DSHS decides to use will be provided to the local level for reference (though local health departments will not be pressured to adopt any of the practices). On a somewhat related note, the viral respiratory infection (VRI) plan was not well-received by local stakeholders, due to the misconception that the plan had to be adopted at the local level. Other recent DSHS preparedness and response activities include: the restructuring of tactical communications teams (and DSHS is looking to enhance access to tactical communications subject matter expertise at the ground level) and severe weather response in May (the State Operations Center [SOC] was open for 5 weeks, include 24/7 operations for 10 days).
h. B.Clements: The 3 hot public health topics recently have been Middle East respiratory syndrome coronavirus (MERS-CoV), Ebola, and avian influenza.

III. Legislative Update: Review of the 84th Legislative Session—Implications for DSHS (K.Cole)

a. K.Cole: Emergency response is a critical function for Texas, and a lot of related activities are occurring within the state, in order to address concerns such as infectious disease challenges and children crossing the border. Regarding the recent legislative session, significant funding was allocated for infectious disease preparedness (Ebola), and a task force for Ebola was established. Based on the "Sunset" legislation, DSHS will focus

on public health, and public health preparedness is a key part of that. Moving forward, organizational changes are a possibility, though disaster response should remain within DSHS, regardless. However, some regulatory functions may move to HHSC. The new executive commissioner for health and human services is really engaged in evaluating and improving operations.

b. E.Olivares: Texas is developing a fantastic model for crisis standards of care. It would be irresponsible for Texas to not take a leadership role on the topic. Also, the global environment is getting tougher, and catastrophic situations can happen. We are working closely with U.S. Customs and Border Protection on border issues, but other federal partners are behind in coordination and preparedness (i.e. local FBI). This was particularly apparent in a recent radiation tabletop exercise. E.Olivarez suggested the creation of a federal collaborative conference on immigration (which is a statewide issue). Also, more emphasis needs to be placed on statewide public health "security," to include health surveillance, laboratory testing, port and border health issues, etc. If people see public health as providing a security role, then it strengthens the position of public health.
c. B.Quiram has been working with the FBI at the local and regional levels for years. Relationship-building took regular contact. The PCC could discuss how to share relationships across the state.
d. K.Cole: Crisis standards of care is a worthwhile topic to revisit. DSHS will continue to work on it. Also, collaborations with the federal government are important. Recent discussions have worked at bringing the health and homeland security sides together. However, when these sides come together, it becomes obvious that silos still exist and agencies don't understand each other. Collaborative systems need be created at the local level to address this issue.
e. E.Olivarez: Perhaps it would be possible to start the systems at the local level and move up. The PCC is trying to provide an advisory function for DSHS. The challenge is to develop at least one or two products for review by executive leadership. The PCC is here to serve DSHS. Please utilize the PCC, Commissioner Cole.

IV. Presentation: A Threat Briefing on H5 High Pathogenicity Avian Influenza (HPAI) in the U.S. (T.Sidwa)

a. Why is avian influenza (AI) an issue for human health? The good news is that highly pathogenic strains of AI were recently detected, dating back to December 2014, but there have been no human cases. The genetic markers on these viruses are not generally associated with human disease. In general, AI viruses occur all the time. They are classified as either high pathogenicity (HPAI) or low pathogenicity (LPAI). HPAI is generally rare. LPAI may go unnoticed. HPAI has high mortality in many bird species—particularly domestic poultry. Water fowl are often a predominant host. Influenza A viruses with H5 or H7 hemagglutinin proteins have a higher tendency to become HPAI and contribute to human disease via viral reassortment. Reassortment can happen when a person or animal is coinfected by both a seasonal flu virus and an AI virus. This coinfection can lead to the mixing of viral genetic material, resulting in a hybrid virus. HPAI can be a significant public health problem (see H5N1). HPAI can spread long distances via migratory bird flyways.
b. Preparedness Efforts
    i. The U.S. conducts poultry and wild bird surveillance to detect HPAI.
    ii. The animal health agency in Texas that oversees the poultry industry is the Texas Animal Health Commission (TAHC).
    iii. The National Poultry Improvement Plan (NPIP) is a relevant preparedness document for HPAI. The goal of the plan is to maintain trust in animal products. The plan was a collaboration between the USDA-APHIS, poultry industry, and state animal health agencies (including TAHC).
    iv. The US Dept. of Interior National Wildlife Health Center, the US Fish and Wildlife Services, USDA Wildlife Services, and Texas Parks and Wildlife monitor wild birds.
    v. Influenza in swine is not reportable by law to TAHC/USDA, but the departments still want to know about it. The national swine influenza virus (SIV) surveillance program is a collaboration between the USDA, states, and industry to conduct flu surveillance in swine and monitor genetic changes in the influenza virus.
c. Currently, the HPAI H5N2 virus is getting the most attention in the U.S., though HPAI H5N1 and H5N8 have also been detected. Two-hundred and thirty-two flocks were infected and depopulated (over 50 million birds)

from December 2014 - June 2015. H5N2 is particularly aggressive in turkeys. Arkansas was the closest state to Texas that reported cases of HPAI. The US government provided producers indemnity for their depopulated birds, to help mitigate the financial impact of the outbreak. Per B.Clements, beyond the economic impact, the mental health impact also has been significant.

d. Both H5N2 and H5N1 have Asian H5 proteins but N proteins of U.S. origin. The H5N8 virus is similar to the H5N8 viruses seen in China, Japan, and most recently Sweden. The H5N8 virus has never been detected in people or non-avian animal species.
e. The last reported case of HPAI in the U.S. was June 17, though there is concern it will reappear in the fall. Biosecurity is key to controlling the spread of disease.

V. Presentation and Discussion: Border Immigration Projections, Implications for Public Health, and the Creation of a Border Health Workshop/Conference

a. E.Olivarez: There were over 268,000 illegal border crossers last year—many of whom were children without guardians. The scale of immigration was unexpected and overwhelmed Customs and Border Patrol (CBP) officers. Since then, there have been a lot of meetings at state, federal, and local levels to prepare for the increase of immigrants. This year it appears the number of illegal border crossings is approximately the same as last year, but the influx is spread more evenly over time. Currently, there is an average of 100 people per day crossing the border, with a peak of ~175 people. CBP provides numbers and updates weekly.
b. The counties in south Texas are better organized this year to address the needs of the immigrants. Catholic Charities provides aid to family units.
c. In general, terrible things often happen to immigrants trying to cross the border, including abuse, manipulation by drug cartels (i.e. they use people as drug mules), etc. Also, the average immigrant must pay $4-5k to get across the border.
d. B.Clements: Representatives from several federal agencies (i.e. CBP, DHS, HHS, ICE, ASPR) met recently with DSHS and HHSC regarding border issues. DSHS asked for a description of health screening pathways. Immigrants who are minors undergo extensive health screening. Single males or females essentially are only inspected for scabies, cuts, and bruises. Family units have a different health screening path. The federal agencies will provide additional information regarding the health

screening processes. DSHS also asked for a weekly report that provides seasonal/weekly trends and situational awareness (in general, immigration declines during the hottest months and when trains are being used for harvests). DSHS can share these reports with the PCC when they are obtained.

e. E.Olivarez: There is a need for a statewide forum of some sort (i.e. workshop or conference) to increase awareness and dialogue between local, state, and federal stakeholders involved in immigrant health issues. What happens at the federal level often doesn't get disseminated to the local policy level.
f. B.Quiram: Until 4 years ago, the states in federal region 6, the schools of public health, the CDC Centers of Preparedness, and key federal partners came together once a year for multi-state strategic planning and to discuss resource sharing. This stopped happening around Hurricane Ike, but perhaps it could be reactivated.
g. B.Clements: The group has continued to meet but not necessarily every year. For instance, region 6 Ebola patient transportation coordination is to be discussed.
h. B.Quiram: Can the A&M School of Public Health be invited? Schools of public health have a lot to contribute.
i. B.Clements: Discretionary funding will become available in the spring. Should an immigrant health forum be created that focuses on the Valley, or should it be a statewide event? And what should the content and attendees looks like? Currently, contracting issues would make hosting an event difficult.
j. R.Hilliard: An event that is co-sponsored by the 3 major sanctuary cities may be best.
k. E.Olivarez: An event should focus on a statewide approach, including infectious disease surveillance/screening, safety and security, training on the consequences of outdoor exposures, etc. The event should be limited to public health with a goal to improve familiarity among federal partners regarding: infectious diseases and how to respond to them, communications, and situational awareness.
l. B.Clements: Based on a recommendation from the PCC that DSHS should plan a statewide immigrant health event, DSHS can start discussing the matter with stakeholders and senior leadership to gauge interest. Updates can then be provided to the PCC at future meetings.
m. E.Olivarez: The PCC should recommend that DSHS develop an immigrant health forum at the state level, which will include federal, state, and local

partners. The forum should address the impact of immigration on the public health system in Texas.

n. M.Nisenbaum: Immigrant mental health issues should be addressed, as well.
o. **A general consensus was reached at 1:20 PM to recommend that DSHS explore the creation of a statewide immigrant health forum.** The question was raised as to the process for making formal recommendations and whether a vote is needed.

VI. Update and Discussion: DSHS Planning for Statewide Infectious Diseases with High Consequences (Ebola) Workshops (A.Romano and J.Alejandre)

a. A.Romano: The Texas preparedness strategy for infectious diseases builds on existing initiatives and aligns with current infrastructure and programs. It will include 8 regional seminars, the purchase of PPE and laboratory equipment, the purchase of technology for epidemiological investigations, a capstone symposium, and a statewide preparedness exercise.
b. Regional Seminars Overview
    i. The purpose is to train, identify preparedness gaps, and share information.
    ii. Four tracks: EMS track, public health track, disaster healthcare track, and disaster behavioral health (DBH) track
    iii. Structure: The seminars will last 3 days (a half day, a full day, and a half day). Days 1-2 will consist of seminars. Day 3 will consist of an exercise and hot wash.
    iv. The proposed exercise is not a true TTX per HSEEP. The results from the seminar exercises will be used to develop a recommendation product, which will be incorporated into the capstone symposium (there are no detailed plans for the symposium yet). DSHS will identify consistent gaps throughout the state, and those gaps will be addressed in the symposium.
    v. DSHS is looking for feedback on topics and speakers (proposed structure provided)
c. PCC Comments/Feedback on Regional Seminars
    i. There might be different needs in different regions.
    ii. There should be a track on legal issues (i.e. isolation) in the general session.
    iii. Participants should include EMS, emergency mgmt., elected officials, federal govt., local govt., state govt., healthcare, public health, public communications groups, and law enforcement.
    iv. EMS and outpatient protocols are important.

v. Don't use the term "hospital." The seminar sessions should be more inclusive of other healthcare entities.
vi. Some sessions may need to be repeated.
vii. Different people will have different levels of interest on several topics. Perhaps a general track should be created to repeat some sessions.
viii. Elected officials may not feel they should take certain courses based on the title of the tracks. Perhaps recommendations should be provided regarding who should attend each session.
ix. Fatality mgmt. and waste mgmt. are huge topics and should be separated into unique sessions.
x. B.Clements asked D.Patterson if he would assist with the mass fatality session. D.Patterson indicated that he would and also recommended Rick Tull.
xi. Dr. Umair Shah from Harris County Public Health and Environmental Services should be invited to present on control orders.
xii. Instead of a session on EMS transport, the session should focus more broadly on pre-hospital providers. However, a comment was made that such a broad topic couldn't be addressed appropriately in an hour.
xiii. Law enforcement and other pre-hospital responders need to be trained further on what they should do.
xiv. Get away from tracks, since they are too exclusive. Provide courses with recommendations regarding participants.
xv. DSHS needs to make sure presentations are consistent.
xvi. A training needs to be added on preparing an Ebola patient for transport. Transportation standards need to come from Phoenix Air.
xvii. Final disposition should be included in the exercise.
xviii. PPE: It was suggested that donning and doffing PPE shouldn't be taught, given that there are plenty of classes available on the topic. Alternatively, they could be taught separately at the regional level. If so, the same presenter should be used throughout the state to ensure consistency. However, per A.Romano and J.Alejandre, feedback from the regions indicated that prospective participants want to learn about PPE. C.Phinney offered that a PPE course needs to include a hands-on component with 3 people donning/doffing PPE. A suggestion was made that PPE training could be offered as a pre- or post-seminar workshop.

xix. In addition to offering CEU credits, offer TCOLE (law enforcement) hours. Consider working with TEEX regarding course credits.
xx. PCC members should reach out to local officials and make sure there aren't conflicts with the proposed seminars.

d. **The PCC would like another update on Ebola preparedness efforts at the next meeting.** Once the regional seminar framework is further developed, the PCC can start to market the seminars to stakeholders.
e. The target date for the regional seminars is late 2015 through May 2016, with the capstone symposium being held in fall 2016.

VII. Other Business (C.Ladd)

a. **Suggested agenda items for next meeting include: stakeholder communications (suggested at the last PCC meeting), crisis standards of care (healthcare and funeral industry), Ebola preparedness updates, a threat briefing on MERs-CoV, impact statement updates, updates regarding PHEP/HPP funding structures, and federal immigration briefs.**
b. **E.Olivarez asked B.Clements if he could provide the federal immigration briefs in a format that could be widely distributed.**
c. C.Ladd addressed the PCC regarding the addition of more members, in order to bring the group into compliance with state law and the PCC bylaws. Per the bylaws, representation is still needed from: a rural public health department, the Texas Association of Infection Control Practitioners, Texas Interagency Interfaith Disaster Response, American Red Cross, and a tribal nation representative. Attendees also felt that representatives should be invited from animal health and the disabilities community. There needs to be a total of at least 18 PCC members.
d. C.Zolnierek (Texas Nurses Association) would like to step away from the PCC and recommended that R.Hilliard take her place on the PCC. A formal recommendation and resume was provided to D.Sheahan. R.Hilliard was introduced to the PCC.
e. D.Sheahan: The protocol for adding PCC members entails soliciting organizations for a recommendation and resume. Administrative paperwork then needs to be completed and passed back and forth between various state committees. The process generally takes 6+ months to complete.
f. A comment was made that the PCC might want to post the vacancies broadly and consult the state legal counsel, to ensure the process follows state policies regarding equal opportunity.
g. **DSHS should take the lead in finding new PCC members and should submit member recommendations in batches.**

h. **Suggestion: List PCC voting members and affiliations.**

VIII. Adjournment

a. E.Olivarez adjourned the meeting at 2:45 PM.

Action Items:

1. Suggested Agenda Items:
    a. Stakeholder communications/information-sharing/collaborative systems
    b. MERS-CoV
    c. Crisis standards of care (healthcare and funeral industry)
    d. Ebola preparedness updates
    e. Updates on the organization of the PHEP/HPP programs
    f. Impact statement updates
    g. Federal immigration briefing updates
2. C.Ladd:
    a. Make suggested corrections to the prior meeting minutes.
    b. In future minutes, include upcoming meeting dates and a list of the voting PCC members and their affiliations.
    c. Provide meeting reminders 1 month prior, earlier minutes, and more frequent meeting reminders.
3. B.Clements: Provide public health impact statements and the federal immigration briefing to the PCC for reference and feedback.
4. D.Sheahan: Begin the process of identifying potential new PCC members.

Upcoming Meetings:

1. October 26, 2015
2. January 25, 2016
3. April 25, 2016
4. July 25, 2016
5. October 24, 2016

TEXAS Department of State Health Services

Approved:_____
PCC Presiding Officer

Date:

MINUTES

Preparedness Coordinating Council
4th Quarter Meeting

October 26, 2015 from 10:00 AM – 3:00 PM
State Medical Operation Center
1100 West 49th Street, Laboratory Services Building, 7th Floor
Austin, TX 78756

Meeting Goals:

- Build awareness of ongoing public health and medical preparedness, response, recovery, and mitigation activities in Texas
- Identify strategic recommendations for consideration by DSHS

PCC Members in Attendance:

Member Name	Represented Entity	Yes	No	Alt
Cuellar Rojas, Adriana	United Ways of Texas		X	
Epley, Eric	Governor's EMS and Trauma Advisory Council (GETAC)	X		
Manifold, Col. Craig	Texas Military Forces (TMF)		X	
Mendez, Margaret	Texas Medical Association (TMA)	X		
Nisenbaum, Miriam	National Association of Social Workers/Texas Chapter	X		
Olivarez, Eddie	Urban Local Health Department	X		
Parisi, James	Texas Hospital Association (THA)	X		
Patterson, David	Texas Funeral Commission	X		
Phinney, Chuck	Governor's Division of Emergency Management (GDEM)	X		
Quiram, Dr. Barbara	University or Health Science Center	X		
Redington, Penny	Texas Association of Regional Councils (TARC)			X
Shine, Larry	Voluntary Organizations Active in Disaster (VOAD)		X	
Zolnierek, Dr. Cindy	Texas Nurses Association (TNA)			X

Others in Attendance:

Name	Name
Adams, Barbara (DSHS)	Kroll, Carrie (THA)
Alejandre, Julia (DSHS)	Ladd, Clint (Witt O'Brien's)
Badke, Megan (Witt O'Brien's)	Lassberg, Hil (DSHS)
Birnberg, Dana (DSHS)	Neisen, Michelle (DSHS)
Brannan, Lesley (DSHS)	Nelson, Uryan (TARC; proxy)
Clements, Bruce (DSHS)	Roberts, Leslie (ARC)
Gruber, David (DSHS)	Romano, Alison (DSHS)
Hilliard, Ron (TNA; proxy)	Sheahan, Donald (DSHS)
Hoogheem, Jeff (DSHS)	

Meeting Notes:

I. Welcome and Introductions (E.Olivarez)

a. At 10:07 the meeting started, and all attendees introduced themselves.
b. Seven PCC members were in attendance as of 3:09, satisfying the requirements for a quorum.
c. The meeting minutes were reviewed and put to a vote. M.Nisenbaum motioned to accept the minutes "as is," and D.Patterson seconded. Acceptance of the minutes passed.

II. DSHS Health Emergency Preparedness and Response Section (HEPRS) Update (B.Clements)

a. B.Clements presented the updated version of national impact statements for the Public Health Emergency Preparedness (PHEP) Program. The target audiences for these impact statements are congress and the public. The statements attempt to capture the key words associated with the PHEP Program. These key words were then used to formulate paragraphs, which were then refined down to five, concise impact statements for use as a promotional "elevator speech."
b. Key messages from this process were as follows:
    i. Since 9/11, the PHEP program has built and sustains a nationwide system that prepares for and responds to public health emergencies.
    ii. As the sole source of federal funding for public health emergency preparedness, the PHEP program protects the health and safety of our communities by helping state and local health departments prepare for and respond to public health threats such as infectious diseases, natural disasters, and biological, chemical, nuclear, and radiological events.
c. Comments regarding key messages:

i. B.Adams: The sentence specified public health emergencies. The wording should be broader (i.e. emergencies/disasters with public health impacts).
ii. The messages should use consistent verbiage (disaster vs. emergency vs. incident).
iii. E.Epley: use the word ”structure,” instead of emergency management “system,” so the wording is more consistent with the National Incident Management System (NIMS)

d. Impact statements:
   i. The PHEP program has developed public health emergency management systems in all 50 states and select local and territorial public health departments.
   ii. The PHEP program has created response-ready state and local health departments capable of leading or supporting a disaster response.
   iii. The PHEP program has been instrumental in developing national laboratory and epidemiologic surveillance systems capable of detecting and identifying public health threats more rapidly.
   iv. The PHEP program has developed a cadre of credible experts in public health emergency preparedness and response at state and local levels capable of mitigating the health effects of a terrorist attack, a disease outbreak, a natural disaster or other public health threats.
   v. The PHEP program has developed a national capability to rapidly distribute and dispense the lifesaving medications to the right people at the right time.
e. Comments regarding the impact statements:
   i. E.Olivarez: In the 5th impact statement, the term “right” seems too exclusive? It is a possible concern. The last part of that sentence could be cut. M.Mendez and M.Nisenbaum agreed.
   ii. After comments are collected, ASTHO and NACCHO will take the feedback, revise the statements, and develop a one-pager for congressional staff members.
   iii. E.Olivarez stated that he is bothered by the fact that public health had to simplify the concepts of public health preparedness so much, in order for congress to pay attention to it.
   iv. J.Parisi didn’t like the passive nature of the statements. The word “has” should be deleted in each statement.
   v. C.Ladd added that the last sentence should reference more than just “medications,” since the statement refers to the Strategic National Stockpile program.
f. Representatives from multiple federal agencies, local governments, and state governments were invited to discuss and create the statements.
g. A new representative from the US Office of Management and Budget (OMB) is overseeing the CDC budget. This representative wants to combine the HPP with the PHEP Program. A meeting was requested with Texas to discuss this matter,

but the meeting was cancelled. Currently, B.Clements is not sure where the matter stands. In general, the President's budget cuts the HPP every year, but congress always re-inserts it.

h. J.Hoogheem: Regarding Ebola After-Action Reports (AARs):
    i. Ten AARs are being finalized and will be distributed in the near future. This includes an internal DSHS AAR, regional AARs, and an AAR for the State Emergency Management Council.
    ii. Ebola response challenges identified by evaluators included a large number of non-public health issues that public health preparedness had to address (i.e. control orders, personal protective equipment, pet issues, and public/media/political interest). Other concerns included: confusion/disconnects due to working out of the Dallas County EOC; a cumbersome process for updating guidance and the DSHS website; hazardous waste transportation problems, due to a lack of suitable contracts, transportation refusals from courier services, and PPE shortages; a lack of evidence regarding transmission from animals to humans; and questions regarding the process for preparing deceased Ebola victims for interment.
    iii. Strengths included the fact that Ebola was stopped where it started; local epidemiologists were bolstered by regional epidemiologists; labs had trained staff that performed well; labs properly detected the disease; and patients were transported without incident.
    iv. AARs will be incorporated into regional workshop materials.
    v. Beyond the Ebola response, PHP supported emergency management with responses to wildfires and flooding.

i. D.Birnberg: Three sources of funding are being provided to regional and local health departments: PHEP funding, discretionary funds (unspent money from the prior year), and Ebola funding. PHEP funding and discretionary funding run through June 30th. Ebola dollars will be available through September. Local health departments have expressed concerns regarding spending the money within the given time frame. DSHS will help facilitate this process.

j. Health departments used to have to submit applications for funding. Now DSHS pushes money out based on a formula. Forty-six local health departments received at least $25,000.

k. The end of the 3rd project period for the PHEP Program is arriving soon. Congress will need to renew the program in 2017. In preparation for this, DSHS will need to spend down funds, or unspent money will be given back to the US Treasury. Unspent funding can impact the amount of future funding that is allocated. Currently, there are ~$7-$10 million dollars that need to be spent within the next year-and-a-half. Spending this amount of money can be challenging due to administrative constraints.

l. Overall, the PHP and HPP budgets have steadily decreased over time. Also, there is a disparity in hospital disaster reimbursement and funding between public and private facilities.

III. Presentation: Middle East Respiratory Syndrome Coronavirus (MERS-CoV) (L.Brannan)

a. The Middle East Respiratory Syndrome Coronavirus (MERS-CoV) is a novel beta coronavirus. Transmission of the disease is not fully understood. What is known is that there is animal to human transmission, particularly involving camels and raw animal products. Human-to-human transmission is also possible via respiratory secretions.
b. Currently, the disease is most prevalent in the Arabian Peninsula, particularly Saudi Arabia. The Republic of Korea has also reported a lot of cases. The U.S. has had 2 imported cases (Indiana and Florida).
c. The incubation period of the disease is typically 2 days - 2 weeks. Common presentations in cases include fever and shortness of breath. Pneumonia also is common, but not always present. Gastrointestinal symptoms are possible, as well. The clinical spectrum ranges from asymptomatic to severe illness.
d. There are no vaccines, chemoprophylaxis, or specific treatments for MERS-CoV.
e. Currently, the US is not screening travelers (i.e. healthcare workers volunteering abroad) for MERS-Cov. The primary objective in the US currently is to get medical providers to ask travel history questions of patients with symptoms consistent with MERS-CoV. A message to medical professionals regarding risks would be beneficial.
f. Healthcare workers are at higher risk, since MERS-CoV has shown the ability to spread in healthcare facilities. Currently there is no indication of disease spreading within the military. In general, people at elevated risk for disease include recent travelers to the Arabian Peninsula (particularly with exposures to camels and raw animal products), exposure to a healthcare setting with recent MERS, or close contact with a case. Individuals with a compromised immune system are at higher risk for severe illness.
g. Twenty-six countries have reported cases, but the majority of cases occurred in Saudi Arabia. Currently there is no sustained human-to-human transmission.
h. In 2014, there was an outbreak in healthcare facilities in Saudi Arabia. From May-July 2015, an outbreak was reported in the Republic of Korea. More recently, a healthcare cluster was reported in Riyadh, Saudi Arabia (175 cases since July 21).
i. Concerns:
    i. In Saudi Arabia, 50% of healthcare professionals are not Saudi citizens.
    ii. Mass gatherings in the Arabian Peninsula could help spread disease.
    iii. Hospital outbreaks are occurring more frequently.
    iv. There is ongoing zoonotic transfer to humans, and no one is sure how it is happening.
    v. There is low awareness of MERS outside of the Arabian Peninsula.
    vi. When hospital assessments have been conducted in Saudi Arabia, infection control breaches have always been reported.

j. CDC revamped infection control guidance in June. The guidance emphasizes that:
    i. Healthcare professionals need to rapidly ID and isolate MERS patients;
    ii. Healthcare workers need to be trained (patient management, PPE, etc.);
    iii. Healthcare facilities need to monitor and manage ill exposed healthcare personnel;
    iv. Healthcare facilities need to implement appropriate environmental Infection control measures; and
    v. Reporting between hospitals and public health agencies needs to be established.
k. Outbreak and pandemic implications:
    i. Cases potentially could go unrecognized.
    ii. Clusters are often linked to healthcare facilities.
    iii. The disease has high mortality.
    iv. MERS has the potential to stress resources.
    v. Facilities and providers need a plan. The CDC has checklists they can reference.
l. DSHS recently updated their internal, statewide pandemic influenza plan to address all respiratory viruses, including MERS. The plan includes roles and responsibilities of health departments at all levels.
m. Reporting/Investigation procedures:
    i. A provider calls the local health department to report a potential case.
    ii. If the case has the correct symptoms and travel history, the health department will ask about infection control procedures (i.e. airborne isolation) and investigate the patient. The MERS Patient Under Investigation (PUI) criteria from the CDC (which includes clinical and exposure information) will be referenced.
    iii. If the patient meets certain criteria, then further lab testing will be requested from one of three designated labs in the state. The following samples will need to be collected from the PUI: lower respiratory, upper respiratory, and serum. Samples collected should be shipped overnight or via courier to the appropriate public health lab. The samples will be tested on the same day they arrive.
    iv. Patients should remain in isolation until they have recovered and are negative for MERS.
    v. Healthcare facilities should keep track of all staff who have come into contact with a suspect patient under investigation for MERS. Likewise, the health department will need to conduct extensive contact tracing and monitoring if a case is identified.
n. Suggestion: There needs to be more talk about MERS—particularly with healthcare professionals.

IV. Discussion: Developing a stakeholder communications framework (**E.Olivarez, C.Ladd)**

a. Members discussed that the PCC is a policy group for advising DSHS and should not have a role in channeling information to stakeholders. As such, no communications framework was developed. Instead, **the PCC would like DSHS to give a presentation on their stakeholder/public communications capabilities** at an upcoming meeting, so the PCC can assess the capability and provide recommendations, if needed. Related to this, **DSHS currently is working toward developing a situational awareness/communications platform. The person in charge of this initiative could be invited to a future PCC meeting**, though it will probably be 6-8 months before someone is hired for this role.

V. Presentation: Texas Ebola/High Consequence Infectious Disease (HCID) preparedness activities

a. TX HCID Activities:
   i. Texas Preparedness Strategy for HICDs: Ebola and Other Pathogens
   ii. Regional public health and healthcare system activities
   iii. Funding allocation
   iv. Regional workshops
   v. Collaborative websites
   vi. Infectious Disease Response Units (IDRUs)

b. Texas Preparedness Strategy for HICDs: Ebola and Other Pathogens
   i. The Texas Preparedness Strategy was a collaboration between DSHS and key stakeholders and is based on:
      1. The US Department of Health and Human Services National Health Security Strategy
      2. Lessons learned from 2014 Ebola activities
      3. ESF 8 Core Functional Areas
      4. PHEP and HPP capabilities
      5. Texas Annex H
   ii. Objectives
      1. Foster informed, empowered individuals and communities by promoting awareness
      2. Develop and maintain the workforce needed to respond
      3. Ensure situational awareness
      4. Foster integrated, scalable public health and healthcare delivery systems
      5. Ensure timely and effective communications
      6. Promote an effective countermeasures enterprise
      7. Ensure prevention or mitigation of emerging threats
      8. Incorporate post-incident health recovery
      9. Work with other states to enhance national health response and recovery activities

10. Ensure that all HCID response systems are based on the best available science, evaluation, and quality improvement methods

c. Regional Ebola/HCID Workshops
   i. Purpose: Training and education, information sharing and networking, identifying and closing gaps, identifying a planning process for concept of operations plans (CONOPS)
   ii. Large target audience
   iii. Day 1: The first day will consist of a threat briefing; lessons learned and challenges; regional preparedness and response strategies; and state, interstate, and federal strategies. The content is directed primarily at senior-level decision makers and elected officials.
   iv. Day 2: The second day will focus on the spectrum of HCIDs, disaster behavioral health in communities, public health law and ethics, and emergency management/HCID response coordination.
   v. Break-out sessions will include the following topics: infection control, EMS ground and air transport, fatality management, waste management, hospital readiness, response for non-medical first responders, infectious disease epidemiology and surveillance of HCIDs, disaster behavioral health in a pandemic, behavioral health ethical challenges, and region-specific presentations.
   vi. Day 3: The third day will consist of a risk and crisis communications session, a regional exercise/guided discussion with follow-up hot wash, and a next steps discussion.
   vii. Continuing education credit for multiple disciplines will be provided for these events. E.Olivarez volunteered to assist with continuing education issues.
      i. Comment: DSHS needs to be sure content appropriate for high-level decision-makers happens on day 1 within the first few hours (the workshops currently are already structured like this).
      ii. J.Alejandre and A.Romano will provide C.Ladd with a letter of invitation for distribution to the PCC.

d. Infectious Disease Response Unit (IDRU): The IDRU program was conceptualized post Ebola. It will leverage the Texas Emergency Medical Task Force (EMTF) system, which includes ambulances, RN strike teams, ambulance busses, etc., in order to support hospitals and jurisdictions with the logistical support, direct patient care, and transportation coordination of patients with high consequence infectious diseases. Currently, the IDRU budget has been finalized and planning will commence around January. The state has started to identify subject matter experts and assess local/regional systems for gaps and synergies.
   i. IDRU Focus Areas:
      1. Collaboration, sharing best practices/lessons learned, and synergy in planning
      2. Regional Coordination of trained, equipped, and exercised EMS transport units

3. Regional and statewide subject matter experts and trained clinical care providers who provide consultation or direct patient care, as requested
4. Eight regional PPE caches to support and augment local and regional capabilities to respond to the needs of healthcare facilities caring for HCID patients
5. Statewide coordination, management, and distribution of critical resources for acute care providers through the EMTF program's organic logistics capability

ii. Next Steps
1. Plan
2. Build supply and equipment caches
3. Train and exercise regional providers
4. Integrate IDRUs into the EMTF system

VI. PCC Business (C.Ladd and D.Sheahan)

a. Reviewed action items:
   i. Crisis standards of care: B.Clements is waiting to brief HHSC, and then if that goes well will proceed with a project.
   ii. Prior minutes were corrected.
   iii. Suggested agenda items were incorporated.
   iv. More meeting reminders were provided. The frequency was deemed good.
   v. The federal government has not provided DSHS with an immigration briefing.
b. Quarterly reports: The format was deemed good, and the PCC agreed that the report was useful and worth producing. Completed quarterly reports will be provided to the PCC via email and reviewed at meetings. An official vote of approval is needed if formal recommendations are documented within a report.
c. Update PCC Membership
   i. The PCC voted to formerly change "GDEM" to "TDEM" in the PCC membership list. D.Patterson motioned, and j.Parisi seconded. All PCC members in attendance were in favor of the motion. The motion passed at 1:55 PM.
   ii. The process to add or change PCC members entails getting a letter of recommendation for a proposed member, obtaining an action memo from DSHS, and sending the memo to the HHSC Executive Commissioner for approval. This process generally takes months and should be performed in batches.
   iii. Agencies to consider adding to the PCC: the Texas EMS Alliance, Texas Association of School Nurses, Council on Aging, Texas Association of School Boards, and the Governors Committee on People with Disabilities. **Also, an agency representing elderly adults needs to be researched. These recommendations, along with the current list of**

member agencies and the Texas Administrative Code outlining the PCC, should be sent to PCC members for review. The PCC will decide at the next meeting how to alter the list of represented agencies.

iv. The PCC can include up to 6 ad hoc members. **D.Sheahan will document and share the 6 ad hoc positions.**

v. E.Olivarez: D.Sheahan should continue to obtain letters of recommendation for prospective PCC members from PCC-approved agencies. Moving forward, the PCC should plan to send letters twice a year to recruit people for the PCC. The PCC will discuss at the next meeting whether a representative from the United Way should be replaced by a representative from a different agency.

vi. **D.Sheahan should distribute his list of PCC members, prospective members, and corresponding agencies.**

d. The vote for the position of PCC Vice Chair was postponed until the next PCC meeting in January. **C.Ladd will send reminders of this.**

e. Suggested PCC Meeting topics for 2016:

i. Future of HPP
ii. HCID updates
iii. Review of the HCID strategy
iv. Legislative priorities and updates
v. PHEP and HPP budget feedback (2nd quarter meeting)
vi. Crisis standards of care: a recommendation to DSHS to formalize a crisis standards of care plan will be considered at the January meeting. **C.Ladd will obtain and distribute documentation (a PowerPoint presentation and framework document) on past DSHS crisis standards of care planning efforts.**
vii. Multi-drug resistant organisms
viii. DSHS communications strategies, methods, target audiences, etc.
ix. The DSHS communications/situational awareness platform under development
x. Review of the PCC membership list

f. E.Olivares will call an emergency meeting of the PCC, if needed, to review DSHS budget issues.

VII. Adjournment

a. E.Olivarez adjourned the meeting at 2:52 PM.

Action Items:

1. C.Ladd:
   a. Obtain and distribute information on past DSHS crisis standards of care planning efforts.
   b. Distribute the Ebola workshop invitation to PCC members.

2. J.Alejandre and A.Romano: Provide a letter of invitation for the regional Ebola workshops to C.Ladd.
3. D.Sheahan: Continue work recruiting PCC members and provide information/updates regarding membership.
4. PCC Members:
    a. Consider spreading the word about MERS-Cov to response partners/ stakeholders
    b. Share the Ebola workshop invitation with response partners/ stakeholders

Upcoming Meetings:

1. January 25, 2016
2. April 25, 2016
3. August 1, 2016
4. October 24, 2016

TEXAS Department of State Health Services

AGENDA

Preparedness Coordinating Council
1st Quarter Meeting

January 25, 2016
State Medical Operation Center
1100 West 49th Street, Laboratory Services Building, 7th Floor
Austin, TX 78756
Optional Teleconference #: 1-877-820-7831 (code: 133281#)
10:00 AM – 3:00 PM

Meeting Goals:

- Build awareness of ongoing public health and medical preparedness, response, recovery, and mitigation activities in Texas
- Identify strategic recommendations for consideration by DSHS
- Elect a new Vice Chair for the PCC

PCC Members in Attendance:

Member Name	Represented Entity	Yes	No	Alt
Cuellar Rojas, Adriana	United Ways of Texas			X
Epley, Eric	Governor's EMS and Trauma Advisory Council (GETAC)		X	
Manifold, Col. Craig	Texas Military Forces (TMF)	X		
Mendez, Margaret	Texas Medical Association (TMA)	X		
Nisenbaum, Miriam	National Association of Social Workers/Texas Chapter		X	
Olivarez, Eddie	Urban Local Health Department	X		
Parisi, James	Texas Hospital Association (THA)			X
Patterson, David	Texas Funeral Commission	X		
Phinney, Chuck	Governor's Division of Emergency Management (GDEM)	X		
Quiram, Dr. Barbara	University or Health Science Center	X		
Shine, Larry	Voluntary Organizations Active in Disaster (VOAD)		X	
Zolnierek, Dr. Cindy	Texas Nurses Association (TNA)			X

Others in Attendance:

Name	
Adams, Barbara (DSHS)	Leary, David (DSHS)
Alejandre, Julia (DSHS)	Lewis, Ginny (TARC)
Badke, Megan (Witt O'Brien's)	Riley, Sidney (Cherokee Co. PH)
Bennett, Greg (United Way; Proxy)	Roberts, Leslie (ARC)
Birnberg, Dana (DSHS)	Romano, Alison (DSHS)
Clements, Bruce (DSHS)	Schmider, Joseph (DSHS)
Hilliard, Ron (TNA; Proxy)	Schultz, Lisa (DSHS)
Kolberson, David (DSHS)	Sheahan, Donald (DSHS)
Kroll, Carrie (THA; Proxy)	Watkins, Lynda (TSICP)
Ladd, Clint (Witt O'Brien's)	Zumbrun, Janna (DSHS)
Lassberg, Hil (DSHS)	

Meeting Notes:

I. Welcome and Introductions (E.Olivarez)

a. At 10:10 the meeting started.
b. All attendees introduced themselves.

II. PCC Business (E.Olivarez)

a. Six PCC members were in attendance, satisfying the requirements for a quorum.
b. The meeting minutes were reviewed and put to a vote. B.Quiram motioned to accept the minutes "as is," and C.Manifold seconded. Acceptance of the minutes passed.
c. Review of Action Items:
    i. All action items were completed, except the item pertaining to crisis standards of care. Regarding that item, DSHS needs to brief organizational leadership on crisis standards of care, and then a way forward can be examined.
    ii. L.Brannan provided a presentation on MERS-CoV to TNA District 5
d. PCC Vice Chair Election:
    i. At 10:23, D.Patterson was nominated for the position of PCC Vice Chair by B.Quiram, and D.Patterson accepted the nomination.
    ii. No other nominations were made.
    iii. C.Phinney motioned to vote D.Patterson as PCC Vice Chair, and B.Quiram seconded. All PCC members in attendance voted in favor of electing D.Patterson to the position of Vice Chair.
e. Update on PCC Membership Changes:
    i. Letters were sent seeking PCC membership approval or renewal for the following individuals: Sidney Riley (Rural Local Health Department), Ron Hilliard (Texas Nurses Association), Ginny Lewis (Texas Association of

Regional Councils), Eddie Olivarez (Urban Local Health Department), and Lynda Watkins (Texas Society of Infection Control & Prevention).

ii. D.Sheahan will continue to follow-up. Approvals are expected by the next meeting.

iii. PCC membership terms last for six years, with no term limits. Officer terms last two years, and officers may be elected for two terms.

f. PCC Annual Report"

i. Overall, the format and content of the 2015 PCC Annual report were accepted by the PCC, with only a few minor edits suggested (i.e. remove sign-in sheets as an appendix; verify attendance for one person; and tweak the wording used in one paragraph).

ii. After those edits are made, the report will be finalized and distributed.

III. DSHS HEPRS Update (B.Clements)

a. Federal Preparedness Funding:

i. The FY16 omnibus appropriations package was approved for $1.1 trillion

ii. PHEP = 2% increase; $660 million for 2016

iii. The HPP program was funded at $255 million.

iv. Texas PHEP funding will be $37 million.

v. Texas hospitals will receive $15.8 million in grant funding.

b. The Public health funding policy committee created a new PHEP funding formula to help make funding allocations more equitable and defensible.

i. The Committee met for 3 days to look at allocation options.

ii. Risk and population were key factors.

iii. Workgroups were comprised of local health departments, academics, and regional representation.

iv. A letter was sent to K.Cole to provide a recommendation.

v. Eight health departments will have their allocations reduced by 10%+, while some are receiving large funding increases.

vi. Questions of concern with the new proposal include:

1. How do you implement this change to prevent infrastructure reductions?
2. What capabilities will be lost?
3. How will increases improve capabilities?

vii. The formula currently is under review by executive DSHS leadership, and DSHS will likely move forward with the formula next year using a phased implementation approach.

viii. E.Olivarez commented that the actual preparedness products/capabilities developed by health departments need to be reviewed to ensure funding is being effectively utilized.

ix. A question was posed regarding whether the recent Ebola incident will influence funding. B.Clements expressed his opinion that it may help to stabilize funding.

x. R.Hilliard offered that hospital preparedness is very costly and needs more funding.
xi. A discussion followed regarding how different types of entities may receive HPP funding, and RACs may not necessarily be the correct agency to lead funding in a particular area. B.Clements indicated that a variety of organizations can propose for funding, and this can be discussed with the PCC in the future, in order to examine the original intent vs. the current situation.
xii. B.Adams added that the focus of healthcare preparedness currently is on coalition building and includes other facilities beyond hospitals.
xiii. B.Quiram requested the most recent annual report summarizing the preparedness activities of agencies that receive HPP funding, in order to look at variations across the state. B.Clements was not sure of the workload required to generate a useful report for the PCC.

c. The Directors of Public Health Preparedness (DPHP) is an organization that includes 62 health department directors and is led by an executive committee of about a dozen directors. DPHP priorities for 2016 include:
   i. Impact Project: This project entails the development of 5 brief impact statements supporting the PHEP. The 3 prior recommendations made by the PCC regarding the impact statements were incorporated. The goals this year are to bridge the gap between the PHEP and HPP impact statements and to define a clear role and execution for the impact statements. In particular, due to similarities in stated capabilities for the PHEP and HPP, confusion has arisen externally that the two programs are duplicating efforts. In response, new HPP capability statements are being developed, and B.Clements will provide the updated statements to the PCC when they become available.
   ii. ORR Tool: DPHP will assess the ORR (Operational Readiness Review) tool (which is used to evaluate the SNS program) and determine its status with the CDC. Currently, there is concern that the ORR is not as effective for evaluating SNS capabilities as prior mechanisms.
   iii. DPHP will work with federal partners to provide a toolkit for policy outreach/education.
   iv. DPHP will provide assistance to federal partners in planning Hill Day activities in March.
   v. DPHP will work to develop an ongoing mechanism for providing stories and data on the impact of the PHEP/HPP, with a focus on future emergency responses. B.Clements asked for feedback regarding the format and kinds of information that should be presented and how to extract data from reports. In regard to this, information collected after the West, TX disaster meets some of these needs and can be used as a template. It was discussed that during a response, Texas could possibly bring in a subject matter expert from another state to record observations of how the PHEP/HPP impacted the outcome. E.Olivarez

agreed that a template for examining a response would be useful. B.Quiram suggested that it may not be possible to rely on a neutral observer to be available and present during a response. As such, a new role may need to be created. It was also suggested during discussion that the response SitRep process might be utilized as a vehicle to collect pertinent PHEP/HPP impact information during response operations. **The PCC will review the West template and information from the Boston Marathon bombing during a future meeting.**

d. Red Sky National:
    i. Red Sky National is a new CDC public health surveillance system that was recently introduced at the NEMA-ASTHO Joint Policy Working Group. It is possibly an 80% solution for surveillance.
    ii. Texas is the probable first state to use the CDC platform.
    iii. Red Sky Texas will include an all-hazards situational awareness and coordination site. The system will collect a large amount of data and compile it on a secure site for access by the right people. Users will be able to share collective knowledge and utilize the information to observe, orient, decide, and act. The system also will map out resources, environmental conditions, key infrastructure, intelligence data, and communications data using multiple data layers.
    iv. Red Sky National was developed by Lockheed Martin and was used to manage the international CDC Ebola response. It is open-source software.
    v. There is hope that Red Sky can be linked with NEDS and that modelling capabilities can be incorporated into the system.
    vi. **B.Clements will have a better idea of timelines for implementation at the next PCC meeting, and he will want to ask the PCC for opinions on how to organize the system.**

IV. The Status of the Public Health Emergency Preparedness (PHEP) Cooperative Agreement and Hospital Preparedness Program (HPP)

a. Current preparedness funding includes conventional funding (PHEP, HPP, and ELC) plus Ebola funding.
b. A June 2017 funding extension (NCE: no cost extension) was awarded for grants. This will allow more time for purchases (i.e. lab equipment, PPE, and epi tablets). Jurisdictions will be allowed a contract amendment for purchasing epi tablets.
c. PHEP Funding Formula:
    i. 46 local health departments participate in the PHEP.
    ii. DSHS has been using the same funding allocation formula since 2009, based on population data. Since then, the formula has only ever been updated to account for CDC funding fluctuations.
    iii. In 2014, the Public health funding and policy committee created a workgroup comprised of small, medium, and large health departments;

DSHS regions; non-PHEP participating LHDs; and the DSHS Central Office (in the role of SMEs) to design a new PHEP funding formula.

a. Proposed formula:
    i. Central office and state efforts = 32%
    ii. Multi-area supplement (MAS) = 14% (i.e. health departments with more than one county)
    iii. Project public health ready recognition = 0.25%
    iv. Base funds = $2.00 per person/first 50K population
    v. Non-base population (variable) = 95% of remaining dollars after fixed funds have been allocated by population
    vi. Land area (variable) = 5% of remaining dollars after fixed items
b. The new PHEP funding allocation strategy will have a two-year rollout period. During the first year, only 50% of the change will be implemented.
c. Currently the new allocation formula is pending final review by Commissioner Hellerstedt.
d. Based on the new formula, the budgets of 8 LHDs will be reduced by 10%+.
e. It is anticipated that dollars are going to be reallocated to SNS and volunteer management initiatives (almost across the board).

2. DSHS has started requesting from LHDs evidence of collaboration (2 examples per quarter).
3. Next year is year 5 of 5 of the PHEP project period. DSHS expects no major changes to end the project period, though big changes are expected at the beginning of the next project period.
4. Looking ahead, DSHS will have LHDs implement a work plan that's updated throughout year. DSHS hopes to create a web-based platform for this.
5. DSHS has found it tricky to conduct hospital visits to help assess capabilities, since hospitals fear the visits are regulatory inspections.
6. HPP updates
    a. National funding is $228,500,000, and Texas received $15,821,740. Funding levels are holding steady right now.
    b. Ebola supplemental funding = Texas received $11,068,913
        i. Part A is for HPP contractors and in Texas consists of $7,818,987, with $1 million for treatment hospitals
        ii. Part B funding is specifically for Ebola treatment centers
    c. ASPR wants to change the name of the program to Healthcare Preparedness Program, but this change would require a Congressional act.
    d. Overall, there is a need to better align PHEP and HPP.
    e. The HPP Capabilities will be updated for the next project period.
    f. In Texas, healthcare coalition boundaries align with Trauma Service Areas.

g. Fourteen contractors manage 22 healthcare coalitions. This includes 11 RACS, 2 LHDs, and 1 stand-alone, non-profit organization.
h. Coalition members make decisions about what projects to support within contract parameters. In general, there is a regional focus on planning, training and exercises—with a goal to align activities and build redundancy, while diminishing unneeded duplication.
i. Eight HPP contractors manage Emergency Medical Task Forces (EMTFs)
j. Current areas of focus for HPP contractors include monthly bed reporting, reviewing deliverables, the pink vest project (using pink vests with patient information to identify nursing home residents during emergencies), outreach to non-acute partners, and issuing RFPs.
k. G.Lewis expressed concern for individuals who are aging in place and/or have mental health needs. Mobile feeding programs potentially could be used to help support these populations during emergencies.
l. L.Roberts with American Red Cross offered that vests would be great for use in shelters.
m. It was mentioned that the end-stage renal disease (ESRD) community already uses purple shirts and fanny packs to identify individuals during emergencies.
n. A general comment was made that patient tracking is a huge issue that needs to be solved.

V. DSHS's Emergency Preparedness and Response Communications Capabilities

a. Public Health Information Network (PHIN):
    i. This is a secure information network used to send health alerts to distribution lists.
    ii. Both the state and local health departments can send alerts.
    iii. Attachments can be added to PHIN notifications.
    iv. One limitation of the PHIN is that not everyone who needs to receive the notifications is enrolled in the system.
    v. Given that each jurisdiction uses the PHIN differently, the types of contacts included on the distribution lists differs. For instance, elected officials may receive notifications in one jurisdiction but not in another.
b. Emails (personal and work)
    i. Information can be sent to PHEP and HPP team leads, and from there to the contractors.
    ii. Information can be sent to regional directors and preparedness managers, and from there to key stakeholders, such as emergency management coordinators.
    iii. Information can be sent from disaster epidemiologists to regional epidemiologists; from regional epidemiologists to local epidemiologists; and from local epidemiologists to hospital infection control practitioners (ICPs).

iv. DSHS Central Office doesn't have all local-level contact information. HSRs have local-level contacts.

c. Telephone (i.e. landlines, cell phones, home phones, and text msg.)
d. PCC comments:
    i. Messages need to clearly indicate the level of urgency. For instance, messages could be labeled as "FYI" or "Action Required." The military labels all messages with who needs it, the priority, and the expected action.
    ii. Lead nurse coordinators for schools should be included in distribution lists.
    iii. Local health departments and regional health departments will bear the burden for fielding calls during emergencies, based on established 24/7 numbers and published email addresses.
    iv. More local healthcare facilities need to be added to the PHIN, and the distribution lists need to be updated.
    v. Call-down systems should be practiced regularly and documented.

VI. Texas High Consequence Infectious Disease (HCID) Preparedness Updates

a. Infectious Disease Response Units (IDRU) will be added to EMTFs.
    i. This will be a state capability in case the local capability to transport an Ebola patient is not available.
    ii. If patients are "wet," the IDRU cannot transport them.
    iii. Additionally, teams can be dropped-in to a local hospital facility to augment the clinicians.
    iv. Multiple caches will be created to treat a patient for up to 2 weeks.
    v. The program is funded, but the capability is not built yet.
    vi. The IDRU program uses Ebola supplemental funds, though IDRUs could respond to any HCID.
    vii. IDRU members will be considered contract employees.
    viii. E.Olivarez recommended that federal partners be included in IDRU trainings/exercises, to ensure coordination.
    ix. **The PCC requested an additional briefing on IDRUs at the next meeting. It was recommended that Joe Palfini be invited to present.**
    x. PCC members expressed concern over the sustainability of the program.
b. A handout was provided showing Ebola funding, including funding by Texas Preparedness Strategy Objective.
c. HCID workshops:
    i. Two have been completed (McAllen and New Braunfels) and both were very successful.
    ii. The speakers are outstanding and world-class—including SME presentations, regional panels, and state-level and federal-level presentations.

iii. Notable speakers include Col. Randy Larson on the threat of WMDs, Allison Winnike on public health law, George Everly on behavioral health response, David Patterson on mortuary protocols, and Vincent Covello on risk communications.
iv. Overall, registration is going well, and there is a travel policy in place to provide reimbursement.
v. Flash drives with presentations and a workshop app are available to help conserve paper.
vi. DSHS contracted with Texas A&M to take notes and facilitate the day-3 exercise.
vii. During the exercise, attendees sit with their applicable District Disaster Committee (DDC). Also, the PHIN is being used for notifications during the exercise.
viii. **PCC members need to participate and spread the word about the workshops.** The target audience includes elected officials, police chiefs, fire chiefs, emergency management coordinators, public health and medical professionals, etc.
    1. The Texas Funeral Directors Association is using the HCID workshops to encourage participation.
    2. THA and TMA are also advertising the workshop.
    3. **Information on the workshops should be sent to the PCC group again.**

d. DSHS is in the process of hiring a planning contractor to help take the workshops to the next step, through regional and state HCID planning assistance (given that the level of planning varies greatly throughout the state). These plans will roll-up into the federal Region VI plan.
e. DSHS currently is working on developing videotaped training modules using txidr.org. The Texas Infectious Disease Readiness Task Force is the driver for txidr.org.
    i. **The PCC may be able to promote txidr.org.**
    ii. TMA and TNA have txdir.org references on their websites, and the Texas Funeral Directors Association will add it.
f. AARs from the regional HCID workshops will be incorporated into a capstone symposium in Galveston in October.
g. E.Olivarez suggested that responding to MDRTB/EDRTB cases is an effective way to test HCID procedures.
h. D.Patterson motioned to adjourn at 2:50 PM and the motion passed.

Action Items:

1. C.Ladd:
    a. Distribute the Ebola workshop invitation to PCC members again.
    b. Finalize the 2015 PCC Annual Report
2. D.Sheahan: Continue work finalizing new PCC members.

3. PCC Members:
    a. Promote txidr.org.
    b. Attend and promote HCID Workshops.
    c. Learn about House Bill 4365 regarding the ability for EMS providers to administer control substance medications without a written order from a physician (C.Manifold can provide information)
4. Suggested Upcoming Meeting Topics:
    a. Update on Arboviruses (Zika, Chikunguru, Dengue, and West Nile)
    b. Role of free standing emergency departments in response efforts, including potential impacts, suggestions for integration; Dr. Emily Kidd and a STRAC representative were suggested as presenters.
    c. Future of HPP/RAC
    d. An update on House Bill 2646; Marylyn Felkner was suggested as a presenter.
    e. An Update on the IDRU; Joe Palfini was suggested as a presenter.
    f. Review of the West/Boston Marathon disaster response AAR templates

Upcoming Meetings:

1. April 25, 2016
2. August 1, 2016
3. October 24, 2016

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Promotor(a) or Community Health Worker (CHW) Training and Certification Advisory Committee

Number of Members: 9

Committee Status (Ongoing or Inactive): Ongoing — Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 1999 **Date to Be Abolished:** 5/1/2019

Budget Strategy (Strategies) (e.g. 1-2-4): 2.1.2 **Strategy Title (e.g. Occupational Licensing):** Women and Children's Health Services

Budget Strategy (Strategies): **Strategy Title:**

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Health & Safety Code, Sec. 48.101
State Authority	Admin Code	25 TAC Sec. 146.3
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$3,764	$5,000	$5,000
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$3,764	$5,000	$5,000

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
8003 - GR for Maternal and Child Health B	$3,160	$5,000	$5,000
555 - Federal Funds	$604	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year

Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
6	6	6

Committee Description: The Promotor(a) or CHW Training and Certification Advisory Committee advises DSHS on the implementation of standards, guidelines, and requirements concerning training and regulation of promotores/community health workers. Advisory Committee efforts helped increase public awareness of CHW roles in Texas and the positive impact CHWs have to create healthier communities. The Advisory Committee should be continued as the members serve as the voice of CHWs in their communities and assist DSHS and HHSC with the CHW training and certification process to meet the needs in Texas.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

The committee meets six times per year. In 2016, the committee will meet via webinar two times and in Austin four times. There is no requirement regarding a specific frequency of meetings. Per 25 TAC Sec.146.3. (h) - the committee shall meet only as necessary to conduct committee business.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

Per 25 TAC Sec.146.3. (n), the committee shall file an annual written report with the Executive Commissioner.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

Key accomplishments in 2015 include: Increased stakeholder participation in Committee meetings through the use of webinars; approved a pilot procedure to have qualified guest speakers in DSHS-certified training; developed and distributed a survey to regional CHW associations to obtain feedback regarding the development of a statewide CHW network; participated in the nomination and application review process for Committee vacancies; held a session at the 2015 American Public Health Association (APHA) Annual Meeting on implementation and preliminary results of the CHW/Promotor(a) Evaluation Survey; and discussed CHW reimbursement models in other states. DSHS implemented the guest speaker procedure and the survey recommended by the committee.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ?

Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

200.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Arrange meeting site and webinar, member travel, identify speakers, topics, develop agenda and materials, minutes, email and other communication, appointment solicitation process for vacant positions, development of the Annual Report

6. Have there been instances where the committee was unable to meet because a quorum was not present?

No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes. - Attendance record included in report.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

Committee meetings are open to the public. Meeting agenda is posted on the Secretary of State website. Public comment is accepted at all meetings.

7b. Do members of the public attend at least 50 percent of all committee meetings?

Yes

7c. Are there instances where no members of the public attended meetings?

No

8. Please list any external stakeholders you recommend we contact regarding this committee.

CHW networks and associations, employers of CHWs, CHW training programs

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

Yes

9b. Please describe the rationale for this opinion.

In recent years, the committee has recommended a guest speaker process to increase access to DSHS-certified continuing education and developed an evaluation survey to obtain the perspective of Texas CHWs on the benefits of certification and challenges in renewing certification.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

Yes

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission? Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

The committee provides valuable stakeholder input that the agency uses to implement its policies and programs. Members serve as the voice of CHWs in their communities and assist DSHS and HHSC with the CHW training and certification process to meet the needs in Texas.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Promotor(a) or Community Health Worker Training and Certification Advisory Committee Meeting Minutes
Friday, November 20, 2015
10:00 a.m. – 12:30 p.m.

Texas Department of State Health Services
Moreton Building
Conference Room M-100
1100 W 49th Street
Austin, Texas 78756

Table 1: Promotor(a) or Community Health Worker Training and Certification Advisory Committee member attendance at the Thursday, November 20, 2015 meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Bustos, Claudia	P		Hansford, Bobby D.	P	
Youngstrom Diebolt, Jean	P		Muñoz, Oscar J.	P	
Eagleton, Gary Glenn	P		Rosing, Richard	P	
Escobar, Mérida	P		St. John, Julie	P	
Ginés, Venus	P				

Yes: Indicates attended the meeting No: Indicates did not attend the meeting
P: Indicates attended meeting via phone/webinar

Agenda Item 1: Welcome and Introductions
The Promotor(a) or Community Health Worker (CHW) Training and Certification Advisory Committee meeting commenced with Ms. Claudia Bustos serving as Presiding Officer. Ms. Bustos welcomed participants to the meeting. Table 1 notes committee member attendance at the meeting.

DSHS Staff present: Tammy Sajak, Caly Fernández, Paige Menking, and Beatrice Smith

Stakeholders present: Two stakeholders attended the meeting in person and 37 attended by webinar.

Agenda Item 2: Approval of Minutes
Dr. Julie St. John moved to approve the minutes from the September 25, 2015 meeting as written. Ms. Venus Ginés seconded the motion. With no nays and no abstentions, the motion was approved with a unanimous voice vote.

Agenda Item 3: Public Comment
Mr. Jorge Bacelis, Texas Outreach Office Coordinator, Office of Border Health, Austin provided public comment regarding the certification process. Adriana Luevanos, Regional Program Coordinator, US Office of Border Health has requested that promotores in Presidio, Texas outside of El Paso be able to participate in the advisory committee and eventually be certified as CHWs even though there is currently no training site operating in their rural area. Beatrice Smith and Tammy Sajak provided information regarding training programs in El Paso for networking and to discuss possible training. Ms. Ginés stated that a team can be sent to El Paso to do training.

Ms. Rosalia Guerrero, UT School of Public Health, Houston, currently participates in one of the Advisory Committee workgroups and encouraged people to get involved through participation in one of the workgroups.

Agenda Item 4: CHW Spotlight: American Public Health Association CHW Group Award- UT School of Public Health- Tu Salud iSi Cuenta!

Ms. Menking introduced Ms. Lisa Mitchell-Bennett and Ms. Vanessa Saldaña of the UT School of Public Health Group in Brownsville, who won the Outstanding CHW Group Award at the American Public Health Association Conference in Chicago.

The presenters expressed happiness with the impact the group has had on the community of Brownsville. The area served contains both rural and urban areas, Mexican culture, lush wildlife, as well as high instances of obesity and diabetes. Community outreach through Tu Salud iSi Cuenta! has taken many forms, from television coverage of events, to web presence and newsletters, to newspaper columns. Special attention is taken to make information accessible to Spanish speakers, complete with a weekly morning segment on Vallevision, with role models and experts and tips on cooking and exercise.

The CHW component has enhanced their campaign, directing people in the community to actionable items. CHWs have also produced an education curriculum as part of a 12-year community-wide campaign. CHWs conduct home visits that are designed to personally help individuals with barriers to behavior change using motivational interviewing and by making goals and plans.

iSi Cuenta! and the promotoras support the community through well-structured opportunities like providing free community-wide exercise classes that are attended by over 1,000 people a week; free nutrition classes complete with cooking classes and recipes; as well as health screenings and community health fairs. CHWs keep track of and follow up with those screened and provide motivational support. Other exercise initiatives include the Biggest Loser Challenge, CycloBia, and the Guinness World Record for largest Zumba class.

The Brownsville farmers market helps ensure nutritious food items for the community, emphasizing accessibility for those with low incomes by accepting food stamps, WIC, and vouchers. Community gardens are an off-shoot of the farmers market. There are six fully subscribed gardens located in the lowest income neighborhoods in the community. Not only are residents able to eat from the garden, but residents can also sell the produce for income.

The Salud y Vida program has grown out of the Tu Salud iSi Cuenta! program. Funded through the 1115 waiver, it is a multidisciplinary, evidence-based chronic care management program that relies on the CHW model to help connect people to needed services and supports. The focus is on uninsured, low income individuals with uncontrolled diabetes. CHWs are also involved in the MEND foundation, an obesity prevention program aimed at youth.

The CHW approach is being replicated in different cities. Each city has hired CHWs as city employees to lead efforts to reach low income and uninsured people to galvanize their communities at large.

Ms. Bustos recognized the importance of maintaining and tracking data, as it is important to show the impact CHWs make. Additionally, now that the project is funded through an 1115 waiver, there are metrics and outcomes tied to that funding. Thus, anyone who is enrolled

in the program has their data and measurements recorded when provided with screenings and follow ups.

Agenda Item 5: Texas CHW Evaluation Survey Preliminary Results: May-September 2015

Dr. St. John shared the preliminary results from the 2015 CHW Evaluation Survey implemented in May 2015. The development of the survey has been the ongoing work of committee members for the past four years, in an effort to explore whether certification benefits CHWs and communities. The preliminary results provide initial feedback containing information gained from May through October.

CHWs, both English and Spanish speaking, were asked to voluntarily provide feedback on certification using a variety of methods. A vast majority of respondents indicated that CHW certification was meaningful and/or valuable. The overwhelming response for why CHWs chose to be certified was to better serve their community and make a difference, increase the respect and value shown to them by the community, increase self-confidence, give value to the profession, and allow for better job responsibilities.

CHWs indicated feeling as though certification is meaningful but included that there are not enough job opportunities, lack of recognition of promotoras/CHWs as navigators, not enough instructors to provide training, and not enough affordable and accessible continuing education (CEU) opportunities. A vast majority of respondents (93% of English speakers and 100% of Spanish speakers) indicated plans to renew.

Staff will continue to analyze data from May to December, and report 2015 results to the CHW Advisory Committee and include the results in the 2015 Annual Report. After January 1st, there are plans to disseminate the survey to CHWs with a certification expiration date in 2016. Limitations of the survey include that it is voluntary, and only goes out to CHWs who are certified, so there is no way of knowing why those who are not certified have not sought certification.

Agenda Item 8: Committee Business

- *CHW guest instructor procedures*

  The Training and Certification Workgroup has been getting input from training programs and instructors, participated in a webinar conducted by DSHS, and held workgroup meetings for further discussion. Feedback provided resulted in separate procedures for certification courses and continuing education courses, both of which require curriculum approval. For certification courses, guest instruction is limited to two hours per core competency (no more than 10% of a total curriculum). For continuing education courses, guest instructors can provide no more than two hours of training per continuing education event. For multiple day events, guest instructors can provide no more than two hours per day. A certified instructor must be available during the presentation to answer questions or provide context. The goal is to implement these procedures for a six month trial period, then revise as necessary. Specific rules, requirements, and qualifications were referred to on the presentation slide. Even if CHW instructor certification requirements are not met, guest-instructors can still provide non-certified credit hours.

  Motion:

  Mr. Rosing moved to approve a six month trial implementation of the draft guest instructor procedures to be revisited in June to determine whether the procedure should become permanent. The motion was seconded by Mr. Hansford. The motion passed with a unanimous voice vote.

- *Dates and location for 2016 meetings*
  Dates and locations for the 2016 Advisory Committee meetings need to be determined, as well as deciding how many of the meetings are in person or via webinar, and if participation by webinar is acceptable for meetings designated as in-person meetings. January 29, March 11, May 20, July 29, September 23, and November 18 were proposed.

  Motions:
  - Ms. Diebolt moved to set 2016 meeting dates for January 29, March 11, May 20, July 29, September 23, and November 18. Dr. St. John seconded the motion. The motion was approved with a unanimous voice vote.

  - Mr. Eagleton moved to have two mandatory in-person meetings. Mr. Rosing seconded the motion.
    Amendment:
    After discussion, Mr. Rosing moved to amend the original motion to define that mandatory meetings require the person to be physically present at the designated location, with the exception of medical reasons/restrictions, which will allow the member to call in and have voting privileges. Mr. Eagleton seconded the amendment. With no nays and no abstentions, the motion passed with a unanimous vote.

  - Mr. Hansford moved to designate January and May as the 2016 mandatory in-person meetings. Ms. Ginés seconded the motion. The motion was approved unanimously voice vote.

- *Review and Recommend to DSHS application for certification of training institutions*
  A training site program application has been received from the Adult and Youth United Development Association (AYUDA Inc.) to provide continuing education to CHWs. Amy Meeks presented information on the El Paso based program, referring to the presentation slides. The intention of the program is to get certification continue to bring change to their community.

  Motion:
  Mr. Eagleton moved to accept AYUDA's application to be a CHW training center for continuing education. The motion was seconded by Dr. St. John. With no nays and no abstentions, the motion passed by voice vote. AYUDA will receive their approval packet and training program certificate.

Agenda Item 6: CHW Core Consensus (C3) Project Update

The C3 project came about because many states are moving towards a commons standard for CHW training at a national level. The aim of the project is to offer CHW and stakeholder-driven contemporary recommendations for consideration and adoption related to CHW core roles, core skills, and core qualities. Benchmark documents were reviewed for states where roles and skills alignment with specific goals was evaluated A crosswalk was created to compare the benchmarks and see gaps in programs. Involvement across the United States was extensive and resulted in a report created from preliminary findings. CHW networks were given the first shot of modifying and studying the findings.

One of the core values of the project is to look at self-determination. One aim of the project is to find different ways to put CHWs in leadership roles. There is a desire, based on network input, to expand the list of roles, skills, and qualities (referred to on the

presentation slide). There is a desire to bring in more stakeholders. The immediate goal is to take the roles, skills, and qualities and resend it to the entire list of networks for review and input. The hope, moving forward, is to encourage people to continue to build consensus and to popularize thinking of how to use these qualities, roles, and skills. As the project moves to the assessment tool, the importance of having diverse representation in community based organizations was expressed.

Agenda Item 7: Committee Vacancies and Solicitation of New Members

Solicitation of new members is underway, as Ms. Diebolt, Ms. Ginés and Mr. Rosing's terms are expiring. Ms. Ginés does not plan on reapplying. Three positions are open for two public members and one higher education member. The applications and solicitation letters were sent out this week. Applications are due Monday, January 11, 2016, and individuals from health service regions 9/10, 7, and 4/5 are especially encouraged to apply. Anyone with questions should contact Ms. Menking.

Agenda Item 9: Program Update

Ms. Menking gave an update on the number of certified CHWs, as well as CHW and instructor renewals, referring to the presentation slide.

Agenda Item 10: 2015 CHW Advisory Committee Workgroups

- Ms. Escobar stated that there are no updates on program rules.
- For Communication & Outreach, a survey was sent to the leaders of regional CHW associations concerning interest in a statewide CHW network, garnering responses from 9 of 11 associations. Association leaders also participated in a webinar regarding the results of that survey. A call will be scheduled for further discussion, which will be led by CHWs and interested parties, rather than the Advisory Committee or DSHS.
- The Training & Certification Workgroup met and discussed the guest instructor procedures. The next topic will be the survey for what types of topics and training programs are needed in the community to add them to the big DML conference next year.
- The Workforce Solutions & Employment Opportunities Workgroup received a report from the Texas Workforce Investment Council showing an increase in CHW employment. The group is currently waiting on the new reports in order to share that data.
- Ms. Menking is assisting Ms. Smith in working on the Annual Report. The CHW Program Coordinators will provide workgroup members an outline of 2015 activities and accomplishments for review and editing.

Agenda Item 11: Committee Updates

Ms. Ginés noted that 10 CHWs and promotoras from the recent Dia de la Mujer certification class have been hired as navigators for the Affordable Care Act. Mr. Rosing shared that there should be 10-12 students graduating from the Houston Community College program in December to become CHWs.

Agenda Item 12: New Business for Consideration at Next Meeting

There will be an update from the Medicaid office to talk about funding models in the January meeting.

Agenda Item 13: Adjourn

The meeting was adjourned by Ms. Escobar at 12:33.

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Promotor(a) or Community Health Worker Training and Certification Advisory Committee Meeting Minutes
Friday, January 29, 2016
10:00 a.m. – 12:30 p.m.

Texas Department of State Health Services
Moreton Building
Conference Room M-100
1100 W 49th Street
Austin, Texas 78756

Table 1: Promotor(a) or Community Health Worker Training and Certification Advisory Committee member attendance at the Friday, January 29, 2016 meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Bustos, Claudia	X		Hansford, Bobby D.	X	
Diebolt, Jean	X		Muñoz, Oscar J.	X	
Eagleton, Gary Glenn	X		Rosing, Richard	X	
Escobar, Mérida	X		St. John, Julie	X	
Ginés, Venus	X				

Yes: Indicates attended the meeting No: Indicates did not attend the meeting
P: Indicates attended meeting via phone/webinar

Agenda Item 1: Welcome and Introductions

The Promotor(a) or Community Health Worker (CHW) Training and Certification Advisory Committee meeting commenced with Ms. Claudia Bustos serving as Presiding Officer. Ms. Bustos welcomed participants to the meeting. Table 1 notes committee member attendance at the meeting.

DSHS Staff present: Caly Fernández, Beverly MacCarty, Monica Maldonado, Paige Menking, and Beatrice Smith

Stakeholders present: 11 stakeholders attended the meeting in person and an additional 37 stakeholders joined the meeting via webinar/phone.

Ms. MacCarty, on behalf of Evelyn Delgado, Assistant Commissioner for Family and Community Health Services, presented plaques and certificates to three members whose terms expired January 2016: Ms. Venus Ginés, Ms. Jean Diebolt, and Mr. Richard Rosing.

Agenda Item 2: Approval of Minutes

The committee reviewed minutes from the November 20, 2015 CHW Advisory meeting. Mr. Oscar Muñoz moved to approve the minutes from the meeting, and Ms. Ginés seconded the motion. With no nays and no abstentions, the motion was approved with a unanimous vote.

Agenda Item 3: Public Comment

Mr. Edwin Marty, Food Policy Manager, Office of Sustainability, City of Austin provided public comment. The Office of Sustainability currently works on the development of a local, sustainable food system that has the potential of working with CHWs to address food insecurity and food justice in the area. The Office of Sustainability has partnered with the Health and Humans Services Commission (HHSC) and Travis County to support school and community-based farm stand initiatives in as many locations as possible in the region, with the goal of hiring CHWs to work in the stands to advocate for health access and health navigation services to the community. A Request for Proposal (RFP) will be posted in the next month and will be shared with committee members. In an attempt to collaborate with as many organizations as possible, the Office of Sustainability is looking into opportunities for integrating CHWs including continuing education, a toolkit on healthy food, and Project Brighter Bites, a pilot program in the Houston area to provide access to fresh produce to kids and their families.

ACTION ITEM:

- Mr. Marty will email the RFP and contact information to DSHS to share with committee members and CHW stakeholders

Agenda Item 4: Committee Business

- *Finalize Advisory Committee 2015 Accomplishments and 2016 Planned Activities*

  Ms. Beatrice Smith referenced the *Advisory Committee 2015 Accomplishments and 2016 Planned Activities* handout related to the development of the annual report of the CHW Training and Certification Program. The handout details the workgroups and activities accomplished in calendar year 2015 and projected activities for calendar year 2016.

  Motion:
  Ms. Ginés moved to approve the finalization of the 2015-2016 planned activities, and Mr. Rosing seconded the motion. The motion passed with a unanimous vote, and activities were finalized.

- *Review and recommend to DSHS application for certification of training institutions*
  The committee reviewed an application from Gateway to Care to add continuing education for instructors to their current CHW training program. Members were referred to review the Gateway to Care Training Program Application information and a sample training module in their packets. Mr. Angel Rivera Gonzalez presented further information on Gateway to Care's CHW programs.

  Motion:
  Ms. Ginés moved to recommend Gateway to Care for DSHS approval as a training institution for instructors, and Ms. Mérida Escobar seconded the motion.

  Mr. Gonzalez responded to a question from Mr. Rosing, and clarified that the instruction focuses on content as well as the process to teach. The plan is to offer both leadership and teaching strategies. With no nays and no abstentions, the motion carried with a unanimous voice vote.

Agenda Item 5: Financing for CHW Services in Medicaid

Ms. Carisa Magee, Special Advisor, Medicaid/CHIP, HHSC, presented on *Financing for Community Health Worker Services in Medicaid*. Highlights of the presentation include:

- Sources for funding with Medicaid clients include Medicaid fee-for-service (traditional Medicaid), Medicaid Managed Care, Medicaid 1115 Demonstration Waiver, and State Innovation Model (SIM) funds.
- Changes to Medicaid regulations related to preventive services allow practitioners other than a physician or other licensed professional to provide recommended preventive services. While this change created a potential avenue for financing CHW services, as of November 2016, no state had requested a state plan amendment to cover CHW services under the preventive services regulatory change.
- Texas Medicaid reviewed the activities of CHWs in Medicaid managed care and 1115 waiver projects with Centers for Medicare and Medicaid Services (CMS). CMS suggested most activities would be deemed outreach or case management, while only a limited set of services might qualify if sufficient condition-specific medical education was involved. Input on how Medicaid can deliver preventive services using non-licensed practitioners is encouraged and can be submitted at the HHSC website at http://www.hhsc.state.tx.us/medicaid/MPR/index.shtml.
- Some states have incorporated CHWs into their Medicaid programs including Minnesota, South Carolina and New Mexico.
    - The Minnesota Medicaid Program is one of the only states that has an approved Medicaid state plan to reimburse CHW health services through the fee-for-service component of the Medicaid program, and the same services can also be billed for members in Medicaid managed care. Less than 100 claims are submitted annually.
    - South Carolina includes CHWS as part of care teams to improving patient follow-though with screenings, office visits, and medications. Nineteen primary care practices participate in a grant-funded pilot program that bills under physician education codes already authorized under the Medicaid state plan. The state is discussing options for a preventive services state plan amendment with CMS.
    - In New Mexico, managed care plans may offer CHW services as part of care coordination. Payment methods include direct employment of CHWs, fee-for-service payments to contracted CHWs, and per-member-per-month (PMPM) payments to providers employing CHWs. New Mexico is conducting a pilot with two federally qualified health centers (FQHCs) that receive PMPM for three levels of care for high-needs clients.
- The Texas 1115 Demonstration Waiver is a Medicaid mechanism to fund innovative projects designed to deliver health services that meet the CMS aim of quality care. These projects have been negotiated for five years of funding and require providers to meet performance goals. CHW Delivery System Reform Incentive Payment (DSRIP) projects include CHW integration in care teams, such as for behavioral health services, patient navigation, particularly to divert nonemergent Emergency Department visits, disease-specific prevention and education, such as for asthma and diabetes, and compliance with appointments and following care regimens, such as prenatal care.
- Mr. Oscar Muñoz expressed concern that while it is time to look at the CHW as a viable employee, it is not their job to be part of a medical care team. The CHW primary role is to refer, outreach, and assist with preventive education, not to provide a specialized role of evaluation. He expressed that caution was needed on this front. Ms. Magee stated that while some coordination roles can be financed in a more limited way, mainstream funding requires medical ties.
- Ms. Ginés stated that a focus in conferences over the past four years is expanding the role of promotores. Many promotores have expressed interest in clinical advocacy, care coordination, and medical research. The Affordable Care Act has allowed CHWs to work as

navigators. Additionally, all community cancer centers are now required to have patient navigators. As the role is expanding, there is funding for patient navigation, and there are funding opportunities from agencies other than CMS. Ms. Magee noted that her area of expertise is Medicaid funding, and the role of Medicaid is to partner with those other funding opportunities.

- Ms. Magee expressed the importance of partnering with agencies such as DSHS and CMS to do evidence-based research studies to show how CHWs make positive impact.
- HHSC is currently implementing a new survey with Medicaid Managed Care Organizations (MCOs) to provide additional information about current practices, opportunities, and challenges related to incorporating of CHWs in the health plans.

ACTION ITEM:

- Ms. Smith will send out Ms. Magee's contact information to the committee.
- Ms. MacCarty will email information from the webinar, specific to Medicaid, to members.

Agenda Item 6: CHW Spotlight

- CHW Partnership through Dia de la Mujer Latina (DML) and Houston Health and Human Services (HHS)
  Since December 2010, DML has trained 865 promotores. The City of Houston selected the program, through an RFP, to train employees who work within their community. DML has held two CHW certification classes for City of Houston staff, one of which has already graduated. DML is putting together a White Paper to see if other cities will put together similar CHW training for their employees as this has the potential to set the stage for health departments across the country. The program success is attributed to learning from and partnering with other community organizations and associations, such as South Texas Promotora Association, Familias Triunfadoras, and Community Health Center of Lubbock. The collaborative efforts have enhanced the program, showing participants how to work with their communities, creating a greater balance, and emphasizing the importance of passion into their training.

- El Paso CHW/Promotor(a) Training Program Highlight: Familias Triunfadoras (FT)
  Ms. Maria Covernali and Ms. Leticia Espinoza presented information about Familias Triunfadoras, Inc. in San Elizario, Texas. FT is a women-led organization partnered with Día de la Mujer Latina and South Texas Promotora Associations. The organization has developed programs, such as CHW training, requiring the completion of 160 hours of training competencies plus 1,000 hours of community work to enhance their education. Community education focuses on competency-based curriculum as well as promotores/CHWs participating in outreach and health fairs. CHWs also conduct support groups for women experiencing domestic violence and assist youth programs. The program has achieved recognition and service awards from all over the country. To date FT has graduated over 300 CHWs, many of whom experienced domestic violence situations, thereby improving the quality of their lives.
  Ms. Escobar noted that FT also works with teenagers and she hopes to organize a teen conference in El Paso.

Agenda Item 7: Oral Health Trainings for CHWs

- Ms. Diane Rhodes, Senior Policy Manager, Texas Dental Association (TDA) presented information on developing an oral health training for CHWs. A goal of the program is to leverage the critical connection CHWs have with the community.

The initial curriculum will be in English and translated to Spanish once the curriculum is finalized. There will be two-hour modules grouped by age, one for children and one for adults. TDA intends to collaborate with CHW training programs to offer this curriculum for free or for a nominal charge by the training program to offer certificates. The intention of the program is not to make a profit.

TDA sees this as a collaborative process, seeking feedback and input along the way. The goal is to provide this curriculum as an online module with written content, embedded forms that can be printed, and embedded videos. TDA will share the detailed outline with DSHS by the end of March 2016 and request more specific feedback on topics that need to be included or removed. Once the formal outline is approved, TDA will design the online module that can be accessed by CHWs any time.

- **Train the Trainer Oral Health**

  Ms. Elaine Vivens, Coordinator, Children's Oral Health Coalition, shared information on the oral health trainings provided for community. The committee members and the public were invited to attend a community training scheduled on March 3, 2016, in the Fort Worth area. Ms. Vivens is open to discussing amending the training into a training program for CHW CEUs.

  ACTION ITEM:
  - Ms. Vivens will send information to Ms. Smith on the community training scheduled for March 3, 2016, to share with members.

Agenda Item 8: CHW Program Update

Ms. Monica Maldonado provided an update on the CHW program for November and December 2015. Highlights of the update as of December 3, 2015 include:

- Certified CHWs as of December 31, 2015: 3,628
- On-time renewals: November - 44%; December - 46%
- CHW and Instructor Applications Received: November -154; December -191
- Application denials: November - 7; December - 2
- Instructor applications certified: November - 3; December – 1
- Certified CHW Instructors – 241
- Certified Training Sites - 38

Ms. Smith added that all the training data will be included in the 2015 CHW Program Annual Report.

Ms. MacCarty shared that April 13, 2016 DSHS Grand Rounds will focus on CHWs. The Grand Rounds will include three case studies focused on international, clinical, and community, and a brief overview of Texas CHW certification.

Ms. MacCarty updated members on the 2015 CHW Evaluation Survey (implemented May through December, 2015. There will be a standalone evaluation report and information will be incorporated into the annual report.

Agenda Item 9: Committee Member Updates

- Ms. Diebolt is starting another clinic health center in San Augustine, Texas. She has already gotten a few grants totaling a commitment of $60,000.
- Mr. Gary Eagleton gave an update as a CHW instructor, noting that the UTSPH Spring 2016 class has the largest number of participants since he has joined the program.

- Ms. Escobar informed the committee that teens have partnered with the American Heart Association to raise heart health awareness. Six teens are following up with 100 individuals for weekly progress and monitoring their blood pressure. The teens have also taken heart health awareness to their schools, encouraging their friends to monitor their blood pressure. The annual Heart Health Conference is scheduled on February 27, 2016. The *It Takes a Village to Raise a Child* Conference, scheduled on April 30, 2016, will focus on parents who have children with special needs and will provide information on how to access resources locally and federally.
- Ms. Ginés shared that ten promotores were trained and certified through DML to become navigators and were offered jobs in Houston. Six promotores have become certified navigators in San Antonio. The program is well-funded, giving the promotoras jobs until September. Additionally, the University of Houston, Prevent Blindness, and DML have partnered to conduct a special training for nine selected promotores to do vision tests at six of the multi-service centers, and will refer clients to the University of Houston for their underserved population program. The 12th generation DML class of promotores will graduate on February 20, 2016.
- Mr. Muñoz shared that the Texas A&M Colonias Training Academy is in the process of scheduling four regional conferences in May, June, July, and August 2016, with tentative sites being El Paso, San Antonio, Laredo, and Weslaco. Texas A&M San Antonio has been approved as a four-year university and has announced approval for a Bachelor of Science and a Master's Program in Community Health. The University is also discussing a potential development path between courses taken for CHW certification and a Bachelors Program in Community Health. Mr. Rosing shared that Houston Community College (HCC) will start a CHW certification course in spring. Other instructors and Mr. Rosing will meet to determine the 2016 CEU course offerings for instructors.
- Dr. St. John shared that the American Public Health Association (APHA) is releasing their CHW of the Year Award and CHW Group Award, to be sent out February 1, 2016. Anyone who wants the nomination form can contact her directly. Attendees were encouraged to nominate a person or group. The Unity Conference, the annual national CHW conference, will be held July 17-20, 2016, in Atlanta, Georgia. Scholarships for CHWs to attend may be made available. The Esther B. Holderby Award will be presented during the conference.
- Ms. Bustos shared information about the Northern Texas Community Health Worker Resource Coalition meeting on February 5, 2016. Two DSHS approved hours will be given to participants. The coalition combines Regions 1, 2, and 3, so they expect approximately 60-70 people to attend the meeting.

ACTION ITEM:

- Ms. Smith will send out the nomination form for the CHW of the Year Award and the CHW Group Award to members.

Agenda Item 12: New Business for Consideration at Next Meeting

The next meeting will be held Friday, March 11, 2016.

New agenda items were as follows:

- Annual report
- 2015 CHW Evaluation report
- Orientation of newly appointed committee members

Agenda Item 13: Adjourn

The meeting was adjourned by Ms. Bustos at 12:34. Ms. Smith thanked participants and reminded them to take the survey.

Table 2. 2015 Advisory Committee Attendance

Committee Member	Jan 30	Mar 27	May 29	July 31	Sept 25	Nov 20
Claudia Bustos, Presiding Officer	✓	X	✓	X	✓	✓
Jean Youngstrom Diebolt, MSN	✓	X	X	✓	✓	✓
Gary Eagleton	✓	✓	✓	✓	X	✓
Mérida Escobar, Assistant Presiding Officer	✓	✓	✓	✓	✓	✓
Venus Ginés, MA	✓	✓	✓	✓	✓	✓
Bobby D. Hansford	N/A	✓	✓	✓	✓	✓
Oscar Muñoz, MPA, Assistant Presiding Officer	✓	✓	✓	X	✓	✓
Richard Rosing, MS	✓	✓	✓	X	✓	✓
Julie Parrish St. John, DrPH, MPH, MA	✓	✓	✓	X	✓	✓

Key

✓	Attended
X	Absent
N/A	Not Applicable (vacant position or not yet appointed)

Promotor(a) or Community Health Worker (CHW) Training and Certification Advisory Committee

2015 Annual Report

Prepared
in compliance with
Chapter 48, Texas Health and Safety Code
Section 48.101(c)

Department of State Health Services
April 2016

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CHW Publication No. 21-14732

Executive Summary

Background

The 2015 Annual Report of the Promotor(a) or Community Health Worker (CHW) Training and Certification Advisory Committee is prepared in compliance with Chapter 48, Texas Health and Safety Code, Section 48.101(c), and Texas Administrative Code, Title 25, Part 1, Chapter 146[1]. The Annual Report describes the Advisory Committee's composition, attendance, accomplishments in 2015, and planned activities for 2016. The report also provides data on certification and renewal rates, trends, curricula, and initial certification and continuing education courses. This data evaluates processes and identifies areas of strength and potential opportunities to improve training and certification of CHWs in Texas.

Definition and Core Competencies

CHWs are also known as promotores de salud. CHWs are individuals who, with or without compensation, are liaisons and provide cultural mediation between health care and social services and their communities. They are trusted members and have a close understanding of the ethnicity, language, socio-economic status, and life experiences of the communities they serve. CHWs assist people to gain access to needed services and build individual, community, and system capacity by increasing health knowledge and self-sufficiency through a range of activities. CHWs demonstrate skills in the following eight core competencies: communication, interpersonal skills, service coordination, capacity building, advocacy, teaching, organizational skills, and knowledge base in specific health issues.

Promotor(a) or CHW Training and Certification Advisory Committee

The Commissioner of the Department of State Health Services (DSHS) appoints individuals to the nine-member Promotor(a) or CHW Training and Certification Advisory Committee (Advisory Committee). The membership is comprised of four certified CHWs, two public members, one member from the Texas Higher Education Coordinating Board or a higher education faculty member, and two professionals who work with CHWs in a community setting.

In 2015, the Advisory Committee met six times through conference calls, webinars and meetings in Austin, Texas to advise DSHS and the Health and Human Services Commission (HHSC) on issues such as the implementation of standards, guidelines, and requirements, as well as employment and funding of CHW services in Texas. Key accomplishments in 2015 include:

- Increased stakeholder participation in Committee meetings through the use of webinars
- Approved a pilot procedure to have qualified guest speakers in DSHS-certified training
- Developed and distributed a survey to regional CHW associations to obtain feedback regarding the development of a statewide CHW network
- Participated in the nomination and application review process for Committee vacancies
- Held a session at the 2015 American Public Health Association (APHA) Annual Meeting on implementation and preliminary results of the CHW/Promotor(a) Evaluation Survey
- Discussed CHW reimbursement models in other states

[1] http://www.dshs.state.tx.us/mch/chw/progrule.aspx

Certified CHWs in Texas

The number of certified CHWs in Texas continues to increase steadily. As of December 31, 2015, there were 3,628 certified CHWs, an increase of 16.5 percent from the 3,113 individuals who were certified in 2014. Most certified CHWs in Texas are female (87 percent) and 13 percent are male. Certified CHWs in Texas are racially and ethnically diverse: Hispanic – 61 percent, Black – 24 percent, White – 11 percent, Asian – 2 percent, Native American – less than 1 percent, and Other – 1 percent.

CHW Renewal

CHWs must complete at least 20 hours of continuing education every two years to renew their certificates. Renewal rates steadily rose from 2008 to 2011 but began to decrease in 2012. Over 690 CHWs did not renew their certification in 2015.

CHW Instructor Certification and Renewal

As of December 31, 2015, Texas had 241 certified instructors, including 41 who were newly certified during the year. Over 35 instructors did not renew their certification in 2015.

CHW Training Programs

The availability of certification training courses and continuing education opportunities for CHWs has expanded to meet the growing interest. As of December 31, 2015, there were a total of 38 training programs compared to 14 training programs in 2009. Training programs in 23 counties and through distance learning graduated 533 CHWs and 13 instructors and provided continuing education for CHWs and instructors.

CHW Evaluation Survey

The Advisory Committee worked with DSHS to develop a survey to obtain the perspective of Texas CHWs on the benefits of certification and challenges in renewing certification. DSHS distributed surveys to CHWs whose certification was due in 2015 both in English and Spanish and available online and in paper. Of the 1,476 CHWs who were asked to complete the survey, DSHS received 215 completed English surveys (return rate = 18 percent) and 53 completed Spanish surveys (return rate = 20 percent). More than 90 percent of respondents indicated that their certification is meaningful or valuable. The Advisory Committee will continue to explore ways to improve overall survey responses and address concerns CHWs identified regarding certification and renewals.

Administrative Rules

The CHW Training and Certification Program administrative rules are reviewed every four years. On June 24, 2015, the rules were adopted and reflect the Advisory Committee's input. The new rules provide a better alignment to Chapter 48 of the Health and Safety Code and help clarify definitions and changes to eligibility requirements, application procedures, continuing education requirements, and standards for the approval of curricula.

Conclusion

Advisory Committee efforts helped increase public awareness of CHW roles in Texas and the positive impact CHWs have to create healthier communities. The number of certified CHWs is expected to continue to grow as CHWs are increasingly integrated in health and social service systems across the state. Activities in 2016 will work to strengthen retention rates and increase training efforts.

Introduction

House Bill (H.B.) 2610, 82nd Legislature, Regular Session, 2011, amended Chapter 48, Texas Health and Safety Code, to establish a statewide Promotor(a) or Community Health Worker (CHW) Training and Certification Advisory Committee (Committee) to advise the Department of State Health Services (DSHS) on issues such as the implementation of standards, guidelines, and requirements as well as employment and funding of CHWs.

Section 48.101(c) makes the Committee subject to Chapter 2110, Texas Government Code. Specifically, Section 2110.005 requires a state agency that establishes an advisory committee to describe, by rule, the manner in which the committee reports to the agency. Accordingly, 25 Texas Administrative Code, Section 146.3 specifies those requirements, which include:

- the meeting dates of the committee and any subcommittees, the attendance records of its members, a brief description of actions taken by the committee, a description of how the committee has accomplished the tasks given to the committee by the department and the commission, the status of any rules which were recommended by the committee to the department and the commission, anticipated activities of the committee for the next year, and any amendments to this section requested by the committee
- the costs related to the committee's existence

Additionally, the report evaluates processes, certification and renewal rates, and trends. It also identifies areas of strength and potential opportunities to improve training and certification of CHWs in Texas.

Section 1: Background

The nine-member Advisory Committee is composed of representatives from relevant entities appointed by the DSHS Commissioner. The Division for Family and Community Health Services administers the Promotor(a) or CHW Training and Certification Program.

Definition and Core Competencies

Community health workers (CHW) are also known as *promotores de salud*. CHWs are individuals who, with or without compensation, are liaisons between health care and social services and their communities. They are trusted members and have a close understanding of the ethnicity, language, socio-economic status, and life experiences of the communities they serve.

CHWs assist people to gain access to needed services and build individual, community, and system capacity by increasing health knowledge and self-sufficiency through a range of activities. These activities include outreach, patient navigation and follow-up, community health education and information, informal counseling, social support, advocacy, and participation in clinical research. The following eight core competencies form the foundation for skills and knowledge needed by CHWs: communication, interpersonal skills, service coordination, capacity building, advocacy, teaching, organizational skills and a knowledge base related to specific health issues.

Program History

With the passage of HB 1864, 76th Legislature, Regular Session, 1999,[2] Texas became the first state to pass legislation creating a statewide CHW or promotores training and certification program. This was the culmination of efforts that began in the mid-1990s which provided the context for the initial legislation.[3]

Promotor(a) or CHW Training and Certification Advisory Committee

The Promotor(a) or CHW Training and Certification Advisory Committee includes nine appointed members.

- Four DSHS certified CHWs;
- Two public members, which may include consumers of community health work services or individuals with paid or volunteer experience in community health care or social services;
- One member from the Texas Higher Education Coordinating Board or a higher education faculty member who has teaching experience in community health, public health, or adult education and has trained CHWs; and
- Two professionals who work with CHWs in a community setting, including employers and representatives of non-profit community-based organizations or faith-based organizations.

Advisory Committee members serve as the voice of CHWs in their communities and assist DSHS and HHSC with the CHW training and certification process to meet the needs in Texas. The Advisory Committee meets six times per year in Austin, Texas, via conference call or through webinar. In 2015, the Committee met three times in Austin, Texas, and three times via conference call or webinar.

The Advisory Committee is charged with:

- Advising DSHS and HHSC on the implementation of standards, guidelines, and requirements adopted under the Health and Safety Code, Chapter 48, relating to the training and regulation of persons working as CHWs;
- Advising DSHS on matters related to the employment and funding of CHWs;
- Providing recommendations to DSHS for a sustainable program for CHWs consistent with the purposes of Health and Safety Code, Chapter 48, Subchapter C;
- Reviewing applications from training programs/sponsoring organizations, and recommending certification to DSHS, if program requirements are met; and
- Carrying out any other tasks given to the committee by the Commissioner or Executive Commissioner.

The Commissioner appoints Advisory Committee officers after August 31st of each year. In October 2015, Claudia Bustos and Mérida Escobar were appointed to serve as the presiding officer and assistant presiding officer, respectively, with their terms expiring in September 2016.

[2] http://www.legis.state.tx.us/tlodocs/76R/billtext/html/HB01864F.htm
[3] http://www.cdc.gov/pcd/issues/2005/nov/05_0059.htm

Table 1. 2015 Advisory Committee Membership

Member	Position	County	Affiliation	Term
Claudia Bustos, Presiding Officer	CHW	Lubbock	Outreach Coordinator, Community Health Center of Lubbock	4/20/2012-1/1/2018
Jean Youngstrom Diebolt, MSN	Professional Working with CHWs	Shelby	CEO, The HOPE Project	6/13/2011-1/1/2016
Gary Eagleton	CHW	Harris	Instructor, U.T. School of Public Health	1/1/2014-1/1/2017
Mérida Escobar, Assistant Presiding Officer	CHW	Hidalgo	President, South Texas Promotora Association, Inc.	1/1/2014-1/1/2017
Venus Ginés, MA.	Public	Brazoria	Founder, Día de la Mujer Latina, Inc.	1/1/2010 - 1/1/2016
Bobby D. Hansford	CHW	Harris	Eligibility Specialist, Harris Health System	1/1/2015 - 1/1/2018
Oscar J. Muñoz, MPA	Professional Working with CHWs	Bexar	Director, Colonias Program, Texas A&M University	4/20/2012 - 1/1/2018
Richard Rosing, MS	Higher Education	Harris	Faculty, Houston Community College	6/11/2013-1/1/2016
Julie Parrish St. John, DrPH, MPH, MA	Professional Working with CHWs	Jones	Assistant Professor, Texas Tech University Health Sciences Center	1/1/2014-1/1/2017

Advisory Committee Members – January 2016
Left to right: Oscar Muñoz, Jean Diebolt, Julie St. John, Richard Rosing, Bobby D. Hansford, Venus Ginés, Mérida Escobar, Claudia Bustos
Unavailable for photo: Gary Eagleton

CHW Publication No. 21-14732

Table 2. 2015 Advisory Committee Attendance

Committee Member	Jan 30	Mar 27	May 29	July 31	Sept 25	Nov 20
Claudia Bustos, Presiding Officer	✓	X	✓	X	✓	✓
Jean Youngstrom Diebolt, MSN	✓	X	X	✓	✓	✓
Gary Eagleton	✓	✓	✓	✓	X	✓
Mérida Escobar, Assistant Presiding Officer	✓	✓	✓	✓	✓	✓
Venus Ginés, MA	✓	✓	✓	✓	✓	✓
Bobby D. Hansford	N/A	✓	✓	✓	✓	✓
Oscar J. Muñoz, MPA, Assistant Presiding Officer	✓	✓	✓	X	✓	✓
Richard Rosing, MS	✓	✓	✓	X	✓	✓
Julie Parrish St. John, DrPH, MPH, MA	✓	✓	✓	X	✓	✓

Key	
✓	Attended
X	Absent
N/A	Not Applicable (vacant position or not yet appointed)

2015 Advisory Committee Activities

Advisory Committee members participated in the following activities in calendar year 2015.

Program Rules

- Advise on program rules under the Health and Safety Code, Chapter 48, relating to the training and regulation of persons working as CHWs
  - The Committee reviewed and approved a procedure to be tested between January and June 2016 to have qualified guest speakers in DSHS-certified training.
  - DSHS incorporated Committee input on proposed CHW administrative rules that were subsequently adopted in June 2015.

Communication and Outreach

- Assist with the development of the Annual Report
  - Committee members identified accomplishments for 2015 and proposed activities for 2016.
- Increase communication with CHWs

- The Committee developed and distributed a survey to regional CHW associations to obtain their feedback regarding development of a statewide CHW network and held a series of conversations with stakeholders via webinar and conference call to establish a working group to discuss this further.

- Identify and explore additional opportunities for outreach and information regarding the Promotor(a) or CHW Training and Certification Program and the Advisory Committee
  - Committee members participated in the nomination and application review process for Committee vacancies in 2015 and those expected in 2016, including two public members and one higher education position.
  - Committee member, Dr. Julie St. John, served as the Secretary of the CHW Section of the American Public Health Association (APHA) in 2012-2014 and was elected to serve as Section Councilor for 2014-2017. The Committee encouraged nominations for CHWs and CHW groups in Texas for the APHA CHW Section Outstanding CHW of the Year Award and Outstanding CHW Group of the Year award. As a result of this outreach, the Tu Salud Si Cuenta project at the University of Texas Health Science Center at Houston (UTHealth) School of Public Health Brownsville Regional Campus was nominated for, and selected by APHA as the Outstanding CHW Group of the Year. The group received the award at the APHA 2015 Annual Meeting in Chicago November 2015.
- The Committee increased stakeholder participation in Committee meetings through the use of webinars. Stakeholders attended via webinar and/or in-person for all six Committee meetings in 2015, with an average of 55 people participating in each meeting, up from 30 people in 2014 and 20 people in 2013. A total number of 331 individuals attended the Committee meetings in 2015, an increase of 85 percent from 2014 when 179 individuals participated in the meetings.

Certification and Training

- Make recommendations to the department concerning qualifying training programs/ sponsoring organizations
  - The Committee reviewed initial training program applications and recommended that DSHS approve the following CHW and instructor certification and continuing education programs: Diabetes Health and Wellness Institute at Juanita J. Craft Recreation Center, and Adults and Youth United Development Association (A.Y.U.D.A.).
- Increase access to CHW training and continuing education
  - The Committee promoted CHW participation and training in the statewide Healthy Texas Mothers and Babies Conference: A Clinical and Community Life Course Perspective held June 22-24, 2015, in Houston.
  - The Committee endorsed the utilization of a new website/portal developed by UT Health in Houston to help CHWs and instructors stay informed of available educational opportunities. It is anticipated that in 2016 all Texas certified training programs will have the capability to directly post and update certification or continuing education course announcements for CHWs and instructors on this portal.

- Promote the development of a list of specific standardized topics and skill sets to be included in each of the core competencies
    - The Committee provided feedback to the CHW Core Consensus (C3) Project implemented by UTHealth in Houston and in collaboration with the CHW Section of the American Public Health Association and others. The project findings will be released following the review by the U.S. CHW Networks community.

- Distribute the CHW/Promotor(a) Survey to obtain CHWs' perspectives regarding the value and benefits of certification
    - Dr. Julie St. John presented a session at the 2015 American Public Health Association (APHA) Annual Meeting on implementation and preliminary results of the CHW/Promotor(a) Evaluation Survey. The survey, available in English and Spanish, explored CHWs' perspectives regarding the value and benefits of certification.

Workforce Solutions/Employment Opportunities

- Participate in discussions regarding development of potential reimbursement mechanisms for CHW services
    - Committee members discussed CHW reimbursement models in other states.
- Explore CHW roles in telemedicine
    - The Committee identified CHW programs currently using telemedicine. The West Texas Area Health Education Center (AHEC) is developing a resource center for telemedicine and plans to utilize CHWs.

2016 Advisory Committee Activity Plan

Program Rules

- Because new rules were adopted in June 2015, the Program Rules Workgroup will not have any activities for 2016 but will reconvene as needed.

Communication and Outreach

- Assist with the development of the Annual Report, including a segment on volunteers and the program's impact
- Stay abreast on the progress of the independent statewide CHW network workgroup
- Consider mechanisms to support CHW leadership in Texas, including promoting the APHA CHW individual and group awards
- Seek outreach opportunities to promote the value and service that CHWs provide in the community
- Continue to meet in person and by other means to increase stakeholder participation

Certification and Training

- Make recommendations to the department concerning qualifying training programs/ sponsoring organizations
- Increase access to CHW certification training and continuing education
- Evaluate the C3 Project findings and recommendations on CHW skill development and core competencies when released to consider which, if any, can be implemented in Texas
- Develop guidelines to build a quality skill-based instructor continuing education curricula
- Refine the CHW/Promotor(a) Evaluation Survey and process to improve response rates
- Disseminate the Training Center Survey to CHW and instructor training programs
- Develop a flyer on CHW's definition, roles and value in the community

Workforce Solutions and Employment Opportunities

- Promote and explore employment and funding opportunities for CHW services
  - Review annual data from the U.S. Department of Labor, Bureau of Labor Statistics, related to the CHW standard occupational classification code
  - Continue discussions with stakeholders to consider potential reimbursement for CHW services

Section 2: Certification

CHWs

CHWs are eligible to be certified in Texas by completing DSHS-certified training of at least 160 hours, or based on experience, through verification of at least 1,000 hours of community health work services demonstrating competence in the eight core competencies in the most recent six years.

Total Number of Certified CHWs

The number of certified CHWs in Texas continues to increase steadily. As of December 31, 2015, there were 3,628 certified CHWs, an increase of 16.5 percent, as compared to 3,113 certified CHWs at the end of 2014.

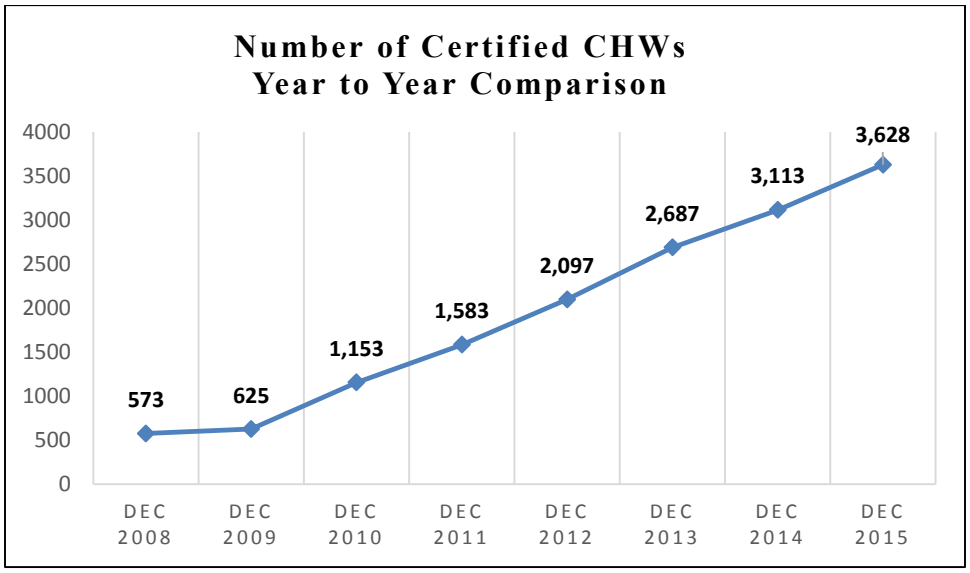

Figure 1. Certified CHWs, 2008 - 2015

CHWs Newly Certified in 2015

The Promotor(a) or CHW Training and Certification Program provided initial certification to 1,150 CHWs during 2015. This represents an increase of 3 percent as compared to 2014 when 1,118 CHWs received their initial certification.

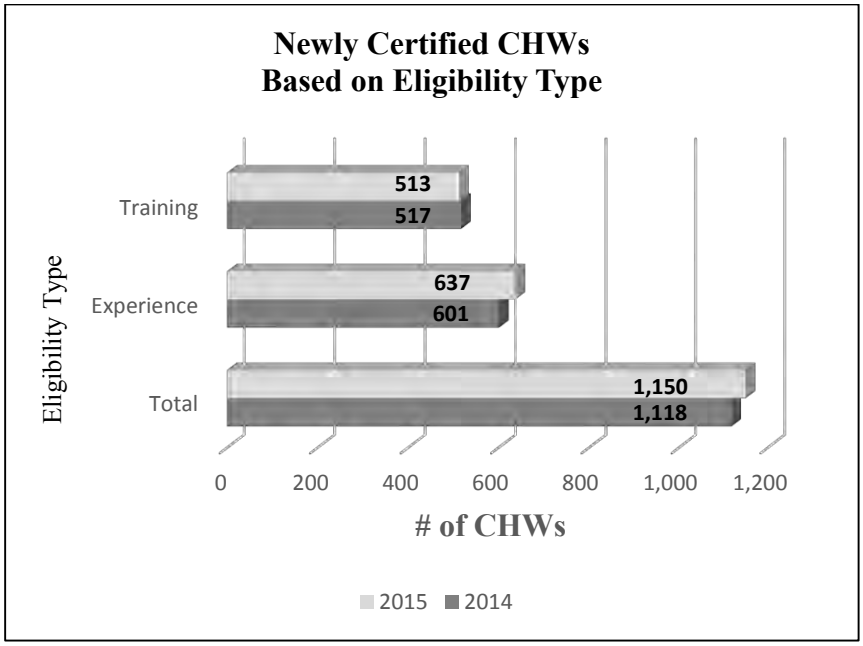

Figure 2. Newly Certified CHWs, 2014-2015

CHW Certification Training Graduates 2015

CHW certification training programs graduated 533 individuals in 2015. The number of graduates increased by 3 percent as compared with 2014 when 517 individuals graduated from a

DSHS-approved CHW certification training program. See Appendix A for information about the number of certification training courses and graduates by county.

Note: Some graduates from DSHS-approved training programs did not apply for certification; therefore, the number of graduates does not reflect the number that applied for certification based on training.

CHW Certification Based on Completion of Training or Experience

Approximately 45 percent of CHWs newly certified in 2015 were certified based on completion of training. The percentage of certification based on training decreased slightly as compared to 2014 when 46 percent of newly certified CHWs were certified based on completion of training. Approximately 55 percent of newly certified CHWs in 2015 were certified based on experience.

Instructors

Instructors can be certified in Texas by completing DSHS-certified instructor training of at least 160 hours or based on experience with at least 1,000 hours of experience training individuals who provide community health work services such as CHWs and other health care paraprofessionals and professionals.

Total Number of Certified Instructors

As of December 31, 2015, there were 241 certified instructors as compared to 237 certified instructors at the end of 2014.

Instructors Newly Certified in 2015

A total of 41 instructors were newly certified during 2015 as compared to 66 instructors newly certified in 2014.

Instructor Certification Training Graduates 2015

In 2015, there were 13 graduates of the DSHS-approved instructor certification training programs. This is a decrease from the 17 who graduated in 2014 and a sharp drop from the 42 who graduated in 2013 from DSHS-approved instructor certification training programs.

Table 3. 2015 Instructor Certification Training

Location	Training Program/Sponsoring Organization	Graduates
Distance Learning	Día de La Mujer Latina, Inc.	**2**
Distance Learning	The National CHW Training Center /Center for Community Health Development, Texas A&M Health Science Center	**11**
Total Instructor Graduates		**13**

Instructor Certification Based on Completion of Training or Experience

Of the 41 new instructors in 2015, approximately 29 percent were certified based on completion of training, while 71 percent were certified based on experience. The percentage of instructors

newly certified based on completion of training is similar to 2014 (29 percent) and reflects a marked decrease from the percentages certified in 2012 and 2013, 40 percent and 53 percent, respectively.

Section 3: Renewals

CHW Renewals and Expired Certificates

CHWs must complete at least 20 hours of continuing education every two years to renew their certificates, including at least ten DSHS-certified contact hours.

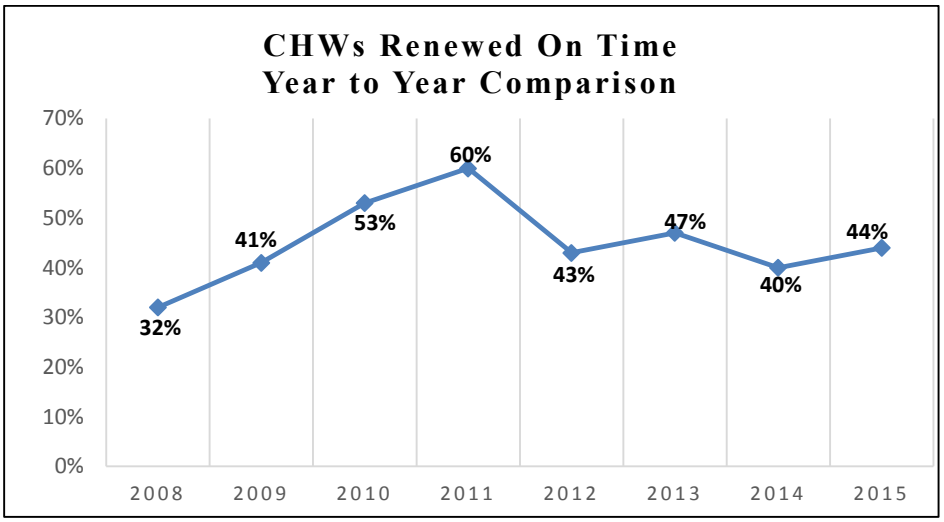

Figure 3. CHW Renewal Rates, 2008 - 2015

Renewal rates steadily increased from 2008 to 2011 but began to decline in 2012. The percentage of CHWs renewing their certifications increased from 40 percent in 2014 to 44 percent in 2015. DSHS and the Advisory Committee surveyed CHWs in 2015 on their perspectives regarding the value and benefits of certification. Survey results will assist the Advisory Committee to develop additional strategies to improve initial and renewal rates.

A CHW may renew a certificate that has been expired for less than one year by submitting a renewal application documenting the completion of the required continuing education. When a certificate has been expired for one year or more, a CHW may request to regain certification by submitting a new initial application.

A total of 692 CHW certifications expired in 2015 which is similar to 2014 when 690 certifications expired. This is a significant increase from 2013 when 372 CHWs allowed their certification to expire. The majority of certifications that expired in 2015 were for CHWs initially certified in 2013 (76 percent), similar to last year's 77 percent. Of those expirations initially certified in 2013, the majority were for individuals certified as CHWs based on experience (65 percent), while 35 percent of expired certifications were initially certified based on completion of training.

Expired certifications in 2015 reflected a different pattern when comparing CHWs based on language preference. A higher percentage of expired CHW certifications where Spanish was the

preferred language were initially certified based on training (58 percent) than CHWs with English as a preferred language (32 percent). A higher percentage of CHWs with English as a preferred language whose certifications expired in 2015 were initially based on experience (68 percent) as compared to CHWs with Spanish as a preferred language (42 percent).

Table 4. 2015 Expired CHW Certifications by Preferred Language

CHW Certification	Spanish	Spanish Percentage	English	English Percentage
Experience	38	42%	412	68%
Training	52	58%	190	32%
Total	90		602	

Instructor Renewals and Expired Certificates

An instructor may renew a license if a renewal application is submitted within one year and documents the completion of the required continuing education. In 2015, fewer instructors renewed their certification than in 2014. Individuals who first certified in 2013 comprised 74 percent of those who allowed their certification to expire in 2015. There were 39 certified instructors who did not renew their instructor certifications in 2015, as compared to 28 instructors who did not renew in 2014.

Section 4: Training Programs

Training Programs 2015

Training programs have expanded the availability of certification training courses and continuing education opportunities for CHWs. As of December 31, 2015, there were 38 training programs in Texas - 29 to provide both certification training courses and continuing education for CHWs and an additional 9 training programs to provide only continuing education for CHWs.

DSHS approved the Diabetes Health and Wellness Institute at Juanita J. Craft in Dallas, Texas as a new training program for instructor continuing education and Adults and Youth United Development Association, Inc. (A.Y.U.D.A., Inc.), in El Paso, Texas as a new site for CHW continuing education. As of December 31, 2015, five training programs were available to provide both certification training courses and continuing education for instructors. Two training programs were available to provide only continuing education for instructors.

Organizations approved to provide training for CHWs include community colleges, other academic centers such as health science centers, Area Health Education Centers (AHECs), Federally Qualified Health Centers (FQHCs), a regional CHW association, and community-based programs. CHWs residing in rural areas may be unable to attend on-site training located in urban areas. However, some training programs also provide training in areas other than their primary locations. Additionally, several training programs have implemented training through distance learning to increase access for CHWs in all parts of the state.

Continuing Education for CHWs

DSHS-approved training programs or sponsoring organizations provided 187 continuing education opportunities for CHWs, offering a total of over 800 DSHS-certified contact hours, including face-to-face events and distance learning continuing education. Training occurred in 23 counties and through distance learning. Over 7,350 participants attended continuing education classes. See Appendix B for information regarding this breakdown of providers and continuing education hours provided. Several of the courses were offered at larger events or conferences. Not all participants attending continuing education events were certified CHWs.

Continuing Education for Instructors

DSHS-approved training programs or sponsoring organizations provided 15 continuing education opportunities for instructors in 2015, offering 68.5 DSHS-certified instructor contact hours. In 2015, instructor training programs provided fewer continuing education opportunities for instructors than the 21 offered in 2014. Both distance learning and on-site opportunities were available for instructor continuing education in 2015 as they were in 2014, as compared to 2013 when the majority of instructor continuing education opportunities were on-site trainings.

Table 5. 2015 DSHS-Certified Continuing Education for Instructors

Location	Training Program/ Sponsoring Organization	# of CEU classes offered	# of CEU contact hours	# of participants
	Health Service Region 6/5 S			
Harris	Día de la Mujer Latina, Inc.	1	18	1
Harris	University of Texas School of Public Health - Houston	3	10.5	32
	Health Service Region 7			
Travis	Texas AHEC East - Coastal Region	2	4	49
	Health Service Region 8			
Bexar	Houston Community College – Coleman College for Health Sciences Houston	1	7	10
	Health Service Region 11			
Hidalgo	The National CHW Training Center /Center for Community Health Development, Texas A&M Health Science Center	1	8	15
Cameron	South Texas Promotora Association, Inc.	2	5	14
Webb	South Texas Promotora Association, Inc.	1	4	2
	Distance Learning			
Día de la Mujer Latina, Inc.		1	5	7
Houston Community College – Coleman College for Health Sciences Houston		2	2	18
The National CHW Training Center /Center for Community Health Development, Texas A&M Health Science Center		1	5	40
Total		**15**	**68.5**	**188**

Section 5: Community Mapping

Location of Certified CHWs

As of December 31, 2015, Texas had 3,628 certified CHWs in 138 counties (by county of residence).

Harris County has the most certified CHWs with 975 and the second largest county with certified CHWs is Bexar County with 359. See Appendix C for information on counties with certified CHWs.

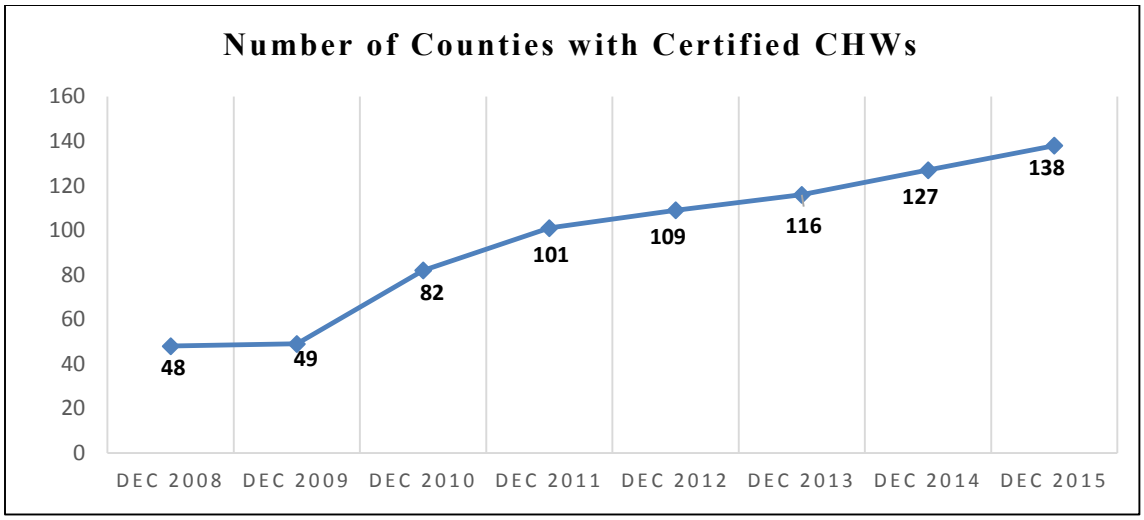

Figure 4. Number of Counties with Certified CHWs, 2008 – 2015

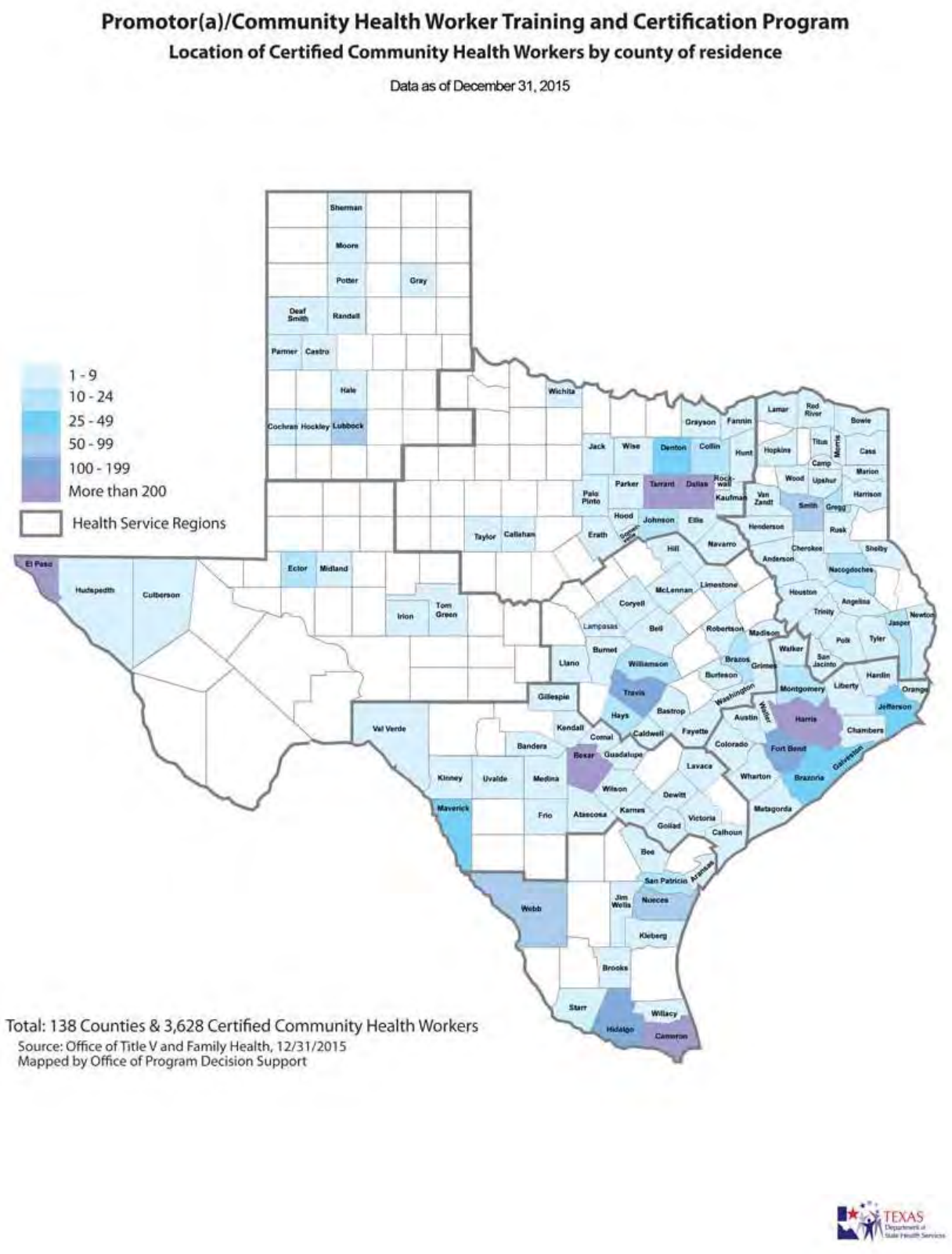

Figure 5. 2015 Map of Counties with Certified CHWs

Certified CHW Demographics

Approximately 87 percent of Texas certified CHWs are women and 13 percent are men. There has been a slight increase in the percentage of male CHWs since 2008. Certified CHWs in Texas are racially and ethnically diverse; Hispanic - 61 percent, Black - 24 percent, White - 11 percent), Asian - 2 percent, Other - 1 percent, and Native American - less than 1 percent. Approximately 76 percent of CHWs are between 30 and 59 years of age.

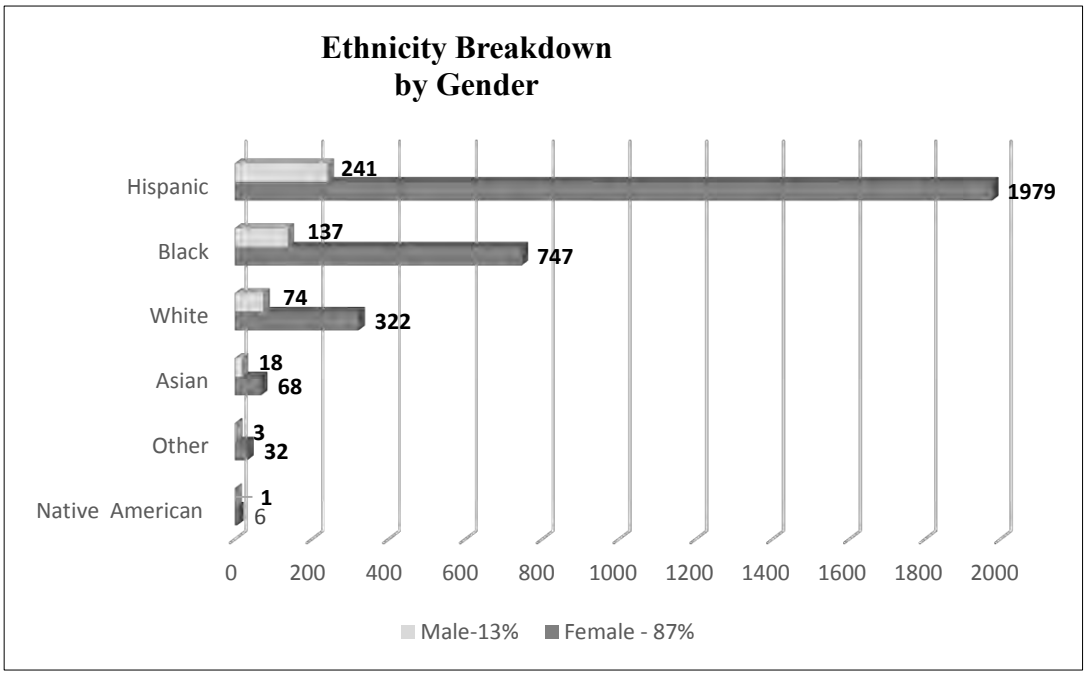

Figure 6. Ethnicity Breakdown of Certified CHWs, By Gender

There was a small change in data related to employment for CHWs newly certified in 2015 as compared with 2014. On their certification application, 78 percent of CHWs indicated paid employment (2014 – 73 percent), about 14 percent indicated volunteer work (2014 – 17 percent), and slightly less than 8 percent were unemployed (2014 – 10 percent.) The data will continue to be monitored annually to determine any changes to CHW employment. Paid employment (full or part time) data includes employment other than community health work.

Certified Instructors Locations/Demographics

As of December 31, 2015, Texas had 241 certified CHW instructors in 43 counties (based on county of residence). Nineteen percent of CHW instructors reside in Harris County. Approximately 86 percent of Texas CHW instructors are women and 14 percent are men. Certified CHW instructors in Texas are also racially and ethnically diverse: Hispanic - 54 percent, White - 24 percent, Black - 18 percent, Asian - 2 percent, Native American – 1 percent and Other - less than 1 percent.

Certified Training Programs

As of December 31, 2015, there were 38 CHW certified training programs across the state. Nine programs were available to provide only continuing education (CE) for CHWs. Twenty-nine programs provide CHW certification and CE classes. Of the 29 programs, 6 also provide instructor certification training or instructor CE classes. In addition, Texas Health Steps (THSteps) offers free online modules for healthcare providers, including CHWs. These courses offer updated clinical, regulatory, and best practice guidelines for a range of preventive health, oral health, mental health, and case management topics.

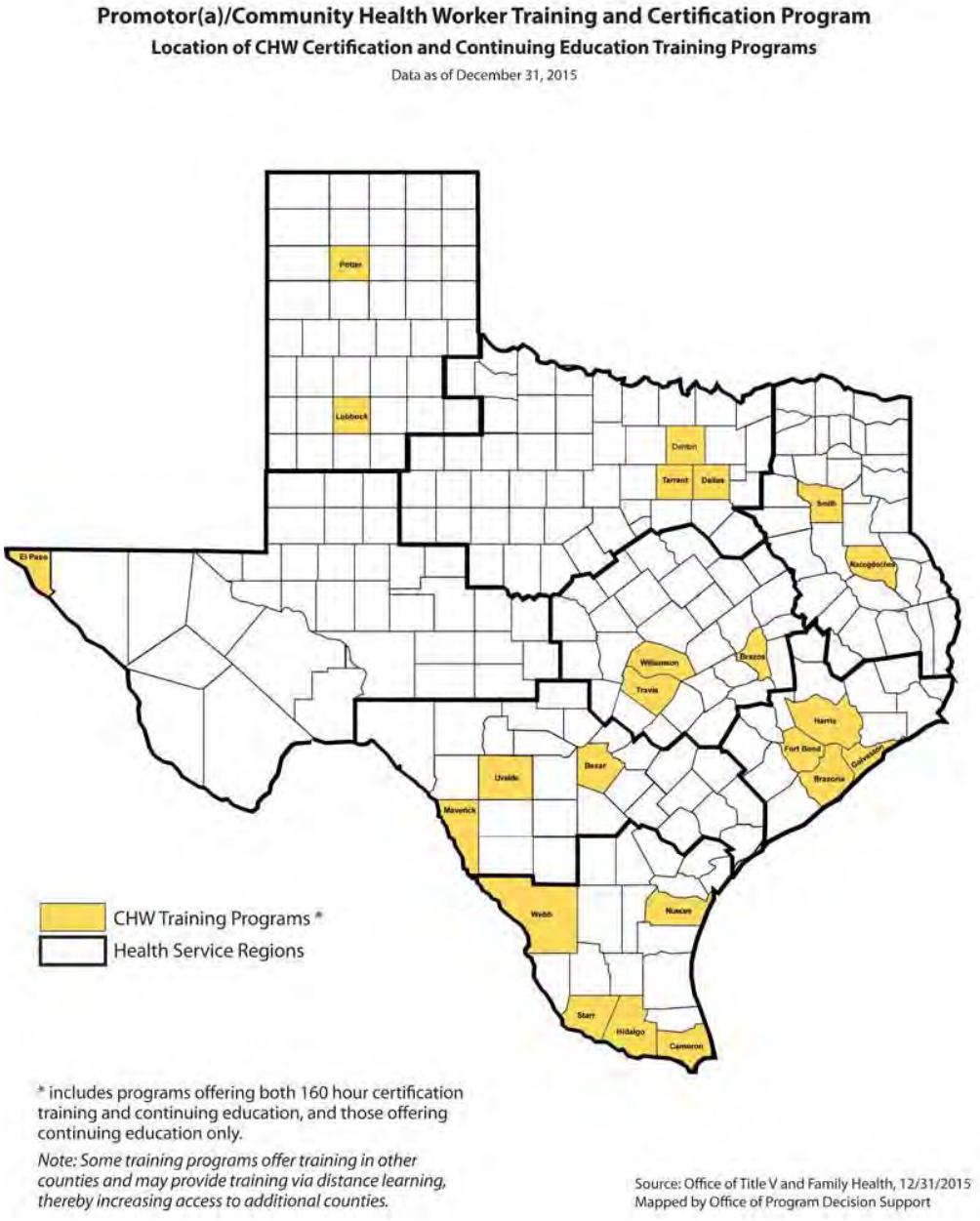

Figure 7. CHW Training Locations, 2015

Section 6: 2015 CHW Evaluation Survey

The Advisory Committee formed an Evaluation Workgroup to identify key survey areas to explore CHWs' perspective on the benefits of certification and the challenges that affect their decision to renew. The Evaluation Workgroup drafted and tested the survey questions.

Over 1,460 surveys in English and Spanish were disseminated to CHWs whose certification was due in 2015. DSHS emailed CHWs a link to the online survey or mailed a paper survey and collected responses between May and December 2015. Survey results will be released soon and preliminary findings indicate that CHWs consider their certification meaningful or valuable and makes a difference in the community. Ninety-one percent of English respondents (n=212) and 98 percent of Spanish respondents (n=54) indicated that their certification is meaningful or valuable.

The Advisory Committee and the Program will continue to explore ways to improve overall survey return rates, and to increase the number of surveys completed by CHWs whose certification expired. The full report of the 2015 CHW Evaluation Survey will be shared with the Advisory Committee and posted on the CHW Program website: http://www.dshs.state.tx.us/mch/chw.shtm

Section 7: Expense Reporting

Pursuant to Health and Safety Code, Section 1001.027, reimbursement of expenses for advisory committee members, out of funds appropriated, is limited to members who represent either the general public or consumers. These include two public members and four certified CHW members. Three other members provide in-kind contribution to the work of the committee by paying their own travel and related expenses while serving on the committee.

Advisory Committee expenses, including airfare and other travel reimbursement, totaled $3,192 in 2015.

Section 8: CHW Program Rules

The CHW Training and Certification Program administrative rules are reviewed every four years. On June 24, 2015, the rules were adopted and reflect the Advisory Committee's input. The new rules provide a better alignment to Chapter 48 of the Health and Safety Code and help clarify definitions and changes to eligibility requirements, application procedures, continuing education requirements, and standards for the approval of curricula.

Conclusion

The number of certified CHWs in Texas continues to increase over time as awareness and utilization of the CHW workforce grows. In December 2009, Texas had 625 certified CHWs, rising to over 3,628 in December 2015. Surveys that were distributed in 2015 will help identify areas to develop or strengthen retention and training efforts. Although the number of certified CHWs is expected to grow in Texas as CHWs are increasingly integrated in health and social

service systems across the state, retaining experienced CHWs and instructors will be among the opportunities and challenges in 2016.

Appendix A: 2015 CHW Certification Training

County	Name of Training Program/ Sponsoring Organization	Graduates
	Health Service Region 1	
Lubbock	Texas Tech Health Sciences Center - School of Nursing	**5**
	Health Service Region 2/3N	
Dallas	Diabetes Health and Wellness Institute	**14**
Dallas	El Centro College	**6**
Dallas	Texas AHEC East - DFW Region	**14**
Tarrant	Community Health Training Center	**26**
	Health Service Region 4/5N	
Nacogdoches	Texas AHEC East – Piney Woods Region	**10**
Smith	Texas AHEC East – Northeast Region	**30**
	Health Service Region 6/5S	
Harris	Día de la Mujer Latina, Inc.	**53**
Harris	Texas AHEC East – Greater Houston	**5**
Harris	Houston Community College – Coleman College for Health Sciences	**21**
Harris	Gateway to Care	**31**
Harris	University of Texas School of Public Health - Houston	**72**
	Health Service Region 7	
Travis	Día de la Mujer Latina, Inc.	**4**
Travis	EBS Leadership Institute - Samaritano Episcopal Mission	**4**
Travis	Texas A&M University Colonias Program Training Academy	**11**
Williamson	Texas AHEC East – Capital Region	**5**
	Health Service Region 8	
Bexar	Northwest Vista College	**38**
Bexar	Presa Community Center	**10**
Uvalde	Texas AHEC South - South Coastal Region	**3**
	Health Service Region 9/10	
El Paso	Familias Triunfadoras, Inc.	**54**
El Paso	Texas A&M University Colonias Program Training Academy	**10**

County	Name of Training Program/ Sponsoring Organization	Graduates
	Health Service Region 11	
Cameron	South Texas Promotora Association, Inc.	**20**
Cameron	Texas A&M University Colonias Program Training Academy	**19**
Cameron	Texas AHEC South - South Coastal Region	**10**
Hidalgo	The National CHW Training Center /Center for Community Health Development, Texas A&M Health Science Center	**6**
Nueces	Texas AHEC South - South Coastal Region	**8**
Nueces	The National CHW Training Center /Center for Community Health Development, Texas A&M Health Science Center	**9**
Webb	Texas A&M University Colonias Program Training Academy	**7**
	Distance Learning	
The National CHW Training Center /Center for Community Health Development, Texas A&M Health Science Center		**25**
Texas AHEC East - Coastal Region		**3**
Total CHW Graduates		**533**

Appendix B: Certified Continuing Education for CHWs

2015 DSHS-Certified Continuing Education for CHWs

County	Name of Training Program/Sponsoring Institution	# of CEU classes offered	# of CEU contact hours	# of participants
	Health Service Region 1			
Lubbock	Community Health Center of Lubbock	1	1	33
Lubbock	Día de la Mujer Latina, Inc.	1	5	48
Lubbock	DSHS – HSR 1	3	6	84
Lubbock	National Center for Farmworkers Health, Inc.	1	3	29
Lubbock	West Texas AHEC	2	2	42
Lubbock	Texas Tech University Health Sciences Center School of Nursing	1	2	33
Potter	DSHS – HSR 1	1	2.5	2
	Health Service Region 2/3			
Dallas	Children's Medical Center	1	7	26
Dallas	Diabetes Health and Wellness Institute	1	3	29
Dallas	Texas AHEC East – DFW Region	1	2	27
Tarrant	Community Health Training Center	2	16	20
Tarrant	Día de la Mujer Latina, Inc.	1	1	24
	Health Service Region 4/5 N			
Nacogdoches	Texas AHEC East – Piney Woods Region	1	1	4
Smith	Texas AHEC East - Northeast Region	3	52	81
	Health Service Region 6/5 S			
Fort Bend	University of Texas School of Public Health - Houston	4	11	34
Harris	Día de la Mujer Latina, Inc.	2	9	33
Harris	DSHS – HSR 1	1	1	64
Harris	Gateway to Care	21	59	488
Harris	Harris Health System	16	39.5	545
Harris	Houston Community College – Coleman College for Health Sciences Houston	2	3	115
Harris	West Texas AHEC	1	.75	125
Harris	The National CHW Training Center /Center for Community Health Development, Texas A&M Health Science Center	3	10.75	61

2015 DSHS-Certified Continuing Education for CHWs

County	Name of Training Program/Sponsoring Institution	# of CEU classes offered	# of CEU contact hours	# of participants
Harris	University of Texas School of Public Health - Houston	34	119.5	719
	Health Service Region 7			
Brazos	The National CHW Training Center /Center for Community Health Development, Texas A&M Health Science Center	1	6	9
Travis	Día de la Mujer Latina, Inc.	5	10	380
Travis	Gateway to Care	1	1.25	172
Travis	Texas AHEC East - Coastal Region	2	4	200
Travis	Texas A&M University Colonias Program Training Academy	2	29	44
	Health Service Region 8			
Bexar	Houston Community College – Coleman College for Health Sciences Houston	1	7	4
Bexar	Northwest Vista College	6	39	215
Bexar	Texas A&M Health Science Center School of Public Health, Office of Special Programs	1	3	16
Bexar	University of Texas School of Public Health - Houston	1	3	17
Maverick	Texas AHEC South – South Coastal Region	2	4	26
	Health Service Region 9/10			
El Paso	Día de la Mujer Latina, Inc.	2	6	94
El Paso	Texas A&M University Colonias Program Training Academy	4	36	28
El Paso	University of Texas School of Public Health - Houston	6	12	136
	Health Service Region 11			
Cameron	DSHS – HSR 1	2	2.5	130
Cameron	Northwest Vista College	1	2	139
Cameron	South Texas Promotora Association, Inc.	1	3	154
Cameron	Texas AHEC South – South Coastal Region	1	6	52
Cameron	Texas A&M University Colonias Program Training Academy	2	8	101
Cameron	University of Texas School of Public Health - Houston	1	6.5	46
Hidalgo	Proyecto Juan Diego	1	24	32

2015 DSHS-Certified Continuing Education for CHWs

County	Name of Training Program/Sponsoring Institution	# of CEU classes offered	# of CEU contact hours	# of participants
Hidalgo	Día de la Mujer Latina, Inc.	1	1	12
Hidalgo	South Texas Promotora Association, Inc.	2	5	210
Hidalgo	Texas A&M University Colonias Program Training Academy	3	26	95
Hidalgo	The National CHW Training Center /Center for Community Health Development, Texas A&M Health Science Center	2	14.5	153
Hidalgo	University of Texas School of Public Health - Houston	1	6.5	22
Nueces	Texas AHEC South – South Coastal Region	1	5	37
Starr	South Texas Promotora Association, Inc.	2	7	70
Starr	Texas A&M University Colonias Program Training Academy	1	6	36
Webb	South Texas Promotora Association, Inc	1	4	53
Webb	Texas A&M University Colonias Program Training Academy	3	9	44
	Out of State – New Mexico			
Bernalillo	National Center for Farmworker Health, Inc.	2	5	5
	Distance Learning			
Cardea Services		1	2	8
Migrant Clinicians Network		1	1	50
Texas AHEC East - Coastal Region		1	4	20
Texas A&M Health Science Center School of Public Health, Office of Special Programs		12	38	522
The National CHW Training Center /Center for Community Health Development, Texas A&M Health Science Center		4	17	80
THSteps Online Provider Education Modules			89	1168
University of Texas School of Public Health - Houston		2	2	138
Total		**187**	**811.25**	**7,384**

Appendix C: Counties with Certified CHWs

By county of residence, as of December 31, 2015

County	#	County	#	County	#	County	#
HARRIS	975	CHEROKEE	7	WALLER	3	FAYETTE	1
BEXAR	359	VICTORIA	6	LAMAR	3	MADISON	1
TARRANT	260	POTTER	6	AUSTIN	3	FANNIN	1
EL PASO	246	GUADALUPE	6	TRINITY	3	HOOD	1
DALLAS	225	BASTROP	6	ORANGE	3	CULBERSON	1
CAMERON	212	RANDALL	6	HARDIN	3	HOPKINS	1
HIDALGO	141	JIM WELLS	6	MORRIS	3	GOLIAD	1
TRAVIS	130	WOOD	6	MARION	3	GRIMES	1
FORT BEND	126	ANGELINA	6	TYLER	2	LLANO	1
NUECES	93	COMAL	5	COLORADO	2	DEAF SMITH	1
SMITH	92	SHELBY	5	BURLESON	2	WISE	1
LUBBOCK	67	ATASCOSA	5	HALE	2	GRAYSON	1
WEBB	54	LIBERTY	5	CALLAHAN	2	MOORE	1
JEFFERSON	46	STARR	5	MCLENNAN	2	SAN JACINTO	1
GALVESTON	37	DE WITT	5	WHARTON	2	COCHRAN	1
BRAZORIA	32	CORYELL	5	CAMP	2	BURNET	1
MAVERICK	28	MATAGORDA	5	HUNT	2	CASTRO	1
DENTON	28	HARRISON	5	BANDERA	2	HOUSTON	1
WILLIAMSON	21	BELL	4	TITUS	2	VAN ZANDT	1
MONTGOMERY	19	ARANSAS	4	FRIO	2	SHERMAN	1
BRAZOS	19	TOM GREEN	4	ANDERSON	2	NAVARRO	1
COLLIN	19	CHAMBERS	4	ROBERTSON	2	LIMESTONE	1
GREGG	18	CASS	4	WALKER	2	KENDALL	1
JASPER	14	BOWIE	4	ROCKWALL	2	SOMERVELL	1
HAYS	13	WILSON	4	KINNEY	2	NEWTON	1
NACOGDOCHES	11	WICHITA	4	LAVACA	2	MEDINA	1
SAN PATRICIO	11	HENDERSON	4	GRAY	2	WILLACY	1
ECTOR	10	ELLIS	4	HUDSPETH	2	CALDWELL	1
JOHNSON	10	BEE	4	RUSK	2	CALHOUN	1
VAL VERDE	8	RED RIVER	3	BROOKS	1	IRION	1
UPSHUR	8	MIDLAND	3	GILLESPIE	1	LAMPASAS	1
KLEBERG	8	WASHINGTON	3	HILL	1	ERATH	1
UVALDE	7	TAYLOR	3	PARMER	1	JACK	1
PARKER	7	HOCKLEY	3	KARNES	1		
KAUFMAN	7	PALO PINTO	3	POLK	1		
Total Counties							**138**

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name:	Public Health Funding and Policy Committee		
Number of Members:	9		
Committee Status (Ongoing or Inactive):	Ongoing	Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.	
Date Created:	9/1/2011	**Date to Be Abolished:**	9/1/2023
Budget Strategy (Strategies) (e.g. 1-2-4)	1.1.1	**Strategy Title (e.g. Occupational Licensing)**	Public Health Preparedness and Coordinated Services
Budget Strategy (Strategies)		**Strategy Title**	

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Health & Safety, Chapter 117
State Authority	Admin Code	25 TAC, Sec. 85.2
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$31,221	$32,002	$32,002
Number of FTEs	0.6	0.6	0.6
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$31,221	$32,002	$32,002

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	$31,221	$32,002	$32,002
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year	6	6	6

Committee Description:

Recommend use/allocation of funds available exclusively to local health entities to perform core public health functions; ways to improve overall public health; methods for transitioning from a contractual relationship between DSHS and local health entities to cooperative-agreement relationship; and methods for fostering continuous collaborative relationships with those entities. Purpose: Define core public health services a local health entity should provide in a county or municipality; evaluate public health in the state and identifies initiatives for areas that need improvement; identify funding sources available for use by local health entities to perform core public health functions; establish public health policy priorities for the state; and make formal recommendations to DSHS regarding public health funding and services.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission.

No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

The committee typically meets at Mission Capital in a room designated for non-profit meetings. The committee is required to meet quarterly but generally meets 6 times per year.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

The committee produces an annual report (available online at www.dshs.state.tx.us/phfpcommittee).

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

This information is available in the committee's annual report and DSHS's response to the recommendations is available in the DSHS annual response report (available online at www.dshs.state.tx.us/phfpcommittee).

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ?

Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

1248.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Program staff: Orient and ensure training for Committee members, maintain appointment expiration of members, solicit committee nominees and coordinate appointment process, coordinate PHFPC meetings (agenda, meeting minutes, action items), coordinate submission of committee annual report, coordinate submission of annual DSHS response to PHFPC recommendations, coordinate communication between DSHS central office divisions/programs and the committee. Deputy Assistant Commissioner: Prepare briefings of DSHS initiatives and brief the committee. Assistant Commissioner: Prepare briefings of DSHS initiatives and brief the committee.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

Meetings are filed with the Texas Register and comply with the Texas Open Meetings Act. Each meetings includes a agenda item for general public comment. Twice a year, invitations are sent to public health stakeholders soliciting input.

7b. Do members of the public attend at least 50 percent of all committee meetings?

Yes

7c. Are there instances where no members of the public attended meetings?

No

8. Please list any external stakeholders you recommend we contact regarding this committee.

Texas Association of City and County Health Officials (TACCHO), Texas Public Health Association (TPHA), Texas Environmental Health Association (TEHA); Texas Medical Association (TMA); Texas A&M Health Science Center School of Public Health; University of North Texas Health Science Center School of Public Health; University of Texas Health Science Center School of Public Health

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

No

9b. Please describe the rationale for this opinion.

The committee has worked toward meeting its goals, but there are still several outstanding.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

Yes

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

The committee provides valuable stakeholder input that the agency uses to implement its policies and programs.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

Texas Department of State Health Services
SB 969 - Public Health Funding and Policy Committee
December 9, 2015
Austin, Texas

Committee Members	Other Attendees	Phone
Stephen Williams	David Gruber, DSHS RLHS	George Roberts, NETPHD
Julie Graves	Michele Austin, Houston HHS	Dr. Lillian Ringsdorf, DSHS
Dr. Jim Zoretic	Dan Smith, DSHS RLHS	
Dr. Jay Maddock	Beverly Pritchett, DSHS, RLHS	
Dr. Phil Huang	Janna Zumbrun, DSHS DCPS	
Dr. Umair Shah	Kevin Veal, DSHS DRS	
Dr. Deb McCullough (phone)	Jennifer Smith, TACCHO	
Dr. Dennis Thombs (phone)	Mary Starboard, DSHS RLHS	
Lou Kreidler (phone)	Judy Porubsky, Bell County HD	
	Casie Stoughton, City of Amarillo HD	
	Vinny Taneja, Tarrant County HD	
	Bonnie Scurzi, Bell County PHD	
	Sherry Williams, Waco-McClennan County PHD	

DRAFT

Mr. Stephen Williams called the meeting to order at 9:38 am and asked the committee members to introduce themselves. All in the room and on the phone introduced themselves.

Dr. Julie Graves made a motion to approve the October 7, 2015 and October 19, 2015 meeting notes as written. Dr. Zoretic seconded the motion.

Office of the Assistant Commissioner Update

Ms. Beverly Pritchett gave the update that Mr. David Gruber is attending the first of the High Consequence Infectious Disease (HCID) meetings which is taking place in Harlingen. She handed out a listing all seven of the next HCID meetings and locations.

Health and Human Services Transition

Meetings are going on around Health and Human Services (HHS) regarding the transition. There is an online survey on the HHS webpage on the transformation link or you can submit written comments on or before January 22, 2016. Mr. Williams said one of the main concerns we have is in regard to regulatory services. He would like to get the details of the five categories sent out to members and then ask if they want to have a call to discuss. Ms. Pritchett said we are not sure that all the decisions have been made on the other categories yet.

Interim Charges

Ms. Pritchett handed out a document showing categories of where studies will be conducted. This has been disseminated before and is available through legislative links, but we will also send out after the meeting. They will do studies and produce reports around these issues.

Syndromic Surveillance

DSHS has been trying to get a statewide system off the ground for a year. We are at the contracting phase now. We still do not have an approved sole source, and the program we will use has not been approved just yet. We expect to hear in two weeks. We are going to hold a statewide conference call in January for Health Service Regions (HSR) and local health departments (LHD) to help clear up questions and concerns. Mr. Williams asked what the level of involvement is of the Syndromic Surveillance Governance Council (SSGC). Ms. Pritchett said they meet quarterly, and they are briefed as to the plans for the next six months to a year. Any questions or

concerns are raised and addressed. They are informed, and they provide input. Dr. McCullough asked if Houston is still hosting the system until this is done. Mr. Williams said he is getting information from his staff that the SSGC is not consistent with original discussions. He is concerned with control of information. One of the interests was around LHDs being able to hold their own data. Dr. McCullough said she never sees the data, and it would be nice for the LHDs to know what it is. Dr. Huang said the ownership of the data discussion might open up a broader issue about ownership. Not recognizing that local public health has the same authority for the data is a problem. We need to work on the relationship there. Mr. Williams said it was his hope that the SSGC would weigh in on those issues. The bottom line with public health in Texas is that we are all dependent on each other, and our behavior should demonstrate that. This is a perfect opportunity to do that. Ms. Pritchett said as far as SSGC goes, that data will reside in a system that is accessible 24/7 by LHDs. It should not be a matter of ownership. The intent is to release the data at a regional level, and then it can be aggregated at the state level. For example, Houston now only sees their data, but in the future they will be able to see HSR 6/5S data. Mr. Williams said the issue is really about the feed of the data. It seems there could be a federated system where not only the data would be available by region, but statewide. Mr. Williams said Tarrant County is going to maintain their own system. If there is a health department that has a system that is capable of running on its own then that's fine. Tarrant County has a grant to mentor Houston in setting up a system. Ms. Pritchett added that the state's intent is to maximize access across the state. Ms. Kreidler asked if her health department will continue getting data from Tarrant County once the statewide system is up. Ms. Pritchett said yes, and if you want to see regional data, then you would need to log into the statewide system. Mr. Williams said it establishes a foundation for us to take a more holistic approach to public health. We would have greater leverage once we start to do this. Mr. Pritchett said syndromic surveillance data is not disease data. It is chief complaint from emergency rooms. Mr. Williams said they can go through the back end and get specific data. Ms. Pritchett said yes, you can write queries. Every health department, regardless of size, should have a point person to receive the daily update automatically. Dr. Huang said it is an opportunity. The conference call will also help discuss this with a broader audience. Mr. Williams said this does not seem settled, and he encourages the activation of the SSGC. Dr. Umair Shah said there continues to be some ongoing uncertainty about where everything will fall, and it does appear it has shifted some from original discussions. At some point it would be helpful to have the conversation about where are we headed and vision. His understanding was that the SSCG would be making decisions, but that does not seem to be the case. He suggests a joint conversation with interested LHDs, SSGC, etc. to get on the same page about where it is going. Mr. Williams said an in-person meeting would be ideal. It was suggested to have a meeting at 11:00 AM after the next PHFPC meeting. Ms. Pritchett said the timeline on that is concerning. Mr. Williams said we could schedule a special meeting. Ms. Pritchett said we will look for dates in early January. Mr. Vinny Taneja said he supports a special meeting of the SSGC. He agrees the SSCG, currently, seems to be a one-way conversation. As a group we can set the strategy and decide what to accomplish. Dr. Huang moved that we convene a special meeting of the SSGC, LHDs and TACCHO to look at future direction for the statewide syndromic surveillance system. Dr. McCullough seconded the motion.

<u>Health Emergency Preparedness and Response Section</u>

Mr. Taneja asked what the status is of the discretionary money. Ms. Kreidler asked Glenna to send out an email to find some dates for the folks identified at the previous PHFPC to come up with projects to meet.

<u>Texas Public Health Services Inventory</u>

The inventory was beta tested in October, and we received much input including a request for a stakeholder meeting. That meeting took place in November, and included several public health organizations. We received additional feedback. The service categories have been changed. We are on round two of the beta test, currently. We have taken into account most of the comments. The format has changed, as well. There are several subcategories within major categories, so we created a survey cross reference document. Survey links will be sent out by section. We are pleased with the progress made so far. We are asking for comments back by December 21, 2015. Originally, we thought we had to do a report by March 1, but we just have to complete the

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survey. Once we get the survey back, we will begin the gap analysis and gather stakeholders for the build of the action plan. Ms. Jennifer Smith asked if DSHS is charged with conducting an inventory of public health or the health system as a whole. Ms. Pritchett said just public health. Ms. Smith asked if this is one piece of something larger. Ms. Pritchett said it is the initial piece of the development of the public health action plan. Mr. Williams said this is a transition to the next item. Rather than the committee doing the inventory and then the department doing it, we are doing it together. As a committee we have to be mindful of what our charge is. It is similar but not the same. We need to maintain a level of independence. Mr. Williams said we are doing similar work, our interests are the same, but our responsibilities are a little different. Dr. Shah advised that we have a new DSHS commissioner, and it would be a good idea to invite him to attend an upcoming meeting to discuss what his perspective is for this committee and to build a bridge to what has been established previously. We could consolidate that meeting with one where he attends with TACCHO.

1115A Waiver Project for Chronic Disease Workgroup Update

Mr. Williams advised that the idea is to look at similar strategies with 1115 waiver funding. It could be a collaborative effort between TACCHO and the committee. Dr. Huang, Dr. Shah and Dr. Maddock will represent the committee, and then during the TACCHO meeting they will appoint some folks. The group would look at a strategy to implement in various jurisdictions. Glenna offered the DSHS Office of Healthcare Delivery Redesign to help coordinate the communication between HHS. Dr. Shah said the biggest challenge would be not to put our colleagues in a room without support from DSHS and HHS. He wants to make sure there is commitment from state partners on the lack of funding for chronic disease. Health inequity is another significant area to make sure we have commitment. Mr. Williams said the people to convince are the Medicaid folks, and he does not think it would be a hard sell. What we are proposing is a systems approach to an approach they have already funded. DSRIP has another set of complexities, but Mr. Williams would be willing to work on it. Dr. Huang said it would be to look at what other statewide projects exists and projects that are currently being funded around chronic disease. Mr. Williams will go to the Medicaid director at HHS and ask him. He knows he is supportive and has acknowledged. Mr. Williams said he would like to be able to tell them what populations this would impact. The workgroup will decide on what to propose and hold a call to define strategies. Glenna will send list of projects to workgroup and set up a time for the initial conference call.

Timeline for 3rd & 4th Annual Public Health Funding & Policy Committee Reports

The committee is on a final draft of the 2014/2015 combined report. Glenna sent it out to the committee on Monday afternoon for a once over. We are looking for more content-based edits. We have already received some feedback that it looks good. I asked for responses by Friday. DSHS is working on the response. Hopefully both of those can move up to the chain and be on their way to the Governor's office. Dr. Shah said there was some confusion about editing previous recommendations. He asked if we could clarify the process with these. Glenna said that six previous recommendations from 2014 should be left intact. Then there were three that were agreed upon to move forward as the 2015 report. Mr. Williams said as recommendations were made, the department has been responsive. In some cases the response was already there. He likes the process even though it can be a little messy.

General public comment

N/A

Agenda items for next meeting

Syndromic Surveillance, Access to Data, Discretionary PHEP Funding, DSRIP Chronic Disease Prevention, Focus of Public Health Funding and Policy Committee

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Dr. Shah said NACCHO and ASTHO have challenged LHDs to look at ways to address health equity. He asked if this is something we could get a status update on from DSHS as to how health equity work being done across the state. Mr. Williams said we can discuss this as a committee.
Regarding syndromic surveillance, Mr. Roberts asked what the sense of urgency is for contracts that Ms. Pritchett mentioned. Ms. Pritchett said we have contracts that are beginning the procurement process for sole source approval for installation of ESSENCE, the use of the Gateway and expansion of Rhapsody which is the software used to ingest the data. There is also a contract for Data Center Services (DCS) which is the required IT vendor for statewide IT. If there is a change to that, we would need to know as soon as possible in order to ensure the contract is the right configuration.
Dr. Shah said he is not sure about what our role is but has been watching discussion around refugee services, a lot of LHD services are providing refugee health activities. We need to make sure we can communicate that funding should continue. Mr. Williams said that seems more appropriate for a TACCHO meeting. Dr. Shah said he also wants is to remind everyone that the San Bernardino County situation did impact the public health community, and we would be remiss without taking a moment to remember those who are dealing with the loss.

Meeting was adjourned at 11:06.

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Texas Department of State Health Services
SB 969 - Public Health Funding and Policy Committee
February 10, 2016
Austin, Texas

Committee Members	Other Attendees	Phone
Stephen Williams	David Gruber, DSHS RLHS	Mary Starboard, DSHS, RLHS
Dr. Julie Graves	Michele Austin, Houston HD	Maribeth Sexton, Milam Co. HD
Dr. Dennis Thombs	Dan Smith, DSHS RLHS	Raouf Arafat, Houston HD
Dr. Deb McCullough	Beverly Pritchett, DSHS, RLHS	Marlene McNeese-Ward, Houston HD
Dr. Phil Huang	Jennifer Smith, TACCHO	
Dr. Umair Shah	Sherry Williams, Waco-McLennan Co PHD	
	Judy Porubsky, Bell County PHD	
	Bonnie Scurzi, Bell County PHD	
	Robert Resendez, City of El Paso HD	
	Camden Hallmark, Houston HD	
	Paul Norman, DSHS, DCPS	
	Rebecca Filipowicz, DSHS, DCPS	

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Dr. Deb McCullough called the meeting to order at 9:38 am and asked the committee members to introduce themselves. All in the room and on the phone introduced themselves.

Sexually Transmitted Disease Management Information System Centralization

Mr. Camden Hallmark advised that Sexually Transmitted Disease (STD) Management Information System (MIS) is the data system used for ensuring public health follow up and ensuring newly infected people with STDs gets linked into care. The system is used to monitor trends in our jurisdiction and to monitor individuals. Recently all jurisdictions have been centralized into one system. Ms. Rebecca Filipowicz confirmed there were 18 local databases, and now they have been centralized. Mr. Hallmark continued that as a result, access has been limited, and it impacts staff being able to plan their day. Another issue is locals having access to their own data. This is important to monitoring trends, and it impacts the response to leadership. DSHS staff have been responsive in attempting to export and send data, but we are having difficulty reporting back to the state. The issue is really a communication problem. We were not aware of the impacts that were going to take place. There has not been a plan on how this will be addressed. Mr. Williams said that the bigger question is whether the state understands that locals need access daily. Dr. Huang said these same topics keep coming up. It seems locals do not have the same authority for the data. This goes back to the original request by locals to have a relationship with the state that is different than a contractor. Dr. Huang said that a concern is that we have to ask for the data back once it is submitted to the state. Ms. Filipowitz said we have been in the process of developing the database. The TB, HIV, STD Integrated System (THISIS) will allow everyone access in real time at any time. We had to centralize MIS to be able to convert all of the data into the system to keep from having to import data from 18 systems. The new system will be rolled out by the end of the year. Mr. Williams asked why it was difficult to give the locals back their data. Ms. Filipowicz said the current MIS does not have an export capability. When DSHS accesses it from the main database, it is easier to use. Mr. Hallmark said he is concerned with THISIS, and he is afraid this may not resolve the issues. He still has not heard anything about locals being able to export their own data. We have not been asked what we need and whether or not this will resolve this issue. Ms. Maribeth Sexton asked if there will be separate systems so functionality will not be as cumbersome.

Dr. Huang said we just need to improve communication and make sure it is a two way street. Mr. Williams said that the process is apparently not working. Bidirectional communication needs to happen. In the end you are sacrificing program continuity. Ms. Filipowicz said it is not that we are trying to keep the data to ourselves. The system is antiquated. Dr. Huang said it sounds like we can work together to improve getting access to the data as a whole. Dr. Julie Graves asked who has chosen the metric that it takes a year to have up to date data. What is our process for choosing that timeline? Should this committee discuss how long it should take to have data available? Ms. Pritchett said if we are going to address this at the department level, we are going to have to get a group of people together to look at this. Data resides at the program level. Ms. Pritchett advised that Mr. Gruber asked us to find out from LHDs what the major issues are you would like us to address, and what the timeframe is in which you need it. Mr. Williams said the data is generated locally and then it is sent in. Dr. Huang said it should not be an adversarial relationship. We are all in this together and we have the same goals. We understand to have finalized data take a while to clean that up. At the local level we can understand there is preliminary data and can work with the state on that. Ms. Filipowicz said that with this system it will be in real time. She said that a lot of time it is hard to justify putting out data when it is preliminary. Dr. Graves said not reporting is making everything not work. You can issue foot notes to advise the data is preliminary. Mr. Williams said we are talking about a culture. At the local level we are able to analyze our own data, and we do not need assistance with that. Summary data taking six months to a year is fine. Dr. Graves asked if the reports can be run daily. Ms. Filipowicz said we do that. Mr. Hallmark said that it does not help, because we cannot access the data. Mr. Williams said you can just dump the raw data back to the LHDs. Mr. Williams said we need a quick fix, but to also look closer at the larger data accessibility issue. Dr. Graves said she wants her data, too, and is unable to get it. Ms. Marlene McNeese-Ward, said that this became a problem when the 18 systems were combined. She suggests beginning communications again among the 18. Mr. Paul Norman advised that DSHS has invited an individual from City of Houston to monthly meetings to discuss these issues but he has been a no show. Mr. Williams said we need an IT person and a program person. There is a new project manager on the project, and that communication is happening. Mr. Williams said there needs to be representation from several locals. The bottom line is that locals want raw data back. We need a recommendation to ensure broader representation on the long-term workgroup. Dr. Huang said he will represent Austin/Travis County HHS, and Mr. Williams will ask Mr. George Roberts. Mr. Vinny Taneja is also recommended. For the short term data dump issue, Mr. Williams said he will volunteer to work with Mr. Felipe Rocha to discuss with him how to get the data back to the locals.

Approval of the December 9, 2015 meeting minutes

Dr. Graves made a motion to approve the minutes as written, and Dr. Thombs seconded.

Public Health Emergency Preparedness Funding Formula Update

Ms. Pritchett advised that DSHS has decided not to implement the Public Health Emergency Preparedness (PHEP) funding formula to allow time for further analysis to impact on LHDs. Some received a significant decrease in funding. There will be further study, and Mr. Bruce Clements will lead an effort to figure out what the degree of the impact is. We thought DSHS would get increased funding in PHEP but it came to Hospital Preparedness Program instead. We will look at options for the next year, but this year will be same as last year. Ms. Sexton said that last week Mr. Clements shared that the commissioner wanted more information, and the earliest it could be implemented was July 2017. She added that many LHDs have to propose our budget by June in order to be prepared for January, so this could be an issue. Ms. Pritchett said she would pass that along to the program.

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Discretionary Public Health Emergency Preparedness Funding
Mr. Williams advised that a workgroup was put together last meeting. They used his strawman document and added to it. Then the workgroup ranked the projects that were submitted. The process was for the workgroup spreadsheet to be given to Bruce and go from there. Mr. Williams proposes asking Mr. Clements and the department to consider these rankings depending on how much money is available.

Syndromic Surveillance
Ms. Pritchett said DSHS still does not have Memorandums of understanding (MOUs) from DSHS Legal, but we are hoping to have them by the end of the week. We have forward movement on the sole source procurement, and that will be moving forward. There was a statewide call on Monday for all LHDs and helped clear up some confusion on accessibility and how data will be shared. The Syndromic Surveillance Governance Council recommended having a call for all hospitals. Currently, Mr. Chris Meredith works for City of Houston through a contract with DSHS. He will come on board with DSHS part-time and then once the statewide system is up, he will be full time with DSHS. Dr. McCullough asked if people who do not currently have access will have it. Ms. Pritchett said yes. Mr. Williams asked when the transition will occur. Ms. Pritchett advised that the timeline is to start initial development of the system in April 2016. Mr. Williams asked that DSHS please work with locals so nothing is left out. Ms. Pritchett said we have been talking on a weekly basis. There is a survey coming out to hospitals to gain contact info for the MOUs and for IT. For regions 2/3 and 6/5 we are asking if the hospitals will let us know if they have an emergency department and an electronic health record so we know the potential of who could be connected at some point in the future. Dr. Huang asked if the agreement will include locals. Ms. Pritchett said it is inclusive. She added that we have no intention is closing down old TALHO system and we cannot transition without an MOU. Mr. Williams said he is committed to keeping the TALHO system up and running until we know the statewide system is up and running strongly.

Texas Public Health Inventory and Action Plan Update
Ms. Pritchett advised that the survey was launched on January 8 to 160 local health entities and to eight regional offices on January 13. It was sent to DSHS central office on January 14. We do not have a high completion rate. The highest region has 50 percent completion. We hope the email that went out yesterday will be a reminder to submit as quickly as possible. The next step is to start working on the state action plan. We will have a steering committee of about 10-15 people to review the categorical workgroup data and provide recommendations to build the plan. Dr. McCullough asked what the purpose of the action plan is. Ms. Pritchett read the legislative charge to DSHS. The plan will be a compilation of strategies with regional goals. The survey will provide some of the data points. Dr. Huang said we have already determined what the core public health functions are. The survey data will identify a gap where we need to build capacity. Dr. McCullough added that the things we identified are broad based but how it gets done is up to the jurisdiction. The finding will be that there is a gap and there has not been a lot of investment in these services. Ms. Pritchett said the stakeholders will be local health entities, health service regions, central office program areas and health related organizations and professionals. RLHS is proposing 10 categorical workgroups based on public health service categories. The cross over categories the workgroups needs to consider are population health, surveillance/epidemiology and preparedness. Mr. Williams asked if the committee wants to have discussions in these areas while the work is ongoing or wait until after the groups have done their work. As a committee, we would look at the results as the workgroups are starting. Ms. Pritchett advised that the intent is to start the workgroups in mid-March. Mr. Williams said we should have a call before the workgroups start to pose a couple of questions to the committee in each of these areas so the issues can be incorporated in the deliberations of the workgroups. Ms. Pritchett said we hope to have the majority of the input by the first of March. Next we will review and compare survey outcomes and brief Dr. Hellerstedt. The development of the action plan would begin the early part of June. Dr. Graves said this seems like a real opportunity to talk about the science of this. We can apply the science of it to Texas government in a way that is unprecedented. As a committee we have a responsibility to address that. We

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should also think about involvement with the academic side. Dr. Thombs said heard that the University of Texas vice chancellor was heading up some similar initiative. Dr. Graves said we should talk to Dr. Lakey to hear what they are doing along these efforts. Jennifer Smith presented Dr. Lakey's Triple Aim initiative and his top priorities. We will work on asking Dr. Lakey to present to the committee.

1115A Waiver Project for Chronic Disease Workgroup Update

Dr. Huang shared that the workgroup had two conference calls and narrowed the scope down to diabetes and tobacco prevention. San Antonio Metro, Austin/Travis County and Denton County presented their projects. Mr. Williams asked for Dr. Huang to map out a chronic disease strategy as if money was not an issue. Mr. Williams said we will know more when we get feedback from the federal government. Mr. Williams said next steps would be to come up with specific strategies that are available universally and then consider what seems to fit more under the 1115 Waiver. Later we can have dialogue with LHDs depending on whether or not an opportunity presents itself. Dr. Huang said tobacco is the low hanging fruit going the environmental route through policy. Dr. Shah said he would point out that the distinction between the home rule jurisdictions and their ability to address some of the policies is different than how counties can approach these things.

Next Meeting Agenda Items

There will be a special meeting by phone to discuss preliminary data from the Texas Public Health Inventory. Glenna will send out Doodle request to determine members' availability.
April meeting will be at the TPHA conference in Galveston on April 11.

Meeting was adjourned.

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Texas Department of State Health Services
SB 969 - Public Health Funding and Policy Committee
March 16, 2016
Austin, Texas

Committee Members	**Other Attendees**
Stephen Williams	Lisette Osborne, DSHS, RLHS
Dr. Julie Graves	Michele Austin, Houston HD
Dr. Dennis Thombs	Dan Smith, DSHS RLHS
Dr. Deb McCullough	Beverly Pritchett, DSHS, RLHS
Dr. Phil Huang	Jennifer Smith, TACCHO
Dr. Umair Shah	Amanda Ortez, Grayson County
Dr. Jay Maddock	Cathy Sbrusch, Brazoria County HD
Dr. Jim Zoretic	Lisa Dick, Brownwood/Brown County HD
	Robert Resendez, City of El Paso HD
	Sherry Williams, Waco-McLennan PHD
	Jessica Boston, Texas Medical Assn
	Hanna Bell, Rep Molly White
	Zack Thompson, Dallas County HD
	Chris Taylor, Cherokee County
	George Roberts, Northeast Texas PHD
	Victoria Ford, K&L Gates
	Gale Morrow, DSHS, HSR 8

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Committee Chair, Stephen Williams, called the meeting to order and conducted roll call and introductions. Mr. Williams advised that the purpose of this call is to hear the latest on the Texas Public Health Action Plan and to have the committee give input before the workgroups begin. The goal is to make sure we are on same page.

Review Process For Development of the Texas Public Health Action Plan

Ms. Beverly Pritchett advised that the survey was sent to 160 local health departments (LHDs) on January 8, 2016. DSHS has continued to take input as long as the surveys are being submitted.

As far as completion rates go, we have had great success in some regions. We continue to reach out encouraging folks to respond. The next steps in the development for the action plan are for workgroups and a steering committee to be established. We will brief Dr. Hellerstedt on the proposal on March 22. We will then finalize the meeting schedule and continue to engage stakeholders. We are also going to reach out to all professional associations and public health organizations. There are seven categorical workgroups based on the primary areas in which the survey was broken down. There are areas that cross over all categories such as access and linkage to care, population health, preparedness and response, and surveillance and epidemiology. Ms. Pritchett said the workgroups will consider the crossover categories while reviewing all seven service categories. Ms. Pritchett reviewed which stakeholder groups will serve on the steering committee. Dave Gruber is trying to see if Kirk Cole or Mike Maples will serve on it, as well. Mr. Gruber will chair the steering committee as they provide oversight to the workgroups. They will also review the workgroups' input to the plan to ensure they are addressing is appropriate to develop statewide strategies and regional goals. Mr. Williams asked how the Public Health Funding and Policy Committee (PHFPC) will interact with the steering committee. Ms. Pritchett said that there are representatives from PHFPC on the steering committee. Dr. Umair Shah said he has thoughts on how

heavily the steering committee is weighted with healthcare associations. Dr. Huang said he agrees that there are too many representatives from healthcare and not enough who understand public health. Ms. Kreidler said she does not understand how these organizations are going to give input on public health issues when they do not understand what we do. Ms. Jennifer Smith said she does think the Texas Public Health Association should be included because they are the state public health association. Mr. Williams asked if DSHS is planning to limit the number of participants on the steering committee. Ms. Pritchett said we would limit the associations, but we will not limit the involvement of LHDs. Mr. Williams said a lot of the plans for communicable diseases have already been set federally, so how will you factor that into the plan? Ms. Pritchett said we are asking that each workgroup would be lead by a subject matter expert (SME) from DSHS central office. Dr. Shah said he sees it problematic that there is a representative from a local health unit with environmental health focus. This needs to be looked at in a nuanced way, because that is going to be important in making sure there is good buy in. He said he would be concerned if LHDs did not have appropriate representatives and vetting. Mr. Williams said the focus should be on the LHDs because they will be the ones who will have a major role in carrying out the plan. Dr. Huang said he recommends putting the healthcare associations at the workgroup level but maybe not on the steering committee. Ms. Pritchett said we could use the Texas Public Health Coalition to push info out to their representatives, and that would cut down on the associations. The initial meeting of the steering committee is planned for April 5, 2016. Ms. Pritchett said the first spreadsheet she will review is a subset of data points. These are the major sub-areas that folks would want to know and that indicate that those services were being provided by that entity. For example if you said do testing and treatment then we said ok, they have a TB program. We selected key questions out of that subject area. We can take the 27 selected questions that are represented by the data set and send that out. The other spreadsheet is the frequency data for each question. It has all possible answers. Mr. Williams said we are seeing what people are doing, and we can probably see where they are doing it. Mr. Williams asked how we are going to get to gaps and capacity. The gap piece is that the intent is for the SME to be able to bring with them the disease burden data. Ms. Kreidler said we have aggregate data, but there is nowhere that shows what health departments responded. Ms. Pritchett said the workgroups will have data sorted by health service region and by LHD within the health service region. Mr. Williams said he would be interested in how the workgroups will arise to some conclusions. We need to know to what extent the services exist, where the gaps are and what can be done to fill the gap. Ms. Pritchett said it is a large time commitment and big undertaking. Mr. Chris Taylor said it is all very fluid based on funding. Ms. Pritchett said those are important points that should be carried to the workgroups. Mr. Williams asked the PHFPC what their thoughts are so far. Dr. Shah said this has been helpful, and he suggests some ongoing process of keeping the PHFPC updated, especially before any final decisions are made. He wants to encourage the spirit of ongoing communication between the committee and DSHS. Mr. Williams said we need to come up with a way to do this. He called the meeting because he wanted to make sure the committee is on board. Ms. Pritchett said we will give an update at the committee's stakeholder meeting in Galveston. Mr. Williams suggested having a standing agenda item on Texas Association of City and County Health Officials (TACCHO) where a member from the committee briefs TACCHO. The reason would be to ensure sufficient buy in. Mr. George Roberts, TACCHO president said he agrees. Dr. Shah said we want to be responsive to state partners but we cannot own it. Mr. Williams said we have to co-own the process, because we all have a responsibility. Mr. Williams said the committee has to make recommendations that may or may not agree with the state. He said he thinks we will end up on the same page. Ms. Pritchett said we encourage anyone who has not done so to please complete the survey. Mr. Williams suggested sending the list of those who have and have not completed it to TACCHO, so they can help encourage LHDs to complete it.

Dr. Graves made a motion to adjourn. Dr. Zoretic seconded.

Meeting was adjourned.

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Public Health Funding and Policy PHFP Committee

Annual Report

March 2015

Stephen L. Williams, M.Ed., M.P.A, Chair

Harlan "Mark" Guidry, MD, MPH, Vice Chair

Acknowledgements
The Public Health Funding and Policy Committee (PHFPC) acknowledges and thanks the following individuals for their subject matter expertise, facilitation, and support of the PHFPC:

Michele Austin, Houston Department of Health and Human Services

Rachael Hendrickson, Texas Department of State Health Services

Glenna Laughlin, M.A, CHES, Texas Department of State Health Services

Dan Smith, M.Ed., CHES, Texas Department of State Health Services

All the public health stakeholders who provided testimony during the PHFP Committee meetings

Contact Information

For more information on this report or the PHFPC, please see www.dshs.state.tx.us/phfpcommittee or contact:

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Public Health Funding and Policy Committee – Members

James N. Burdine, Dr. P.H.
Dean, Texas A&M Health Science Center School of Rural Public Health
College Station, Texas
Schools of Public Health – 4-year term

Harlan "Mark" Guidry, M.D., M.P.H.
Chief Executive Officer and Health Authority, Galveston County Health District
Texas City, Texas
Local Health Authority – 6-year term

Richard Kurz, Ph.D.
Dean, UNT Health Science Center School of Public Health
Fort Worth, Texas
Schools of Public Health –6-year term

Deb McCullough, D.N.P., R.N., FNP
Director, Andrews County Health Department
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Local Health Entity – 4-year term

Paul McGaha, D.O., M.P.H.
Regional Medical Director, Health
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Regional Health Director – 6-year term

VACANT
Local Health Authority – 6-year term

James Zoretic, M.D. M.P.H.
Regional Medical Director, Health
Service Region 2/3
Arlington, Texas
Regional Health Director – 6-year term

Stephen L. Williams, M.Ed., M.P.A.
Director, Houston Health and Human Services Department
Houston, Texas
Local Health Entity – 6-year term

VACANT
Local Health Entity 6-year term

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Public Health Funding and Policy Committee (PHFPC)

Department of State Health Services
P.O. Box 149347. Austin, Texas 78714-9347

Attention: Governor Greg Abbott
Lieutenant Governor Dan Patrick
House Speaker Joe Straus
Senator Charles Schwertner
Senator Jane Nelson
Representative Myra Crownover
Interim Commissioner Kirk Cole

Attached please find the annual report of the Public Health Funding and Policy Committee (PHFPC). This report is abbreviated in lieu of the upcoming Sunset Advisory Commission recommendation of reporting every off year of the legislative session. The PHFPC favors biennial reporting because it allows for more time to work on business and will provide time to submit an expanded report in order to better inform legislative entities of recommendations prior to the session.

This report outlines the PHFPC's focus over the current year, details the new recommendations to the Texas Department of State Health Services (DSHS) and provides the PHFPC's objectives for future activities.

The PHFPC's current, ongoing activities include the implementation of a statewide syndromic surveillance system, the PHFPC's work with DSHS on the public health emergency preparedness funding formula and analysis of the Sunset Advisory Commission report. These activities are detailed in the report.

The PHFPC's recommendations focus on the need for continued funding for public health programs and initiatives. Public health funding is the key to assessment, education, raising awareness, research and treatment. It is also the key to protection against infectious diseases, chronic diseases, and preventable deaths. Adequate funding leads to healthier communities.

Funding provides the safeguards that are essential for local health departments to maintain good public health practices in their communities and to plan for unexpected public health emergencies. The lack of funding leads to a higher risk of public health conditions, chronic diseases and inability to adequately prepare for disasters. We understand that funding is a major issue statewide but well-spent resources lead to better efficiencies.

Since the PHFPC's inception it has engaged in activities to meet its charge under Chapter 117 of the Health and Safety Code. While the PHFPC is pleased with its progress to date, there is still a great deal of work to be accomplished. In the next year the PHFPC has several definite objectives it would like to meet. The objectives include continuing its efforts to define core public health services, working with DSHS to develop the funding criteria for the next identified program and initiating a project that will track the stream of federal funds from point of release to the local health department. The report outlines these activities in detail.

The PHFPC is grateful for the opportunity to improve public health in the state and looks forward to the activities of the year ahead. Your continued support in the PHFPC's endeavors is greatly appreciated.

Sincerely,

Stephen L. Williams, M.Ed., M.P.A.
Chair, Public Health Funding and Policy PHFP Committee
Director, Houston Department of Health and Human Service

SECTION I: PHFPC CHARGE

DUTIES OF PHFPC

Sec. 117.101. GENERAL DUTIES OF PHFPC. (a) The PHFPC shall:

(1) define the core public health services a local health entity should provide in a county or municipality;

(2) evaluate public health in this state and identify initiatives for areas that need improvement;

(3) identify all funding sources available for use by local health entities to perform core public health functions;

(4) establish public health policy priorities for this state; and

(5) at least annually, make formal recommendations to the department regarding:

(A) the use and allocation of funds available exclusively to local health entities to perform core public health functions;

(B) ways to improve the overall public health of citizens in this state;

(C) methods for transitioning from a contractual relationship between the department and the local health entities to a cooperative-agreement relationship between the department and the local health entities; and

(D) methods for fostering a continuous collaborative relationship between the department and the local health entities.

(b) Recommendations made under Subsection (a)(5)(A) must be in accordance with:

(1) prevailing epidemiological evidence, variations in geographic and population needs, best practices, and evidence-based interventions related to the populations to be served;

(2) state and federal law; and

(3) federal funding requirements.

SECTION II: CURRENT PHFPC PROJECTS

Statewide Syndromic Surveillance System

The statewide syndromic surveillance system is an ongoing project that involves DSHS housing all of the surveillance data from every jurisdiction throughout the state. This is a massive undertaking considering the number of jurisdictions and the systems utilized by each. The PHFPC worked with DSHS to outline the work plan for this project and DSHS began execution of the plan. DSHS provides updates to the PHFPC on its implementation efforts and the PHFPC is looking forward to a unified system. This project is part of the foundation for the development of a statewide public health system.

Emergency Preparedness Funding Formula

Another current activity of the PHFPC is its work with DSHS on the Public Health Emergency Preparedness (PHEP) funding formula. DSHS convened a workgroup to complete this project with the primary goal being to develop objective measures to identify and address: participation criteria, lapsing funding, the withdrawal of participants, and the addition of new participants. DSHS and the workgroup have made good progress on this funding formula and the PHFPC anticipates that this project will be completed within the second quarter of 2015.

Texas Sunset Advisory Commission Report

The PHFPC has been very engaged with the recommendations offered by the Texas Sunset Advisory Commission (Commission) and has thoroughly reviewed both the Health and Human Services Commission (HHSC) Report and the DSHS Report. The PHFPC appreciates the comprehensive approach the Commission staff took in preparing the reports. They sought information from different organizations and entities throughout the state to ensure they captured the interests of all who would be affected by the recommendations made. The PHFPC was in agreement with a majority of the recommendations but is concerned about the recommendation to consolidate the five HHSC system agencies into one. The concern is that funding for public health will be diverted to other areas within HHSC that may appear to have a greater need due to low funding and crisis diversion.

SECTION III: PHFPC RECOMMENDATIONS

In preparation for the 84th Texas Legislative Session, the PHFPC formed a Legislative Themes Subcommittee to identify public health issues that may require legislative action for the improvement of public health. As a result, the following recommendations were made to DSHS:

Recommendation 1: The PHFPC recommends that DSHS provide additional funding to address specific areas of chronic disease prevention such as obesity, tobacco cessation and cardiovascular disease, which includes high blood pressure and stroke.

Progress to Date: Pending

Discussion: the PHFPC specifically identified these conditions because local health departments (LHDs) reported an increase in the negative effects in their communities. The PHFPC believes additional funding would enable LHDs to target the most problematic conditions in their jurisdictions.

Recommendation 2: The PHFPC recommends that DSHS provide support for access to care initiatives.

Progress to Date: In progress

Discussion: The PHFPC recommends that DSHS continue its support and funding to LHDs in areas where LHDs provide safety net services such as TB, family planning, immunization, refugee health screening, etc.

Recommendation 3: The PHFPC requests that DSHS provide funding to assist with marketplace expansion and resources to assist with Affordable Care Act enrollment.

Progress to Date: Pending

Discussion: The PHFPC believes the state should support programs that assist people in obtaining health care and health care insurance to provide a greater opportunity for access to care.

Recommendation 4: The PHFPC recommends that DSHS continue to provide mental health funding.

Progress to Date: Pending

Discussion: Inadequate mental health funding and services contributes to a broad spectrum of community dysfunction including, increased communicable disease, homelessness and family dissolution.

Recommendation 5: The PHFPC recommends that adequate funding be provided to LHDs for syndromic surveillance.

Progress to Date: In progress

Discussion: The PHFPC believes surveillance initiatives are critical in assessing the overall state of health in Texas, because they provide for early detection and investigation of disease outbreaks, monitoring disease trends, identifying unusual disease clusters, establishing disease prevalence and defining health trends and behaviors associated with those trends.

Recommendation 6: The PHFPC recommends that DSHS support legislation to ease the third party billing application process for LHDs and other governmental entities.

Progress to Date: Pending

Discussion: As governmental entities and essential community providers, LHDs should either receive assistance in or a waiver from the tedious third party billing application process.

SECTION IV: FUTURE PHFPC CONSIDERATIONS

Defining Core Public Health Services

The PHFPC intends to complete the process of defining core public health services. This project is fascinating, because prior to its inception, core public health services had as many definitions as there are jurisdictions. Public health stakeholders have now come to a consensus regarding the fact that there should be a standard of public health services made available to every citizen in the state.

Developing Funding Formulas

The PHFPC will be engaged in the process of working on a funding formula for the next program identified by DSHS. The process of developing funding formulas for the programs has become more routine with each program, because there is now an established approach that can be used as an outline and adjusted as needed.

Tracking the Flow of Federal Funds

The PHFPC intends to initiate a project tracing the stream of federal funds from the origin to its distribution to LHDs. A portion of funding comes from the federal government whether it is received directly or funneled through the state or other entity as pass through funds. Tracking the flow of the funding will assist the PHFPC to understand the different courses the funding takes to get to LHDs and why. This task will assist the PHFPC to identify sources of funding for the LHDs and help in the development of policy with regard to that funding.

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Registered Sanitarians Advisory Committee

Number of Members:

Committee Status (Ongoing or Inactive): Inactive

Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created:

Date to Be Abolished:

Budget Strategy (Strategies) (e.g. 1-2-4)

Strategy Title (e.g. Occupational Licensing)

Budget Strategy (Strategies)

Strategy Title

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Occupations Code, Chapter 1953
State Authority		
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year

Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
0	0	0

Committee Description:

The committee has provided professional advice to the Sanitarian Registration Program, a regulatory program that administers Occupations Code, Chapter 1953, relating to the registration of professional sanitarians. This includes advice on rules for the certification and regulation of sanitarians, continuing education requirements, and the required certification examination. The regulation of sanitarians is transferring to the Texas Deparment of Licensing and Regulation and an advisory committee is no longer needed at DSHS.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ?

No

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

7b. Do members of the public attend at least 50 percent of all committee meetings?

7c. Are there instances where no members of the public attended meetings?

8. Please list any external stakeholders you recommend we contact regarding this committee.

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

9b. Please describe the rationale for this opinion.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

11b. Please describe the rationale for this opinion.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: DSHS Preventive Medicine Residency Program-Resident Advisory Committee (RAC)

Number of Members: 15

Committee Status (Ongoing or Inactive): Ongoing

Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: Unknown

Date to Be Abolished: NA

Budget Strategy (Strategies) (e.g. 1-2-4) 1.1.1.

Strategy Title (e.g. Occupational Licensing) Gen Rev-Residency Program

Budget Strategy (Strategies)

Strategy Title

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	NA	
State Authority		
State Authority		
Federal Authority	NA	
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

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Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year 2 | 2 | 2

Committee Description: The RAC advises and assists the program director with goals, objectives, educational experiences, rotations, new and emerging knowledge, internal review of program, and evaluations of residents/faculty/program.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

RAC meets twice per year via teleconferencing, as required for the Accreditation Council of Graduate Medical Education.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

Tangible outcomes include resident and faculty evaluations and an annual written report of program quality that is presented to the Designated Institutional Official (DIO). There are no required documents.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

a. Improving faculty orientation and training/in progress. b. Development of customized MPH/completed. c. Expand elective opportunities/ongoing. d. Increase Program Director interactions with residents/completed. e. Improve program structure and content/ongoing.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ? Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees? No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015? 25.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Completing agency required reports about the committee. Scheduling dates, times, logistics for meetings. Preparing agendas. Developing minutes from meetings. Participating in meetings. Sharing findings of reports, surveys and/or evaluations.

6. Have there been instances where the committee was unable to meet because a quorum was not present? No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

N/A - meetings are not public.

7b. Do members of the public attend at least 50 percent of all committee meetings? No

7c. Are there instances where no members of the public attended meetings? Yes

8. Please list any external stakeholders you recommend we contact regarding this committee.

Graduate medical education programs in preventive medicine

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals? Yes

9b. Please describe the rationale for this opinion.

Accreditation Council of Graduate Medical Education (ACGME) standards now require a two year program (following a one year clinical experience) for completion of residency. This has required modification and growth of the program and the RAC guidance and feedback is essential to this process.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute? No

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area? No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

Retain

11b. Please describe the rationale for this opinion.

Based on analysis conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

RAC is required by the Accreditation Council of Graduate Medical Education. The DSHS Preventive Medicine Residency Program accredited status requires the program to adhere to ACGME standards.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

Committee will be reviewing its purpose to define and focus its mission, purpose and active role in the Residency Program.

MINUTES

Residency Advisory Committee Meeting

Date | time 12/9/2015 9:00 AM | *Meeting called to order by* Jeff Levin

In Attendance

Lewis Foxhall, MD	(external)	MD Anderson Cancer Center
Linda Gaul, PhD	(internal)	DSHS State Epidemiologist
Jeff Levin, MD, MSPH	(external)	UT Tyler Occupational Medicine Residency
Paul McGaha, MD, MPH	(external)	UT Tyler
Peter Pendergrass, MD, MPH	(ex-officio)	DSHS Region 1
Beatriz Tapia, MD, MPH	(external)	UT Health Science Center
Lillian Ringsdorf, MD	(internal)	DSHS Region 8
Andrew Gorchs, MD	(external)	VA
Courtney Dezendorf	(external)	UT School of Public Health
Srivani Kanumuri, MD	(internal)	Resident
Raafia Muhammad, MD	(internal)	Resident
Anita Buck	(internal)	Preventive Medicine Residency Program
Annette Lara	(minutes taker)	DSHS Office of Academic Linkages

Call to Order

Dr. Jeff Levin called the meeting to order at 9:05 a.m. Dr. Levin asked for a motion to approve the minutes from the previous meeting. Motion made by Dr. McGaha, seconded by Dr. Pendergrass

Program Updates

Welcome new residents Dr. Raafia Muhammad and Dr. Emilie Prot

Dr. Pendergrass shared Raafia Muhammad and Emilie Prot started July 1st. Prior to joining our program Raafia completed her Surgical Residency at Brookdale University Hospital and Medical Center. Emilie completed her Internal Medicine Residency training at St. Vincent Charity Medicine.

GMEC Evlauation

Dr. Pendergrass advised that we are working with Courtney at the UT School of Public Health in developing a customize MPH. Also, the Residency Program has also been working with excutives to pay for the resident's tuition up front to alleviate any financial burden this may have on them. The resident's tuition will

be made directly to UT School of Public Health. The residents are required to complete all course work with a grade of a B or higher.

Dr. Pendergrass advised that we will be implementing a weekly board review. This residents will be required to present and discuss topics throughout the Jekels book. The residents will also be working in the US Preventive Task Force recommendations and requirements.

Dr. Pendergrass shared QI projects will be started once the residents are on boarded. The first month the residents will spend a week in Lubbock and at this time Dr. Pendergrass will work with them on formulate their project and set up the teams that will be working with them.

Dr. Pendergrass shared our first set of 360 evaluations will be included in our milestones at the CCC meeting today.

Dr. Pendergrass advised we are looking to expand our elective opportunities. The program has spoken with John Villanacci to develop an environmental option within the health department. We are currently looking for some clinical opportunities to focus on STD and Immunizations.

Dr. Levin asked if Dr. Pendergrass could give an update on the accreditation system (faculty surveys, resident's survey, and core faculty scholarly work) and the programs interaction with the GMEC. Dr. Pendergrass advised we had our first milestone report last December 2014. 75% of the core faculty completed the survey and 100% of the resident survey was completed. Dr. Pendergrass and Annette are currently working on developing the methodology for the PEC and plan to schedule this meeting at the end of August. This will allow the committee to review a full year of activity. Dr. Levin advised since the program has less than 4 residents the Preventive Medicine Program will not be receiving feedback on the survey from ACGME to protect the confidentiality of the resident.

Dr. Pendergrass advised there was a lot of discussion on the Preventive Medicine list serve regarding the resident survey and how it does not apply to Preventive Medicine Program. Dr. Johnson advised that a lot of the questions on the standard resident survey talked about the problems, concerns or issues that are raised in that clinical area. So the survey does not align completely with activities of a Preventive Medicine Program. As a specialty group we do have the opportunity to add questions to the resident survey. Most Residency Directors do not take this direction. Guidance that has been given out is not to coach the residents but interpret some of the questions in the appropriate way for their learning environment.

Dr. Johnson advised the program does need to be formalized but it also has to be flexible based upon the resident's evaluation and what the needs are of the program.

Faculty and resident evaluation of program

Dr. Pendergrass shared we will be having two residents start on July 1, 2015. Dr. Emilie Prot is from Houston has undergraduate degree from Notre Dame. She went to Ohio University HCOM. She is completing an internal medicine preliminary year at St. Vincent Charity Medical Center in Cleveland, Ohio. She currently serves on the American Medical Association Public Health Committee as a resident in fellow section. Emilie is interested in global health.

Raafia Muhammad is from California, and went to Saint James School of Medicine. She is completing her surgical preliminary year at Brookdale University Hospital and Medical Center. She was living in New Orleans during the time of the hurricane and this peaked her interest in preparedness activities.

We will start reviewing applications on September 15th when ERAS opens up. We will have two positions to fill for 2016. The program had been talking with Dr. Lakey about expanding the positions to 3 per year. We did have a 3rd resident starting in July 2015 but due to the death of her father, she was unable to complete her

preliminary year on time and we had to rescind her offer. This will allow us to have 2 residents per year if we are unable to expand. At the last GMEC meeting, Kirk Cole the acting Commissioner of the Health Department asked us to put together a budget and proposal for expansion of the residency program. Dr. Pendergrass shared he is hoping to expand the residency position to 3 per year and then eventually to ACGME max to 4 per year.

PEC Report

Annette shared Srivani has earned all A's in the classes she has completed towards her MPH. She is currently busy finishing up her MPH while completing rotations. Srivani said the 1st year of the residency you are taking many courses for your MPH and there is little time to focus on other projects. Dr. Pendergrass advised Srivani will be taking 9 hours this summer and 6 hours in the fall. The practicum and capstone will be taking in spring 2016.

Srivani shared that she is working on her QI project with Dr. Gorchs at the VA Hospital in Austin and working on Community Assessment project with a staff member in Lubbock.

Program Updates

Dr. Pendergrass shared that he has found it difficult to have regular interactions with the residents since he is in Lubbock and the residents are in Austin. Dr. Pendergrass is trying to formalize the interaction with the residents. Dr. Pendergrass is meeting once a month with Srivani and she has monthly mentor meeting with Dr. McGaha. Dr. Pendergrass is planning on visiting Austin every other month to set up time to visit with each resident. The residency program has purchased a video conferencing unit as well which can be utilized by the resident to schedule video conference with Dr. Pendergrass. Dr. McGaha shared he has enjoyed his monthly conference calls with Srivani but agrees formalizing the interactions will enhance the

Dr. Levin asked if the School of Public Health has an assigned advisor who works with them throughout the program and has a good understanding about the relationship between the residency and the MPH program and how to work together to better advise the residents. Courtney advised they are assigned a faculty advisor. All advisors are required to meet with their students once at the end of the fall and once at the end of the spring semesters. This meeting is to ensure the student is on track or if they have any questions or concerns. The students can meet with their advisor as often as they like.

Comments

Dr. Jeff Levin

Dr. Levin shared he is looking forward to having Srivani attend the Occupational Medicine rotation in UT, Tyler. Dr. Levin advised hearing some of the items today in the meeting suggest there is significant progress being made in the mechanics of the program.

Dr. Johnson shared the program has shown progress in the structure and content.

Motion to adjourn was made at 11:00 a.m. and was passed unanimously.

Minutes not found in electronic files.

Residency Advisory Committee

Meeting Agenda

Date | *time* 6/1/2015 9:00 AM | *Location* T-609

Co-Chairs Bob Johnson, MD

Jeffrey Levin, MD

Items

- ☐ Call to order
- ☐ Approval of minutes from last meeting
- ☐ Welcome new committee member Courtney Dezendorf advisor at UT School of Public Health- *Annette Lara*
- ☐ Program Updates - *Peter Pendergrass*
- ☐ Resident recruitment and selection- *Peter Pendergrass*
- ☐ Updates on current residents- *Annette Lara & Peter Pendergrass*
- ☐ Mentor and program Interactions with residents-*Peter Pendergrass*
- ☐ Co-Chair comments

Other Information

Special notes:

MINUTES

Residency Advisory Committee Meeting

Date | time 12/9/2014 10:00 AM | *Meeting called to order by* Bob Johnson

In Attendance

Bob Johnson, MD, MPH, MBA	(external)	Humana
Linda Gaul, PhD	(internal)	State Epidemiologist
Chanteau Ayers, JD	(ex-officio)	DSHS Office of Academic Linkages
Lewis Foxhall, MD	(external)	MD Anderson Cancer Center
Linda Gaul, PhD	(internal)	DSHS State Epidemiologist
Andrew Gorchs, MD	(external)	Central Texas VA Hospitals
Kimberly Leighton, MD	(external)	Covenant Health Partners
Jeff Levin, MD, MSPH	(external)	UT Tyler Occupational Medicine Residency
Paul McGaha, MD, MPH	(internal)	DSHS Region 4/5
Peter Pendergrass, MD, MPH	(ex-officio)	DSHS Region 1
Leonel Vela, MD, MPH	(external)	UT Health Science Center
Lillian Ringsdorf, MD	(internal)	DSHS Region 8
Phillip Huang, MD	(external)	Austin-Travis County Health and Human Services
Bruce Clements	(internal)	Community Preparedness Director
Srivani Kanumuri, MD	(internal)	Resident
Annette Lara	(minutes taker)	DSHS Office of Academic Linkages

Call to Order

Dr. Bob Johnson called the meeting to order at 10:05 a.m. Dr. Johnson asked for a motion to approve the minutes from the previous meeting. Motion made by Dr. Johnson, seconded by Dr. Pendergrass and passed unanimously.

Program Updates

Introducing new resident member Srivani Kanumuri

Annette Lara introduced Srivani Kanumuri as one of the new residents that started on July 1, 2014. Srivani attended medical school at S.V. Medical College in Tirupati, India. She completed her Transitional Residency Program at St. Mary Mercy Hospital in Livonia, MI. During her transitional year, she treated patients of different backgrounds suffering from a variety of issues including chronic diseases and substance abuse/mental problems. Srivani has attended the fall session at UT School of Public Health, currently

participating in rounds at the VA Clinic, and Travis County. She just finished attending our Preventive Medicine Lecture Series.

Srivani shared she is honored to be chosen for a positon in the residency program at DSHS. In the past 6 months she has been exposed to several programs throughout DSHS and also worked at the Austin Refugee Clinic. Dr. Pendergrass advised that Srivani received an A in her biostatistics class for the fall.

Clinical Preventive Medicine Lecture Series

Dr. Pendergrass shared we are in the process of completing our first semester of block lectures which included: Tuberculosis; Food Borne Illness; STD's; Parasitic, Mycoses and Emergent Infection; Immunization and Zoonosis. Faculty who had expertise in these areas gave the lectures once a week for the residents. Srivani shared they were very helpful. Dr. Pendergrass advised that after each block an exam was given to the residents. The spring lecture series will be on US Preventive Services Task Force Recommendations along with Primary and Secondary Prevention activities. We will be focusing on the leading cause of death and looking at the sciences coming out of Lifestyle Medicine that indicate you can prevent and in some cases reverse disease. Dr. Gorchs who works at the VA Clinic will continue to work with the residents with the acute and chronic care of these diseases.

Since the residents are only using UT School of Public Health it was recommended that the advisor become a member of the RAC.

Miller's Pyramid

Dr. Johnson presented a PowerPoint on the Miller's Pyramid. Miller's pyramid provides a framework for clinical competence in medical education and can assist teachers in matching learning outcomes with expectations of what the resident should be able to do at each stage. The Dreyfus module was the foundation for the milestones. The milestones are competency-based developmental outcome expectations that can be demonstrated progressively by residents and fellows from the beginning of their education through graduation to the unsupervised practice of their specialty. Resident's performance on milestones will become a source of data for the CCC to use in assessing the quality of residency program and facilitating improvements to program curriculum and residents performance if and when needed.

Preparedness Project

Bruce Clements advised the residents will be doing some Emergency Management Courses by FEMA online. The first course will be the Emergency Manager Orientation Course which is the basic overview of the Emergency Management process. This will be followed up with the IS100 course (Introduction to Incident Command Systems). The remaining courses will be IS200 (ICS for Single Resources and Initial Action Incidents), IS800 (National Response Framework, An Introduction) and, IS700 (A National Incident Management Systems (NIMS) an Introduction). The following lectures will also be given to residents: 1) Public Health Preparedness and Response Overview 2) Case study on the West Fertilizer Explosion 3) Epi Study of the West Fertilizer Explosion. Bruce extended an invitation for the residents to attend 1) Hospital Preparedness Stakeholder meeting 2) Public Health Preparedness quarterly meetings 3) Texas Disaster Medical System meeting 4) Preparedness Council Coordinating meeting. January 7, 2015 there will be a discussion on the State response to Ebola in the Lab. January 15th there will be a Regional Ebola after Action Conference in Arlington. Since the MPH courses will start on January 12th so Dr. Pendergrass suggested the residents talk with their professors about missing class to attend this meeting.

Epidemiology Project

Dr. Linda Gaul shared the activities the residents will be involved in will be surveillance, investigation, control, and education of the public and/or providers. During the winter and spring residents will be involved in any outbreaks that may occur. Dr. Gaul will coordinate with the residents to participate in the listeriosis outbreak that is currently happening in Texas. The second year the residents will be involved with evaluating a surveillance system and designing a new surveillance system.

Austin Travis County Clinic

Dr. Philip Huang shared the residents participated in the Refugee and TB clinic. The Residents shadowed Dr. Ming Ting and his nurses at the Refugee Clinic which included the mental health screening labs, immunizations, case management, and routine exams. The residents learned how to communicate with patients through the AT&T language lines. The residents had the opportunity to experience how to communicate with patients with diverse backgrounds.

Veterans Continuity Clinic

Dr. Andrew Gorchs recommended not extending the MPH courses over 2 years because the residents will have more opportunities the 2nd year to get more involved without worrying about projects due at school.

The residents work 2 days a week at the VA clinic. On Friday both residents worked at the VA which gave them an opportunity to discuss literature on certain topics.

Faculty Development Opportunities

Chanteau advised that we are currently working on faculty development opportunities. Early next year we will start a faculty development email series that will educate on various topics related to faculty in teaching. We will schedule meetings to discuss the topics in more depth. We are currently working with the Continuing Education Services to get continuing medical education credits for faculty that provide lectures in Clinical Preventive Lecture series.

New Residents for July 2015

Annette shared there will be two new residents starting on July 1, 2015. Emilie Prot who graduated from Ohio University Heritage College of Osteopathic Medicine, and is currently finishing her preliminary residency program with St. Vincent Charity/Case Western. The second resident is Raafia Muhammead who graduated from Saint James School of Medicine Boaire, and is currently finishing her preliminary surgery at Brooklyn Hospital Center.

Comments

Clinical Competency Committee

Dr. Pendergrass shared the first CCC meeting will be held today.

Dr. Bob Johnson

Dr. Bob Johnson closed with thanking the DSHS Residency Program on the continuous progress of the program and also thanked the members for their time supporting the committee.

Motion to adjourn was made at 11:40 a.m. and was passed unanimously.

MINUTES

Residency Advisory Committee Meeting

Date | *time* 6/1/2015 9:00 AM | *Meeting called to order by* Jeff Levin

In Attendance

Bob Johnson, MD, MPH, MBA	(external)	Humana
Lewis Foxhall, MD	(external)	MD Anderson Cancer Center
Linda Gaul, PhD	(internal)	DSHS State Epidemiologist
Jeff Levin, MD, MSPH	(external)	UT Tyler Occupational Medicine Residency
Paul McGaha, MD, MPH	(external)	UT Tyler
Peter Pendergrass, MD, MPH	(ex-officio)	DSHS Region 1
Beatriz Tapia, MD, MPH	(external)	UT Health Science Center
Lillian Ringsdorf, MD	(internal)	DSHS Region 8
Bruce Clements	(internal)	Community Preparedness Director
Srivani Kanumuri, MD	(internal)	Resident
Annette Lara	(minutes taker)	DSHS Office of Academic Linkages

Call to Order

Dr. Jeff Levin called the meeting to order at 9:05 a.m. Dr. Levin asked for a motion to approve the minutes from the previous meeting. Motion made by Dr. McGaha, seconded by Dr. Pendergrass and passed with the exemption of Dr. Levin was not in attendance of the December 9th meeting.

Program Updates

New committee member Courtney Dezendorf

Annette Lara introduced Courtney Dezendorf, advisor at UT School of Public Health. Courtney works as an academic advisor and in recruiting at the UT School of Public Health. She currently works with our Preventive Medicine Residents and incoming residents to ensure the classes for the MPH meet the ACGME requirements.

Program Updates

Dr. Pendergrass advised that we are working with Courtney at the UT School of Public Health in developing a customize MPH. Also, the Residency Program has also been working with excutives to pay for the resident's tuition up front to alleviate any financial burden this may have on them. The resident's tuition will be made directly to UT School of Public Health. The residents are required to complete all course work with a grade of a B or higher.

Dr. Pendergrass advised that we will be implementing a weekly board review. This residents will be required to present and discuss topics throughout the Jekels book. The residents will also be working in the US Preventive Task Force recommendations and requirements.

Dr. Pendergrass shared QI projects will be started once the residents are on boarded. The first month the residents will spend a week in Lubbock and at this time Dr. Pendergrass will work with them on formulate their project and set up the teams that will be working with them.

Dr. Pendergrass shared our first set of 360 evaluations will be included in our milestones at the CCC meeting today.

Dr. Pendergrass advised we are looking to expand our elective opportunities. The program has spoken with John Villanacci to develop an environmental option within the health department. We are currently looking for some clinical opportunities to focus on STD and Immunizations.

Dr. Levin asked if Dr. Pendergrass could give an update on the accreditation system (faculty surveys, resident's survey, and core faculty scholarly work) and the programs interaction with the GMEC. Dr. Pendergrass advised we had our first milestone report last December 2014. 75% of the core faculty completed the survey and 100% of the resident survey was completed. Dr. Pendergrass and Annette are currently working on developing the methodology for the PEC and plan to schedule this meeting at the end of August. This will allow the committee to review a full year of activity. Dr. Levin advised since the program has less than 4 residents the Preventive Medicine Program will not be receiving feedback on the survey from ACGME to protect the confidentiality of the resident.

Dr. Pendergrass advised there was a lot of discussion on the Preventive Medicine list serve regarding the resident survey and how it does not apply to Preventive Medicine Program. Dr. Johnson advised that a lot of the questions on the standard resident survey talked about the problems, concerns or issues that are raised in that clinical area. So the survey does not align completely with activities of a Preventive Medicine Program. As a specialty group we do have the opportunity to add questions to the resident survey. Most Residency Directors do not take this direction. Guidance that has been given out is not to coach the residents but interpret some of the questions in the appropriate way for their learning environment.

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Resident recruitment and selection

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We will start reviewing applications on September 15th when ERAS opens up. We will have two positions to fill for 2016. The program had been talking with Dr. Lakey about expanding the positions to 3 per year. We did have a 3rd resident starting in July 2015 but due to the death of her father, she was unable to complete her preliminary year on time and we had to rescind her offer. This will allow us to have 2 residents per year if we are unable to expand. At the last GMEC meeting, Kirk Cole the acting Commissioner of the Health

Department asked us to put together a budget and proposal for expansion of the residency program. Dr. Pendergrass shared he is hoping to expand the residency position to 3 per year and then eventually to ACGME max to 4 per year.

Updates on current residents

Annette shared Srivani has earned all A's in the classes she has completed towards her MPH. She is currently busy finishing up her MPH while completing rotations. Srivani said the 1st year of the residency you are taking many courses for your MPH and there is little time to focus on other projects. Dr. Pendergrass advised Srivani will be taking 9 hours this summer and 6 hours in the fall. The practicum and capstone will be taking in spring 2016.

Srivani shared that she is working on her QI project with Dr. Gorchs at the VA Hospital in Austin and working on Community Assessment project with a staff member in Lubbock.

Mentor and program interactions with residents

Dr. Pendergrass shared that he has found it difficult to have regular interactions with the residents since he is in Lubbock and the residents are in Austin. Dr. Pendergrass is trying to formalize the interaction with the residents. Dr. Pendergrass is meeting once a month with Srivani and she has monthly mentor meeting with Dr. McGaha. Dr. Pendergrass is planning on visiting Austin every other month to set up time to visit with each resident. The residency program has purchased a video conferencing unit as well which can be utilized by the resident to schedule video conference with Dr. Pendergrass. Dr. McGaha shared he has enjoyed his monthly conference calls with Srivani but agrees formalizing the interactions will enhance the

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Comments

Dr. Jeff Levin

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Dr. Johnson shared the program has shown progress in the structure and content.

Motion to adjourn was made at 11:00 a.m. and was passed unanimously.

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Sickle Cell Advisory Committee

Number of Members: 7

Committee Status (Ongoing or Inactive): Ongoing

Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 7/1/2016 **Date to Be Abolished:** 9/1/2018

Budget Strategy (Strategies) (e.g. 1-2-4): 2.1.2 **Strategy Title (e.g. Occupational Licensing):** Strategy - Women and Children's Health Services

Budget Strategy (Strategies): 2.1.2.3 **Strategy Title:** Sub-strategy - Population Health

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Senate Bill 200 and Senate Bill 277, 84th Legislature, Regular Session, 2015
State Authority	Admin Code	Proposed rules to be adopted/effective 7/1/2016; 25 TAC Sec. 37.40
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$500	$1,000
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$500	$1,000

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Method of Financing

Method of Finance	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
666 - Appropriated Receipts	$0	$500	$1,000
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year 0 0 0

Committee Description: Purpose and Duties: To raise awareness of sickle cell disease and sickle cell trait in Texas; and 1) the committee reviews and suggests methods for raising public awareness of sickle cell disease and sickle cell trait; 2) recommends two specific strategies to raise public awareness; 3) files annual reports with the Executive Commissioner.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?
Per proposed rules, the committee will meet three times per year, and may do so by teleconference or in-person in Austin, Texas.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

The new committee files an annual report with the Texas HHSC Executive Commissioner.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

N/A

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ? Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees? No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015? 0.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Newly created committee: (1) Meeting Dates: Set and confirm meeting dates with Chairperson; secure meeting room(s);
(2) Agenda: assist Chairperson with soliciting agenda items from committee members; finalize agenda and submit to OGC for submission to TX Register; confirm presenters and time slots;
(3) Meeting Packet: prepare meeting packets and distribute to members prior to meetings;
(4) Meetings: Ensure equipment is available for conference calls and in-person meetings; coordinate with Chairperson; Post-meeting: provide follow-up information and/or action items as necessary; coordinate travel reimbursement, transcribe meeting minutes.

6. Have there been instances where the committee was unable to meet because a quorum was not present? No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes. - The committee has not yet met.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

This committee is subject to Government Code, Chapter 551, Open Meetings, and includes a time slot for Public Comment at the end of each meeting. The details of the meeting (time, location, topics/discussion items) will be included on the agenda which is posted on the Texas Register, the new Sickle Cell Advisory Committee business page, and via gov delivery email. The Minutes will be posted on the new Sickle Cell Advisory Committee business page.

7b. Do members of the public attend at least 50 percent of all committee meetings? Yes

7c. Are there instances where no members of the public attended meetings? No

8. Please list any external stakeholders you recommend we contact regarding this committee.

Individuals with sickle cell disease or sickle cell trait; hematology specialists.

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals? No

9b. Please describe the rationale for this opinion.

N/A, committee has not met at this time.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute? No

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area? No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

The committee is expected to provide valuable stakeholder input regarding how to raise awareness about sickle cell disease and sickle cell trait.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Texas Child Fatality Review Team (SCFRT)

Number of Members: 22

Committee Status (Ongoing or Inactive): Ongoing

Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 6/17/1995 **Date to Be Abolished:** NA

Budget Strategy (Strategies) (e.g. 1-2-4) **Strategy Title (e.g. Occupational Licensing)**

Budget Strategy (Strategies) **Strategy Title**

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Family Code, Sec. 264.501-264.515
State Authority	Admin Code	Rules in development to be adopted by 7/01/2016; 25 TAC 37.410
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year 4 4 4

Committee Description: The State Child Fatality Review Team Committee (SCFRT) works closely with local Child Fatality Review Teams (CFRT) to promote public awareness and action to reduce the number of preventable child deaths.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

As required in proposed rules, the committee meets quarterly, typically in Austin, TX.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

Biennial State Child Fatality Review Team Report, position statements regarding various injury topics

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

Committee supplies recommendations to the legislature, DSHS and DFPS. Recommendations are provided in biennial report.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ?

Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

1391.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

CFRT coordinator organizes and assists in facilitating the quarterly SCFRT meetings. Coordinator works to carry out recommendations of the state team, such as increasing coverage of local child fatality review teams and working to increase and improve injury prevention initiatives with local child fatality review teams.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

Committee meeting is open to the public, meeting agenda is posted on the Secretary of State website, public comment is accepted at all meetings

7b. Do members of the public attend at least 50 percent of all committee meetings?

Yes

7c. Are there instances where no members of the public attended meetings?

No

8. Please list any external stakeholders you recommend we contact regarding this committee.

Jessica Schmidt, Williamson County Justice of the Peace, Precinct 4; Kathryn Sibley, DFPS

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

Yes

9b. Please describe the rationale for this opinion.

Recently, progress has been made to increase coverage of counties with CFRTs and a biennial report was published with trended data and recommendations to the legislature, governor, DSHS and DFPS.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

Yes

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission? Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

The committee provides valuable guidance and recommendations to DFPS and DSHS to reduce the incidence of preventable child injuries and deaths.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

Texas State Child Fatality Review Team Committee Meeting Minutes

August 7th, 2015
1100 W. 49th, Austin, TX 78756, Moreton Rm 653

Attendee	Organization/Agency
Amy Bailey**	Department of State Health Services
Ada Booth, MD*	Driscoll Children's Hospital
Kim Cheung, MD, PhD*	UT Health Science Center-Houston/Harris County CFRT
Susan Etheridge*	CASA of Collin County
Sgt. Sarah Fields*	Panola County Sheriff's Department/Tri-County CFRT
Raquel Flores**	Department of State Health Services
Angela Goodwin*	Child Protective Services
Joe Granberry*	Williamson County
Carol Harvey***	Department of State Health Services
Judge Judy Schier Hobbs*	Pct. 4 Williamson County
Sheriff Chris Kirk*	Brazos County Sheriff's Office
Ramah Leith**	Department of State Health Services
Tracie Mendez	TXDOT
Denise Oncken, JD*	Harris County District Attorney's Office
Reade Quinton, MD*	Office of the Dallas County Medical Examiner/Dallas County CFRT
Katherine Ratcliff*	Any Baby Can-San Antonio
Kathryn Goering Reid*	Family Abuse Center
Tammy Sajak*	Department of State Health Services
Kathryn Sibley***	Department of Family and Protective Services
Anna Teran*	Dallas Independent School District
Jeannie Von Stultz, PhD*	Bexar County Juvenile Probation/Bexar County CFRT
Fredlyn Wideman*	Department of State Health Services

* Denotes State Child Fatality Review Team Committee member or representative
** Denotes Child Fatality Review staff and other DSHS staff
*** Guest attendee

Introductions

Chair Dr. Reade Quinton called the meeting to order. All State Child Fatality Review Team members and meeting attendees introduced themselves. A quorum was established. .

Review & Approval of Meeting Minutes, May 15th, 2015 meeting

Members were given time to review the minutes from the May 15th, 2015 meeting. Dr. Kim Cheung requested her name be added to the committee list on page 2. Team requested that committee lists include first and last name. Motion was made by Dr. Emilie Becker and seconded by Chief Gary Cox to approve the meeting minutes. Meeting minutes were approved with revisions.

Selection of new SCFRT member - Emergency Medical Services (EMS)

Denise Oncken, chair of the Nominating Committee, discussed the process that occurred to determine which candidates would be brought before the team. There were three applications for EMS position. The Nominating Committee decided to bring two candidates for review to the full meeting. Steven Tellez reviewed Patrick Murphy. Denise Oncken reviewed Steven Clinkscales. The Nominating Committee tallied the ballots. Sarah Fields announced the new member, Steven Clinkscales. Dr. Reade Quinton stated that we need approval from the three permanent SCFRT members. Dr. Reade Quinton stated that he will contact the new member and the other applicants. The team discussed the strength of the applicants and the response to the request for nominees.

Legislative update from Clayton Travis, Texas Pediatric Society

Dr. Don McCurnin introduced Clayton Travis. He stated that he saw Clayton present at grand rounds and gave an explanation of the Texas Pediatric Society and the American Pediatric Society. Please see attached presentation for more information. Clayton discussed with the team that TPS is currently identifying priorities for next session. Many of the SCFRT legislative priorities align with TPS priorities. The bill to ban texting and driving was brought up by Denise Oncken. It was discussed by Clayton Travis and the team that local municipalities are trying to pass the ban on texting and driving. One issue with this is that drivers do not know when they are in a jurisdiction that has

banned texting and driving. Multiple coalitions are working on this issue and TXDOT has their Don't Text and Drive campaign. Chris Kirk stated that one problem that hinders the legislation is enforcement.

Children's Justice Act

Tammy Sajak stated that the Protect Our Kids Commission is focusing on data. The grant from the Children's Justice Act will measure impact on having a coordinator. Dr. Kim Cheung asked how the counties will be chosen. Tammy Sajak mentioned that the coordinators will handle the data entry, communication and meeting organization. She also mentioned that DSHS will contract with a data entry person. This person will handle technical assistance and data entry for the teams, and will travel for technical assistance. Denise Oncken mentioned that this will increase data reporting. Raquel Flores stated that it might be beneficial to build a toolkit for teams.

The CFRT stand-alone conference was discussed. Amy Bailey explained that DSHS is working to put on the stand-alone conference and it working with Kathryn Sibley. Save the dates will go out once more details are known.

Tammy Sajak mentioned the Infant Mortality CoIIN. CFRTs may be asked to be a part of the PDSA cycles.

Position statements

Amy discussed that we would like to review position statements and update the ones that are out of date. The drowning position statement was discussed. Denise Oncken discussed that there was a recent study on the number of drowning corresponding to the heat index in the summer months. Kathryn Sibley mentioned that there was a recent DFPS email blast with prevention campaign information. Fifteen hundred emails were sent out to camps, pool companies, etc. Tammy mentioned that DSHS is working with various partners such as Texas Parks and Wildlife, on linking drowning and near drownings.

The motor vehicle safety workgroup was discussed. Distracted driving, speeding and arresting jaywalkers was discussed by Captain Tellez. The group working on the motor vehicle position statement will be working on updates. Training for car seat techs was discussed by Tammy Sajak and Tracie Mendez.

Amy Bailey stated that the data entry for 2013 data was due from local teams by November 1st.

Next SCFRT Meeting: Friday November 6th, 2015
10:00 a.m. – 2:00 p.m.
1100 W. 49th St, Austin, TX 78756, Moreton Building, Room 653

Minutes prepared by Amy Bailey, October 28th, 2015

Texas State Child Fatality Review Team Committee Meeting Minutes

November 6th, 2015
1100 W. 49th, Austin, TX 78756, Moreton Rm 653

Attendee	Organization/Agency
Amy Bailey**	Department of State Health Services
Ada Booth, MD*	Driscoll Children's Hospital
Kim Cheung, MD, PhD*	UT Health Science Center-Houston/Harris County CFRT
Steven Clinkscales*	Air Evac Lifeteam - Central Texas
Gary Cox*	Cibolo Police Department
Sgt. Sarah Fields*	Panola County Sheriff's Department/Tri-County CFRT
Angela Goodwin*	Child Protective Services
Carol Harvey***	Department of State Health Services
Geraldine Harris*	Department of State Health Services
Judge Judy Schier Hobbs*	Pct. 4 Williamson County
Sheriff Chris Kirk*	Brazos County Sheriff's Office
Ramah Leith**	Department of State Health Services
Toni Nall***	Bikers Against Child Abuse
Sarah Northup***	UT Health Science Center at San Antonio
Denise Oncken, JD*	Harris County District Attorney's Office
Terry Pence	TXDOT
Reade Quinton, MD*	Office of the Dallas County Medical Examiner/Dallas County CFRT
Katherine Ratcliff*	Any Baby Can-San Antonio
Kathryn Goering Reid*	Family Abuse Center
Tammy Sajak*	Department of State Health Services
Jessica Schmidt***	Pct. 4 Williamson County
Kathryn Sibley***	Department of Family and Protective Services
Anna Teran*	Dallas Independent School District
Jeannie Von Stultz, PhD*	Bexar County Juvenile Probation/Bexar County CFRT
Fredlyn Wideman*	Department of State Health Services

* Denotes State Child Fatality Review Team Committee member or representative
** Denotes Child Fatality Review staff and other DSHS staff
*** Guest attendee

Introductions

Chair Dr. Reade Quinton called the meeting to order. All State Child Fatality Review Team members and meeting attendees introduced themselves. A quorum was established. .

Review & Approval of Meeting Minutes, August 7th, 2015 meeting

Members were given time to review the minutes from the August 7th, 2015 meeting. Gary Cox requested his name be added to the attendee list. Motion was made by Sheriff Chris Kirk and seconded by Chief Gary Cox to approve the meeting minutes. Meeting minutes were approved with revisions.

Presentation by Toni Nall "Phoenix", Bikers Against Child Abuse

Phoenix discussed that BACA is a unique organization that works with kids. There are 28 BACA chapters across Texas. BACA only accepts verifiable cases from children's advocacy centers, state and local officials, law enforcement and child protective services to give a few examples. BACA works to empower the child and does not discuss the details of the case. New members of BACA must go through background checks and ride with an existing member for one year to be eligible for a back patch. Many organizations, including members of the SCFRT, work with BACA and make referrals to BACA. For more information, see BACA website http://texas.bacaworld.org/.

Presentation by Dr. Sarah Northup, UT Health Science Center at San Antonio

Dr. Sarah Northup presented about the data project that UT Health Science Center at San Antonio is doing with DSHS. The survey was developed to determine if there is variability in the way the local CFRT coordinators complete the omission/commission questions regarding abuse and neglect from the national database. Dr. Northup has developed the survey on survey monkey for local child fatality review team coordinators to complete.

This survey has 10 mock cases followed by omission/commission child abuse and neglect questions. It is hypothesized that there will be a higher degree of agreeability with urban areas. The survey is currently going through IRB. Team coordinators will receive a $50 amazon gift card for the completion of the survey.

Review of local CFRT recommendations for biennial report

The SCFRT reviewed the attached excel spreadsheet of recommendations from local CFRTs and discussed possible inclusion in to final report.

Next SCFRT Meeting: Friday January 22nd, 2016
10:00 a.m. – 2:00 p.m.
1100 W. 49th St, Austin, TX 78756, Moreton Building, Room 653

Minutes prepared by Amy Bailey, January 18th, 2016

Texas State Child Fatality Review Team Committee Meeting Minutes

January 22nd, 2016
1100 W. 49th, Austin, TX 78756, Moreton Rm 653

Attendee	Organization/Agency
Amy Bailey**	Department of State Health Services
Emilie Becker, M.D	Health and Human Services Commission
Ada Booth, MD*	Driscoll Children's Hospital
Kim Cheung, MD, PhD*	UT Health Science Center-Houston/Harris County CFRT
Steven Clinkscales*	Air Evac Lifeteam - Central Texas
Gary Cox*	Cibolo Police Department
Evelyn Delgado	Department of State Health Services
Sgt. Sarah Fields*	Panola County Sheriff's Department/Tri-County CFRT
Raquel Flores	Department of State Health Services
Angela Goodwin*	Child Protective Services
Carol Harvey***	Department of State Health Services
Judge Judy Schier Hobbs*	Pct. 4 Williamson County
Ramah Leith**	Department of State Health Services
Terry Pence	TXDOT
Reade Quinton, MD*	Office of the Dallas County Medical Examiner/Dallas County CFRT
Karen Ruggerio	Department of State Health Services
Jessica Schmidt***	Pct. 4 Williamson County
Patricia Schnitzer	National Center for Fatality Review and Prevention
Kathryn Sibley***	Department of Family and Protective Services

* Denotes State Child Fatality Review Team Committee member or representative
** Denotes Child Fatality Review staff and other DSHS staff
*** Guest attendee

Introductions

Chair Dr. Reade Quinton called the meeting to order. All State Child Fatality Review Team members and meeting attendees introduced themselves. Amy Bailey introduced Patty Schnitzer from the National Center for Fatality Review and Prevention and explained that Texas will receive technical assistance for data quality. A quorum was established. .

Review & Approval of Meeting Minutes, November 22nd, 2015 meeting

Members were given time to review the minutes from the November 22nd, 2015 meeting. Motion was made by Dr. Emilie Becker and seconded by Chief Gary Cox to approve the meeting minutes. Meeting minutes were approved.

Presentation by Raquel Flores, 2012 and 2013 Child Fatality Review Team data

Raquel Flores with OPDS at DSHS did a power point presentation of local child fatality review team data from 2012 and 2013. Raquel discussed data trends. The rate for all child deaths was at an all-time low in 2011 and back to previous trend rates in 2012 and 2013. The rates of natural deaths and infant mortality dipped in 2011. Rate of accidental child deaths was at an all-time low in 2013. Regarding motor vehicle deaths, Dr. Emilie Becker asked if services like Uber and Lyft affect the numbers in those regions/areas that have Uber (or another quick ride service). Raquel Flores explained that current data collection doesn't have this information but this is something to consider as data collection is fine-tuned. Dr. Reade Quinton asked if the unknown line should be taken from the graph. [After further consultation, Raquel and OPDS left the unknown line in the graph to keep it consistent with other graphs and previous years. This issue will be considered in future graphics.] Kathryn Sibley asked about the definition of preventable death and Amy Bailey replied that she would send the definition to Kathryn. Amy Bailey discussed increasing the number of cases reviewed and data consistency. Raquel Flores discussed giving teams localized data reports and how this will give communities a snapshot of trends and areas for prevention.

Chief Gary Cox asked if bullying was one of the questions asked when investigating a suicide. Amy Bailey responded that it is in the case report form. Raquel pointed out that bullying has not risen as a factor for current data. Group discussed ways to capture the information better and strategies for local CFRTs to delve into the subject in more detail. Another question to the group was determining if school districts know how many bullying instance reports they get within a certain time period. It was also asked if the current system allows for

identification of kids killing kids. Raquel pointed out the current project of DSHS that will look at this aspect of violence. Dr. Kim Cheung asked if gang-related violence was captured in the case report form. Amy Bailey stated that it was asked in the case report form that teams use to collect data. Dr. Reade Quinton suggested that a list of missing data points be created to promote uniform data. Chief Gary Cox wanted to know the number of unknowns that were preventable. Dr. Emilie Becker inquired about the opiate drug overdose numbers. She stated that the number of adult overdose deaths staying steady. Kathryn Sibley asked why the percentage of preventability was less in unintentional deaths.

Chief Gary Cox discussed that one challenge for law enforcement is that they are not provided with the training to report on this level of detail. Many precincts don't consider suicide to be a criminal investigation. Discussion among the group about other risk factors – such as sexual orientation – that contribute to this type of death. Judge Judy Hobbs described a Williamson County case investigation where the police went in to the school to speak to the students regarding the suicide. The right questions were never asked previously. Dr. Emilie Becker talked about the high risk of suicide among gay youth. It was also discussed that social media is used to bully on a large scale. Chief Cox wanted to know how many instances of bully through social media. It is currently unknown. Kathryn Sibley asked how teams capture data on protective measures such as family or peer relationships. Amy Bailey and Raquel Flores discussed the places on the case report form that captured this information.

Regarding homicide, some members asked for clarification of when it would be appropriate to use "other". Members offered examples of this – a child who was beaten, stabbed, and drowned – multiple contributors to the death such as homicidal violence, so the local CFRT might put this under "other". Dr. Kim Cheung suggested that local CFRTs invite juvenile justice representation to their reviews. This might help the teams decide on causality.

At the end of the presentation there were some listed issues that created difficulty in getting good data. Raquel provided the group with some examples that complicated the analysis – for example, there were 10 data points that could not be included because the records didn't match up. DSHS requires that the "n" be at least 15 cases. In some instances, there weren't enough cases to allow DSHS to share the data. When Raquel Flores was asked about intoxicated manslaughter, she shared that this was an example of the "n" being too small – the numbers weren't big enough to be included. Another issue with the data was that there were cases entered into the system in which there was no matching death certificate file. The group discussed some possible reasons for this including a possible glitch in the reporting system – local teams have entered the data only to find out later that it never uploaded. Amy Bailey will look into this.

The group asked that data issues – like the ones presented – be addressed with local CFRTs if possible. Amy Bailey has access to the identified data and will be providing technical assistance to teams at the 8 regional trainings.

Dr. Reade Quinton recommended that information like the issues presented at the end of the slide show be considered as a presentation at the Injury Conference (or during regional trainings) so that local CFRTs understand the need for accurate data input.

The final slide was a map of CFRT coverage in Texas.

Finalize State Child Fatality Review Team annual report recommendations

The team reviewed the recommendations and justifications for the legislative report.

Regarding the Legislative Recommendations to Reduce Preventable Child Death in Texas: After careful deliberation on each recommendation, the team decided to include all 7 recommendations in the report.

When discussing distracted driving, Chief Cox and Terry Pence informed the group that there is a list of cities in Texas that already have some form of distracted driving ordinances. Chief Cox will send the link to Amy Bailey. Dr. Emilie Becker told the group that DSHS also had a Grand Rounds speaker that was familiar with this list. Law enforcement forms have changed and there is new case law to subpoena phone data. San Antonio was one of the first cities with the texting city ordinance. Since inception, there has been over 10,000 violations and over $2 million in revenue. After a brief debate about narrowing the focus, the group decided to keep the recommendation broad.

When discussing the detectable amount of alcohol, Sgt. Tellez recommended that this be a Class C infraction. The SCFRT decided that the recommendation can be for zero tolerance and negotiate to .05 if needed. The group agreed.

When discussing the residential swimming pool fence recommendation, Chief Cox reminded the group that they may have more success if the recommendation included changing the building code as well. It was suggested that language be added that specifies how many times the SCFRT has made this recommendation.

When discussing the safe storage campaign for gun safety, Chief Cox informed the group that there is a NRA campaign in place that offers free gun locks – it is called Eddy the Eagle. He will send Amy the link. Anyone can go on the site and order boxes of locks. The new open carry law was discussed. Dr. Emilie Becker voiced her concerns over guns at state hospitals and local mental health authorities. Chief Gary Cox stated that Texas is the 44th state to allow open carry.

When discussing active shooter training, Chief Cox shared the specific recommendation chapter change: Chapter 37 of the Education code – specifically 37.108 (safe schools). After the meeting, he provided additional information that in 37.1081, it lists the drills necessary for a school to get certified – SCFRT could recommend adding a Live Shooting drill to the list. Emergency preparedness training on school premise was discussed and led to an active shooter recommendation.

Regarding sleep-related deaths, Raquel pointed out that there were some cases included in this data where the child was actually over the age of 1. The group was reminded that SIDS is identified through CFRT review. The crib bumper ban recommendation was discussed. Judge Hobbs talked about commercials advocating for co-sleeping. It was decided to not use this recommendation.

Regarding the Legislative Recommendations to Improve the Effectiveness of the State Child Fatality Review Team Committee and Child Fatality Review Operations: After careful deliberation and discussion on each recommendation, the team decided to include the recommendation to "Amend the current Child Fatality Review statute to allow adjacent counties of any population size to form joint CFRTs" And "Amend the current Child Fatality Review statute to allow local registrars to notify CFRTs of child deaths".

When discussing amending current statute to include a government liaison to the State CFRT roster, the group decided that this would be better as an operational procedure – it would be good to have a designated governmental liaison within the Speaker of the House, Lieutenant Governor, or Governor's office to be able to provide regular information to these Government Heads but the group did not feel this liaison needed to become an official part of the State CFRT process.

When discussing addition of military representation to the State CFRT roster, the group felt there wasn't enough information to make an informed recommendation. Additional factors and details – i.e. does the military have their own child fatality review process; would there need to be a representative from each branch; are there current local CFRTs that include military personnel on their teams – and if so, how does that work – need to be investigated before making this type of recommendation.

Regarding the Recommendation s on Child Protective Services Operations:
After careful deliberation and discussion, the team decided to include the recommendation to "report all children less than six years old who have died non-natural or unexplained causes to DFPS".

When discussing permanent high-level advisory board, the team felt this was already in the process of being developed through the PEI program at DFPS.

Regarding the Recommendations to Texas Department of State Health Services:
After careful deliberation and discussion, the team recommended inclusion of all 3 recommendations into the Legislative Report.

When discussing funding CFRT Coordinators in eleven public health regions, the group amended the recommendations to say in each Health Service Region.

Updates from CFRT coordinator – Amy Bailey

1. Injury Prevention Conference and regional trainings – Amy Bailey shared with the group that the Injury Prevention Conference contract is still not finalized; therefore, it will be difficult to plan and coordinate a conference by May. This conference could potentially take place in the summer but Amy Bailey will keep the group informed of the status. Because of this delay, the May 6th State CFRT meeting will be held in Austin.
2. EMS record availability – Amy Bailey was asked to solicit recommendations from the SCFRT regarding a local CFRT's difficulty in obtaining EMS records. Some suggestions were – add EMS to the local team reviews, ask the prosecutor to help, reach out to the Regional Advisory Council for help (Steve Clinkscales might be able to connect Amy to some of his EMS contacts – Amy will follow up with Steve.)
3. Child Safety CoIIN – Amy shared with the group that the kick-off meeting for this CoIIN was held in December in Boston. The Texas group is considering three potential goals – child passenger safety, suicide prevention, and teen driving safety. Amy will update this group as more information becomes available.
4. Team member lists – Amy asked the group if they felt there would be benefit to setting up a listserv for all local CFRT members. Her understanding from some groups is that information is not always shared – the presiding officer or the coordinator get the information but don't send it out to the local members. One idea was to use GovDelivery as a mechanism to not only reach out to all local members but will also provide data on the number that open the email, follow the links, etc. The group decided that Amy will send a link for local members to sign up for GovDelivery once Amy has set up this process within DSHS.

Next SCFRT Meeting: Friday May 6th, 2016
10:00 a.m. – 2:00 p.m.
1100 W. 49th St, Austin, TX 78756, Moreton Building, Room 653

Minutes prepared by Amy Bailey, April 6th, 2016

Texas Child Fatality Review Team

Biennial Report
2014-2015

TCFRT
Texas Child Fatality Review Team

ACKNOWLEDGEMENTS

The Texas State Child Fatality Review Team (SCFRT) Committee would like to acknowledge the following individuals for their dedicated service to the children of Texas and their contributions to the SCFRT. They are gratefully applauded for their service on the SCFRT and wished the best in future endeavors.

- Juan Parra, M.D., Bexar County pediatrician and founding member of the SCFRT.
- Tammy Sajak, MPH, former Director, Office of Title V and Family Health, Department of State Health Services (DSHS), who served as a permanent member in the role of MCH Director.
- Joe Granbury, Emergency Medical Technician, Williamson County EMS, who served in the role of Emergency Medical Technician.
- Susan Rodriguez, former Child Fatality Review Coordinator, Office of Title V and Family Health, Department of State Health Services (DSHS), who served as the coordinator from 2006 to 2014.

This report is based on the data collected and recommendations made by local Child Fatality Review Teams (local CFRTs), as well as the research, recommendations and advocacy of the SCFRT. This report would not be possible without the dedication and input of the members of the SCFRT (Appendix A) and the local CFRT Coordinators, Presiding Officers and respective team members. The diverse range of professionals who volunteer as members of the local CFRTs give the child fatality review process its multi-disciplinary perspective and add immeasurably to the goal of understanding child death and reducing risk to Texas children.

The report was prepared by DSHS staff in the Division for Family and Community Health Services:

- Amy Bailey, MPH, Texas Child Fatality Review Coordinator, Office of Title V & Family Health; and,
- Raquel Flores, M.A., Researcher, Office of Program Decision Support.

Paula Kirby, Child Fatality Specialist, DSHS Center for Health Statistics, also contributed to the preparation of this report.

Questions about the biennial report should be directed to:
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LETTER FROM THE CHAIR

During my years as a medical examiner for Dallas County, it has been my pleasure to serve on the local Dallas County Child Death Review Team and subsequently on the State Child Fatality Review Team (SCFRT). It is a distinct honor as the current chair of the SCFRT to present the 2015 Texas Child Fatality Review Team Biennial Report. The report outlines the local child fatality review team data and recommendations developed by the SCFRT aimed at reducing preventable child deaths in the state of Texas. This report would not be possible without the work of health care providers, law enforcement officers, social workers, teachers, lawyers and many others who dedicate their lives to the safety and security of one of our most vulnerable populations – our children.

The following points highlight the activities of the SCFRT over the last two years:

Protect Our Kids Commission: During the 83rd Texas Legislative Session, Senate Bill 66 created the Protect Our Kids Commission to study child abuse and neglect fatalities and make recommendations concerning prevention. This commission began its work in 2015 and several members of DSHS and the SCFRT served as subject matter experts for the commission. Recommendations by the commission recognize the value of the SCFRT and the need for more coordinator support.

Position Statements: Position statements on a variety of child safety topics are one way for the SCFRT to communicate best practices in injury and death prevention to a wide audience. These statements are available on the DSHS Child Fatality Review (CFR) website (www.dshs.state.tx.us/mch/Child_Fatality_Review.shtm) and are distributed widely through local teams and other injury prevention partners. SCFRT workgroups revised and updated position statements on child suicide, child maltreatment, and safe sleep in 2015.

State Team Development: Senate Bill 66 added new disciplines to the SCFRT including an emergency services provider, and a provider of services to, or advocate for, victims of family violence. These new members have been valuable additions to the team. The SCFRT and DSHS also received a grant from the Children's Justice Act to hire two local child fatality review team coordinators in one urban and one rural jurisdiction in Texas. These positions will serve as a pilot project to demonstrate the need for a full time CFRT coordinator in each of the public health service regions. The addition of coordinators throughout Texas will serve to increase effectiveness and consistency by providing coordination, training and data entry assistance to local CFRTs and ultimately lead to a better child fatality review process and prevention efforts.

Local Team Development: The SCFRT has continued to work towards the goal of 100 percent coverage in all Texas counties. As of 2015, there are 74 active local CFRTs covering 194 counties in Texas. Approximately 94% of all Texas children reside in counties covered by a Child Death Review Team. The SCFRT continues to push for 100% coverage while providing support to the existing teams. Local teams have been participating in a wide range of prevention-oriented activities cited in detail in this report. These activities include large-scale media campaigns,

community outreach, and social media campaigns focusing on child suicide, bicycle safety, child passenger safety, infant safe sleep, and child maltreatment.

While we can never prevent everything bad from happening to our children, the SCFRT has focused heavily on certain areas that we have identified as preventable dangers. Unsafe sleep environments, unsafe vehicular practices (including distracted driving, driving under the influence of alcohol or drugs, and even how we administer driver's education), drug overdoses, child suicide, child abuse and neglect, and unsafe firearm storage have been a major focus for the team over the last few years. As advocates for Texas children, the SCFRT will continue dedicating its efforts to reduce the number of preventable child deaths through collaboration, outreach, and action.

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Background

Child Fatality Review (CFR) is a public health strategy to understand child deaths through multidisciplinary review at the local level. Data are collected and analyzed to best understand risks to children. The lessons learned from the reviews inform local and statewide prevention activities and reduce preventable child deaths. CFR is practiced in every U.S state and in other countries.

The Texas CFR process was created in 1995 by the Texas Legislature: Texas Family Code, Title 5, Chapter 264, Subchapter F, §264.501-§264.515. CFR consists of two critical components with distinct yet complementary roles: the State Child Fatality Review Team Committee (SCFRT) which is also known as the Texas Child Fatality Review Team (TCFRT) and local Child Fatality Review Teams (local CFRTs). The Department of State Health Services (DSHS) provides CFR support and oversight.

The 22-member SCFRT is a statutorily-defined multidisciplinary group of professional disciplines with unique perspectives on child safety. SCFRT members serve three-year terms and are subject matter experts who represent fields such as from law enforcement, the medical community, child advocacy organizations, the court system, and the behavioral health community. The Department of Family and Protective Services, Department of State Health Services, Department of Public Safety and Department of Transportation are also members of the Committee. For a complete list of SCFRT membership, see Appendix A.

The SCFRT meets quarterly to discuss issues related to child risks and safety, develop strategies to improve child death data collection and analysis, develop position statements specific to child safety issues, and research and develop recommendations that will make Texas safer for children. The SCFRT statutory charges are to:

- Develop an understanding of the causes and incidences of child death in Texas;
- Identify procedures within agencies represented on the SCFRT to reduce the number of preventable child deaths; and,
- Promote public awareness and make recommendations to the governor and legislature for changes in law, policy, and practice to reduce the number of preventable child deaths.

Texas Family Code §264.503(f) requires that not later than April 1 of each even-numbered year, the SCFRT reports to the Governor, Lieutenant Governor, and the Speaker of the House of Representatives the aggregate child fatality data collected by local child fatality review teams and recommendations to prevent child fatalities and injuries. The report is also required to provide recommendations to the Department of Family and Protective Services operations based on input from the child safety review subcommittee.

Local CFRTs are volunteer-based and organized by county or multi-county geographic areas. Local memberships mirror that of the SCFRT. Local CFRTs conduct retrospective reviews of deaths of children 17 years of age or younger in their geographic areas. Team members collect information that corresponds to their disciplines and specific questions in the National Center for Fatality Review and Prevention database. Local CFRTs meet to share what each member knows about the specific child deaths being reviewed and identify risk factors specific to their

communities. All reviews conclude with the question: was this death preventable? Local CFRTs monitor child death trends in the community, share the lessons learned with the SCFRT and stakeholders, and spearhead or participate in local prevention activities. Local CFRTs are responsible for:

- Providing assistance, direction, and coordination in child death investigations;
- Promoting cooperation, communication, and coordination among agencies involved in responding to child fatalities;
- Developing an understanding of the causes and incidence of child death in a designated county or counties where the local CFRT is located; and,
- Advising SCFRT on changes in law, policy, or practice that will assist the local CFRTs and the member agencies represented on the team to best fulfil their duties.

In 2014 and 2015, there were 74 active local CFRTs covering 194 of the 254 counties resulting in 94 percent of Texas children residing in a county where child deaths are reviewed. In 2014 and 2015, local CFRTs reviewed child deaths that occurred in 2012 and 2013. There were 3,741 child deaths in Texas in 2012 and 3,742 child deaths in Texas in 2013. Active local CFRTs reviewed 1503 (40.2 percent deaths) of the total child deaths in 2012 and 1384 (37.0 percent) of the total child deaths in 2013.

Data Trends

The overall child death rate in Texas increased to 54.4 per 100,000 children in 2012 and 54.3 per 100,000 children in 2013 following an all-time low in 2011 (52.7 per 100,000 children). The motor vehicle death rate among children aged 15-17 years increased from 2011 (9.7 per 100,000 children) to 2013 (10.4 per 100,000 children).

The data collected by local CFRTs augment death certificate data and provide rich insight into the causes and circumstances surrounding child fatalities in Texas. The detailed information gathered by local CFRTs provides a better understanding of the scope and nature of child fatalities. This information can then be used to drive the development of quality preventive plans and measures. It is important to understand that local CFRT data are only a sample of all child deaths. Unlike death certificate data that provide exact numbers and rates for fatalities, local CFRT data provide a more general understanding of a smaller number of those deaths.

Analysis of local CFRT data identifies the leading causes of preventable child death. The data illustrate specific conditions and risks that suggest ways to educate the community and to enact statutes that will prevent child deaths.

- **Motor vehicle crash deaths:** Motor vehicle deaths are a leading cause of accidental death for children. Most children were passengers (57.6 percent in 2012 and 54.1 percent in 2013), with the majority sitting in the back seat. Correct seat belt usage among back seat passengers in motor vehicle crash deaths declined from 9.9 percent in 2012 to 4.3 percent in 2013. Contributing factors in all child motor vehicle crash deaths included speed, drugs/alcohol and reckless driving.
- **Drowning deaths:** Pools are the most common site for drowning deaths. Approximately 62 percent of all children who drowned in both years drowned in pools, hot tubs or spas.

Children ages 1-4 years accounted for 68.8 percent of pool, hot tub or spa drowning fatalities. Of those deaths that occurred in a private pool, hot tub or spa, 35 percent of the pools had no barrier to limit access to the pool. Poor or absent supervision was cited as a contributing factor in 44 percent of the deaths of children younger than five years old.

- **Homicides:** Of the child homicides reviewed, local CFRTs determined that 34.9 percent in 2012 and 27.6 percent in 2013 were caused by child abuse or neglect. Child abuse and neglect fatalities primarily involved children under the age of five years. Assault, which does not include child abuse, was the second leading contributing cause to child homicides at 22.9 percent in 2012, and 29.9 percent in 2013. Most homicides involved a weapon (62.7 percent in 2012 and 66.7 percent in 2013).
- **Suicide deaths**: Child suicide rates have remained relatively constant over the past nine years. In 2012, weapon/firearm (45.8 percent) was the most prevalent method by which children less than 18 years old committed suicide, followed by asphyxiation (38.9 percent). In 2013 asphyxiation became the most prevalent method at 43.0 percent followed by weapon/firearms at 36.7 percent.
- **Sleep-related deaths**: Local CFRTs identified 187 sleep-related deaths in 2012 and 153 sleep-related deaths in 2013 to children less than one year of age. Approximately 50 percent of all infant sleep-related deaths occurred while the infant was sleeping on an adult bed. Local CFRTs found that of all infant sleep-related deaths, infants were found primarily on their stomach (41.2 percent in 2012 and 37.3 percent in 2013).

Child Fatality Review Team (CFRT) Data

Data gathered in the Child Fatality Review Team (CFRT) process is an important task of CFRTs. The detailed information gathered by local CFRTs enhances and supports death certificate data, and provides a better understanding of the scope and nature of child fatalities. This information is used to drive the development of quality preventive plans and measures.

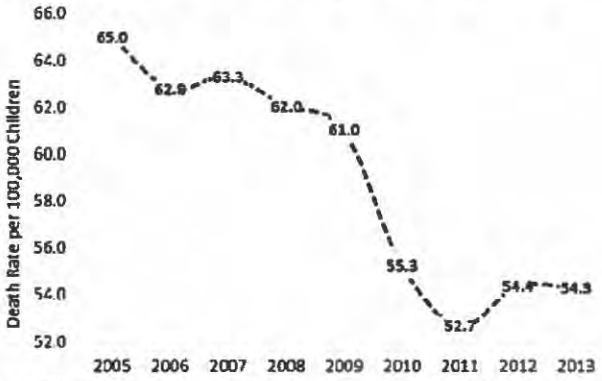
The data presented in this report is a combination of state-level trends from death certificate data, and the more detailed sample data collected by the CFRTs during the review process. The data included in this report are child deaths that occurred in Texas, regardless of the child's residence. Deaths are reviewed based on where they occurred because the prevention efforts developed by the CFRTs are designed to impact a local problem; for example, changing the line of sight at dangerous intersections.

It is important to understand that CFRT data is only a sample of child deaths. Unlike death certificate data that provides exact numbers and rates for fatalities, CFRT data provides a more thorough understanding of a smaller number of those deaths. Therefore, throughout this data section, percentages for CFRT data will be reported instead of exact numbers. The unknown categories throughout this report include missing data, where missing indicates data quality efforts are still needed, a skip due to a lack of information, or an actual unknown.

Overview of Child Deaths in Texas

Overall, there was an increase in the number of child deaths in Texas, from 3,625 in 2011 to 3,741 in 2012 and 3,742 in 2013. The Texas child death rate increased to 54.4 per 100,000 children in 2012 and 54.3 per 100,000 children in 2013. This increase followed an all-time low Texas child death rate of 52.7 per 100,000 children in 2011 (Figure 1). Child deaths include child natural deaths and non-natural deaths.

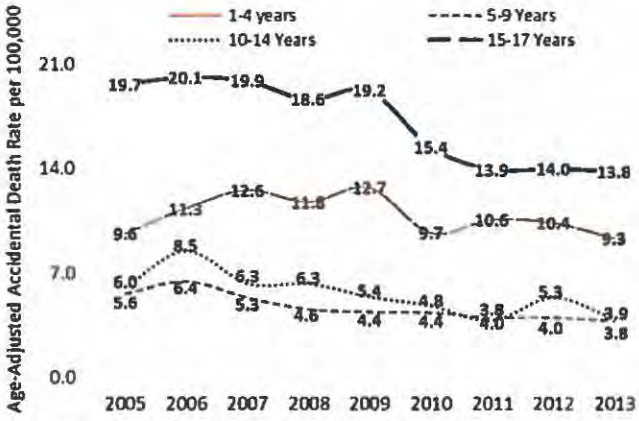
Figure 1. Texas Child Death Rate – All Deaths



Source: Office of the State Demographer, Texas State Data Center, Texas Population Projections
Center for Health Statistics, DSHS Death Data Files 2005-2013
Prepared by: Office of Program Decision Support 12/14/15

The child death rate for natural deaths decreased from 2007 to 2011 (Figure 2), but steadily increased from 2011 (36.1 per 100,000 children) to 2013 (38.6 per 100,000 children). Approximately 75 percent of all natural deaths occur in children younger than one year of age. An increase in natural child deaths can also be explained by the infant mortality rate, which increased from 2011 (5.7 per 1,000 live births) to 2013 (6.0 per 1,000 live births)[1].

Figure 2. Trend in Natural Child Death Rate



Source: Office of the State Demographer, Texas State Data Center, Texas Population Projections
Center for Health Statistics, DSHS Death Data Files 2005-2013
Prepared by: Office of Program Decision Support 12/14/15

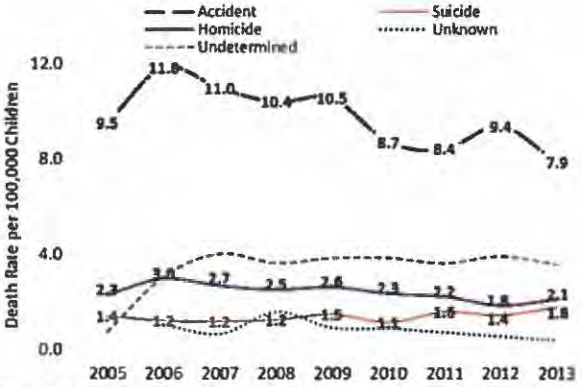
For more information on infant mortality, refer to the latest Healthy Texas Babies Data Book at: https://www.dshs.state.tx.us/healthytexasbabies/data.aspx

Non-natural deaths primarily consist of accidents, homicides, and suicides. Non-natural deaths also include unknown and undetermined manners of death, but there is too little information available to include details in this report. The non-natural child death rate is considerably lower than the natural child death rate.

[1]Mandell, D.J., & Kormondy, M. 2015 Healthy Texas Babies Data Book. Austin, TX: Division for Family and Community Health Services, Texas DSHS, 2015.

While suicides and homicides may be sensationalized by media, accidents are where preventative efforts can make the greatest impact in decreasing actual deaths and the death rate. The accidental child death rate increased from 2011 (8.4 per 100,000 children) to 2012 (9.4 per 100,000 children), but decreased again in 2013 (7.9 per 100,000 children), the lowest rate in nine years (Figure 3).

Figure 3. Trend in Non-Natural Child Death Rate



Source: Office of the State Demographer, Texas State Data Center, Texas Population Projections
Center for Health Statistics, DSHS Death Data Files 2005-2013
Prepared by: Office of Program Decision Support 12/14/15

Figure 4. Trends in Accidental Child Death Rates

Source: Office of the State Demographer, Texas State Data Center, Texas Population Projections
Center for Health Statistics, DSHS Death Data Files 2005-2013
Prepared by: Office of Program Decision Support 12/14/15

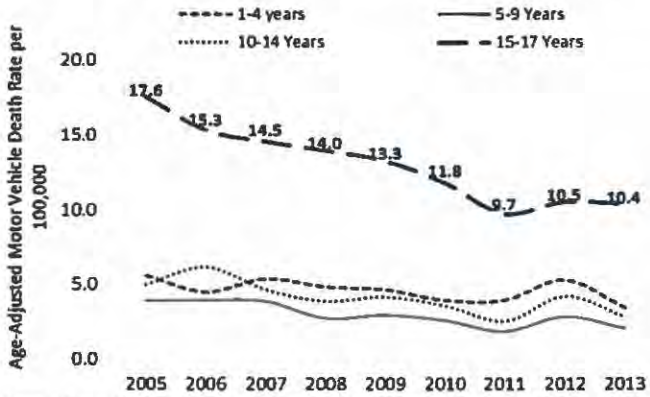
Accidental death rate age-group trends remained consistent among youth aged 15-17 years from 2011 to 2013 (Figure 4). However, there was a spike in the accidental child death rate among children aged 10-14 years from 2011 (3.8 per 100,000 children) to 2012 (5.3 per 100,000 children), which subsided in 2013 (3.9 per 100,000 children). For all age groups, 2013 saw the lowest accidental child death rates in years.

Accidental deaths primarily consist of motor vehicle fatalities followed by drowning deaths.

Motor Vehicle Deaths

Motor vehicle crashes are the leading cause of accidental deaths for children.[2] Motor vehicle child death rates increased among all age groups from 2011 to 2012, but decreased from 2012 to 2013 (Figure 5). Teens are more likely than all other children to die in motor vehicle accidents. The motor vehicle death rate among children aged 15-17 years increased from 2011 (9.7 per 100,000 children) to 2013 (10.4 per 100,000). This increase followed a seven-year decline from 2005 to 2011, when the age-adjusted motor vehicle death rate for this age group was at its lowest.

Figure 5. Age-Adjusted Motor Vehicle Child Death Rates



Source: Office of the State Demographer, Texas State Data Center, Texas Population Projections
Center for Health Statistics, DSHS Death Data Files 2005-2013
Prepared by: Office of Program Decision Support 12/14/15

[2] Motor vehicle deaths are defined by ICD10 codes between V01 through V99.

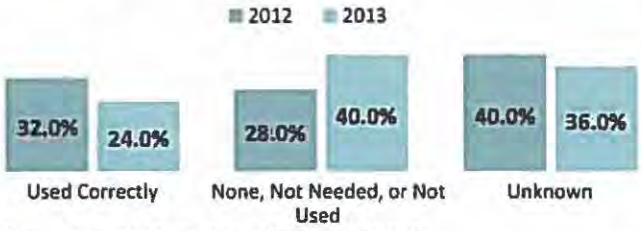
Figure 6 shows that in 2012 there were 343 child motor vehicle deaths (63.3 percent reviewed by CFRTs) and 275 in 2013 (65.8 percent reviewed by CRFTs). CFRTs estimated that about 85 percent of the motor vehicle child fatalities reviewed for 2012 and 2013 could have been prevented. The CFRTs identified the need for improvement in prevention efforts, and Texas law changed in May 2014, requiring all vehicle occupants to wear a seat belt, regardless of front or back seat — hopefully, reducing future motor vehicle death rates.

Figure 6. Motor Vehicle Child Deaths by Position

Source: Center for Health Statistics, DSHS, Death Data Files 2012-2013;
Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

CFRTs identified that most (57.6 percent in 2012 and 54.1 percent in 2013) children who died from motor vehicle crashes were passengers, while 11.5 percent in 2012 and 13.8 percent in 2013 were drivers. Among drivers, most were between the ages of 15 to 17 years (88 percent in 2012 and 96 percent in 2013). The majority of passengers who died were sitting in the back seat of the vehicle. The seat belt usage and passenger position in the vehicle are determined from the records which are reviewed at CFRT meetings. This information is not available on the death certificate.

Figure 7. Child Driver Motor Vehicle Deaths by Seat Belt Usage

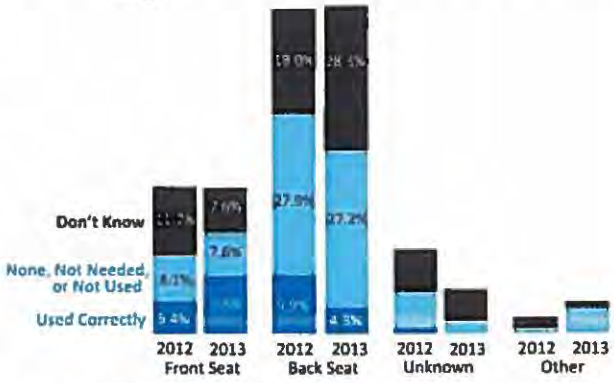


Source: Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

Prevention efforts should primarily focus on correct seat belt usage. CFRTs determined that child drivers who died from motor vehicle crashes used their seat belt correctly 32 percent of the time in 2012, and only 24 percent in 2013 (Figure 7).

Front seat passenger child fatalities were more likely to use their seat belt correctly (5.4 percent in 2012 and 9.8 percent in 2013; Figure 8) compared to back seat passengers. Back seat passengers correct seat belt usage declined from 9.9 percent in 2012 to 4.3 percent in 2013. Many of the CFRTs were not able to determine if a seat belt was used in the majority of motor vehicle child fatalities. The only true unknown is when teams could not determine where the child was in the vehicle at the time of the death. This determination is important to inform the development of targeted prevention and intervention efforts across the state.

Figure 8. Child Passenger Motor Vehicle Deaths by Seat Belt Usage



Source: Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

The top three causes contributing to motor vehicle child deaths were speed, drugs/alcohol, and reckless driving in 2012 and 2013 (Table 1).

In 2012, 18.9 percent of child driver deaths and 13.3 percent in 2013, involved drugs and alcohol. It is important to point out that while these causes contributed to the fatal crash when the child was driving, it does not necessarily mean that the child was taking drugs/alcohol. The local CFRT reviewed data does not indicate the state of the child, only the contributing causes of the fatal crash.

Table 1. Top Causes Contributing to Motor Vehicle Child Deaths

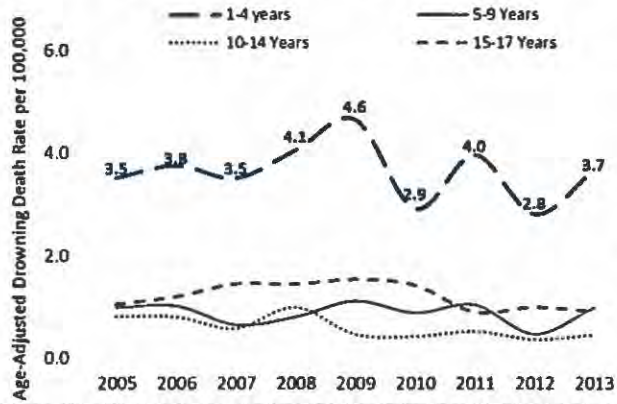
2012		2013	
Speed	22.1%	Speed	26.0%
Drug/Alcohol	17.1%	Reckless Driving	20.4%
Reckless Driving	14.7%	Drug/Alcohol	16.6%
Distracted	10.6%	Unsafe	15.5%

*Multiple causes can be selected per record.

Source: Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

Drowning Deaths

Figure 9. Age-Adjusted Drowning Child Death Rates

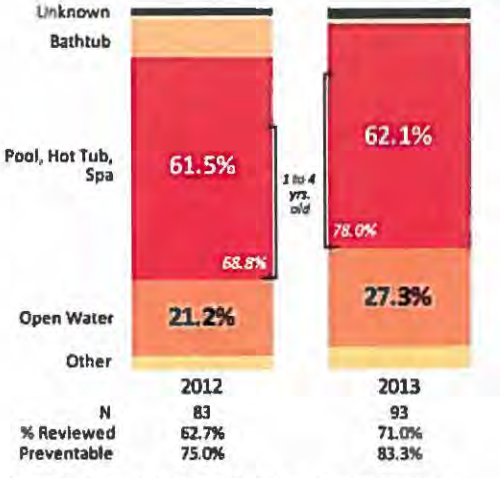


Source: Office of the State Demographer, Texas State Data Center, Texas Population Projections
Center for Health Statistics, DSHS Death Data Files 2005-2013
Prepared by: Office of Program Decision Support 12/14/15

Drowning was the second most prevalent cause of accidental deaths in children. Children ages 1-4 years are the most likely to die in drowning accidents. The age-adjusted drowning child death rate for this age group decreased from 2011 (4.0 per 100,000 children) to 2012 (2.8 per 100,000 children), when it reached the all-time lowest rate (Figure 9) yet this rate increased again in 2013 (3.7 per 100,000 children).

The death certificate identified 83 (62.7 percent reviewed by CFRTs) accidental child drowning deaths in 2012 and 93 (71.0 percent reviewed by CFRTs) in 2013 (Figure 10). Of the child drowning deaths reviewed, CFRTs determined that 75.0 percent in 2012 and 83.3 percent in 2013 could have been prevented. Approximately 62 percent of children in both years drowned in pools, hot tubs or spas. The second most prevalent place of drowning was in open bodies of water, with 21.2 percent in 2012 and 27.3 percent in 2013. Children in the 1-4 year age-group accounted for 68.8 percent (2012) and 78.0 percent (2013) of drowning deaths in pools, hot tubs or spas, while children ages 10-17 years accounted for 55 percent of open water drowning deaths in both years.

Figure 10. Place of Child Drowning Deaths



Source: Center for Health Statistics, DSHS, Death Data Files 2012-2013
Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

It is clear that improvements in pool safety and continued prevention still need to be made to decrease the child drowning death rate. Of the drowning deaths that occurred in a pool, approximately 35 percent in both 2012 and 2013 had no barrier to limit access to the pool (Figure 11). Local CFRTs found that a fence, door, or gate was used as a barrier in less than 16 percent of pool child deaths; however, it is unclear whether these barriers were being used correctly. Additionally, local CFRTs cited poor or absent supervision as a contributing factor in 44 percent of the child drowning deaths among children younger than 5 years of age.

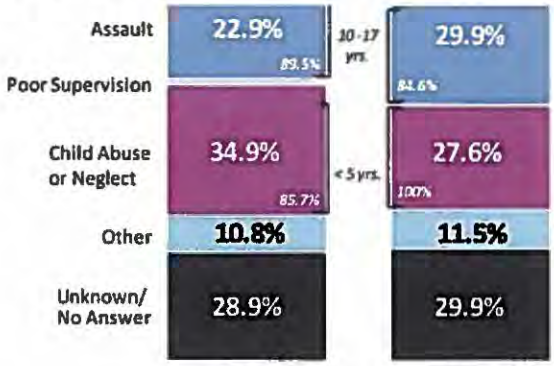
Figure 11. Pool Child Deaths by Barrier Type

Source: Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

Homicides

There were 127 child homicides in 2012 (65.4 percent reviewed by local CFRTs) and 145 in 2013 (60.0 percent reviewed by local CFRTs; Figure 12). The rate of child homicides reached an all-time low in 2012 at 1.8 per 100,000 children, but returned to rates consistent with the past nine years in 2013 to 2.1 per 100,000 children (see Figure 3). Please note that in previous years, there was some inconsistency between the death certificate and local CFRT in determining the manner of death as homicide, but more recently, the two determinations have been consistent—98 percent in both 2012 and 2013. Local CFRTs determined that 69.1 percent in 2012 and 86.2 percent in 2013 of the reviewed child homicides could have been prevented (Figure 12).

Figure 12. Contributing Causes to Child Homicides



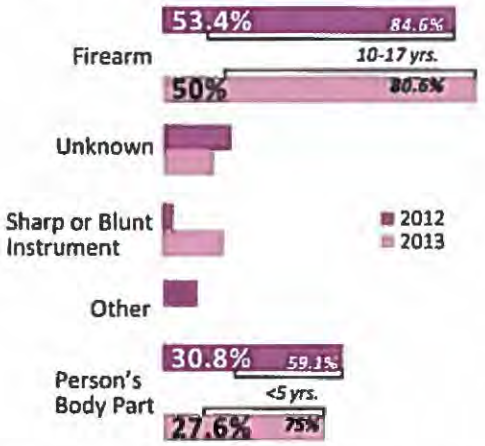
Source: Center for Health Statistics, DSHS Death Data Files 2012-2013
Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

The circumstances and context of the homicides were different based on the age of the child. Of the child homicides reviewed, local CFRTs determined that 34.9 percent in 2012 and 27.6 percent in 2013 were caused by child abuse or neglect (Figure 12). Child abuse or neglect deaths primarily involved children under the age of 5 years (85.7 percent in 2012 and 100.0 percent in 2013). According to the local CFRTs, a small percentage of all homicides, 19.3 percent in 2012 and 18.3 percent in 2013, had a history of maltreatment, but not an open Child Protective Services case at the time of death.

Assault, which does not include child abuse, was the second leading contributing cause to child homicides at 22.9 percent in 2012, and 29.9 percent in 2013. Assault deaths primarily involved children aged 10-17 years (89.5 percent in 2012 and 84.6 percent in 2013).

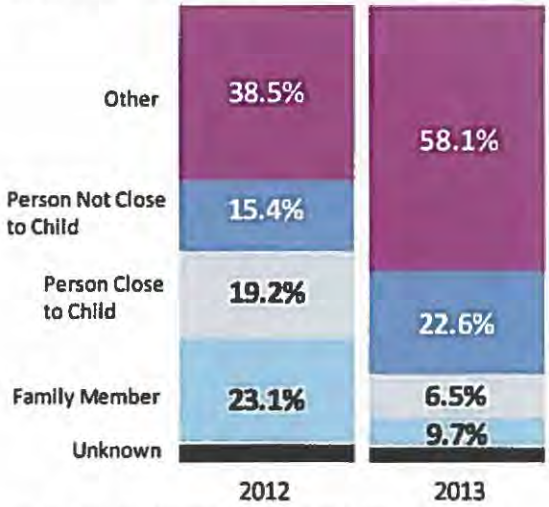
Local CFRTs identified that 62.7 percent of 2012 homicides and 66.7 percent of 2013 homicides involved a weapon. For children younger than 5 years, the weapon most identified in child homicides was a body part (59.1 percent in 2012 and 75.0 percent in 2013; Figure 13). For children aged 10-17 years, most weapon-related homicides involved a firearm (84.6 percent in 2012 and 80.6 percent in 2013).

Figure 13. Child Homicides by Weapon



Source: Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

Figure 14. Firearm Child Homicides by Firearm Owner



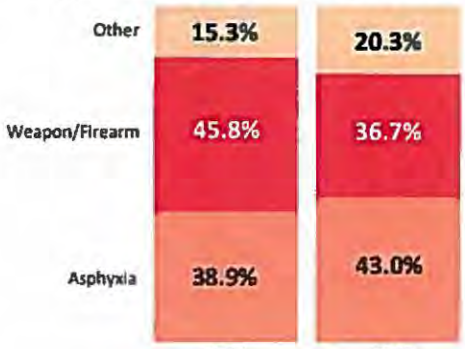
Source: Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

Figure 14 shows the firearm owner among firearm-related child homicides. In many reviewed cases, the owner was listed as "other" by the local CFRT (38.5 percent in 2012 and 58.1 percent in 2013). In cases where the owner was known, the firearm was more likely to belong to a family member in 2012 (23.1 percent), but in 2013, the firearm was more likely to belong to someone not close to the child (22.6 percent).

Suicides

There were 99 child suicides in 2012 and 122 in 2013, of which 72.7 percent and 64.8 percent were reviewed, respectively, by local CFRTs (Figure 15). Of the reviewed cases, local CFRTs determined that 54.2 percent in 2012 and 48.1 percent in 2013 could have been prevented. Please recall that the child suicide rate dropped from 2011 (1.6 per 100,000 children) to 2012 (1.4 per 100,000 children), but then rose again in 2013 (1.8 per 100,000 children; see Figure 3, page 10). Despite the increase in 2013, the nine-year trend in the child suicide rate has remained relatively constant. In 2012, weapon/firearm (45.8 percent) was the most prevalent method by which children younger than 18 years committed suicide, followed by asphyxiation (38.9 percent). In 2013, these methods switched, with asphyxiation at 43.0 percent and weapon/firearm at 36.7 percent.

Figure 15. Child Suicides by Method



	2012	2013
N	99	122
% Reviewed	72.7%	64.8%
Preventable	54.2%	48.1%

Source: Center for Health Statistics, DSHS, Death Data Files 2012-2013.
Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

As with other causes and manners of death, understanding the context that leads to the suicide is important for developing intervention efforts to prevent them in the future. Table 2 outlines some of the top psychosocial factors that local CFRTs identified that contributed to the child suicides. Family and peer relationships were the top two known factors contributing to child suicides in both 2012 (9.7 percent and 9.7 percent, respectively) and 2013 (22.8 percent and 16.5 percent, respectively).

Table 2. Top Factors Contributing to Child Suicide

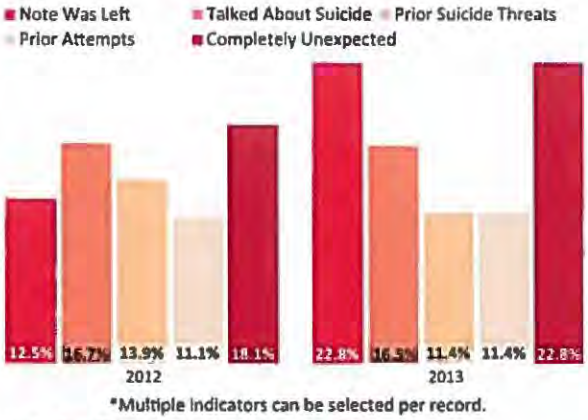
Top Factors Contributing to Child Suicide*

2012		2013	
Family Relationships	9.7%	Family Relationships	22.8%
Peer Relationships	9.7%	Other Identified Problems	22.8%
Other Identified Problem	5.6%	Peer Relationships	16.5%
No Identified Problem	5.6%	Bullying	8.9%
		Other Unidentified Problem	8.9%

*Multiple factors can be selected per record.

Source: Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/10/15

Figure 16. Indicators of Child Suicide



*Multiple indicators can be selected per record.

Source: Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/10/15

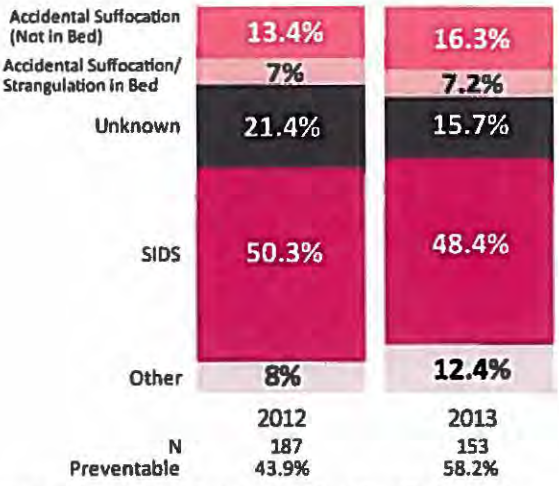
Family relationship factors include arguing with parents, parents getting a divorce, or family discourse. Peer relationship factors include fighting with peers and fighting or breaking up with a boyfriend or girlfriend. It is important to note the low percentages in 2012 because of the lack of information available to the local CFRTs to determine the causes contributing to child suicides.

Approximately one in five child suicides were determined to be completely unexpected—18.1 percent in 2012 and 22.8 percent in 2013 (Figure 16). In 2012, fewer than 17 percent of those who committed suicide showed an indication of

suicide, including talking about suicide (16.7 percent), prior suicide threats (13.9 percent), leaving a note (12.5 percent), or prior attempts (11.1 percent). However, in 2013, 22.8 percent of those who committed suicide left a note, followed by talking about suicide, and prior suicide attempts and threats.

Sleep-Related Deaths

Figure 17. Causes of Infant (<1yr.) Sleep-Related Deaths as Given on Death Certificate



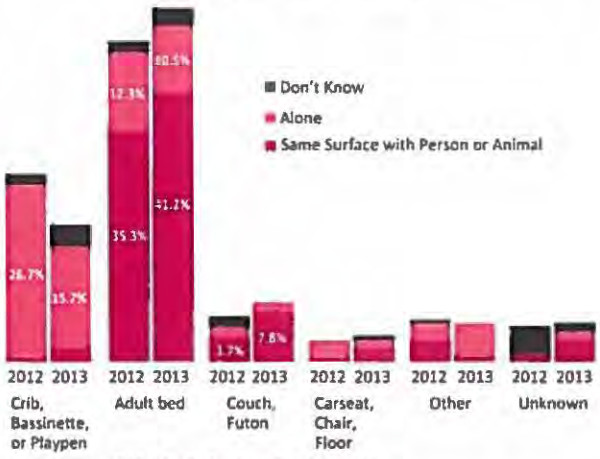
Source: Center for Health Statistics, DSHS, Death Data Files 2012-2013, Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

Death certificate data does not provide specific information on sleep-related deaths. Additionally, because of the ambiguity of the manner and cause of these deaths, it is difficult to identify sleep-related deaths from coded death certificate data. Local CFRTs identified 187 sleep-related deaths in children younger than one year in 2012, and 153 in 2013 (Figure 17). Local CFRTs estimate that close to half (43.9 percent in 2012 and 58.2 percent in 2013) of these deaths could have been prevented. This estimate is based solely on local CFRT samplings as data cannot be identified through the death certificates.

It is important to note that the local CFRT data does not list a primary cause for most infant sleep-related deaths (49.2 percent in 2012 and 41.8 percent in 2013). In many cases this was left blank because the teams had not ruled out enough possibilities to agree that the death was the same as listed on the death certificate, nor could they determine another clear cause of death.

This is why Figure 17 shows death certificate determinations for sleep-related deaths. Local CFRTs determined approximately 50 percent of all infant sleep-related deaths occurred while the infant was sleeping in an adult bed (Figure 18). Of those sleeping in an adult bed, 35.3 percent in 2012 and 41.2 percent in 2013 were sharing a bed with a person or animal.

Figure 18. Infant (<1yr.) Sleep-Related Deaths by Sleep Surface and Bed Sharing

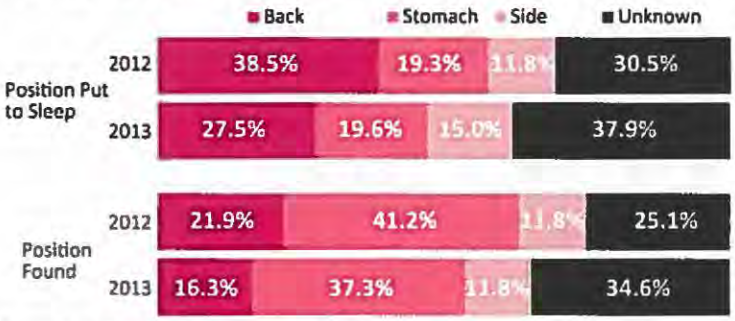


Source: Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

The leading cause of infant sleep-related deaths identified by the death certificate was Sudden Infant Death Syndrome (SIDS) (50.3 percent in 2012 and 48.4 percent in 2013; Figure 19). SIDS is determined through exclusion; that is, SIDS cannot be determined to be the cause of death until all other possible explanations for the death are ruled out. This exclusion criterion makes determining a SIDS death difficult, and hence, it is often subject to disagreement. Local CFRTs only agreed that the cause of death was SIDS in 39.4 percent of the reviewed cases in 2012 and in 12.2 percent of the reviewed cases in 2013. Asphyxiation, regardless of whether the infant was sleeping in bed, was the second leading cause of infant sleep-related deaths in both years.

Thorough death scene investigations are important for identifying sleep positions, particularly data from local CFRTs, when the team finds a discrepancy between the positions in which the infant was placed to sleep versus the position in which the infant was found (Figure 19). When the position was known, children were reported to most likely have been put to sleep on their back in both years (38.5 percent in 2012 and 27.5 percent in 2013). On the other hand, the local CFRTs have found that among cases of infant sleep-related deaths, infants were found primarily on their stomach (41.2 percent in 2012 and 37.3 percent in 2013). Despite available training, the public service announcement, "Alone on your Back in a Crib (ABC)" has not spread statewide. Cultural and generational beliefs may create barriers for safe sleep. Training to help investigators in these difficult cases can lessen the unknown and also lower discrepancies as to the cause of these infant deaths.

Figure 19. Position Infant (<1yr.) Put to Sleep and Position Found



Source: Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

SCFRT Committee Recommendations

Recommendations to the Governor and Legislature

1. **Pass distracted driver legislation to address the risks of using wireless communication devices while driving.**

   A study by Virginia Tech Driving Institute revealed that those who resort to texting while driving are 23 times more likely to crash. According to the 2014 Texas crash statistics compiled by TxDOT[3], 51 fatalities and 654 serious injuries were attributed to the use of a wireless device while driving. There were a total of 3,423 motor vehicle crashes in which mobile phone use was a contributing factor.

   Currently there are 14 states and the District of Columbia with an ordinance to prohibit the use of wireless communication while driving. Thirty-seven states and the District of Columbia ban the use of all cellphones by novice drivers[4]. Many jurisdictions in Texas have a local ordinance prohibiting cell phone use. While this is a step in the right direction, the ordinances are not standardized throughout the state, leading to confusion among drivers.

   The SCFRT recommends legislation to limit at all times the use of wireless communication devices by drivers and cyclists, unless a hands-free device is used in the moving vehicle or bicycle. The penalty for violation should be up to the maximum Class C fine. This is necessary due to the increased risk and occurrence of motor vehicle crashes, injuries, and fatalities for motor vehicle operators, passengers, and pedestrians. Drivers of all ages are inattentive and distracted while using a wireless communication device with their hands.

2. **Pass legislation that makes it an offense if a person operates a motor vehicle on a public highway while having any detectable amount of alcohol in the person's system while transporting a minor (under the age of 17);**

   Impaired driving is a national epidemic. Every hour, one person is killed, and 20 people are injured in crashes involving an alcohol-impaired driver. This equates to nearly 10,000 deaths and more than 173,000 injuries each year. In addition, the annual cost of impaired driving is $129.7 billion[5].

   National Highway Traffic Safety Administration (NHTSA) has demonstrated that virtually every person who has a blood alcohol concentration (BAC) level of at least 0.08 experiences impaired driving. An alcohol-impaired-driving fatality is defined as a fatality in a crash involving a driver or motorcycle rider (operator) with a BAC of 0.08 or greater. According to NHTSA, there were nearly 10,000 alcohol-related motor vehicle traffic fatalities in 2014,

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[3] Texas Department of Transportation (TxDOT), Texas Motor Vehicle Crash Statistics – 2014, Fatalities by age, person type and gender, http://ftp.dot.state.tx.us/pub/txdot/trf/crash-statistics/2014/06.pdf

[4] Insurance Institute for Highway Safety, Distracted Driving, http://www.iihs.org/iihs/topics/laws/cellphonelaws/maphandheldcellbans

[5] Zaloshnja, Eduard, and Ted R. Miller. 2009. "Cost of Crashes Related to Road Conditions, United States, 2006."Annals of Advances in Automotive Medicine 53: 141–53.

accounting for 31 percent of overall traffic fatalities. This translates into one alcohol-impaired driving fatality every 53 minutes in the United States in 2014[6].

Motor vehicle crashes claim many child victims. According to the Centers for Disease Control and Prevention (CDC), in 2013 a nationwide total of 7,266 children (5 to 24 years of age) died in motor vehicle crashes, making this the leading unintentional injury cause of death among children 5 to 24 years of age[7]. Many child deaths in Texas occur in motor vehicle crashes when the driver was alcohol-impaired. In 2014, there were 1,041 fatalities in Texas due alcohol impaired-driving crashes. These deaths accounted for 32.64 percent of the total number of Texas motor vehicle crash deaths. Of the 1,041 fatalities in alcohol-impaired-driving crashes in 2014, 134 of those deaths were children age 21 or under[8]. NHTSA reports that Texas experienced an increase in motor vehicle crash fatalities from 2010 to 2014, from 3,023 fatalities in 2010 to 3,538 fatalities in 2014, a 17 percent increase[9]. For those over 21 years of age, the legal BAC level for non-commercial drivers is <0.08, and for commercial drivers the legal BAC level is <0.04. For persons younger than 21 years of age, Texas has a zero-tolerance law[10], making driving with any detectable BAC illegal.

Scientific evidence shows that impairment begins with the first drink, and any alcohol consumption associated with driving reduces safety. A review of research findings from laboratory and driving simulator studies concerning the effects of alcohol on driving-related skills, such as divided attention, vigilance, tracking, perception, and reaction time, found that several types of performance are affected by BAC levels as low as 0.01[11]. Another more recent study found significant cognitive decrements in speed of information processing, reductions in working memory, and increases in errors of commission at 0.04 BAC[12].

The National Transportation Safety Board (NTSB) recommends a set of targeted interventions that will prevent crashes, reduce injuries, and save lives. Specifically, a report adopted by the NTSB in May 2013 recommends reducing the BAC legal limit for all drivers to 0.05 or lower. Three very specific conclusions support the NTSB's decision to recommend lowering the BAC legal limit: (1) alcohol impairs critical driving tasks; (2) crash risk is

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[6] National Highway Traffic Safety Administration, Traffic Safety Facts, 2014, Motor Vehicle Crashes: Overview, December 2015, http://www-nrd.nhtsa.dot.gov/Pubs/812231.pdf

[7] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. 10 Leading Causes of Injury Deaths by Age Group Highlighting Unintentional Injury Deaths, United States – 2013. http://www.cdc.gov/injury/images/lccharts/leading_causes_of_injury_deaths_highlighting_unintentional_injury_2013-a.gif

[8] Texas Department of Transportation, Texas Motor Vehicle Crash Statistics – 2012, DUI (Alcohol) Fatalities by Age. http://ftp.dot.state.tx.us/pub/txdot-info/trf/crash_statistics/2012/34_2012.pdf.

[9] National Highway Traffic Safety Administration, Fatality Rates: Texas, US and Best State. http://www-nrd.nhtsa.dot.gov/departments/nrd-30/ncsa/STSI/48_TX/2014/48_TX_2014.htm

[10] Tex. Alco. Bev. Code § 106.041. See also https://www.tabc.state.tx.us/laws/underage_drinking_laws.asp

[11] Moskowitz, H., and D. Fiorentino. 2000. A Review of the Literature on the Effects of Low Doses of Alcohol on Driving-Related Skills. DOT HS 809 028. Washington, DC: National Highway Traffic Safety Administration.

[12] Dry, Matthew J., Nicholas R. Burns, Ted Nettelbeck, Aaron L. Farquharson, and Jason M. White. 2012. "Dose-Related Effects of Alcohol on Cognitive Functioning." PLoS ONE 7(11): e50977.

consistently and significantly elevated by the time an individual reaches 0.05; and (3) lowering the BAC legal limit has been shown to reduce crashes, injuries, and deaths[13].

The SCFRT recommends that current statute (Texas Penal Code §49.01) be amended to reduce the legal BAC level in Texas from 0.08 to any detectable level for drivers transporting a passenger who is younger than 15 years of age; and making the offense a Class C fine. Texas Penal Code §49.045 addresses driving while intoxicated with a child passenger. Lowering the BAC legal limit in Texas for drivers transporting a passenger who is younger than 15 years of age would reduce the number of motor vehicle crash deaths on Texas highways and save the lives of many children who are not likely to be able to make the decision to avoid riding with an impaired driver.

3. **Repeal Texas Transportation Code, Section 521.205, which allows a parent, step-parent, legal guardian, step-grandparent or grandparent to provide a driver education course to eligible minors 16-18 years of age.**

Texas is one of only three states with statutes allowing parent-taught driver education (PTDE). Section 521.205 of the Texas Transportation Code was added in 1995 by Senate Bill 964 during the 74th Texas Legislature. DPS implemented the rules for this legislation in April 1997. An unsuccessful attempt was made to repeal the legislation in 1997.

Motor vehicle crashes are the leading cause of death for all teens in the United States. Research studies report that teens 15-19 years of age are at high risk for motor vehicle crashes, especially during the first year of driver eligibility. The CDC reported that in 2013, about 2,200 teens aged 16-19 in the United States were killed, and almost 243,000 were treated and released from emergency departments for injuries suffered in motor vehicle crashes. This statistic translates into six teens per day dying in motor vehicle crashes[14].

No comparative evaluation of driver education in Texas had been conducted until NHTSA published a study in April 2007: Parent-Taught Driver Education in Texas: A Comparative Evaluation[15]. A review of the study, abstract, and executive summary yields that nearly 40 percent of the 218,054 driver education certificates issued in 2004-2005 were from parent-taught driver education (PTDE), and PTDE youth were obtaining driver's permits at a slightly younger age. Although the study cites few self-reported differences in driving knowledge and skills related to the type of driver education, differences are noted when driving records are reviewed.

PTDE drivers demonstrated lower driving knowledge early in their training, poorer driving skills, and a lower rate of passing the state-administered driving test on the first attempt. Furthermore, PTDE novice drivers committed more traffic offenses and were in more

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[13] National Transportation Safety Board, Safety Report. 2013. Reaching Zero: Actions to Eliminate Alcohol Impaired Driving.

[14] National Highway Traffic Safety Administration, Fatality Rates: Texas, US and Best State. http://www-nrd.nhtsa.dot.gov/departments/nrd-30/ncsa/STSI/48_TX/2014/48_TX_2014.htm

[15] V,J, Pezoldt, K.N. Womack, and D.E. Morris, Texas Transportation Institute, The Texas A&M University System, College Station, TX. http://opi.mt.gov/pdf/DriverEd/RR/NHTSA.pdf

crashes. When most, if not all, supervision is eliminated (full licensure), then PTDE students are involved in more traffic convictions and increasingly serious motor vehicle crashes than their peers trained through other driver education methods.

In Texas, there are approximately 300,000 teens eligible to get a driver license each year. Of those, about one-third of teens wait until they are 18 years old to get their licenses, after which age, driver education is not required. In fiscal year 2013, the number of driver education completion certificates issued to driving schools shows that 13 percent of the driver education students were taught in public schools, 34 percent were parent-taught, and 53 percent received instruction through commercial driving schools.

Given the high risk of serious injury and death experienced by minor drivers and their passengers and the lack of any requirement for parents who teach driver education to demonstrate driving knowledge and skills or undergo DPS monitoring, the SCFRT recommends repeal of legislation allowing for parent- or guardian-taught driver education.

4. **Pass legislation to amend the Code of Criminal Procedure, Article 45.0215, to include defendants younger than 18 years of age and their parent, guardian or managing conservator to appear in court on hearings of moving violation.**

   According to data from the 2014 TxDOT Crash Records Information System, minors 15 to 17 years of age were drivers in 97 fatal crashes, 3,675 serious injury crashes, and 5,131 crashes with other injuries. In 2014, 35 minor drivers 15 to 17 years of age died in motor vehicle crashes[16]. Additionally, minor drivers in the same age group were involved in 18,488 non-injury crashes. A 17-year-old minor is a young, less-experienced driver who requires the permission of a parent, guardian, or managing conservator to obtain a driver's license (Transportation Code, Chapter 521, Sec.521.145), and who deserves the protection and involvement of a parent, guardian, or managing conservator (Texas Family Code).

   Current law requires only defendants younger than 17 years old to appear in court with their parents, guardians, or managing conservators on hearings for moving violations. The law excludes minors who are 17 years old from this requirement and these minors miss the safety benefits of this statute. Required joint appearance in court means a 17-year-old driver and the accompanying adult will both be aware of the driving behavior that led to the infraction and will both be provided with information on safe driving practices. Amending the law would also enable the parent or guardian to be aware of any fines, liability for the conduct of the minor, and the parent or guardian's options to impose added restrictions, inclusive of withdrawing the permission or revoking the minor's driver's license.

5. **Pass legislation that requires new residential swimming pools have a circumferential isolation pool fence installed that completely separates the house and play area of the yard from the pool.**

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[16] Texas Department of Transportation, Texas Motor Vehicle Crash Statistics – 2014. Ages of Drivers in Crashes. http://ftp.dot.state.tx.us/pub/txdot/trf/crash-statistics/2014/25.pdf

Drowning is the leading cause of unintentional injury death for children one to four years of age and the second leading cause of unintentional injury death for children five to nine years of age[17]. In 2013, 93 children drowned in Texas[18]. Data from reviews conducted by Texas local CFRTs and from the Texas Submersion Registry indicate that the vast majority of these deaths occurred in residential swimming pools (in-ground, above-ground and portable), hot tubs, and spas.

The American Academy of Pediatrics (AAP) Drowning Prevention policy statement asserts that four-sided, or circumferential, isolation fencing controls unsupervised access to residential pools, hot tubs, and spas and could prevent up to 50-90 percent of drowning deaths in young children[19]. However, a national survey indicates that fewer than 30 percent of residential pool owners have a circumferential isolation fence around their pools. The Consumer Product Safety Commission (CPSC) stresses the importance of installing an outdoor swimming pool barrier as a physical obstacle that surrounds an outdoor pool or spa so that access to the water is limited to adults. A successful pool barrier prevents a child from getting over, under, or through it to gain access to the pool or spa. The CPSC recognizes this strategy to be an evidence-based strategy to prevent drownings. The CPSC recommends that the fence or other barrier be at least four feet high or taller and have no footholds or handholds that could help a young child to climb it; that vertical fence slats should be less than four inches apart to prevent a child from fitting between; that, if chain link fencing is used, no part of the diamond-shaped opening be larger than 1 ¾ inches; that the gate be self-closing, self-latching, and outside of a child's reach; and that the maximum clearance at the bottom of the barrier should not exceed four inches above ground[20].

Safe Kids Worldwide, an international nonprofit organization dedicated to preventing unintentional childhood injury, estimates that medical costs for each near-drowning victim can range from $8,000 for initial medical care to more than $250,000 for long-term care. Legislation requiring installation of circumferential isolation fencing around new residential swimming pools, hot tubs, and spas throughout Texas would prevent drowning deaths and reduce the burden of health care costs associated with non-fatal submersions.

The SCFRT has made this recommendation for new residential swimming pools to have circumferential isolation pool fences annually since 2007.

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[17] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 10 Leading Causes of Injury Deaths by Age Group Highlighting Unintentional Injury Deaths, United States – 2010. http://www.cdc.gov/injury/wisqars/pdf/10LCID_Unintentional_Deaths_2010-a.pdf

[18] Texas Department of State Health Services, Texas Vital Statistics, provisional 2011 death data pending review and approval of final data set.

[19] American Academy of Pediatrics Policy Statement—Drowning Prevention. www.pediatrics.org/cgi/doi/10.1542/peds.2010-1264

[20] Consumer Product Safety Commission Pool Safely Campaign, Pool and Spa Safety: Barriers. http://www.poolsafely.gov/pool-spa-safety/safety-system/barriers/

6. **Promote a statewide Safe Storage Campaign for gun safety.**

   The SCFRT supports the promotion of a statewide Safe Gun Storage Campaign for gun safety. Examples of campaigns messages address keeping guns unloaded and locked[21] and storage of ammunition separately[22]. Research shows that safe gun storage reduces unintentional injury and suicide risk. A recent systematic review of firearm storage campaigns found that communities which offered free devices had improved safe gun storage practices versus communities which offered economic incentives to obtain safe firearm storage[23].

   Parent education is another important aspect of a gun safety campaign. The SCFRT also encourages and supports medical providers' role in gun safety and accident prevention. Medical providers should assess patients' access to firearms and educate on the importance of safe gun storage.

7. **Pass legislation to add active shooter training for school personnel to the Center for Safe Schools School Safety Certification Program.**

   The Texas Education Code, Section 37.1081 mandates that Texas schools have a school safety certification program. The Texas School Safety Center, along with the School Safety Task Force and stakeholders, established a school safety certification program with criteria based on the Texas Unified School Safety and Security Standards. This program assesses school districts on their safety and security practices; and will award school districts with a school safety certificate when they meet all the specified criteria. The SCFRT recommends the addition of active shooter training for school personnel to the criteria specified in the School Safety Certification Program[24].

8. **Fund Child Fatality Review Team Coordinators in each of the public health service regions as recommended by the Protect Our Children Commission.**

   The SCFRT supports the Protect Our Kids recommendation[25] to fund a Child Fatality Review Team Coordinator in each of the public health service regions. Local CFRT coordinators, presiding officers and data entry coordinators are members who serve as volunteers on their review teams. Funding a local CFRT coordinator in each of the public health service regions will increase consistency in the way local CFRTs function throughout the state. The coordinator will be responsible for assisting with meeting preparation, meeting coordination, data entry and spearheading prevention efforts in the communities in which they serve.

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[21] Ad Council, Safe Firearm Storage, http://www.adcouncil.org/Our-Campaigns/Safety/Safe-Firearms-Storage
[22] Project Safe Child, Safe Storage, http://www.projectchildsafe.org/safety/safe-storage
[23] Ali Rowhani-Rahbar*, Joseph A. Simonetti and Frederick P. Rivara, (2016) Effectiveness of Interventions to Promote Safe Firearm Storage Epidemiol Rev (2016) doi: 10.1093/epirev/mxv006 First published online: January 13, 2016
[24] Texas State School Safety Certification Program, https://cert.txssc.txstate.edu/certifications/1
[25] Protect Our Kids Commission, Final Report, http://texaschildrenscommission.gov/our-work/basic-projects/child-fatalities-protect-our-kids-(pok)-commission.aspx

Recommendations to the Department of Family and Protective Services

1. **Amend Texas Family Code. Sec 261.102 [Matters to be reported] to report all children less than six years old that have died due to unexplained or non-natural causes, excluding motor-vehicle occupant deaths unless there is suspicion of alcohol or substance use to DFPS.**

   The current law states that professionals must report a death to Child Protective Services if they have a belief that the child has been abused or neglected. Child deaths resulting from possible abuse and/or neglect may be missing due to the lack of notification and investigation by Child Protective Services, as well as potential services to the families of children who have died. Therefore, the SCFRT recommends amending the existing Texas Family Code Chapter 261.102 to include reporting all children less than six years old that have died due to unexplained or non-natural causes, excluding motor-vehicle occupant deaths unless there is suspicion of alcohol or substance use to DFPS in order to better identify possible cases of abuse and/or neglect.

   The Department of Family and Protective Services handbook [2311.2 Medical Examiner or Justice of the Peace] states that investigators must report the death of a child younger than six years old to the medical examiner or justice of the peace (JP) in the county in which the death occurred. The death must be reported to the medical examiner or JP regardless of whether the death was alleged to be the result of abuse or neglect. Implementation of this recommendation will help increase the number of timely investigations and services offered to families at the time of a child's death in addition to improving the continuity of reporting among agencies.

Recommendations to the Department of State Health Services

1. **Amend the current Child Fatality Review statute (Texas Family Code, Chapter 264) to allow adjacent counties of any population size to form joint local CFRTs or join an existing local CFRT and to allow local registrars to notify local CFRTs of child deaths.**

   In its December 2015 Report to the Legislature, the Protect Our Kids (POK) Commission recommended these revisions to Chapter 264 of the Texas Family Code. These recommendations are supported by the SCFRT. The POK Commission recommended allowing adjacent counties of any population size to form joint local CFRTs because it would permit counties that do not currently have a local CFRT to create or join with a strong team in an adjacent county, increasing the number of counties covered by local CFRTs. The POK Commission recommended that the Family Code allow local registrars to notify local CFRTs of child deaths. Currently, local CFRTs receive deaths certificates 12-18 months after the death and reviews of child deaths are typically conducted up to two years after the deaths, particularly in urban counties where the volume of child deaths has made it difficult review cases within one year. Allowing local registrars to notify local CFRTs of child deaths will lead to more timely review of child deaths.

2. **Provide ongoing support for annual training of Texas local CFRT members.**

The SCFRT recommends that DSHS provide funding for annual training for local CFRT members. Local CFRT members come from a wide variety of disciplines and serve as volunteers on their review teams. They are in need of frequent training to keep current with the process, research, and best practices in the prevention of child deaths. More concentrated focus on training specific to child fatality review would go far to improve the Texas process and have greater impact upon the safety of Texas children. The trainings would focus on local CFRT member skill development in collecting data, death scene investigation training, conducting reviews, and implementing effective injury prevention activities at the community level.

3. **Promote and support work towards the goal that all Texas counties have an independent local CFRT or participate in a multi-county local CFRT to review and document all deaths of children less than 18 years of age.**

   In 2015, there were 74 active local CFRTs covering 194 of Texas' 254 counties, and 94 percent of Texas children lived in a county where child deaths are reviewed. A total of 3,742 children died in Texas in 2013. To fully understand the circumstances and risks leading to a child death, identify trends, and implement effective prevention activities, the SCFRT recommends that all Texas counties participate in CFR and that 100 percent of child deaths be reviewed and recorded. It is recommended that DSHS continue to promote and support the development of local CFRTs in counties without teams and to focus on promoting more robust data collection, review, and entry by the existing local CFRTs.

Appendix A. State Child Fatality Review Team Committee Members

EMILIE A. BECKER, MD Child Mental Health Provider Term expires 2/1/16 Medicaid CHIP Mental Health Director Health & Human Services Commission 6330 Hwy. 290 East, Suite 350 Austin, TX 78723 (512) 380-4345 emilie.becker@hhsc.state.tx.us	**SUSAN ETHERIDGE, MSSW, LMSW** Child Advocate Term Expires 2/1/17 CASA of Collin County Executive Director 101 E. Davis McKinney, TX 75069 (972) 529-2272 setheridge@casaofcollincounty.org	**DONALD MCCURNIN, MD** Neonatologist Term expires 2/1/18 UT Health Science Center at San Antonio San Antonio, TX (210) 567-5232 mccurnin@uthscsa.edu
LISA BLACK, MSW CPS Assistant Commissioner Permanent member Department of Family & Protective Services 701 W. 51st St. Austin, TX 78751 (512) 438-3313 lisa.black@dfps.state.tx.us	**SGT. SARAH FIELDS** Ad Hoc Expert Advisor Term expires 2/1/18 Panola County Sheriff's Office 314 W. Wellington St. Carthage, TX 75633 (903) 693-0333 sgtfields@hotmail.com	**DENISE ONCKEN, JD** Assistant District Attorney Term expires 2/1/16 Harris County District Attorney's Office 1201 Franklin, Suite 600 Houston, TX 77002 (713) 755-5919 oncken_denise@dao.hctx.net
ADA BOOTH, MD **VICE CHAIR** Child Abuse Prevention Term expires 2/1/18 Driscoll Children's Hospital 3533 S. Alameda St. Corpus Christi, TX 78411 (361) 694-4345 ada.booth@dchstx.org	**ANGELA GOODWIN, JD** Child Protective Services Specialist Term expires 2/1/16 Director of Investigations Department of Family & Protective Services 701 W. 51st St. Austin, TX 78751 (512) 438-4746 angela.goodwin@dfps.state.tx.us	**TERRY PENCE** TxDOT representative Term expires 2/1/16 Traffic Safety Director Dept. of Transportation 125 E. 11th St. Austin, TX 78701 (512) 416-3167 terry.pence@txdot.gov
KIM CHEUNG, MD, PHD Pediatrician Term expires 2/1/17 UT Health Science Center at Houston Department of Pediatrics Child Protective Services Clinic 6300 Chimney Rock Houston, TX 77081 (713) 295-2579 kim.k.cheung@uth.tmc.edu	**GERALDINE R. HARRIS, MLA** State Registrar, Vital Statistics Permanent member Dept. of State Health Services P.O. Box 149347 Austin, TX 78714-9317 (512) 458-7366 geraldine.harris@dshs.state.tx.us	**READE QUINTON, MD** **CHAIR** Medical Examiner Term expires 2/1/17 Office of the Dallas County Medical Examiner 5230 Southwestern Medical Ave. Dallas, TX 75235 (214) 920-5900 reade.quinton@dallascounty.org
STEVEN CLINKSCALES, EMT-P Senior Program Director Term expires 2/1/2018 Air Evac Lifeteam - Central Texas PO Box 713 Rio Vista, TX 76093 (417)-293-2626-Cell (682) 651-0688-Fax Steven.Clinkscales@air-evac.com	**JUDGE JUDY SCHIER HOBBS** Justice of the Peace Term expires 2/1/16 Pct. 4, Williamson County P.O. Box 588 Taylor, TX 76574 (512) 365-8922 jhobbs@wilco.org	**KATHERINE RATCLIFF** SIDS Family Service Provider Term expires 2/1/16 Center for Infant & Child Loss Any Baby Can of San Antonio 217 E. Howard St. San Antonio, TX 78212 (210) 547-3026 kratcliff@anybabycansa.org
CHIEF GARY W. COX Chief of Police Term expires 2/1/18 Cibolo Police Department P.O. Box 826 Cibolo, Texas 78108 (210) 659-1999 (210) 659-1080 gcox@cibolotx.gov	**SHERIFF CHRISTOPHER KIRK** Term expires 2/1/16 Brazos County Sheriff's Office 1700 Highway 21 West Bryan, TX 77803-1300 (979) 361-4150 chriskirk@highsheriff.com	**KATHRYN GOERING REID** Domestic Violence Victim Advocate Term expires 2/1/16 Family Abuse Center 3407 Chateau Waco, TX 76710 (254) 772-8999 kathy.reid@familyabusecenter.org

ANNA TERAN, RN, BSN, NCSN Educator Term expires 2/1/18 Dallas Independent School District 3700 Ross Ave., Room 206 Dallas, TX 75204 (972) 925-3386 ateran@dallasisd.org	**CAPTAIN STEVEN TELLEZ** Public Safety representative Term expires 2/1/18 Department of Public Safety 6502 S. New Braunfels San Antonio, Texas 78223 (210) 531-2206 Steven.Tellez@dps.texas.gov	**JEANNINE VON STULTZ, PHD** Juvenile Probation Officer Term expires 2/1/18 Bexar County Juvenile Probation 301 E. Mitchell San Antonio, TX 78210 (210) 335-7515 jvonstultz@bexar.org
FREDLYN WIDEMAN Public Health Nurse Term expires 2/1/17 Texas Department of State Health Services 112 Joe Carper Drive Uvalde, TX 77801 (830) 591-4387 Fredlyn.wideman@dshs.state.tx.us		

Texas Child Fatality Review Team

Texas State Child Fatality Review Team Committee Position Statement: Safe Sleep for Infants

The State Child Fatality Review Team Committee (SCFRT) works closely with local Child Fatality Review Teams (CFRT) to promote public awareness of risk factors in order to reduce the number of preventable child deaths. The SCFRT and local CFRTs recognize that unsafe sleep conditions are either a direct or contributing cause of many sudden infant deaths. Safe sleep recommendations are intended to address sleep-related asphyxial deaths or deaths due to environmental factors (e.g. hyperthermia). The SCFRT, as well as other state and national organizations, supports community education efforts for safe sleep practices and safe sleep environments to reduce the number of preventable infant and child deaths. Safe sleep practices address a number of risk factors, including the position of the infant, the quality and characteristics of the sleep surface, the presence of other objects in the sleep environment (e.g. toys, bumper pads), the presence of other individuals on the same surface (bed-sharing), and the environment in which the sleep surface is located.

Safe sleep can be a difficult and somewhat confounding topic due to the overlapping relationship with Sudden Infant Death Syndrome (SIDS) and Sudden Unexplained Infant Death (SUID). It should be recognized that SIDS is not a diagnosis or a disease, but in fact a classification for unexplained infant deaths with negative or inconclusive findings after a complete autopsy and scene investigation. Some of these deaths may be due to genetic disorders, infectious etiologies, or even unrecognized violence, but many studies demonstrate that a significant number of sudden unexplained deaths are likely attributable to unsafe sleep practices. This concept was most famously illustrated by the "Back to Sleep" campaign in the mid-1990s. After the recommendation was made by the American Academy of Pediatrics (AAP) to place infants on their back to sleep, the rate of SIDS dropped by almost fifty percent. This modification of sleep practices (from prone to supine position), resulted in less asphyxial deaths due to smothering (obstruction of the airway associated with the prone position). Subsequent studies have clearly shown a higher incidence of SIDS-type deaths associated with bed-sharing and other potentially dangerous sleep environments.

To understand the extent of the issue, it is important to look at the data of the deaths reviewed and data analysis for the 2012 CFRT Annual Report. Data presented are for deaths reviewed for Sudden Unexplained Infant Deaths (SUID), including Sudden Infant Death Syndrome (SIDS) and asphyxia-related deaths. There were 179 deaths classified as SIDS on the death certificate. Of the sleep-related deaths (as identified by the local CFRTs) there was agreement in only 19.1% of SIDS deaths where the CFRT and the death certificate both concluded the death was the result of SIDS. Forty-seven percent of SIDS deaths were infants two to four months of age. Almost half (47.3%) of SIDS deaths occurred in an adult bed. 31.4 percent of SIDS deaths occurred while the infant slept on their stomach or side. The fact that infants continue to die while sleeping on their backs, the recommended sleep position for infants, illustrates the complexities of SIDS and the importance of documenting the risk factors associated with sudden deaths for infants. However, it is important to recognize that the recommendation made in the early 1990s of placing infants on their backs to sleep as well as other recommendations to avoid other risk factors has greatly reduced the number of SIDS deaths in the U.S.

The 2012 CFRT Annual Report cited reviews of 68 asphyxia deaths in children less than 1 year of age. Thirty-four percent of these deaths were related to "threats to breathing" and sixty-six percent were related to "accidental suffocation in bed."

Response to these data regarding preventable deaths has been impressive. Many local CFRT's have formed work groups to better understand the risk factors for infant deaths in sleep environments and to promote community education on safe sleep practices. CFRT members were polled about training and education they would like to receive for regional training held in 2009. Five out of eight regions asked for and received training on how to address safe sleep practices for infants and children.

The Texas Department of Family and Protective Services (DFPS) and the Texas Department of State Health Services (DSHS) collaborated to launch the "Give Babies Room to Breathe" campaign in 2009. DSHS and DFPS have continued to work together on this issue and released two products in 2010. The first product, a curriculum *Safe Sleep for Infants: A Community Training* (in English and in Spanish), is designed for educating expectant and new parents, grandparents and caregivers and is intended for wide use in the community. It was piloted in three sites and now is in use throughout the state. The second product is *Safe Sleep 360*°, an interactive online training designed specifically to train Child Protective Services (CPS) caseworkers on how to recognize risk in infant sleep environments and how to educate parents on providing a safe sleep environment for their babies. This training is required of all CPS casework staff. In order to better understand infant sleep practices, DSHS conducted the Texas Infant Sleep Study, a survey of 1,800 women who had given birth during the previous year. The survey revealed that more than three-quarters of all mothers reported that their infant usually sleeps or naps on an appropriate sleep surface, such as a crib, bassinet or cradle. Additionally, 75 percent of all mothers reported sharing the same sleep surface with their infant at some point.

RECOMMENDATIONS TO THE STATE OF TEXAS, THE TEXAS LEGISLATURE, PARENTS, HEALTHCARE PROVIDERS AND CHILD FATALITY REVIEW TEAMS

The SCRFT, as well as other state and national organizations, makes the following recommendation:

The safest place for an infant to sleep, particularly within the most vulnerable time between birth and 4 months, is in the same room with a parent or caregiver but on a separate sleep surface, such as a safety-approved crib or bassinet. This allows parents to monitor and bond with the baby and makes breastfeeding more convenient. Infants are often breastfed or comforted in an adult bed, then returned and placed in a crib or bassinet to sleep or when the parent is ready to return to sleep. Infants should not be brought onto an adult bed when the parent(s) are overly tired, on medications or substances that make them drowsy and less alert, when they are ill and are very upset or angry.

RECOMMENDED SLEEP POSITION:

- Infants should be placed on their backs to sleep for every sleep period(for naps and at night.)
- Infants should be given time on the tummy while awake and supervised by a responsible caregiver.
- Parents should tell caregivers, relatives, friends and babysitters that their infant will be placed on the back to sleep.
- All healthcare providers counsel parents on safe sleep environments and practices.

RECOMMENDED SLEEP ENVIRONMENT:

- Infants should be placed to sleep in a safety-approved crib or bassinet with a firm mattress, using a well-fitting sheet made for the mattress.
- Parents should maintain the home and the infant's sleep area free of cigarette smoke.
- The sleep location should have adequate environmental heating or cooling with respect to the time of year.
- Infants should never be placed to sleep on soft mattresses or other soft surfaces such as cushions, sofas, chairs, waterbeds, or beds up against the wall or with loose headboards.
- The sleep environment should be free of unsafe items, such as pillows, quilts, comforters, sheepskins, stuffed toys, other soft objects, bumper pads, plastic sheets, or plastic bags. Strings, cords or ropes should not be allowed within or in proximity to the sleep surface
- Infants should not share a sleep surface with adults, siblings, or pets.

- Infants should not wear excessive layers of clothing in bed.
- Parents should avoid sharing the same sleep surface with their infant, particularly if they are excessively tired or under the influence of alcohol, sedating medications, or other substances.

ADDITIONAL RECOMMENDATIONS:

- Parents who do not have a safe or adequate area for a baby to sleep should look for resources in their community that can help provide such items.
- Parents should inquire on safety information on cribs, bassinets and other related items found in sleep environments, such as toys, bedding and blankets.
- Pregnant women take care of themselves during pregnancy and receive early prenatal care.
- Family members support pregnant women in efforts to get prenatal care.
- Parents quit smoking and remain smoke-free after the birth of the child.
- Children receive regular well-child check-ups.
- Mothers should diligently attempt to exclusively breastfeed their infants for the first six months and should continue to breastfeed for the first year and beyond
- Consider offering a pacifier at each sleep opportunity
- Avoid overheating, head-covering.
- Infant should receive immunizations as appropriate for age.
- Avoid commercial devices marketed to reduce the risk of SIDS.
  Do not use home cardiorespiratory monitors as a strategy for reducing the risk of SIDS.

The SCFRT makes these recommendations on sleep environments and safe sleep practices to help reduce the number of preventable infant deaths. These recommendations are made to reinforce researched best practices for safe sleep of infants. This position statement is intended as a support document for those working to reduce infant deaths and not as a general handout.

The SCFRT Position Paper on Safe Sleep is a product of the SCFRT Workgroup on Safe Sleep (Dr. Donald McCurnin, Dr. Ada Booth, and Dr. Reade Quinton). The Position Paper on Safe Sleep will be reviewed annually and updated as new validated information indicates.

June 2008, reviewed and renewed August 2009, reviewed and renewed April 2011, reviewed and renewed July 2013, reviewed and renewed December 2015.

SOURCES:

American Academy of Pediatrics Policy Statement, SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment, Pediatrics 2011;128:1030–1039

A Child Care Provider's Guide to Safe Sleep, www.healthychildcare.org/pdf/SIDSchildcaresafesleep.pdf; A Parent's Guide to Safe Sleep, www.healthychildcare.org/pdf/SIDSparentsafesleep.pdf

Center for Disease Control: Sudden Infant Death Syndrome (SIDS), www.cdc.gov/SIDS/index.htm

First Candle: Important Safe Sleep Tips, www.firstcandle.org/new_exp_parents/new_exp_safesleeptips.html

Indiana Perinatal Network & Baby First: www.nd.edu/~jmckenna1/lab/pamphlets/safesleepv2.pdf.

National Institute of Child Health and Human Development (NICHD) Pub. No. 06-5759, January 2006.

Safe Sleep for Babies: A Community Training, http://www.dshs.state.tx.us/mch/default.shtm#safesleep2

Texas Department of State Health Services, Office of Program Decision and Support. "Texas Infant Sleep Study", www.dshs.state.tx.us/mch/pdf/TISS_Fact_Sheet.pdf

UNICEF UK's Baby Friendly Initiative, with support of the Foundation for the Study of Infant Deaths (FSIC): www.unicef.org.uk/press/news_detail.asp?news_id=178.

U.S. Consumer Product Safety Commission: Crib Safety Tips (in English and in Spanish) www.cpsc.gov/CPSCPUB/PUBS/5030.pdf, www.cpsc.gov/CPSCPUB/PREREL/prhtml01/01131s.pdf

https://www.aap.org/en-us/my-aap/advocacy/workingwiththemedia/speaking-tips/Pages/SIDS-and-Safe-Sleep-for-Infants-Speaking-Points.aspx#sthash.P37wpL4U.dpuf

Texas State Child Fatality Review Team Committee
Position Statement: Youth Suicide

The State Child Fatality Review Team Committee (SCFRT) works closely with local Child Fatality Review Teams (CFRT) to promote public awareness and action to reduce the number of preventable child deaths.

General Facts about Suicide

Between 2000 and 2013, the suicide rate for all ages in the United States rose from 10.43 (per 100,000) to 13.02. Over the same time period, the suicide rate for males went from 17.11 to 20.59. Among females, the rate rose from 4.00 to 5.67. Overall, men die by suicide at four times the rate of women. Although suicide rates are lower for younger age groups than for older adults, suicide is the second and third leading cause of death (depending upon age) for young people in the United States.

- 10-14; 3rd leading cause of death after unintentional causes and malignant neoplasms
- 15-24; 2nd leading cause of death after unintentional causes
- Rates of ideation (i.e., considering and planning suicide) among female high school students are nearly double that of male high school students. Thoughts and attempts among high school students are higher than among adults in general, although deaths among adolescents are lower.

Suicide in Texas

- Young people age 15-19 complete suicide nationally at a rate of 7.53% and at a 7.49% in Texas.
- Children 11-14 years of age complete suicide nationally at a rate of 1.5% and at 1.41% in Texas. http://webappa.cdc.gove/sasweb/ncipc/dataRestriction_inj.html

Suicide Attempts in Texas

- 10.1% of high schools students have attempted suicide in the past 12 months, YRBS 2013

Perhaps the most important statistic is that ***suicide is preventable***!

RECOMMENDATIONS TO THE STATE OF TEXAS, THE TEXAS LEGISLATURE, PARENTS, AND HEALTHCARE PROVIDERS:

Community Leaders and Organizations: It is essential for the whole community to understand the risks of suicide and know the proper steps to take to protect children and youth. Bringing communities together in working partnerships facilitates and promotes a more public, broad based involvement to child suicide prevention and intervention.

Recommendations:

- Develop and expand partnerships that contribute to mental health promotion and prevention efforts. Create a mental health literacy plan to ensure that information on mental health and mental disorders is accessible and accurate, thus improving mental health literacy in the general population and addressing stigma and discrimination. DSHS offers services to reduce stigma http://speakyourmindtexas.org/
- Ensure that mental health services are available and accessible to diverse populations within the community. Services should be culturally and linguistically competent with respect for the cultural preferences and traditions of the child and family. These services should be child and family-driven.

- Take a leadership role in the development of a local suicide prevention strategy. Foster support for community-based and school-based prevention efforts. Establish and promote compliance with recommended media guidelines for reporting suicides in an effort to minimize copy-cat suicides and youth suicide contagion.
- Monitor suicide frequencies within the community and establish a protocol for addressing emerging trends. Texas House Bill 1067 (81st Legislative Session) allows for collection and coordination of suicide data on the local level by providing that authorized local government entities specified in the bill may enter into memoranda of understanding to share suicide data that does not name a deceased individual or any other individual.

Educational Institutions and Schools: Educational specialists' have day-to-day contact with many young individuals who are struggling with thoughts of death or suicide. These struggling children are at high risk for serious injury or even death by their own hand. Educators are in a position to observe students' behavior and to act if they suspect that a student may be at risk of self-harm. There are well- established steps to identify and help young people at risk in order to keep them healthy and safe.

- Ensure parental/teacher coordination. Teachers need to make sure that parents are informed and actively involved in decisions regarding their child's welfare. Connect and communicate with parents and guardians.
- Provide training to educators regarding the risk factors associated with child suicide and mental health literacy per health and safety code.
- Encourage school-based suicide prevention initiatives as mandated by education code.
- Develop and ensure that staff is familiar with the school's postvention plan in the event of a local youth suicide.
- Become familiar with community-based resources and advocate for the particular screening and intervention needs of that school population.
- More can be found in the Mental Health America report with DSHS MHSA titled Texas Suicide Safer Schools 2015 (see attached PDF)

Medical Institutions and Doctors/Scientists: Community healthcare providers have long been committed to preserving the health, safety, and welfare of children and youth; suicide prevention must be a top priority in this effort. In order to continue making a difference in suicide prevention, professionals believe that an increase in research-based suicide intervention studies, that provide clear standards and replicable results, will help decrease the loss of young lives to suicide.

Recommendations:

Medical Community
- Provide better training to pediatricians and family practitioners to recognize suicide risk factors
- Support and encourage the implementation of early identification and screening within primary care settings. Pediatricians should recognize that routine screening of adolescents and children for suicide risk factors and mental health issues is critical. Incorporate mental health screening into routine child and adolescent wellness visits. Routine screening is now recommended for Texas Health Steps patients, ages 13-18 years old.
- Refer children/adolescents identified as at risk to appropriate mental health professionals for treatment. Be familiar with mental health resources available locally and statewide.

Parents
- Seek early treatment for children with emotional problems, possible mental disorders (particularly depression and impulse control disorders) and substance abuse problems.
- Find professional help if your child appears angry, sad, lonely, is being bullied at school, has other school problems, or is withdrawn.
- Learn how to recognize the warning signs of suicide and appropriate ways to respond.
- Limit access to lethal means of suicide, particularly firearms.
- Provide supervision, support, and constructive activities for children and adolescents.
- Regularly communicate with your child's school about how your child is doing both academically and behaviorally.
- Look, listen, talk, and seek help.
- Call 1-877-273 TALK the National Suicide Prevention Lifeline if you need help with a suicide crisis.

Resources:

Best Practices Registry. Suicide Prevention Resource Center. www.sprc.org/bpr

Coming Together to Care: A Suicide Prevention Toolkit for Texas Communities. Texas Suicide Prevention Council, www.texassuicideprevention.org.

National Strategy for Suicide Prevention. U.S. Department of Health and Human Services
www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html

Suicide Prevention: A Parent & Teen Guide to Recognizing Suicide Warning Signs. Mental Health America of Texas, www.texassuicideprevention.org/pdf/Suicide.pdf

Suicide Prevention Resource Center. www.sprc.org

Teaching Pediatric Residents to Assess Adolescent Suicide Risk With a Standardized Patient Module, Pediatrics Volume 125, Page 953, Number 5, May 2010.

Texas Suicide Prevention Plan
http://www.texassuicideprevention.org/

Department of State Health Services Suicide Prevention website
www.dshs.state.tx.us/suicideprevention/

Texas Toolkit for behavioral health providers for Zero Suicide in Texas
https:/sites.utexas.edu/zest/

The SCFRT Position Statement on Child Suicide is a product of the SCFRT workgroup on child suicide (Dr. Emilie Becker, Dr. Kim Cheung, and Jeannine Von Stultz, PhD). The Position Statement on Child Suicide will be reviewed annually and updated as new validated information indicates.

September 2010 March 2013 September 2015

References:

American Academy of Pediatrics. AAP 2007 Policy Statement: B. In: Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition. Elk Grove Village, Ill: American Academy of Pediatrics; 2008.
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US Preventive Services Task Force. Screening and treatment for major depressive disorder in children and adolescents: US Preventive Services Task Force Recommendation Statement. Pediatrics. 2009;123:1223-1228
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ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: State Preventive Health Advisory Committee (SPHAC)

Number of Members: 8

Committee Status (Ongoing or Inactive): Ongoing — Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 1992 **Date to Be Abolished:** N/A

Budget Strategy (Strategies) (e.g. 1-2-4): A.1.1.1 **Strategy Title (e.g. Occupational Licensing):** Public Health Preparedness & Prevention

Budget Strategy (Strategies): **Strategy Title:**

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Admin Code	25 TAC, Sec. 84.1
State Authority		
State Authority		
Federal Authority	Other	42 USC, 300w-4(d)
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year

Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
2	2	2

Committee Description: The committee was created in 1992 by federal legislation now codified in 42 USC §300w-4(d). The purpose of the committee is to provide advice to DSHS regarding activities to be supported with Preventive Health and Health Services Block Grant (PHHSBG) funds, the conduct of needs assessments, the allocation of payments, and the collection of data.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

Committee meets twice a year via conference call. Per rule, the committee shall meet not less than twice each federal fiscal year.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

The committee reviews and approves the development and implementation of the annual Preventive Health & Health Services Block Grant Annual State Plan.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

The approval of the FY15 State Work Plan.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ? Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees? No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015? 1000.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Assistance in the development and solicitation of public hearings. Posting of meeting notices in Texas Register.

6. Have there been instances where the committee was unable to meet because a quorum was not present? No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

Information is conveyed via Texas Register, Health Service Regions, community organizations and general public.

7b. Do members of the public attend at least 50 percent of all committee meetings? No

7c. Are there instances where no members of the public attended meetings? Yes

8. Please list any external stakeholders you recommend we contact regarding this committee.

Schools of Public Health, Advocacy Groups, Regional & Local Health Departments, Community Health Organizations, Sexual Assault & Prevention Groups

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals? Yes

9b. Please describe the rationale for this opinion.

The committee provides advice on the annual work plan and funding of programs.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute? No

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area? No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)? Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission? Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

The committee is required by federal legislation to provide to DSHS regarding activities to be supported with Preventive Health and Health Services Block Grant (PHHSBG) funds, the conduct of needs assessments, the allocation of payments, and the collection of data.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

Preventive Health & Health Block Grant
State Preventive Health Advisory Committee

Date: January 27, 2014

To: State Preventive Health Advisory Committee Members (SPHAC)

From: Amy Pearson, PHHS Block Grant Coordinator

Subject: SPHAC Meeting Minutes from January 22, 2014

Members Present: Hector Balcazar, Ph.D.; Paul McGaha, M.D.; John Herbold, DVM; Linda Lloyd, Ph.D., Kim Petrili; Zach Thompson; and Amy Pearson

Agenda Item #1: Update on CDC Preventive Health & Health Services Block Grant Funding

Discussion: Block Grant funded amount for Fy14 is $2,864,615. The block grant had an unobligated amount of $2,241,811 from FY13 to carry forward into FY14. This amount of carry forward is due to the delay to DSHS receiving the Notice of Grant Award from CDC. The receipt of the quarterly installment was delayed whereas, in the past, the installments were always received on time & funds allocated / budgeted in a timely manner. The funds for FY13 have been budgeted in Fy14 bringing locals to level funding on their contracts. The delay in Notice of Grant Awards by CDC is due to the unknown funding and continuation of the block grant. In FY14, we still face the same situation where funds will lapse due to the delayed release of funds by the federal government. However, the sexual assault and prevention program will receive a $200,000 increase to expand existing services as well as add an evaluation component to that program. And, the local health departments will receive level funding for FY14 with a projection of all funds being expended.

Action: No Action.

Agenda Item #2: Approval of FY14 Preventive Health & Health Services Block Grant Work Plan

Discussion: Motion by Hector Balcazar to approve the FY14 Work Plan. Seconded by John Herbold and approved. The plan will be submitted to CDC on or before February 1, 2014.

Action: FY15 Work Plan Approved by SPHAC Members.

Preventive Health & Health Block Grant
State Preventive Health Advisory Committee

Telephone Conference Call
March 24, 2015
10:00 a.m. CDT

Physical Location
1100 West 49th St
Conference Room M-101
Austin, TX 78754
1-877-820-7831 Passcode: 682566#

Welcome …….....

Approval of June 18, 2014, Minutes……

Status of FY15 Preventive Health & Health Services Block Grant (PHHSGB) Funding …..…

Preventive Health & Health Services Block Grant Program Reports.....

Stakeholder Public Comment.....Public

Adjourn .....

*Denotes Action Items

Information may be obtained from Amy Pearson, P.O. Box 149347, Mail Code 1908, Austin, Texas 78714-9347, (512) 776 2028, amy.pearson@dshs.state.tx.us . Persons with disabilities who plan to attend this meeting and require auxiliary aids or services are asked to contact Anne Mosher at (512) 776-7404 72 hours prior to the meeting so that appropriate arrangements may be made.

The committee accepts public testimony at meetings. Persons wishing to address the committee must complete a registration form at the reception desk before the start of the meeting. Agenda items may be taken in any order at the discretion of the Chair.

Preventive Health & Health Block Grant
State Preventive Health Advisory Committee

Date: March 30, 2015

To: State Preventive Health Advisory Committee Members (SPHAC)

From: Amy Pearson, PHHS Block Grant Coordinator

Subject: SPHAC Meeting Minutes from March 24, 2015

Members Present: Amy Pearson; Zach Thompson; Hector Balcazar; Kim Petrilli; John Herbold, DVM; Linda Lloyd; and Paul McGaha

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Agenda Item #1: **Approval of June 18, 2014, Minutes**

Discussion: Minutes from the June 18, 2014, were approved as written with no comment or changes. There was a motion by John Herbold, DVM, to accept the minutes as written for June 18, 2014. Seconded by Kim Petrili; and approved by all members.

Action: Minutes approved as written with no changes or amendments.

Agenda Item #2 **Updates on the FY15 Preventive Health & Health Services Block Grant (PHHSBG) Funding**

Discussion: Ms. Amy Pearson, Block Grant Coordinator, reported on updates for CDC on the block grant. CDC released the Fy15 Funding Allocation Table with $6.1 million dollars awarded to Texas. DSHS leadership is recommending to utilize those funds and to continue funding for existing programs and staff personnel as identified in the FY14 Work Plan. Statewide block grant public hearings will be scheduled with additional information forthcoming. Texas will submit the FY15 Work Plan on or before July 1, 2015.

Action: No Action.

Agenda Item #3: **Preventive Health & Health Services Program Reports**

Discussion: Ms. Pearson reported that the FY14 Annual Report was submitted and approved by CDC. In FFY 2014, the four activities funded under the Preventive Health & Health Services Block Grant met or completed their objectives. These include local health departments, sexual assault prevention and crisis services, Community and Clinical Preventive Services and the Texas Healthy Communities Recognition Program.

The total award for the FY 2014 Preventive Health and Health Services Block Grant was $6,268,434. This amount is based on a funding update allocation table distributed by CDC in the previous fiscal year.

Sexual Assault-Rape Crisis (HO IPV 40): $562,234 of this total is a mandatory allocation

to the Texas Department of State Health Services which provides this funding to supports local sexual assault programs and one statewide program to develop and implement community and statewide based strategies and activities that support the primary prevention of sexual violence. These primary prevention efforts address the underlying causes of sexual violence and goes beyond awareness to include activities designed to change attitudes, beliefs and behaviors that allow sexual violence to occur.

Public Health System Assessment (HO PHI-14): $2,442,359 of this total will be utilized to support 60 Local Health Departments by strengthening local public health infrastructure through education and outreach; disease surveillance; mobilization of community groups to address local public health concerns; and development of policies to safeguard and protect local community health and safety.

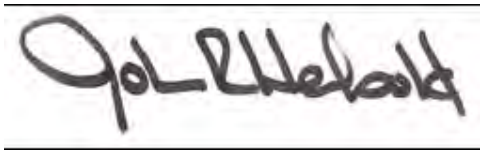
Receipt of Evidence-Based Clinical Preventive Services (AHS-7), Community-Based Primary Prevention Services (ECBP-10), Older Adults' Confidence in Managing Their Chronic Conditions (OA-3) , and Tobacco Screening in Health Care Settings (TU-9) : $1,832,154 of this total will be utilized to ensure the continuation and expansion of the priority activities developed through the DSHS Community Transformation Grant (CTG) that are evidence-based strategies to reduce the impact of chronic diseases on the State of Texas and on individuals, families, and communities.

Community-Based Primary Prevention Services (ECBP-10):$1,431,487 will fund the Texas Healthy Communities (TXHC) Program which was established in 2003 by the DSHS Cardiovascular Disease Program and the Texas Council on Cardio-vascular Disease and Stroke with the help of public and private partners. The TXHC Program assists cities to assess their existing environments, implement changes in local environmental and policy infrastructure and adopt priority public health practices to reduce risk factors for cardiovascular disease (CVD), stroke, and other chronic diseases.

Administrative costs associated with the Preventive Health Block Grant total $570,620 that is 10% of the grant. Activities include: provision of legal services, personnel and accounting services, information technology services, office space, utilities, printing, phone, building and equipment maintenance supporting the operation of the PHHS Block Grant within the Texas Department of State Health Services.

Agenda Item #4: **Adjournment**

Discussion: No Discussion
Action: Meeting was adjourned.



3/30/2015

Preventive Health & Health Block Grant
State Preventive Health Advisory Committee

Telephone Conference Call
May 12, 2015
10:00 a.m. CDT

Physical Location
1100 West 49th St
Conference Room M-101
Austin, TX 78754
1-877-820-7831 Passcode: 682566#

Welcome …….....

Approval of Meeting Minutes for March 24, 2015……..…….……..

Status of the FY15 Preventive Health & Health Services Block Grant (PHHSBG) Funding ……..……

PHHS Block Grant Program Reports ……

Approval of FY15 Preventive Health & Health Services Work Plan*……..…….……

Stakeholder Public Comment.....

Adjourn .....

*Denotes Action Items

Information may be obtained from Amy Pearson, P.O. Box 149347, Mail Code 1908, Austin, Texas 78714-9347, (512) 776 2028, amy.pearson@dshs.state.tx.us . Persons with disabilities who plan to attend this meeting and require auxiliary aids or services are asked to contact Anne Mosher at (512) 776-7404 72 hours prior to the meeting so that appropriate arrangements may be made.

The committee accepts public testimony at meetings. Persons wishing to address the committee must complete a registration form at the reception desk before the start of the meeting. Agenda items may be taken in any order at the discretion of the Chair.

Preventive Health & Health Block Grant
State Preventive Health Advisory Committee

Date: May 15, 2015

To: State Preventive Health Advisory Committee Members (SPHAC)

From: Amy Pearson, PHHS Block Grant Coordinator

Subject: SPHAC Meeting Minutes from May 12, 2015

Members Present: Amy Pearson; Zach Thompson; Hector Balcazar; John Herbold, DVM; Linda Lloyd; Kim Petrili.

The State Preventive Health Advisory Committee meeting was called to order for May 12, 2015.

Agenda Item #1: Approval of March 24, 2015, Minutes

Discussion: Minutes from the March 24, 2015, were approved as written with no comment or changes.

Action: Minutes approved by Hector Balcazar; seconded by Linda Lloyd and approved by members as written with no changes or amendments.

Agenda Item #2 Updates on the FY15 Preventive Health & Health Services Block Grant (PHHSBG) Funding

Discussion: Ms. Amy Pearson, Committee Member and Block Grant Coordinator, reported on updates for CDC on the block grant. CDC released the Fy15 Funding Allocation Table with $6.1 million dollars awarded to Texas. DSHS leadership is recommending to utilize those funds and to continue funding for existing programs and staff personnel as identified in the FY14 Work Plan.
Statewide block grant public hearings have been scheduled for May 19-20, 2015, in Health Service Regions 1, 4/5, 7 and 11. Comments received from the public hearings will be submitted within the FY15 Work Plan that is due on or before July 1, 2015. Texas will be submitting the FY15 Work Plan prior to the July 1st deadline after DSHS leadership has reviewed for submission.

Action: No Action.

Agenda Item #3: PHHS Block Grant Program Reports

Discussion: Block grant funded program accomplishments and updates were provided by each program manager responsible for program activities.

Ms. Peggy Helton, with the Office of the Attorney General reported on local sexual assault programs and statewide programs that implement strategies and activities to support the primary prevention of sexual assault and/or sexual violence utilizing any of the following approved activities: educational seminars, training programs for professionals, preparation of information materials, training programs for students and campus personnel designed to reduce the incidence of sexual assault at colleges and universities, education to increase the awareness about drugs used to facilitate rapes or sexual assault, and other efforts to increase awareness of the facts about or to help prevent sexual assault.

Ms. Kristy Hansen reported on the continued and expanded activities of the Community and Clinical Preventive Services that are developed to reduce the impact of chronic diseases on the State of Texas, focusing on clinical and community systems-level enhancements to improve quality of care and health outcomes. Through contracts with three external partners (Texas Association of Community Health Centers, TMF Health Quality Institute, and the University of Texas at Austin Tobacco Research and Evaluation Team), funds will support a coordinated statewide approach to enhance preventive services throughout the state. Program strategies include clinical quality improvement activities such as promoting standardized clinical quality measures and tobacco cessation support within clinical systems; coordinated care team development; enhanced training of community health workforce; and strengthening of clinical-community linkages. These efforts align with goals to improve the quality of care to improve health outcomes, lower health care costs, and improve population health.

Ms. Cecila Braesly reported on the Texas Healthy Communities Program that has expanded activities to encourage and enable Texas communities to implement evidence based practices to make policy and environmental improvements that reduce the burden of chronic diseases. Eighteen contracts with local health departments will support 20 communities to complete a needs and assets assessment and to implement evidence-based practices in identified areas of need, which may include the following priority areas: accessible health food options, physical activity areas and opportunities, breastfeeding-friendly worksites, school health programs, worksite wellness programs, comprehensive tobacco control, cardiac and stroke response, and/or promotion of primary and secondary prevention of CVD and stroke in healthcare systems.

Agenda Item #4: **Approval of FY15 Preventive Health & Health Services Work Plan**

Discussion: Ms. Pearson reported that in FFY 2015, four activities are proposed to be funded under the Preventive Health & Health Services Block Grant. These include local health departments, sexual assault prevention and crisis services, Community and Clinical Preventive Services and the Texas Healthy Communities

Recognition Program. The PHHS Block Grant award for FFY 2015 is $6,166,855. This work plan is for the Preventive Health and Health Services Block Grant (PHHSBG) for Federal Year 2015. It is submitted by the Texas Department of State Health Services as the designated state agency for the allocation and administration of PHHSBG funds. Proposed Allocation and Funding Priorities for FY 2015:

Sexual Assault-Rape Crisis (HO IPV 40): $562,234 of this total is a mandatory allocation to the Texas Department of State Health Services which provides this funding to supports local sexual assault programs and one statewide program to develop and implement community and statewide based strategies and activities that support the primary prevention of sexual violence. These primary prevention efforts address the underlying causes of sexual violence and goes beyond awareness to include activities designed to change attitudes, beliefs and behaviors that allow sexual violence to occur.

Public Health System Assessment (HO PHI-14): $2,180,419 of this total will be utilized to support 60 Local Health Departments by strengthening local public health infrastructure through education and outreach; disease surveillance; mobilization of community groups to address local public health concerns; and development of policies to safeguard and protect local community health and safety.

Receipt of Evidence-Based Clinical Preventive Services (AHS-7), Community-Based Primary Prevention Services (ECBP-10), Older Adults' Confidence in Managing Their Chronic Conditions (OA-3) , and Tobacco Screening in Health Care Settings (TU-9) : $1,408,386 of this total will be utilized to ensure the continuation and expansion of the priority activities developed through the DSHS Community Transformation Grant (CTG) that are evidence-based strategies to reduce the impact of chronic diseases on the State of Texas and on individuals, families, and communities.

Community-Based Primary Prevention Services (ECBP-10):$1,455,354 will fund the Texas Healthy Communities (TXHC) Program which was established in 2003 by the DSHS Cardiovascular Disease Program and the Texas Council on Cardio-vascular Disease and Stroke with the help of public and private partners. The TXHC Program assists cities to assess their existing environments, implement changes in local environmental and policy infrastructure and adopt priority public health practices to reduce risk factors for cardiovascular disease (CVD), stroke, and other chronic diseases.

Administrative costs associated with the Preventive Health Block Grant total $560,462 which is 10% of the grant. Activities include: provision of legal

services, personnel and accounting services, information technology services, office space, utilities, printing, phone, building and equipment maintenance supporting the operation of the PHHS Block Grant within the Texas Department of State Health Services.

The grant application is prepared under federal guidelines, which require that states use funds for activities directed toward the achievement of the National Health Promotion and Disease Prevention Objectives in Healthy People 2020

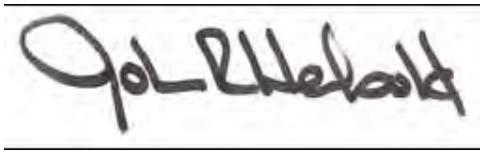
Action: Motion by Hector Balcazar to approve the FY15 Work Plan with the identified programs and funding of $6,166,855 written as noted above. Seconded by Linda Lloyd and approved by members.

Agenda Item #5: **Public Comments**

Discussion: No Comments

Agenda Item #6 **Adjournment**

Action: Meeting was adjourned.



5/15/2015

Texas FY 2014
Preventive Health and Health Services Block Grant

Annual Report

Annual Report for Fiscal Year 2014
Submitted by: Texas
DUNS: 807391511
Printed: 1/28/2015 3:30 PM

Governor: Rick Perry
State Health Officer: David Lakey
Block Grant Coordinator:
Amy Pearson
P.O. Box 149347
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Based on Work Plan: TX 2014 V1 R1 Approved 7/23/2014
Annual Report Created on: 12/15/2014
Annual Report Submitted on: 1/28/2015

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Executive Summary

This REVISED work plan is for the Preventive Health and Health Services Block Grant (PHHSBG) for Federal Year 2014. It is submitted by the Texas Department of State Health Services as the designated state agency for the allocation and administration of PHHSBG funds.

Funding Assumptions:

The total award for the FY 2014 Preventive Health and Health Services Block Grant is $6,268,434. This amount is based on a funding update allocation table distributed by CDC in the previous fiscal year.

Proposed Allocation and Funding Priorities for FY 2014:

Sexual Assault-Rape Crisis (HO IPV 40): $562,234 of this total is a mandatory allocation to the Texas Department of State Health Services which provides this funding to supports local sexual assault programs and one statewide program to develop and implement community and statewide based strategies and activities that support the primary prevention of sexual violence. These primary prevention efforts address the underlying causes of sexual violence and goes beyond awareness to include activities designed to change attitudes, beliefs and behaviors that allow sexual violence to occur.

Public Health System Assessment (HO PHI-14): $2,442,359 of this total will be utilized to support 60 Local Health Departments by strengthening local public health infrastructure through education and outreach; disease surveillance; mobilization of community groups to address local public health concerns; and development of policies to safeguard and protect local community health and safety.

Receipt of Evidence-Based Clinical Preventive Services (AHS-7), Community-Based Primary Prevention Services (ECBP-10), Older Adults' Confidence in Managing Their Chronic Conditions (OA-3) , and Tobacco Screening in Health Care Settings (TU-9) : $1,832,154 of this total will be utilized to ensure the continuation and expansion of the priority activities developed through the DSHS Community Transformation Grant (CTG) that are evidence-based strategies to reduce the impact of chronic diseases on the State of Texas and on individuals, families, and communities.

Community-Based Primary Prevention Services (ECBP-10):$1,431,487 will fund the Texas Healthy Communities (TXHC) Program which was established in 2003 by the DSHS Cardiovascular Disease Program and the Texas Council on Cardio-vascular Disease and Stroke with the help of public and private partners. The TXHC Program assists cities to assess their existing environments, implement changes in local environmental and policy infrastructure and adopt priority public health practices to reduce risk factors for cardiovascular disease (CVD), stroke, and other chronic diseases.

Administrative costs associated with the Preventive Health Block Grant total $570,620 which is 10% of the grant. Activities include: provision of legal services, personnel and accounting services, information technology services, office space, utilities, printing, phone, building and equipment maintenance supporting the operation of the PHHS Block Grant within the Texas Department of State Health Services.

The grant application is prepared under federal guidelines, which require that states use funds for activities directed toward the achievement of the National Health Promotion and Disease Prevention Objectives in Healthy People 2020

State Program Title: Community and Clinical Preventive Services

State Program Strategy:

Goal: The goal is to ensure continuation and expansion of the priority activities developed through the Texas Department of State Health Services (DSHS) Community Transformation Grant (CTG) that is evidence-based strategies to reduce the impact of chronic diseases on the State of Texas and on individuals, families, and communities.

Health Priorities: The health priorities of Community and Clinical Preventive Services include optimization of clinical preventive care through quality improvement strategies such as use of standardized clinical quality measures and training for integrated team care in Federally Qualified Health Centers (FQHCs); tobacco cessation through system enhancements that improve tobacco use screening, counseling, and QuitLine referral in clinical settings; and efforts to enhance community-clinical linkages through efforts to increase chronic disease training opportunities for Community Health Workers and develop strategies for improved coordination between clinical systems and community based resources such as chronic disease self-management programs.

Primary Strategic Partnerships: Strategic partnerships will continue with TMF Health Quality Institute, Texas Association of Community Health Centers (TACHC) and the University of Texas at Austin Tobacco Research and Evaluation Team for specified programmatic activities.

Evaluation Methodology: The Health Promotion and Chronic Disease Prevention Section at DSHS will dedicate a database administrator and evaluation specialist to coordinate all data reporting and develop evaluation plans for subcontractors' programmatic activities. Evaluation methods will include both qualitative and quantitative approaches, including process measures as well as health outcome data (e.g. tobacco cessation, diabetes and blood pressure control).

National Health Objective: AHS-7 Receipt of Evidence-Based Clinical Preventive Services

State Health Objective(s):

Between 07/2014 and 12/2020, Expand quality improvement strategies to optimize provision of evidence-based clinical preventive services to vulnerable populations served by federally qualified health centers (FQHCs) throughout Texas.

State Health Objective Status
In Progress

State Health Objective Outcome
In July 2014, TACHC began expansion of quality improvement strategies by hiring a new Clinical Innovation Specialist to promote quality improvement strategies in FQHCs. The Clinical Innovation Specialist will serve as a resource for quality improvement strategies that FQHCs around the state can utilize.

Reasons for Success or Barriers/Challenges to Success
N/A

Strategies to Achieve Success or Overcome Barriers/Challenges
N/A

Leveraged Block Grant Dollars
No

Description of How Block Grant Dollars Were Leveraged

N/A

OBJECTIVES – ANNUAL ACTIVITIES

Impact/Process Objective 1:
Clinical quality improvement
Between 07/2014 and 09/2014, Texas Association of Community Health Centers (TACHC) will increase the number of Clinic Innovation Specialists on staff from 0 to **1**.

Impact/Process Objective Status
Met

Impact/Process Objective Outcome
Between 07/2014 and 09/2014, Texas Association of Community Health Centers (TACHC) increased the number of Clinic Innovation Specialists on staff from 0 to **1**.

Reasons for Success or Barriers/Challenges to Success
N/A

Strategies to Achieve Success or Overcome Barriers/Challenges
N/A

Activity 1:
Clinical Innovation Specialist Training
Between 07/2014 and 09/2014, Specialist will begin training to enhance TACHC's ability to provide Team-based Care Training and Technical Assistance to federally qualified health centers in Texas

Activity Status
Completed

Activity Outcome
Clinical Innovation Specialist was hired July 1, 2014. In July 2014, the CIS attended NCQA's three-day Patient Centered Medical Home training in Providence, RI. This training is required for certification as a PCMH content expert. In Dec 2014, Lily successfully completed the NCQA PCMH content expert exam and is now a certified PCMH content expert. The certification is valid for two years. Between July-September 2014 the CIS visited three FQHCs (all PCMH recognized) and one non-FQHC organization that are examples of best practices for team-based care. One or two days were spent at each organization to observe their work processes, interview staff members, and collect information to bring back to TACHC members.

The CIS participated in weekly technical assistance calls for a Center seeking PCMH Level 1 recognition from NCQA. Through these calls CIS was able to learn from experienced coaches within TACHC, familiarizing herself with the practice transformation process and with coaching techniques. The CIS contributed to planning Learning Session 2 (September 2014) of the OC3 curriculum and contributed findings from the national site visits to a training session led by Barb Boushon.

Reasons for Success or Barriers/Challenges to Success
N/A

Strategies to Achieve Success or Overcome Barriers/Challenges
N/A

National Health Objective: ECBP-10 Community-Based Primary Prevention Services

State Health Objective(s):

Between 07/2014 and 12/2020, Engage community-based organizations and health care systems to develop and strengthen community-clinical linkages to improve health outcomes.

State Health Objective Status
In Progress

State Health Objective Outcome
As an initial step toward this objective, a community collaborative model approach is being developed in the Tyler, Texas area to serve as a model for how to better strengthen community-clinical linkages.

Reasons for Success or Barriers/Challenges to Success
Communities that have invested stakeholders and adequate resources and infrastructure (such as Tyler) have facilitated this approach.

Strategies to Achieve Success or Overcome Barriers/Challenges
We will need ongoing buy-in and engagement from health care systems, community organizations, and their representative stakeholders for this approach to be successful.

Leveraged Block Grant Dollars
No

Description of How Block Grant Dollars Were Leveraged
N/A

OBJECTIVES – ANNUAL ACTIVITIES

Impact/Process Objective 1:
Engaging a target community
Between 07/2014 and 09/2014, TMF Health Quality Institute will identify **1** target community with which to develop a community collaborative model to address chronic disease prevention.

Impact/Process Objective Status
Met

Impact/Process Objective Outcome
Between 07/2014 and 09/2014, TMF Health Quality Institute identified **1** target community with which to develop a community collaborative model to address chronic disease prevention.

Reasons for Success or Barriers/Challenges to Success
TMF Health Quality Institute ("TMF") carefully analyzed potential target communities to develop a community collaborative model and narrowed the choices down to 4 communities: Atascosa County area, Corpus Christi area, Tyler area, and Uvalde area. Potential communities were evaluated for information on chronic disease burden, as well as detailed analysis of community assets and challenges. Factors such as organizational strength of health care systems, identification of potential stakeholders, and community resources and infrastructure were included in the analysis. Upon further consultation with our team at DSHS, the community of Tyler was chosen as the target community in which to develop the model.

Strategies to Achieve Success or Overcome Barriers/Challenges
TMF has excellent experience in quality improvement strategies and working relationships with stakeholders around the state, which greatly enhanced their ability to analyze potential communities. DSHS worked closely with TMF to consider organizational support in the potential target communities as well as understand demographic and health data for the different communities. Though TMF is

experienced in developing collaborative quality improvement projects, we anticipate that the success of this project will greatly depend on ongoing engagement and buy-in of the community's stakeholders in advancing this community collaborative model.

Activity 1:

Target community identification

Between 07/2014 and 09/2014, TMF will identify one target community for this approach. TMF will work with Texas Department State Health Services to identify a selected community of interest using data from the Office of Surveillance, Education and Research to build upon existing community resources and Community Health Worker (CHW) networks and to provide structure to the community-clinical linkage. If data is not available to select the area of interest, TMF in partnership with DSHS, will map out current power structures statewide to select a community of interest.

Activity Status

Completed

Activity Outcome

Tyler, Texas selected for community collaborative

Reasons for Success or Barriers/Challenges to Success

A community was chosen after careful consideration of health status, infrastructure, and stakeholders in target communities, and with collaboration with DSHS.

Strategies to Achieve Success or Overcome Barriers/Challenges

N/A

Activity 2:

Community engagement

Between 07/2014 and 09/2014, TMF will recruit strong community and medical representatives to build a coalition of 5-7 to begin redesigning the network of care around our selected topic and community

Activity Status

Completed

Activity Outcome

TMF identified the "power players" in the communities they considered, and also developed the structure they wanted to provide to the collaborative. TMF provided to DSHS the recommendations on the communities with the existing groups and infrastructure that could support the work.
Selection of coalition members followed this initial identification of community representatives.

Reasons for Success or Barriers/Challenges to Success

This work requires significant effort to vet potential collaborative members to ensure they are committed to the project's success.

Strategies to Achieve Success or Overcome Barriers/Challenges

TMF utilizes a well-established network to identify and vet potential representatives and networked with our staff at DSHS and regional/local health offices to best identify the stakeholders who will advance the project's success.

Activity 3:

Operational planning

Between 07/2014 and 09/2014, Develop a plan for building foundations and operational maintenance. TMF will break its efforts into two phases (building foundations and operational maintenance). TMF will develop a plan to coordinate the steering committee, identify possible training needed for committee members, and prepare for the first community meeting.

Activity Status
Completed

Activity Outcome
Additional community meetings will be hosted to provide updates on rapid cycle improvements each of the representatives completed from the last meeting. Subsequent meetings will focus on theories that break down habits, such as the theory of perceived behavioral control, social norms theory, and social cognitive theory. TMF will guide the collaborative members to understand the benefits of quality improvement, root cause analysis, and appreciative inquiry. Community organizing techniques will be employed to keep the collaborative group engaged in the work and the process of appreciative inquiry. The use of personal stories to develop individual and collective narrative is a community organizing technique that will be used. Additionally, TMF will develop training for the collaborative group on any identified topic to further the work. Some ideas that may help strengthen relationships and participation in the collaborative include:
Jay Conger's Four Distinct and Essential Steps for Effective Persuasion
Kate B. Hilton's Developing and Coaching for a Public Narrative
Edgar Schein's Levels of Culture
Lencioni's Five Levels of Team Dysfunctions
Rogers' Five Attributes that Affect the Rate of Adoption of new ideas in a social system.
By the end of the project, the stakeholders will have the tools to facilitate continuous improvement and will begin to use community organizing skills to sustain the community plan.

Reasons for Success or Barriers/Challenges to Success
N/A

Strategies to Achieve Success or Overcome Barriers/Challenges
N/A

National Health Objective: OA-3 Older Adults' Confidence in Managing Their Chronic Conditions

State Health Objective(s):
Between 07/2014 and 12/2020, TMF will enhance the capacity of community health workers in Texas to provide excellent patient-centered services for health promotion and chronic disease prevention.

State Health Objective Status
In Progress

State Health Objective Outcome
A preliminary list of training topics was developed from the first focus group and will be further refined and further training tools will be developed.

Reasons for Success or Barriers/Challenges to Success
This work builds on previous work that developed education and training tools for community health workers. By engaging CHWs in focus groups to identify their learning needs related to health promotion and chronic disease prevention we expect to further refine and develop improved educational materials for CHWs.

Strategies to Achieve Success or Overcome Barriers/Challenges
TMF has excellent experience developing educational materials. Continued collaboration with DSHS and CHW training programs will facilitate the development of training materials that enhance CHW's knowledge of disease prevention strategies.

Leveraged Block Grant Dollars
No

Description of How Block Grant Dollars Were Leveraged
N/A

OBJECTIVES – ANNUAL ACTIVITIES

Impact/Process Objective 1:
Community Health Worker Needs Assessment
Between 07/2014 and 09/2014, TMF Health Quality Institute will conduct **1** focus group of Community Health Workers to provide input on their training needs to enhance chronic disease prevention and education programming.

Impact/Process Objective Status
Met

Impact/Process Objective Outcome
Between 07/2014 and 09/2014, TMF Health Quality Institute conducted **1** focus group of Community Health Workers to provide input on their training needs to enhance chronic disease prevention and education programming.

Reasons for Success or Barriers/Challenges to Success
Excellent focus group facilitation was important for success.

Strategies to Achieve Success or Overcome Barriers/Challenges
TMF decided to conduct an additional focus group to better understand CHW training needs, which occurred after this funding term.

Activity 1:
Community Health Worker Focus Group Recruitment
Between 07/2014 and 09/2014, **Identify a community health worker association to participate in a focus group setting**

Activity Status
Completed

Activity Outcome
Focus group was conducted.

Reasons for Success or Barriers/Challenges to Success
TMF utilized its network to recruit community health workers into the focus group.

Strategies to Achieve Success or Overcome Barriers/Challenges
N/A

Activity 2:
Focus Group of Community Health Workers
Between 07/2014 and 09/2014, Conduct a focus group of Community Health Workers (CHWs). TMF will conduct one focus group of CHWs to assist in identifying knowledge and skill-based needs they perceive would enhance chronic disease prevention and education efforts among CHWs. TMF will use this information to further enhance the CHW Chronic Disease Modules TMF has developed and will prepare for dissemination of the curriculum.

Activity Status
Completed

Activity Outcome
Focus group was conducted.

Reasons for Success or Barriers/Challenges to Success
TMF has experience with conducting focus groups that enabled a successful focus group experience.

Strategies to Achieve Success or Overcome Barriers/Challenges
N/A

Activity 3:
Webinar-based CHW education and training topic list
Between 07/2014 and 09/2014, TMF will develop a webinar-based agenda of topics to address CHW knowledge and skill gaps to improve their capacity to address chronic disease education and prevention.

Activity Status
Completed

Activity Outcome
Potential topics were identified as part of focus group.

Reasons for Success or Barriers/Challenges to Success
Excellent focus group facilitation was important for success. No significant challenges noted.

Strategies to Achieve Success or Overcome Barriers/Challenges
It was decided an additional focus group would be done to elicit additional input.

National Health Objective: TU-9 Tobacco Screening in Health Care Settings

State Health Objective(s):
Between 07/2014 and 12/2020, Expand by 100 the number of clinical systems in Texas (hospital and clinic-based, as well as dental and mental health/substance abuse providers) implementing evidence-based tobacco cessation strategies, especially through use of an e-tobacco protocol incorporated into electronic medical records. This systems strategy will improve the delivery of effective tobacco screening, counseling, and referral to Quitline services, thereby improving rates of tobacco cessation and reducing the burden of tobacco-related diseases in Texas.

State Health Objective Status
In Progress

State Health Objective Outcome
In FY14, University Medical Center of El Paso serving 10 locations was fully integrated using NextGen. Three dental clinics have been identified for integration next year.

Reasons for Success or Barriers/Challenges to Success
The funding period was only 3 months in FY14. In that time, the University Medical Center of El Paso was fully integrated with NextGen and 3 dental clinics were identified as targets in the following funding year.

The UT Tobacco Research and Evaluation Team discovered through this and prior work that working directly with the EMR vendors is more productive than targeting individual health systems.

Strategies to Achieve Success or Overcome Barriers/Challenges
The UT Tobacco Research and Evaluation Team will continue to provide support directly to healthcare systems who wish to integrate with an EMR vendor and adopt the eTobacco protocol, and will shift their focus to working with a smaller list of EMR vendors that cover multiple healthcare systems.

Leveraged Block Grant Dollars
No

Description of How Block Grant Dollars Were Leveraged
N/A

OBJECTIVES – ANNUAL ACTIVITIES

Impact/Process Objective 1:
Tobacco E-protocol Implementation
Between 07/2014 and 09/2014, The University of Texas at Austin Tobacco Research and Evaluation Team will identify **5** medical and/or dental systems to pursue tobacco e-protocol implementation.

Impact/Process Objective Status
Not Met

Impact/Process Objective Outcome
Between 07/2014 and 09/2014, The University of Texas at Austin Tobacco Research and Evaluation Team identified **4** medical and/or dental systems to pursue tobacco e-protocol implementation.

Reasons for Success or Barriers/Challenges to Success
The funding period was only 3 months in FY14. In that time, the University Medical Center of El Paso was fully integrated with NextGen and 3 dental clinics were identified as targets in the following funding year.

The UT Tobacco Research and Evaluation Team discovered through this and prior work that working directly with the EMR vendors is more productive than targeting individual health systems.

Strategies to Achieve Success or Overcome Barriers/Challenges
The UT Tobacco Research and Evaluation Team will continue to provide support directly to healthcare systems who wish to integrate with an EMR vendor and adopt the eTobacco protocol, and will shift their focus to working with a smaller list of EMR vendors that cover multiple healthcare systems.

Activity 1:
Logic Model Development
Between 07/2014 and 09/2014, Begin creation of a logic model, based on the Coordinated Framework for Implementation Research (CFIR) as well develop a standard process for working with healthcare systems.

Activity Status
Completed

Activity Outcome
A logic model was developed in order to develop and disseminate a standard process for measuring the outcomes of the project deliverables. Since the project has many pieces, the logic model is based on a process evaluation tool called the Consolidated Framework for Implementation Research. In addition to the logic model, a constructs page was developed with specific measures. These measures are meant to assist with the measurement of the process evaluation as data is collected. In addition to the logic model, overall, large-scale promotion of the eTobacco protocol was integrated in the Texas Medical Association Journal as well as banner ads on WebMD. The promotion reached more than 23,000 providers across the state.

Reasons for Success or Barriers/Challenges to Success
N/A

Strategies to Achieve Success or Overcome Barriers/Challenges
N/A

Activity 2:

Engaging Medical Systems

Between 07/2014 and 09/2014, Identify and engage large health care systems to participate in effort to implement practice changes for tobacco screening, counseling, and referral; targeted areas to reflect highest tobacco burden in order to address disparities.

Activity Status

Completed

Activity Outcome

University Medical Center of El Paso integrated 10 clinic locations into the EMR vendor, NextGen, to implement practice changes for tobacco screening, counseling, and referral. El Paso County is located on the border of New Mexico and Mexico. The population is predominately Hispanic/Latino and includes the Ysleta del Sur Pueblo tribal community. According to UMC, over 30% of their patients are covered by Medicaid/Medicare. UMC's Neighborhood Healthcare Centers are primary care facilities for the area.

Reasons for Success or Barriers/Challenges to Success

N/A

Strategies to Achieve Success or Overcome Barriers/Challenges

N/A

Activity 3:

Dental Approach for Tobacco E-protocol

Between 07/2014 and 09/2014, Explore opportunities with the dental clinic systems. Begin discussing the concept with three (3) dental clinic settings to gauge interest for the concept.

Activity Status

Completed

Activity Outcome

The process has started to identify dental clinics to target in the next year. The project team has connected with the 49 FQHCs in the original objectives and has asked if they offer dental services. Moving forward, we will likely target these dental clinic systems. Forty-one of the 49 FQHCs identified offer dental services. Three of these systems will be explored further over the next year to work towards integration.

Reasons for Success or Barriers/Challenges to Success

Each dental system has a separate dental EMR, so the process will have to start from the beginning in order to identify interest and to work with the specified dental EMR to create buy-in for full implementation.

Strategies to Achieve Success or Overcome Barriers/Challenges

UT is identifying three systems to begin the process of integration.

State Program Title: Local Health Departments

State Program Strategy:

Goal: The goal of the Division for Regional and Local Health Services (RLHS) of the Texas Department of State Health Services (DSHS) is to provide a coordinated system of public health services through local health departments and agency health service regions by ensuring the provision of the ten essential public health services.

As a public health priority for all Texans, the Texas Health and Safety Code, Chapter 121, Local Public Health Reorganization Act identified the Texas Department of State Health Service (DSHS) as one of several partners responsible for provision of essential public health services. The essential services are public health activities that ensure a healthy community at the local level. A priority for the state of Texas is to provide local health department funding in order to assure the provision of essential public health service to its citizens. To do so, DSHS and its health service regions must strengthen the statewide public health systems' ability to implement essential public health functions at the local level through increasing partnerships with current local health departments and establishing new local public health systems through collaborative processes. The RLHS division's overall strategy is to work with local health departments in establishing work plans based on community assessed public health essential service need. Work plans will identify and focus on current priority community health needs, using established state or national standards of performance, and identified activities to support the work plan based on best practices.

Health Priorities: Each PHHSBG funded local health department will be addressing essential public health service in their communities based on the 10 Essential Public Health Services. Local health department objectives will be developed to increase the community's ability to meet the gaps in service in order to build local capacity for public health.

Primary Strategic Partnerships: The RLHS division has established several external and internal partnerships throughout the state and nationally. Internal partners include the Center for Program Coordination, Family and Community Health Services, the DSHS Center for Health Statistics, Prevention and Preparedness programs. Strategic partners critical to accomplishing the divisions goal are current local health departments and districts, identified Local Health Authorities, the Texas Health Association, the Texas Health Institute, the Texas State System of Academic Schools of Public Health, affiliated non-profit public health agencies, and local stakeholders as defined by communities throughout the state.
Evaluation Methodology: Surveillance data will be used from local health department reports as they relate to meeting identified deliverables within specific work plan objectives. The RLHS division staff will evaluate completion of work plan objectives accomplished to meet essential public health service needs, DSHS programmatic goals, state wide identified public health priorities, and national public health performance standards such as Healthy People 2020.

National Health Objective: PHI-14 Public Health System Assessment

State Health Objective(s):

Between 10/2013 and 09/2014, the Texas Department of State Health Service will maintain the number of local public health agencies (60) working on locally defined goals for providing essential public health services.

State Health Objective Status
Not Met

State Health Objective Outcome
The Department of State Health Services was unable to meet their state health objective of maintaining the number of local public health entities working on essential public health services.

Reasons for Success or Barriers/Challenges to Success
Local health departments vary greatly in Texas from large urban metropolitan areas such as Houston, Dallas and San Antonio, to rural and frontier communities in the pan-handle and western areas of the state. Limited funding for local health department is an ongoing challenge, and even when we can award funding such as the PHHSBG dollars, some local governments choose to put funding towards other priorities which in turn places the burden on state to fill this gap. In this year, one local chose to close their doors of their public health department, although trend over the last several years in limited funding and services was evident and this was not unexpected. The states role in supporting local public health services continued to increase over time to this end where they ultimately determined they (the locals) could not support a health department.

Strategies to Achieve Success or Overcome Barriers/Challenges
The number of local health departments using PHHSBG funding to address essential public health services was reduced by one, from 60 to 59. This is an ongoing challenge as we've continued to see this happen over the last few years. We continue to seek out opportunities to work with locals, and where support is needed. As a home rule state, we cannot require locals to provide public health services, and in the event they choose not to continue, this becomes a challenge to meet from a state resource perspective. Ongoing collaboration with state and local leadership continues, and we are reviewing opportunities in the upcoming state legislative session to obtain financial support to local efforts.

Leveraged Block Grant Dollars
Yes

Description of How Block Grant Dollars Were Leveraged
Some success has been seen with our local health department's ability to leverage funding and support from PHHSBG funded activities. Local community garden activities funded through the PHHSBG were able to gather additional support and ongoing funding from our Women Infants and Children (WIC) program. The WIC program took on support of the community garden program and expanded it to include nutrition education programs, cooking and food preparation classes aimed at underserved populations in the respective local communities.

OBJECTIVES – ANNUAL ACTIVITIES

Impact/Process Objective 1:
Assure Competent Workforce
Between 10/2013 and 09/2014, Local Health Departments who select this essential service will review **2** times per year workforce staff requiring licensure as part of their public health role within their respective programs to assure compliance.

Impact/Process Objective Status
Met

Impact/Process Objective Outcome
Between 10/2013 and 09/2014, Local Health Departments who select this essential service reviewed **4** times per year workforce staff requiring licensure as part of their public health role within their respective programs to assure compliance.

Reasons for Success or Barriers/Challenges to Success
The local health departments choosing this essential service on assuring a competent workforce met their established objective by reviewing public health workforce training and certification requirements on a quarterly basis.

Strategies to Achieve Success or Overcome Barriers/Challenges
All local health departments are required by their scope of work to complete quarterly reviews of their

work plans, and report progress on their activities associated with their identified objectives. Locals monitoring and tracking of workforce training and assurance was documented by including training logs, training attendance sheets, and program required staff performance plans.

Activity 1:
Workforce Development
Between 10/2013 and 09/2014, Where needed, local health departments will provide their public health workforce access to staff development training and education, either live or online, on identified public health workforce needs.

Activity Status
Completed

Activity Outcome
Locals utilized state and federal training opportunities for staff that allowed where needed required training that aided in meeting license, certification or program needs. Contracted locals attended events such as epidemiology/sanitarian trainings, immunization conferences and workshops that included the majority of local contractors. Ongoing training for local public health preparedness opportunities are provided through state and federal partners for local workforce efforts.

Reasons for Success or Barriers/Challenges to Success
Local public health workforce staff was offered in person, on-line, and in some cases just-in-time training through state and federal resources.

Strategies to Achieve Success or Overcome Barriers/Challenges
Continued reduction in funding for some programmatic areas continues to hinder locals ability to travel. Increase opportunities for online web-based training will be critical, especially in Texas to assure opportunities for continuing education are provided for our statewide local public health workforce.

Impact/Process Objective 2:
Develop Policies and Plans
Between 10/2013 and 09/2014, Local Health Departments who select this essential service will review **1** time per fiscal year their agency strategic plans and update any associated public health policies as needed.

Impact/Process Objective Status
Met

Impact/Process Objective Outcome
Between 10/2013 and 09/2014, Local Health Departments who select this essential service reviewed **1** time per fiscal year their agency strategic plans and update any associated public health policies as needed.

Reasons for Success or Barriers/Challenges to Success
Local health departments selecting this essential public health service objective utilized state and local associations such as the Texas Association of County and City Health Officers (TACCHO), the Texas Municipal League (TML), and local community commissioner's court to discuss and deliberate on policies and procedures associated with local public health systems across the state. As required, local health departments review their strategic plans with their commissioner's court, local boards of health, etc. in order to get approval for funding and resources.

Strategies to Achieve Success or Overcome Barriers/Challenges
As an agency we actively participate with local health department stakeholder associations in examining ongoing practices of public health at the state and local level. We encourage dialogue between our state health service regions, their staff, and leadership with their local partners to plan and coordinate where needed.

Activity 1:

Strategic Planning and Policy Development

Between 10/2013 and 09/2014, Based on annual reviews, local health departments will work with jurisdictional leaders, public health stakeholders, and community leaders in strategic planning and policy development around identified community public health priorities.

Activity Status

Completed

Activity Outcome

Local health departments were successful in completing activities around this essential service. All local health departments routinely interact with their local boards of health, commissioner's courts and local public health partners in developing and creating their strategic planning.

Reasons for Success or Barriers/Challenges to Success

PHHSBG funded local health departments are required to create their work plan based on identified public health priorities in their communities. Prior to work plans being submitted to the state as final, approval must be obtained by local jurisdictional leaders or local boards of health.

Strategies to Achieve Success or Overcome Barriers/Challenges

Continued state support to locally driven work plans will aid in gaining local approval of priorities and those needs being met. Where challenges exist, work with state wide associations to encourage or support dialogue that results in positive shared outcomes.

Impact/Process Objective 3:

Diagnose and Investigate

Between 10/2013 and 09/2014, Local Health Departments will review **1** time per year their local disease outbreak strategic plans to ensure local programs comply with CDC and DSHS state epidemiologic standards.

Impact/Process Objective Status

Met

Impact/Process Objective Outcome

Between 10/2013 and 09/2014, Local Health Departments reviewed **1** time per year their local disease outbreak strategic plans to ensure local programs comply with CDC and DSHS state epidemiologic standards.

Reasons for Success or Barriers/Challenges to Success

Local health departments choosing this objective indicated they were successful in meeting their public health

Strategies to Achieve Success or Overcome Barriers/Challenges

As the lead agency for public health in Texas, we continue to work and plan with state leadership to obtain local disease surveillance support for our local health departments. Opportunities continue to give us needed epidemiologist in at risk areas of the state where recent funding was made available to put staff in local health department to increase their capacity to diagnose and investigate disease outbreaks.

Activity 1:

Disease Surveillance and Investigations

Between 10/2013 and 09/2014, Local Health Departments will semi-annually review local systems used in tracking of disease outbreaks in their jurisdictions, to include reporting and updating of appropriate data sources in accordance to local, state and federal guidelines.

Activity Status

Completed

Activity Outcome
Local health departments achieved their objectives associated with this activity through ongoing quarterly reporting requirements associated with their disease surveillance and reporting guidance.

Reasons for Success or Barriers/Challenges to Success
Workplans by local health departments used state and federal reporting requirements in establishing objectives as per their required scope of work.

Strategies to Achieve Success or Overcome Barriers/Challenges
Scope of work used in establishing contracts for local health departments included language requiring locals to meet federal or state programmatic standards when using funding for disease surveillance activities.

Activity 2:
Disease Surveillance Strategic Planning
Between 10/2013 and 09/2014, Local Health Departments will annually review disease surveillance strategic plans to assure compliance with DSHS and CDC standards, incorporating any needed improvements based on evaluation outcomes.

Activity Status
Completed

Activity Outcome
Local health departments reviewed disease surveillance work plans at a minimum of one time over the past year in completing their contract requirements.

Reasons for Success or Barriers/Challenges to Success
As part of required scopes of work, annual reporting and review of plan for all who are awarded PHHSBG contracts. In doing so, self-evaluations of plans that review problems or barriers required recommended corrective action to be included in future activities.

Strategies to Achieve Success or Overcome Barriers/Challenges
Ongoing quarterly reviews of local health department work plans associated with disease surveillance activities is a required part of the PHHSBG contract, upon identification of barriers or needed improvements appropriate amendments put in place.

Impact/Process Objective 4:
Enforce Laws and Regulations
Between 10/2013 and 09/2014, Local Health Departments will conduct **1** annual review of the LHD strategic plans associated with environmental health and sanitation code enforcement activities in their jurisdiction to ensure plans are in accordance with state and federal health codes.

Impact/Process Objective Status
Met

Impact/Process Objective Outcome
Between 10/2013 and 09/2014, Local Health Departments conducted **1** annual review of the LHD strategic plans associated with environmental health and sanitation code enforcement activities in their jurisdiction to ensure plans are in accordance with state and federal health codes.

Reasons for Success or Barriers/Challenges to Success
Local health departments choosing this essential service objective were able to meet their required annual review of their strategic planning around environmental and sanitation public health code enforcement activities. Local jurisdictions review and approve work plans through commissioner's courts or local boards of health that ensure plans are meeting local needs and required reporting is mandated to meet state and federal health codes.

Strategies to Achieve Success or Overcome Barriers/Challenges
Continue to support ongoing local jurisdictions involvement in the review and approval of public health strategic planning that addresses environmental and sanitation code enforcement efforts. Encourage state and local partnerships in coordinated efforts for prevention, monitoring and control, as well as training where needed.

Activity 1:
Code and Regulatory Enforcement
Between 10/2013 and 09/2014, Local health departments will develop semi-annual reports of all code enforcement monitoring and tracking activities to identify ongoing public health trends, and the regulatory activity used to enforce local public health codes.

Activity Status
Completed

Activity Outcome
Local health departments completed this activity through ongoing reporting to state and federal partners as required by program guidelines. Ongoing quarterly reporting of activity associated with objectives outlined in work plans was required by PHHBG funded locals.

Reasons for Success or Barriers/Challenges to Success
Ongoing activities were monitored and tracked accordingly through a required quarterly reporting process established in the scopes of work. All locals were required to complete quarterly reports around PHHSBG funded activities to enable the state and local leader's opportunities to appropriately address any barriers or issues that occurred in meeting objectives.

Strategies to Achieve Success or Overcome Barriers/Challenges
Continue to require ongoing quarterly reporting. Encourage the use of state and federal resources when needed to meet identified public health needs, such as training or local efforts to address large outbreaks or investigations.

Impact/Process Objective 5:
Evaluate Health Programs
Between 10/2013 and 09/2014, Local Health Departments will conduct **4** evaluations of PHHSBG work plans (1 per quarter) to assure program goals and objectives are on track for completion.

Impact/Process Objective Status
Met

Impact/Process Objective Outcome
Between 10/2013 and 09/2014, Local Health Departments conducted **4** evaluations of PHHSBG work plans (1 per quarter) to assure program goals and objectives are on track for completion.

Reasons for Success or Barriers/Challenges to Success
Local health departments choosing the essential service objective for evaluating PHHSBG work plans were successful in meeting their goals and objectives. Detailed reviews of the objectives are required as per the scope of work expectations for all who are funding using the PHHSBG and quarterly report submissions and reviews aid in visibility around ongoing activities associated with their plans.

Strategies to Achieve Success or Overcome Barriers/Challenges
The requirements included in the scope of work around reporting assure that documentation occurs, as well as awareness of issues that may arise around barriers to their success. Reporting on a quarterly basis requires project managers locally to acknowledge their need to amend contracts were appropriate to shift focus or create alternatives to existing planning efforts to meet their goals.

Activity 1:

Program Evaluation and Assessment

Between 10/2013 and 09/2014, Local health departments will utilize the quarterly reporting process on PHHSBG funded program areas to evaluate and assess any needed changes to current goals or objectives, and implement changes where appropriate.

Activity Status

Completed

Activity Outcome

All local health departments utilized the quarterly reporting process required in their scope of work in agreement to receiving PHHSBG funding. Instances occurred where amendments were needed changed as a result of the reporting. Additionally, locals used reports to share with local governing bodies to update on status and progress of their grants.

Reasons for Success or Barriers/Challenges to Success

Local health departments choosing the essential service objective for evaluating PHHSBG work plans were successful in meeting their goals and objectives. Detailed reviews of the objectives are required as per the scope of work expectations for all who are funding using the PHHSBG and quarterly report submissions and reviews aid in visibility around ongoing activities associated with their plans.

Strategies to Achieve Success or Overcome Barriers/Challenges

The requirements included in the scope of work around reporting assure that documentation occurs, as well as awareness of issues that may arise around barriers to their success. Reporting on a quarterly basis requires project managers locally to acknowledge their need to amend contracts were appropriate to shift focus or create alternatives to existing planning efforts to meet their goals.

Impact/Process Objective 6:

Inform and Educate

Between 10/2013 and 09/2014, Local Health Departments who select this essential service to address will conduct **1** time per year a review of their public health education planning associated with programs across their agency to evaluate methods used for the dissemination and accuracy of information to identified stakeholders.

Impact/Process Objective Status

Met

Impact/Process Objective Outcome

Between 10/2013 and 09/2014, Local Health Departments who select this essential service to address conducted **1** time per year a review of their public health education planning associated with programs across their agency to evaluate methods used for the dissemination and accuracy of information to identified stakeholders.

Reasons for Success or Barriers/Challenges to Success

Local health department choosing this essential health service objective were able to review programmatic plans and materials directed toward public health awareness and education activities supported by the PHHSBG funds and met their objectives as described in their plans.

Strategies to Achieve Success or Overcome Barriers/Challenges

Local health departments utilized focus groups and public feedback to materials and resources used during their public health education and awareness campaigns. Efforts included cross programmatic input in to planning and outreach coordinated by their agencies aimed at meeting strategic planning goals and objectives.

Activity 1:

Public Health Education Initiatives

Between 10/2013 and 09/2014, Programs within the LHDs will annually review health education literature used for outreach and education campaigns reflecting current data and resource information.

Activity Status

Completed

Activity Outcome

Local health departments addressing this activity were able to complete updates and reviews of materials used in education and outreach campaigns.

Reasons for Success or Barriers/Challenges to Success

Locals built into their work plans objectives that included systematic processes to review public health literature used in education and outreach campaigns. Efforts included reviewing materials for their cultural appropriateness.

Strategies to Achieve Success or Overcome Barriers/Challenges

Data and information used in the materials were in many cases used to educate not only the general public but also elected officials. This reinforced the need for many to review materials being developed or updated to be accurate in their information.

Activity 2:

Activity 2 - Public Health Education Initiative

Between 10/2013 and 09/2014, Local health departments will gather local public health data and vital statistics associated with their jurisdiction to be shared with local lawmakers, commissioners courts, city or county public health advisory committees to educate them on health issues and or initiatives associated with the population they serve.

Activity Status

Completed

Activity Outcome

Local health departments involved in activities around this essential service objective provided ongoing data and information related to community health assessments, outreach activity evaluations and public health education curriculum reviews with local commissioners courts and judges, agency leadership, and curriculum planners to increase knowledge, make improvements on initiatives, and changes to learning practices where needed in the communities they serve.

Reasons for Success or Barriers/Challenges to Success

Requirements to work plans in quarterly reporting established ongoing reviews and evaluations of efforts, documenting feedback, gather data, and providing opportunities for improvement in multiple public health areas of effort. This ensured that more than once over the period of a year, they examine their processes and data to show efforts and gains or in addressing needs for change.

Strategies to Achieve Success or Overcome Barriers/Challenges

Continue to encourage reporting efforts to local stakeholders and continue with the built in component of quarterly reporting to work plans.

Impact/Process Objective 7:

Link People to Services

Between 10/2013 and 09/2014, Local Health Departments who select to address this essential service will conduct **1** time per year a review of program referral systems linking clients to providers or services in order to measure overall referral rates.

Impact/Process Objective Status
Met

Impact/Process Objective Outcome
Between 10/2013 and 09/2014, Local Health Departments who select to address this essential service conducted **1** time per year a review of program referral systems linking clients to providers or services in order to measure overall referral rates.

Reasons for Success or Barriers/Challenges to Success
Local health departments who chose to address this essential service were successful in meeting their local planning objectives. Locals used PHHSBG funding to address community resource referral systems, planning guides, and program materials used in client referral efforts.

Strategies to Achieve Success or Overcome Barriers/Challenges
Locals identified needs to update and use systems that the community utilized in obtaining community based public health resources. Program staff collaborated with non-for profits, local emergency managers, and 211 call centers to coordinate review and updates to their referral systems to address any needed changes.

Activity 1:
Resource Connectivity
Between 10/2013 and 09/2014, Local health departments will review annually client service referral directories are in place, whether these are through existing phone directories, or online client service databases to be used for linking stakeholders to local, state, or national public health services.

Activity Status
Completed

Activity Outcome
Local health departments work plans developed to address this activity were successful in reviewing client referral databases, online resources and resource guides used by their agencies and made available to the general public.

Reasons for Success or Barriers/Challenges to Success
Locals ongoing planning and review processes identified in work plans included systematic reviews of client referral resources, updates to their online web sites. Many coordinated their information with local 211 networks that included ongoing reviews and updates.

Strategies to Achieve Success or Overcome Barriers/Challenges
Continue to encourage systematic processes that include data management and resource material update plans. Partnering with 211-like services referral systems requires ongoing reviews and monitoring of information used by these systems and brings increase need to keep them up-to-date and accurate.

Activity 2:
Resource Coordination and Collaboration
Between 10/2013 and 09/2014, Local health departments will annually evaluate their internal policies for client referrals and case management activities in population based service programs to identify inefficiencies or needed program changes.

Activity Status
Completed

Activity Outcome
Locals using the PHHSBG funding for this area were successful in reviewing their plans for case management referrals.

Reasons for Success or Barriers/Challenges to Success
The locals were able to use staff evaluations and feedback to review policies. Ongoing dialogue with state program staff on updated policy requirements was communicated regularly from through the states contracting services staff.

Strategies to Achieve Success or Overcome Barriers/Challenges
Continue to support ongoing activities that allow for staff input on services and policies associated with case management services. Additional support is needed at the state levels provide ongoing quality assurance around implementation of policies and needed evaluations to effective client referral practices.

Impact/Process Objective 8:
Local Health Department Accreditation
Between 10/2013 and 09/2014, Local Health Departments who select this essential service will develop **1** strategic plan for their agency in accordance to Public Health Accreditation Board guidelines related to preplanning for local public health accreditation.

Impact/Process Objective Status
Met

Impact/Process Objective Outcome
Between 10/2013 and 09/2014, Local Health Departments who select this essential service developed **1** strategic plan for their agency in accordance to Public Health Accreditation Board guidelines related to preplanning for local public health accreditation.

Reasons for Success or Barriers/Challenges to Success
One local health department used the PHHSBG funding in evaluating their public health strategic planning and quality improvement processes relate to public health accreditation board (PHAB) standards.

Strategies to Achieve Success or Overcome Barriers/Challenges
The local health department was successful in continuing their quality improvement initiative through review and evaluation of required standards for documentation needed in the review process. Staff attended site visit training on PHAB accreditation requirements that aided in quality improvement planning and coordination of their local programs. The process is ongoing and will continue as indicated in their current FY15 work plan.

Activity 1:
Accreditation Pre-Planning and Development
Between 10/2013 and 09/2014, Local Health Departments establish a process for conduction system wide assessment on accreditation readiness through appointment of an accreditation coordinator who will oversee the process.

Activity Status
Completed

Activity Outcome
The local health department using PHHSBG was successful in meeting this activity requirement through the appointment of a staff to oversee their quality improvement process related their accreditation plans.

Reasons for Success or Barriers/Challenges to Success
The local health department's accreditation coordinator attended public health accreditation (PHAB) site visit training providing necessary guidance on standards required in planning for a future site visit.

Strategies to Achieve Success or Overcome Barriers/Challenges
Some challenges exist with the local health department such as staffing, and documentation for standard requirements. The process is lengthy and time consuming for them and some services are provided by

the state health department where ongoing coordination is needed. They continue to communicate across programs and with their state partners in planning needs, and utilize input from PHAB on technical support.

Activity 2:

Activity 2 - Accreditation Pre-Planning and Development

Between 10/2013 and 09/2014, Local health departments will create plans for implementing pre-requisite steps in place outlined by the PHAB to evaluate their agency's readiness to move forward toward accreditation.

Activity Status

Completed

Activity Outcome

The local health department using PHHSBG funds for their accreditation planning was successful in a addressing the activity for this essential service.

Reasons for Success or Barriers/Challenges to Success

The local health department evaluated annual plans they've established towards becoming accredited in accordance to current year public health accreditation board (PHAB) standards. Upon review necessary updates and changes were implemented where needed.

Strategies to Achieve Success or Overcome Barriers/Challenges

The local health department has incorporated agency wide strategic planning around PHAB requirements needed to becoming accredited. These plans are ongoing as they were part of years planning for accreditation. The local is committed to the process, which is evident through their identification of a accreditation coordinator and investments in training on site visit processes.

Impact/Process Objective 9:

Mobilize Partnerships

Between 10/2013 and 09/2014, Local Health Departments who select this essential service will review **1** time per year their community for potential stakeholders who contribute to or benefit from public health in order to increase the value of local public health.

Impact/Process Objective Status

Met

Impact/Process Objective Outcome

Between 10/2013 and 09/2014, Local Health Departments who select this essential service reviewed **1** time per year their community for potential stakeholders who contribute to or benefit from public health in order to increase the value of local public health.

Reasons for Success or Barriers/Challenges to Success

Local health departments choosing the essential service objective addressing mobilizing partnerships met their objective of reviewing their communities for potential stakeholders who contribute or benefit from public health in order to increase the value of public health in their communities. Several health departments coordinated with local law enforcements agencies, fire protection, non-profit organizations and school districts/parent teacher organizations in promoting public health practices that aid in protecting their communities from disease outbreaks, emergency preparedness planning, extending staff and workforce trainings and multiple resource materials distributions that increased visibility and ongoing relationships in their communities.

Strategies to Achieve Success or Overcome Barriers/Challenges

Continue to support partnerships that reach across communities and organizations that support common themes, like EMS, Police, Schools, and community non-profit organizations.

Activity 1:

Community Resource Management

Between 10/2013 and 09/2014, Local Health Departments conduct one strategic planning meeting with locally identified public health stakeholders and partners to review commonalities and resources in order to build collaborative approaches to preventing prevalent public health issues.

Activity Status

Completed

Activity Outcome

PHHSBG funded local health departments reached out to local public health stakeholders to design outreach and public health awareness/promotional efforts towards addressing public health priority issues in their communities. Examples included locals working with college campuses in STD/HIV preventions, local law and fire in community coordinated training efforts, parent teacher organizations and locals planning ongoing nutrition/obesity prevention collaborative.

Reasons for Success or Barriers/Challenges to Success

Local health departments are encouraged to establish cross cutting initiatives that reach out into their communities to build partnerships that build and value public health preventive activities.

Strategies to Achieve Success or Overcome Barriers/Challenges

The flexibility in allowing locals to choose the areas they would like to focus on for the use of the PHHSBG funding allows for creativity in their strategic planning efforts. The variability that exists from local to local with their public health need may not be much, but the resources available can vary greatly. This encourages locals to seek out partnerships when appropriate and we've encouraged them to do so if the need is there to help address their public health issue.

Impact/Process Objective 10:

Monitor Health Status

Between 10/2013 and 09/2014, Local Health Departments who select this essential service will evaluate **1** times per year the data used for their community health profile to ensure accuracy and that the data is readily available and in a usable manner for stakeholder planning.

Impact/Process Objective Status

Met

Impact/Process Objective Outcome

Between 10/2013 and 09/2014, Local Health Departments who select this essential service evaluated **1** times per year the data used for their community health profile to ensure accuracy and that the data is readily available and in a usable manner for stakeholder planning.

Reasons for Success or Barriers/Challenges to Success

17 Local Health Departments chose this essential service to monitor the data around current public health issues in their communities, such as disease outbreaks, immunization needs and improvements in the number of breast cancer screenings.

Strategies to Achieve Success or Overcome Barriers/Challenges

Local health departments successfully used strategies in epidemiology and disease surveillance practices to meet this objective. Examples included a Shigela outbreak in a school district that was identified, monitored over the extent of the outbreak and prevention efforts aided in preventing further disease transmissions. Based on ongoing investigations to at risk children in need of proper immunizations, locals were able to meet identified objectives to get vaccines administered. In one local community over 87% of children identified as at risk received vaccinations, the remaining was not at risk.

Activity 1:

Disease Outbreak Tracking

Between 10/2013 and 09/2014, Local Health Departments will establish semi-annual reports that track and record required jurisdictional program data submissions to state and federal guidelines that help create their local health status profiles.

Activity Status

Completed

Activity Outcome

Local health departments were successful in meeting their state and federally required guidelines for data submissions.

Reasons for Success or Barriers/Challenges to Success

Reporting requirements established by state programs in areas such as the Texas Vaccine for Children Program, Newborn Screening, and TB/STD/HIV were indicated to have been successfully met by locals.

Strategies to Achieve Success or Overcome Barriers/Challenges

Ongoing support from program areas to the local health departments was provided in accessing systems for reporting data, local meetings with regional or central office based staff.

Activity 2:

Community Health Status

Between 10/2013 and 09/2014, Local Health Departments will act as a resource for local stakeholders and partners in conducting community health assessments based on documented public health need and use for local planning and health profiles.

Activity Status

Completed

Activity Outcome

Programmatic health data associated with public health issues such as TB prevention, immunizations, and sanitation control were provided to local stakeholders, city commissioner courts and associated local coalitions used in local planning efforts to address the overall community health needs.

Reasons for Success or Barriers/Challenges to Success

Health data obtained from multiple public health areas were used to establish ongoing direction for community health plans. A local health department efforts in promoting employee wellness was extended to the community and business owners to serve as a model and resource in improving health and wellness of their communities.

Strategies to Achieve Success or Overcome Barriers/Challenges

Public health efforts in this area are challenged by the limited resources that go beyond the local health department.

Impact/Process Objective 11:

Research

Between 10/2013 and 09/2014, Local Health Departments who select this essential service will analyze **1** time per year research and best practices published by state local or federal partners for information that can be incorporated when appropriate into existing PHHSBG funded programs.

Impact/Process Objective Status

Met

Impact/Process Objective Outcome
Between 10/2013 and 09/2014, Local Health Departments who select this essential service analyzed **1** time per year research and best practices published by state local or federal partners for information that can be incorporated when appropriate into existing PHHSBG funded programs.

Reasons for Success or Barriers/Challenges to Success
Local health departments who selected the essential service objective met their goal in building education and training efforts based on evidence based best practices in order to meet local stakeholder needs. Using ongoing evaluations of educational and community outreach efforts locals were able to identify gaps and needs. Based on research of best practices, they were able to plan and incorporate those practices into their education, training and outreach efforts.

Strategies to Achieve Success or Overcome Barriers/Challenges
Ongoing support to local stakeholder groups needing assistance in providing quality evidence based education and training to public health staffs or community members in need.

Activity 1:
Public Health Research
Between 10/2013 and 09/2014, Local health departments will annually review public health programs for opportunities to collaborate with Texas public health academic institutions of higher education in order to promote research towards established best practices.

Activity Status
Completed

Activity Outcome
Local health department recipients of the PHHSBG funding participate in statewide conferences partnering with state schools of public health to provide education and training, internship opportunities, and research aimed at encouraging best practice opportunities for current and future public health workforce.

Reasons for Success or Barriers/Challenges to Success
Local health department funded PHHSBG members hold positions on state and academic institution planning committees that encourage local, and state wide collaboration in public health best practice efforts.

Strategies to Achieve Success or Overcome Barriers/Challenges
Continue to work with institutions of higher education schools of public health in Texas who assist in research, evaluation efforts or in collaborative internships with local health departments to ensure evidence based best practices are being incorporated or provided to local partners across the state.

State Program Title: Rape Prevention

State Program Strategy:

Goal: The Texas Department of State Health Services (DSHS) contracts with the Texas Office of the Attorney General (OAG) to administer the Preventive Health and Health Services (PHHS) Block Grant Sex Offense Set Aside funds. The OAG will use this funding to support statewide and community-based strategies and activities for the primary prevention of sexual violence and to support a state level project to standardize the quality of service for survivors of sexual assault by developing criteria for the minimum services identified in the Texas Government Code, Section 420.003. Funds will be awarded to local sexual assault programs and one state sexual assault coalition for these purposes.

Health Priorities: Local PHHS Block Grant funded sexual assault programs will implement comprehensive primary prevention programs to address priorities identified in *Preventing Sexual Violence in Texas, A Primary Prevention Approach* (Plan) using any one or more of the following approved activities or community change strategies. Approved activities include: Educational seminars; training programs for professionals; preparation of informational materials; education and training programs for students and campus personnel designed to reduce the incidence of sexual assault at colleges and universities; education to increase awareness about drugs and alcohol used to facilitate rape or sexual assault; and other efforts to increase awareness of the facts about, or to help prevent, sexual assault, including awareness in underserved communities and awareness among individuals with disabilities (as defined in section 3 of the American with Disabilities Act of 1990 [42 U.S.C. 12102]). Community change strategies include: Community mobilization, coalition building, policy education and social norms change.

The Plan, completed by the Texas Primary Prevention Planning Committee (PPPC) in October 2009 and distributed to sexual assault programs in January 2010, identifies Texas specific risk factors for sexual violence and provides guidance to PHHS Block Grant funded sexual assault programs on the development and implementation of strategies and activities to address these risk factors. The Plan is available to the public at http://www.taasa.org/programs/primary-preventionsocial-justice/.

The state sexual assault coalition - Texas Association Against Sexual Assault (TAASA) - will use these funds to provide technical assistance and training to PHHS Block Grant funded local sexual assault programs on the implementation and evaluation of sexual violence primary prevention strategies; support efforts of the PPPC; and support local and statewide primary prevention efforts including but not limited to engaging men and youth in primary prevention efforts. Additionally TAASA will use a portion of these funds to convene a group of stakeholders to assist with the development of criteria for the minimum services identified in Texas Government Code, Section 420.003.

Primary Strategic Partnerships: Internal partnerships include the OAG Crime Victim Services Division (CVSD) staff which provides the programmatic guidance for this grant and the Grants Administration Division (GAD) staff who work closely with CVSD staff develop the application kit used by sub-grantees to apply for funds, develop policy and procedures for awarding funds to sub-grantees, and serve as grant managers and grant monitors to sub-grantees ensuring compliance with the use of grant funds.

External partnerships include the following members of the PPPC along with OAG program staff - representatives from DSHS, TAASA, local sexual assault programs, the Texas Council on Family Violence (TCFV) and community stakeholders. The PPPC was formed in 2007 to develop the Plan and guide the state's transition to a primary prevention approach to end sexual violence. The PPPC meets quarterly and currently provides guidance on the Plan's implementation and evaluation efforts.

Evaluation Methodology: PHHS Block Grant funded organizations will use pre-and post-tests, surveys, etc. during educational seminars and training programs for professionals to measure participants' increase in knowledge of the factors that allow sexual violence to occur. The PPPC is in the process of finalizing an evaluation capacity building action plan that will identify specific activities to build the

capacity of PHHS Block Grant funded organizations to strengthen their evaluation of primary prevention strategies/activities.

National Health Objective: IVP-40 Sexual Violence (Rape Prevention)

State Health Objective(s):

Between 01/2000 and 12/2020, Reduce rapes or attempted rapes to 34 per 100,000 population

State Health Objective Status
Exceeded

State Health Objective Outcome
For 2013 using the Rape legacy definition, Rape or attempted rapes = 28.4 per 100,000 population, 2013 Federal Bureau of Investigations (FBI) Uniform Crime Reports (Rape – legacy definition).

Reasons for Success or Barriers/Challenges to Success
Ending sexual violence is a long-term commitment and primary prevention strategies and activities do not provide immediate results. Although the rates of rape are lower than the objective, it is not feasible to attribute the overall decline of sexual violence to the strategies and activities conducted with these funds at this time. A more robust evaluation of these primary prevention strategies, currently planned for the next three years, will give a more accurate picture of the impact of these programs.

In 2011, the definition of rape was changed in the Federal Bureau of Investigation, Uniform Crime Reporting Program to get a more inclusive and accurate understanding of the prevalence of sexual violence. The revised definition[1]:

- Includes either male or female victims or offenders.
- Includes instances in which the victim is incapable of giving consent because of temporary or permanent mental or physical incapacity (e.g., due to the influence of drugs or alcohol or because of age).
- Reflects the various forms of sexual penetration understood to be Rape.

In this report Texas used the old (legacy definition) to measure the objective as that was what was in place when the objective was determined. Using the new definition, Rape = 36.9% per 100,000 population, 2013 FBI Uniform Crime Reports (Rape (revised definition). Moving forward, Texas will use the revised definition to determine the state health objective and to report progress toward the objective.

[1] Uniform Crime Reporting Program Summary Reporting System, New Rape Definition is Effective January 1, 2013, New Rape Fact Sheet accessed on December 29, 2014 at http://www.fbi.gov/about-us/cjis/ucr/new-rape-fact-sheet.

Strategies to Achieve Success or Overcome Barriers/Challenges
To reach the state health objective, in FY 2014, the Office of the Attorney General (OAG) awarded PHHS Block Grant funds to 49 sexual assault programs[1] to develop and implement primary prevention strategies/activities designed to change attitudes, beliefs and behaviors that allow sexual violence to occur in the first place. Funds were also awarded to the state sexual assault coalition – Texas Association Against Sexual Assault (TAASA) - to build the capacity of sexual assault programs to implement primary prevention strategies/activities. PHHS Block Grant funded organizations followed *Preventing Sexual Violence in Texas: A Primary Prevention Approach* (Plan) as a guide to develop and implement comprehensive primary prevention programs across Texas. The Plan, developed and distributed by the Texas Primary Prevention Planning Committee (PPPC) in 2010, identified Texas specific risk factors for the first time perpetration and victimization of sexual violence and prioritized goals to address these risk factors. The Plan was the first in the state to use a primary prevention approach to end sexual violence and the first to offer sexual assault program a unified approach to sexual violence prevention efforts. PHHS Block Grant funded sexual assault program and their community partners

chose goal(s) to address and strategies/activities to implement that were identified in the Plan and met the unique needs of their communities.

Below are the goals identified in the Plan and the corresponding risk factors shown within the frame work of the ecological model. The number of PHHS Block Grant funded sexual assault programs that addressed each goal is also included:

Individual Level Goals

- Goal 1: To reduce attitudes, beliefs, and behaviors supportive of sexual violence. Individuals will exhibit fewer attitudes, beliefs, and behaviors supportive of sexual violence including, but not limited to: entitlement and hostility toward women. Risk Factor: Attitudes and beliefs supportive of sexual violence. (27 funded sexual assault programs addressed this goal)
- Goal 2: To increase social competencies among youth. Youth within target age group would exhibit an increase in socially competent behaviors such as planning and decision making, interpersonal competence, cultural competence, resistance skills, and peaceful conflict resolution. Risk Factor: Witnessing or experiencing sexual, physical emotional/psychological/verbal abuse as a child. (22 funded sexual assault programs addressed this goal)
- Goal 3: Decrease bullying and/or sexual harassment behavior in youth ages 5-18. Risk Factor: Impulsive and aggressive behaviors. (22 funded sexual assault programs addressed this goal)

Relationship Level Goals

- Goal 4: Increase adult modeling of social competencies, positive values, and positive identity (as defined by the 40 Developmental Assets®). Social competencies include planning and decision making, interpersonal competence, cultural competence, resistance skills, and peaceful conflict resolution. These competencies will serve as protective factors for children who have been exposed to interpersonal violence. Risk Factor: Living in a family environment characterized by physical, emotional/psychological and/or sexual abuse. (21 funded sexual assault programs addressed this goal)
- Goal 5: Increase positive peer influences among males ages 10-24. Risk Factor: Associating with sexually aggressive and delinquent peers. (5 funded sexual assault programs addressed this goal)
- Goal 6: Increase interventions to change attitudes, beliefs, and behaviors supportive of sexual violence. Risk Factor: Associating with sexually aggressive and delinquent peers. (26 funded sexual assault programs addressed this goal)

Community Level Goal

- Goal 7: Reduce the tolerance of sexual violence and other forms of violence in the community, such as objectification of women and gender inequality. Organizations and neighborhood associations and other community entities will mobilize to end sexual violence. Risk Factor: General tolerance of sexual violence and other forms of violence. (16 funded sexual assault programs addressed this goal)

Societal Level Goals

- Goal 8: Reduce the norms that support sexual violence, such as male superiority, sexual entitlement and objectification of women. Risk Factor: Norms supportive of sexual violence. (2 funded sexual assault programs addressed this goal)
- Goal 9: Reduce disparity based on gender, race, class, ethnicity, and sexual orientation. Risk Factor: Inequalities based on gender, race, class, ethnicity, sexual orientation (includes objectification of women). (No funded sexual assault programs addressed this goal)
- Goal 10: Increase positive, healthy, realistic images and representations of women. Risk Factor: Gender role socialization and objectification of women. (1 funded sexual assault program addressed this goal)
- Goal 11: Increase mutability of gender roles without fear of marginalization or violence. Risk Factor: Gender role socialization and objectification of women. (No funded sexual assault programs addressed this goal)

During FY 2014, PHHS Block Grant funded rape crisis center choice of goal(s) was supported by a community needs and resources assessment, observational, descriptive and/or statistical data. With these funds, sexual assault programs across Texas brought primary prevention programs to youth, parents, teachers, coaches, community professionals and others in an effort to stop sexual violence before it occurs.

The OAG also awarded funds to TAASA to provide technical assistance and training to PHHS Block Grant funded sexual assault programs. The goal of technical assistance and training was to increase sexual assault programs' capacity to develop and implement appropriate strategies/activities to address goals identified in the Plan.

[1] Sexual assault program means any local public or private nonprofit corporation, independent of a law enforcement agency or prosecutor's office that is operated as an independent program or as part of a municipal, county, or state agency and that provides the minimum services to adult survivors of stranger and non-stranger sexual assault. Section 420.003, Texas Government Code

Leveraged Block Grant Dollars
No

Description of How Block Grant Dollars Were Leveraged
Not Applicable

OBJECTIVES – ANNUAL ACTIVITIES

Impact/Process Objective 1:
Inform and Educate
Between 10/2013 and 09/2014, PHHS Block Grant funded sexual assault programs will increase the percent of knowledge of the factors that allow sexual violence to occur from baseline of 0 to **75% of participants who complete a pre-and post-test or some other outcome instrument will show an increase in knowledge of the factors that allow sexual violence to occur. Approximately 6% of all participants (2,500) will complete an outcome instrument**.

Impact/Process Objective Status
Exceeded

Impact/Process Objective Outcome
Between 10/2013 and 09/2014, PHHS Block Grant funded sexual assault programs increased the percent of knowledge of the factors that allow sexual violence to occur from baseline of 0 to **95% of participants who completed a pre-and post-test or some other outcome instrument showed an increase in knowledge of the factors that allow sexual violence to occur. Approximately 9 % of the participants of educational seminars and training programs for professionals completed an outcome instrument.**.

Reasons for Success or Barriers/Challenges to Success
To meet the objective, PHHS Block Grant funded organizations used *What Works in Prevention, Principles of Effective Prevention Programs* to develop and enhance their education programming. Below is a list of the principles and how PHHS Block Grant funded organizations used each principle:

- Comprehensive: Multiple sessions were delivered to youth participants. Some follow-up or "booster" sessions were provided. Education programs were also conducted with parents, teachers and other adult influencers of youth participants so adults could model the desired behavior for youth as well as reinforce primary prevention messages. Policy change activities complemented educational seminars and worked to change the environment of the target audience – specifically through the development of policies on bullying and sexual harassment behaviors or through procedural changes designed to enforce policies already in place. Some PHHS Block Grant funded organizations continued to work with youth after completion of a series of educational seminars to help them create

visual displays on primary prevention topics. These projects were displayed throughout the community.

- Varied Teaching Methods: Teaching methods included presentations, role plays, videos and digital versatile discs (DVDs), handouts, small group discussions, small group exercises, artwork, games, music and journaling.
- Sufficient Dosage: Most PHHS Block Grant funded organizations presented multiple times to the same audience with the goal of meeting a sufficient dosage benchmark of 7-9 sessions with the same audience. When sufficient dosage could not be met through educational seminars alone, PHHS Block Grant funded organizations found creative ways to reinforce the primary prevention message. Strategies included sending exercises home with youth to complete with parents, working with teachers to include messages in lesson plans and developing and distributing visual displays and other informational materials to youth that supported the desired positive behavior. Technical assistance was provided to all sexual assault programs whose programming fell below 7 sessions. This technical assistance focused on ways to increase dosage and reinforce the messages provided during educational sessions.
- Theory Driven: According to the CDC, there is a dearth of evidence-informed and evidence-based strategies designed to prevent sexual violence perpetration and victimization. The few evidence-informed and evidence-based prevention strategies that are available primarily target individual level change and replication studies are limited[1]. In the absence of evidence based strategies, PHHS Block Grant funded organizations used programs that were informed by a behavior or social change theory, that reflected prevention principles and included sexual violence primary prevention content (meaning it addressed risk factors associated with the chosen goal). Curriculums used were either developed in-house or purchased, and modified to include primary prevention sexual violence content. The OAG required PHHS Block Grant funded organizations to identify the theory used on their quarterly performance report and detail how the theory was applied to the development of their program. OAG staff provided technical assistance when needed. Theories used most were the Transtheoretical Model/Stages of Change, the Health Belief Model and the Theory of Reasoned Action.
- Opportunities for Positive Relationships: PHHS Block Grant funded organizations dedicated time during educational seminars for participants to interact and discuss topics with each other. Small group discussions were encouraged between youth participants giving them an opportunity to develop positive relationships with their peers. Time was set aside for discussions between youth participants and their parents, teachers or other adult influencers. Primary prevention staff established rules for a safe environment during discussions, modeled positive behavior throughout the educational seminars and gave participants an opportunity to ask questions and discuss topics. Presentations to adults, specifically parents and teachers of youth participants, assisted in building their skills to discuss these topics with youth. PHHS Block Grant funded organizations also developed educational exercises for youth participants to take home and complete with their parents. Follow-up was conducted to ensure the exercises were completed and youth had the opportunity to talk with their parents about the topics.
- Appropriately Timed: PHHS Block Grant funded organizations conducted educational seminars that were developmentally appropriate for the age of the target audience and delivered at an age most likely to achieve the desired outcome. If PHHS Block Grant funded organizations did not have the expertise in-house to determine if their program met this criteria, they reviewed the program materials with teachers, counselors and other professionals to ensure they were appropriately timed.
- Socio-Culturally Relevant: PHHS Block Grant funded organizations ensured their educational seminars were culturally relevant through a variety of ways which included involving the target audience, youth advisory groups and other community stakeholders in the development of programs or reviewing materials with these groups prior to implementation.
- Outcome Evaluations: All PHHS Block Grant funded organizations reported on one outcome – an "Increase in knowledge of the factors that allow sexual violence to occur." PHHS Block Grant funded organizations measured this outcome in a variety of ways including the use of pre-and post-tests, surveys, observations, etc.
- Well-Trained Staff: PHHS Block Grant funded organizations established education and training requirements of primary prevention staff at the local level and reported training completed on their

quarterly performance reports. In FY 2014, the OAG required all PHHS Block Grant funded organizations to attend at least one primary prevention focused training. TAASA offered primary prevention workshops at their annual conference and at their *Prevention Institute* which is a two-day conference that was well attended by PHHS Block Grant funded organizations and focused entirely on primary prevention. The OAG also required PHHS Block Grant funded organizations to report on the organizational support and supervision provided to primary prevention staff on their quarterly performance reports.

Historically, Texas has measured an increase in knowledge of the factors that allow sexual violence to occur with a benchmark of 75% of participants who complete a pre-and post-test or some other outcome instrument will show an increase in knowledge. While this benchmark was exceeded, given that most programming has moved beyond increasing knowledge to skill building and attitude and behavior change, Texas is in the process of identifying additional benchmarks for which to measure the impact of these programs.

[1] Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, CDC Division for Violence Prevention, Developing an Evaluation Plan, 2014

Strategies to Achieve Success or Overcome Barriers/Challenges

Texas has three projects that are in process and are expected to have a positive impact on meeting the overall goals and objectives of this program. First, a curriculum development project, started in FY 2012, is in the final stages of piloting new curriculum (promising programs) in select sites across Texas. TAASA has collected both process and outcome evaluation data from the test sites and will use that data to revise the curricula and make them ready for distribution to all PHHS Block Grant funded sexual assault programs.

Secondly, the Texas PPPC is in the final stages of revising the Plan providing further clarification and prioritization of Plan goals and objectives, including new outcome measures directly connected to risk and protective factors for sexual violence.

Thirdly, Texas is working with an outside evaluator to develop the criteria, process and mechanism to assess PHHS Block Grant funded organizations use of the public health model and prevention principles in developing and implementing primary prevention programming. This evaluation when completed will assist technical assistance providers in developing targeted technical assistance and training to build capacity of sexual assault programs to implement programs using best available practices and methods.

These three projects, once completed will provide additional resources to PHHS Block Grant funded organizations and give the Texas PPPC vital information to use to guide future primary prevention efforts in Texas.

Activity 1:

Approved Activities and Complementary Strategies

Between 10/2013 and 09/2014, PHHS Block Grant funded local sexual assault programs will implement at least one comprehensive primary prevention program that includes multiple components addressing at least two goals of the Plan in at least two spheres of the ecological model in a complementary manner. Programs will utilize the approved activities and community change strategies (listed below). PHHS Block Grant funded organizations will conduct approximately 1,500 educational seminars and training programs for professionals reaching approximately 40,000 participants. Strategies and activities implemented will focus on changing beliefs, attitudes, and behaviors that allow sexual assault to initially occur using the Plan as a programmatic guide.

Approved activities include: Educational seminars; training programs for professionals; preparation of informational materials; education and training programs for students and campus personnel designed to reduce the incidence of sexual assault at colleges and universities; education to increase awareness about drugs and alcohol used to facilitate rape or sexual assault; and other efforts to increase awareness

of the facts about, or to help prevent, sexual assault, including awareness in underserved communities and awareness among individuals with disabilities (as defined in section 3 of the American with Disabilities Act of 1990 [42 U.S.C. 12102]). Community change strategies include: Community mobilization, coalition building, policy education and social norms change.

Activity Status
Completed

Activity Outcome
Between 11/2013 and 09/2014, PHHS Block Grant funded organizations conducted Approved Activities and Community Change Strategies to various target groups consisting of 2,068 educational seminars and trainings for professionals reaching a total of 38,329 participants. All Approved Activities, with the exception of informational materials were reported as either educational seminars or training programs for professionals.

PHHS Block Grant funded organizations conducted educational seminars and training programs for professionals on following topics including: attitudes, belief and behaviors supportive of sexual violence; bystander intervention; healthy relationships; primary prevention of sexual violence; bullying and sexual violence; gender roles; sexual violence; sexual harassment; masculinity and sexual violence; media literacy/ policy and organization practice; drug-facilitated sexual violence; and social competencies including planning and decision making, interpersonal competence, cultural competence, resistance skills and peaceful conflict resolution.

Educational seminars (1,584 seminars) were conducted to 33,507 participants including pre-school students, elementary school students, middle/junior high school students, high school students, college/university students, youth not in a school setting, and other audiences such as parents, GLBT (gay, lesbian, bisexual, transgender) , faith community members, the elderly, persons with disabilities, coaches, men and boys, general mixed groups, high risk groups; and participants within the African American, Hispanic, and Asian/Pacific Islander communities.

Training programs for professionals (482 sessions) were conducted to 4,821 individuals. Participants included professionals in the following disciplines: Education (Teachers); Social Services; Criminal Justice; Rape Crisis Center Staff; Organizations Serving Youth Not in School; Medical/Health; Violence Prevention; Organizations Serving Underserved Communities; Faith Communities Leader; Organizations Serving Parents; College/University Faculty/Staff; Mental Health; Multidisciplinary Groups; Organizations Serving Men/Boys; Substance Abuse; Disability Services; ESL/Adult Education; Military; Human Resources; Public Health; GLBT Services; Immigrant Services; HIV/AIDS Services; and Elder Services.

Informational materials were distributed (approximately 46,678) to participants during educational seminars, training programs for professionals and to the community at large. Informational materials included brochures, educational exercises, educational fact sheets, handouts, posters, and other visual messaging. Some of the informational materials were on the same topics presented in educational seminars and training programs for professionals and were distributed as additional information or to reinforce the message presented through education programs. These materials also included toolkits/guidebooks, copies of the Plan and other technical assistance materials distributed by TAASA.

PHHS Block Grant funded organizations developed 779 pieces of information materials including: brochures, educational exercises, educational fact sheets or handouts, posters or other visual messaging and curriculums/presentations. Developed materials also included toolkits/guidebooks and other resource materials developed by TAASA.

Reasons for Success or Barriers/Challenges to Success
PHHS Block Grant funded organizations were successful in meeting this objective by using a wide range of strategies/activities to implement a comprehensive primary prevention program. PHHS Block Grant funded organizations spent time fostering collaborative relationships with community partners and building relationships with schools and organizations serving youth not in the school setting to ensure

community support for implementation of activities. As a result, PHHS Block Grant funded organizations reached youth through new avenues and provided multiple presentations to the same audience fostering in-depth discussions and deeper learning.

The following is a list of strategies/activities used by PHHS Block Grant funded organizations and a short description of how PHHS Block Grant funded organizations used each strategy:

- Educational seminars –PHHS Block Grant funded organizations conducted educational seminars for youth in and out of the school setting, parents and other adult influencers in youth's lives;
- Training programs for professionals – PHHS Block Grant funded organizations trained teachers and other professionals connected to their youth participants and trained other professionals in the community to engage them in primary prevention efforts;
- Preparation of informational materials – PHHS Block Grant funded organizations developed educational materials and distributed materials during educational seminars and training programs for professionals in order to reinforce the lessons taught in the classroom. Materials were also distributed at community events;
- Training programs for students and campus personnel designed to reduce the incidence of sexual assault – PHHS Block Grant funded organizations conducted primary prevention education and activities on campuses to engage students and campus personnel in discussions of risk factors for sexual violence and to mobilize the campus to engage in primary prevention efforts;
- Education to increase the awareness about drugs and alcohol used to facilitate sexual assault – PHHS Block Grant funded organizations addressed these issues as a component of their educational seminars regarding the risk factors for sexual violence;
- Other efforts to increase awareness of the facts about or to help prevent sexual assault included efforts to increase awareness among individuals with disabilities – One PHHS Block Grant funded organization focused a portion of their programming on this specific population, and used age and developmentally appropriate materials to address risk factors for sexual violence;
- Coalition Building – PHHS Block Grant funded organizations facilitated the organization and activities of community coalitions specifically convened to plan and implement community based initiatives to address risk factors for sexual violence. Some PHHS Block Grant funded organizations joined other community coalitions that were working on common risk factors or those that focused on drug and alcohol prevention, etc. As members of community coalitions, PHHS Block Grant funded organizations ensured risk factors for sexual violence was included in these community initiatives.
- Community mobilization – PHHS Block Grant funded organizations worked in their communities to educate and engage professionals and citizens in primary prevention efforts and a to increase community readiness for primary prevention activities;
- Policy change – PHHS Block Grant funded organizations worked with teachers, professionals, administrators and other stakeholders to develop policies associated with risk factors for sexual violence such as bullying, sexual harassment, etc. or to develop procedures to enforce policies already in effect;
- Norms change – PHHS Block Grant funded organizations worked towards norms change by including primary prevention sexual violence content in all educational seminars and facilitated discussions on norms around gender roles and stereotypes and gender equality; and/or
- Strategic planning - PHHS Block Grant funded organizations used a portion of their funding for strategic planning of primary prevention initiatives with their community partners. At the state level TAASA used some PHHS Block Grant funding for supporting efforts of the PPPC.

Strategies to Achieve Success or Overcome Barriers/Challenges

PHHS Block Grant funded organizations implemented comprehensive primary prevention programs meaning programs that combined several strategies and activities together and spanned at least two levels of the ecology. Most PHHS Block Grant funded organizations' activities were aimed at impacting youth through education and by working to change the environments in which youth reside by reaching parents, teachers, coaches, counselors and other adult influencers. Community Change Strategies including coalition building, community mobilization, policy education, and social norms change supported programming aimed at youth furthering a comprehensive approach.

While PHHS Block Grant organizations exceeded output expectations for the number of educational seminars and training programs for professionals conducted, the number of participants was below the number expected. While this may be viewed as a challenge by some, in actuality the reduction in the number of participants is a result of a deliberate move to provide more in-depth instruction to smaller groups of participants leaving more time and space for small group discussions and skill building exercises. PHHS Block Grant funded organization did find that reaching the same youth 7-9 times was challenging especially in school settings. Technical assistance was provided on how funded organizations can increase their dosage to ensure they meet this important benchmark.

Activity 2:
Increase Capacity
Between 10/2013 and 09/2014, TAASA and the OAG will work to increase capacity of local PHHS Block Grant funded sexual assault programs to implement and evaluate sexual violence primary prevention strategies. TAASA and the OAG will provide training and programmatic technical assistance to PHHS Block Grant funded local sexual assault programs on implementing strategies and activities to address modifiable risk and protective factors for sexual violence and other topics identified in the training and technical assistance plan developed in FY 2013.

Activity Status
Completed

Activity Outcome
While not all technical assistance and training provided to sexual assault programs is funded through PHHS Block Grant funds, the following data gives a clear view of the level of technical assistance and training available. The OAG Primary Prevention Program Coordinator provided direct technical assistance to 46 of the 49 funded sexual assault programs. The OAG hosted a primary prevention workshop on engaging youth in primary prevention efforts at the OAG conference held in May 2014. This workshop was well attended by PHHS Block Grant funded organizations. The OAG Primary Prevention Program Coordinator co-facilitated a workshop at TAASA's annual conference in March 2014 with TAASA's Director of Prevention Programs. The workshop included instruction on: using the public health approach, conducting approved activities and community change strategies, the principles of effective prevention strategies, building a comprehensive primary prevention program, and integrating community and societal level strategies into current programming. TAASA provided 93 instances of technical assistance via telephone and on-site visits to PHHS Block Grant funded sexual assault programs on a variety of primary prevention implementation and evaluation topics. TAASA also provided peer learning opportunities and workshops to 65 individuals from 41 PHHS Block Grant funded sexual assault programs as a part of TAASA's Prevention Institute held in August 2014.

Reasons for Success or Barriers/Challenges to Success
Training and technical assistance continues to be a priority to ensure sexual assault programs have the support and capacity they need to implement effective primary prevention programming. In FY 2014, approximately 15% of all funding available for primary prevention efforts in Texas was awarded to TAASA to build capacity of funded organizations to engage in primary prevention efforts, to support the work of the Texas PPPC and to develop primary prevention programming that engages and organizes men in primary prevention efforts.

The OAG provides services of the Primary Prevention Program Coordinator as an in-kind contribution to the grant to ensure technical assistance and training is available to all PHHS Block Grant funded organizations.

Strategies to Achieve Success or Overcome Barriers/Challenges
Ongoing and consistent planned and on demand technical assistance was used to build capacity of sexual assault programs to implement and evaluate primary prevention programming. Planned training and technical assistance was informed by a training and technical assistance needs assessment that was conducted in 2013. On-demand training and technical assistance was provided as requested and included topics identified by the requestor. This type of on-demand technical assistance resulted in

individualized support that met prevention workers where they were in terms of capacity building and program development. Training and technical assistance was offered and provided via the telephone, webinars, and on-site visits to match the needs and resources of prevention workers. TAASA maintained a listserv on primary prevention topics and facilitated a Mobilizing Men Task Force (MMTF) which met monthly. The MMTF force maintained a listserv with several hundred subscribers.

The OAG Primary Prevention Specialist also provided technical assistance to funded organizations on all programmatic related issues mainly through conference calls or training workshops. OAG Grants Administration staff provided oversight and technical assistance on all grant related issues.

In FY 2015 the services of a professional evaluator will be used to develop the criteria, process, and mechanism to evaluate training and technical assistance. The data and feedback from this type of evaluation will be vital to ensure that training and technical assistance provided is effective and continues to meet the ongoing needs of sexual assault programs' prevention staff.

Activity 3:

Develop Minimum Services Criteria

Between 10/2013 and 09/2014, TAASA will convene a committee comprised of local sexual assault programs, TAASA staff, OAG program staff, and other stakeholders to assist with the development of criteria for the minimum services identified in Texas Government Code, Section 420.003. Minimum services include:

- A 24-hour crisis hotline;
- Crisis intervention;
- Public education;
- Advocacy; and
- Accompaniment to hospitals, law enforcement offices, prosecutors' offices, and courts.

Activity Status

Completed

Activity Outcome

In September 2014, minimum standards were completed for each of the five minimum services identified in Texas Government Code, Section 420.003. Minimum services include: a 24-hour crisis hotline; crisis intervention; public education; advocacy; and accompaniment to hospitals, law enforcement offices, prosecutors' offices, and courts. These minimum standards were developed to:

- Ensure that every survivor in the state of Texas has access to a minimum level of consistent services regardless of demographic characteristics or location in the state; and
- Provide a formalized framework for describing and defining the components of each of the five minimum services that must be provided by sexual assault program in Texas[1].

[1] Minimum Service Standards for Sexual Assault Program in Texas, September 2014, Executive Summary

Reasons for Success or Barriers/Challenges to Success

In many states across the country the components of the core (minimum) services of sexual assault programs are defined by law, by funders, or by state coalitions. However, until now, there has been no consensus in Texas on the basic components of the five minimum services. While all Texas sexual assault programs currently offer each of the five minimum services, they exist in many different forms throughout Texas, offering varying levels and degrees of service to survivors[1]. These new minimum standards will provide a vital resource to sexual assault programs and funders in striving to standardize the quality of services provided to survivors of sexual assault.

[1] Ibid, Page 2

Strategies to Achieve Success or Overcome Barriers/Challenges

These standards were developed by a committee comprised of TAASA staff, representative from sexual assault programs throughout Texas, representatives from the OAG, and other community stakeholders. The diverse group of stakeholders met from February through August 2014 to develop standards that could be applicable to all sexual assault programs regardless of size, location, and structure. While the work was challenging each group of representatives brought their own expertise and contribution to the process. Representatives from sexual assault programs were able to identify challenges and benefits to developing and implementing these minimum services standards and guided the process to ensure these standards were realistic, in the best interest of survivors, and would not place an undue hardship on sexual assault programs. The committee reviewed standards used by other states and discussed the unique needs of Texas sexual assault programs. The process was facilitated by a longtime advocate in the field with the expertise and experience needed to ensure the objectives of the project were met. The process used and the heavy involvement of representatives from sexual assault programs was the determining factor in the success of this project.

State Program Title: Texas Healthy Communities Program

State Program Strategy:

Goal: The goal of the Texas Healthy Communities (TXHC) Program is to assist cities to assess their existing environments, implement changes in local environmental and policy infrastructure and adopt priority public health practices to reduce risk factors for cardiovascular disease (CVD), stroke, and other chronic diseases.

Health Priorities: The health priorities of the TXHC Program include physical activity promotion and access, promotion of and access to good nutrition, healthy school environments, healthy worksite environments, tobacco control and prevention, cardiac and stroke event response, and health care quality improvement.

Primary Strategic Partnerships: Primary strategic partnerships will include programs internal to DSHS, such as the School Health Program and the Tobacco Prevention and Control Program, in addition to local health departments, the Texas Council on Cardiovascular Disease and Stroke, the Texas Cardiovascular Disease and Stroke Partnership, and local community based organizations as appropriate.

Evaluation Methodology: Program evaluation will utilize a mixed-methods approach, including surveys, focus groups and key informant interviews. Evaluation will be conducted in collaboration with local health departments and led by the Office of Surveillance, Evaluation and Research within the Health Promotion and Chronic Disease Prevention Section at DSHS.

National Health Objective: ECBP-10 Community-Based Primary Prevention Services

State Health Objective(s):

Between 07/2014 and 07/2015, Increase the capacity of local health departments to implement and sustain community systems and environmental changes to address one or more of the nine priority Texas Healthy Communities (TXHC) indicators. Nine indicators include:
1. City Profile- City demographics
2. Physical Activity -Physical activity areas and opportunities are designated, safe, accessible, and promoted throughout the community
3. Nutrition -Healthy food options are accessible and promoted to all members of the community.
4. Breastfeeding -Mother-friendly worksites, birthing facilities, and hospitals are in place in the communities.
5. Schools-Public schools comply with all legislated components of a coordinated school health program and daily physical activity, and high schools offer an evidence-based health curriculum.
6. Worksites -Worksites wellness programs are in place for the majority of employees.
7. Tobacco- A comprehensive tobacco control program is in place that includes a 100 % smoke free city smoking ordinance.
8. Cardiac and Stroke Response- Defibrillators (Manual and/or Automated External) are available to first responders and the emergency system of care maintains a rapid response time for cardiac events. Stroke is treated as a medical emergency in the community and appropriate acute stroke treatment protocols are in place.
9. Healthcare Quality-Health Care Sites in the community promote primary and secondary prevention of CVD and Stroke. Health Care Sites promote hypertension and diabetes reporting.

State Health Objective Status
In Progress

State Health Objective Outcome
The state health objective is in progress. DSHS has contracted with 18 unique health departments to assess the nine TXHC indicators in 20 communities across Texas. The TXHC contracts began on October 1, 2014. Contractors are required to complete the following performance measures:

1. Conduct and complete the Texas Healthy Communities Assessment (DSHS will review and approve the assessment prior to final submission in Performance Management and Tracking System (PMATS)) on or before November 15, 2014.

2. Develop and complete the Project Work Plan in conjunction with DSHS. The Project Work plan must be reviewed and approved by DSHS prior to the submission date. The Work plan must include objectives with supporting activities that address indicators in the TXHC assessment identified as needing improvement on or before December 15, 2014.

3. Develop an Evaluation Plan and submit to DSHS on or before January 30, 2015 for DSHS Program review.

4. Provide an Interim Progress Report on or before March 31, 2015 to include: summary of all items/activities conducted to date; detailed description of progress toward achieving objectives and activities; and barriers.

5. Provide a Final Progress Report to include: summary of all items/activities conducted to date; detailed description of progress toward achieving objectives and activities; plans for sustaining activities once funding has ended; and barriers/lessons learned. Submission of Final Report must fully address any feedback from DSHS based on draft final report and must be submitted on or before September 15, 2015.

6. Participate in 12 monthly feedback calls (monthly project status reports) with DSHS Program to be conducted on or before the following dates: October 31st, November 28th, December 31st, January 30th, February 27th, March 31st, April 30th, May 29th, June 30th, July 31st, August 31st, September 30th, and submit the collaborative monthly report to DSHS within one week of the call.
All TXHC contractors completed the TXHC assessment of their respective communities by November 2014, and were scored based on eight of the nine indicators. The results serve as their baseline measures, and helped identify gaps in services and opportunities for improvement. DSHS staff recognized contractors with a tiered rating system based on assessment scores, from Gold Level to Honorable Mention.

Assessment score results are listed below by contractor and community.

Contractor	**Community**	**Recognition Level (pts.)**
Angelina County and Cities Health District	Angelina County	Bronze (75.5)
Temple Parks and Leisure Program	City of Temple	Honorable Mention (55.5)
Ector County Health Department	Ector County	Honorable Mention (52.5)
Harris County Public Health and Environmental Services	Harris County	Gold (95)
Hidalgo County health Department	Hidalgo County	Honorable Mention (49.5)
Houston Department of Health and Human Services	City of Houston	Gold (90.5)
Jasper-Newton County Public Health District	Jasper County	Honorable Mention (22)
Paris - Lamar County Health Department	Lamar County	Honorable Mention (52.5)
Texas Tech University Health Science Center	Lubbock County	Bronze (76)
Waco/ McLennan County Public Health District	McLennan County	Honorable Mention (62)
Jasper-Newton County Public Health District	Newton County	Honorable Mention (18.5)
Corpus Christi-Nueces County Public Health District	Nueces County	Silver (86)
Parker County Health District	Parker County	Honorable Mention (53)
Northeast Texas Public Health District	Smith County	Honorable Mention (65.5)
Abilene Taylor County Health Department	Taylor County	Honorable Mention (59)
San Angelo – Tom Green County Health District	Tom Green County	Honorable Mention (66.5)
Victoria City- County Health Department	Victoria County	Honorable Mention (67.5)
City of Laredo Health Department	Webb County	Silver (81)
Wichita Falls/Wichita County Public Health District	Wichita County	Silver (80)
Northeast Texas Public Health District	Wood County	Honorable Mention (45)

In December of 2014, all TXHC contractors created work plans that addressed the gaps identified in their respective assessments. The contractors were instructed to create a work plan that focused on one or two of the indicator areas identified as needing improvement. The TXHC Program provided ongoing technical assistance throughout the work plan process to ensure that the contractors identified sustainable, realistic and measurable activities.
The TXHC contractors are focused on a variety of indicators, based on their respective assessment results. Below are examples of planned activities from a few of the TXHC contractors:
Abilene-Taylor PH District:
- Develop an Active Living Coalition.
- Guide Coalition (above) to develop an Active Living Plan for Taylor County.
- Develop an Active Living Website.
- Establish a Walking Guide for Taylor County.
- Promote above through local media via website, press releases, and interviews (low cost/free methods).

Ector County PH District via sub-contract with Medical Center Health Systems:
- Develop an Active Living Coalition.
- Guide Coalition (above) to develop an Active Living Plan for Ector County.
- Develop a media campaign to increase public awareness of the importance of physical activity, utilizing print, radio and television. Media campaigns will include both English and Spanish language.

Develop two additional mass media campaigns to educate the public on signs and symptoms of heart disease and stroke in tandem with national awareness months (Feb & June respectively).
San Angelo-Tom Green County Health Department:
- Increase opportunities for physical activity by providing six bike fix-it stations and mileage marker signs for local parks and trails, to be installed by community partners.
- Develop a media campaign to increase awareness on the topics of prevention and response to heart disease and stroke.
- Expand county health department website to include prevention and health promotion information and resources. Topics will include prevention of obesity, diabetes, heart disease and stroke, and emergency response.
- Promoting the Texas Ten Step Certification to at least two hospitals/birthing centers, with the goal of at least one to be certified by September 2015.

Reasons for Success or Barriers/Challenges to Success
Much progress has been made to date, given the contractor start date of October 1, 2014. All of the TXHC contractors have completed the community assessments, developed the work plan, and revised their budgets by the due dates specified in their scope of work. These achievements were due in large part of the ongoing technical assistance provided to the contractors by the program. Several contractors have already begun forming workgroups and partnerships to support their TXHC activities. One recent example of success is the convening of Ector County Medical Center Health System's (Odessa, DSHS Health Service Region 9) first meeting of a new coalition formed to support TXHC activities. Over 50 attendees participated in the meeting, representing a wide range of community sectors. The meeting garnered attention from both the local newspaper and a major broadcasting affiliate. Providing technical assistance has been challenging due to the diversity of the contractors and the areas they are serving.

Strategies to Achieve Success or Overcome Barriers/Challenges
The contractors and the TXHC Program will continue to learn more about all of the communities being served, and continue to build relationships. The Program will continue to provide technical assistance and support to contractors to help them achieve their performance measures.

Leveraged Block Grant Dollars
No

Description of How Block Grant Dollars Were Leveraged
The TXHC contractors will identify opportunities to leverage dollars through their activities. This is an ongoing process.

OBJECTIVES – ANNUAL ACTIVITIES

Impact/Process Objective 1:
Community Participation
Between 07/2014 and 06/2015, Texas Department of State Health Services and Local Health Department staff will increase the number of communities participating in the Texas Healthy Communities Program to complete community assessments and implement environmental and systems changes that address one of the nine priority Texas Healthy Communities Program indicators. from 0 to **20**.

Impact/Process Objective Status
Met

Impact/Process Objective Outcome
Between 07/2014 and 06/2015, Texas Department of State Health Services and Local Health Department staff increased the number of communities participating in the Texas Healthy Communities Program to complete community assessments and implement environmental and systems changes that address one of the nine priority Texas Healthy Communities Program indicators. from 0 to **20**.

Reasons for Success or Barriers/Challenges to Success
The DSHS Office of Surveillance, Evaluation, and Research (OSER) compiled prevalence, hospitalization, and mortality data to assist the TXHC staff in identifying Texas counties that would benefit from the TXHC Program. The TXHC staff reached out to the local health departments in the identified areas to provide an overview of the Program and discuss the performance measures involved with receiving the funding.

The TXHC Program, in conjunction with the Office of Public Health, Regional and Local Health Services, held a webinar with the purpose of providing an overview of the TXHC funding opportunity. All of the local health departments in Texas were invited to attend. After the webinar, local health departments expressed their interest in receiving the funding. The TXHC staff contacted the interested health departments to discuss additional funding details and get their commitment to participate.

Strategies to Achieve Success or Overcome Barriers/Challenges
The DSHS OSER helped the Program identify counties that would most benefit from participation in the TXHC. The collaboration between the TXHC Program and the DSHS Regional and Local Health Services was critical to engage and contract with local health departments. Regional and Local Health Services provided guidance during the recruitment process.

Activity 1:
Establish contracts
Between 07/2014 and 06/2015, DSHS staff will establish contracts with 20 communities, through local health departments or community-based organizations, to conduct the Texas Healthy Communities assessment and use results of the assessment to implement a targeted, evidence-based intervention(s) to address one or more of the 9 Texas Healthy Communities Program priority indicators.

Activity Status
Completed

Activity Outcome
DSHS established 20 contracts with 18 local health departments, to conduct the TXHC assessment. The results of the assessment are used to implement a targeted, evidence-based interventions(s) to address one more of the priority indicator areas.

Contractors/ Communities

Contractor	Community
Angelina County and Cities Health District	Angelina County
Temple Parks and Leisure Program	City of Temple
Ector County Health Department	Ector County
Harris County Public Health and Environmental Services	Harris County
Hidalgo County health Department	Hidalgo County
Houston Department of Health and Human Services	City of Houston
Jasper-Newton County Public Health District	Jasper County
Paris - Lamar County Health Department	Lamar County
Texas Tech University Health Science Center	Lubbock County
Waco/ McLennan County Public Health District	McLennan County
Jasper-Newton County Public Health District	Newton County
Corpus Christi-Nueces County Public Health District	Nueces County
Parker County Health District	Parker County
Northeast Texas Public Health District	Smith County
Abilene Taylor County Health Department	Taylor County
San Angelo – Tom Green County Health District	Tom Green County
Victoria City- County Health Department	Victoria County
City of Laredo Health Department	Webb County
Wichita Falls/Wichita County Public Health District	Wichita County
Northeast Texas Public Health District	Wood County

Reasons for Success or Barriers/Challenges to Success
The Program worked very closely with the Contracts Management Unit (CMU) at DSHS to establish the contracts. The TXHC contractors were able to contact CMU and Program staff to answer questions and discuss contract performance measures.

Strategies to Achieve Success or Overcome Barriers/Challenges
Establishing effective internal and external relationships contributed to the successful completion of this activity.

Activity 2:
Technical assistance
Between 07/2014 and 06/2015, DSHS staff will develop technical assistance plans for contractors that will identify areas for improvement based on the Texas Healthy Communities assessment. Plans will also recommend actions/interventions to address areas for improvement. Technical assistance plans will utilize evidence-based practices and guidelines.
In addition to customized technical assistance plans, DSHS staff will conduct site visits and monthly calls to monitor program implementation and provide support.

Activity Status
Not Completed

Activity Outcome
This activity was successfully launched and continues to evolve. The TXHC Program staff developed technical assistance plans for each contractor that identified areas for improvement based on the TXHC assessment. The technical assistance plans also recommended activities to address areas for improvement. The Program staff facilitate one-on-one calls with each TXHC contractor to discuss the plans and answer any questions.

The Program has also held three TXHC monthly calls. The TXHC contractors are contractually required to participate in these calls to receive updates from the Program. The staff provides resources that the

contractors can use to successfully complete their performance measures, and also answer any questions the contractors may have. In the future the contractors will begin providing work plan updates. The Program staff has also been meeting with each contractor one-on-one via teleconference. The Staff has met with the contractors to assist in the completion of the assessment, the development of work plans, the revision of budgets, and on an as-needed basis.

Reasons for Success or Barriers/Challenges to Success
The Program staff worked together in the development of the plans. The staff met often via teleconference to discuss plans, share evidence-based practices, share resources, and make suggestions.

Strategies to Achieve Success or Overcome Barriers/Challenges
The Program staff will continue to work together to provide technical assistance and support contractor activities.

Activity 3:
Conduct evaluation
Between 07/2014 and 06/2015, DSHS staff will work with contractors to develop evaluation plans for targeted interventions and for the Texas Healthy Communities Program overall. Evaluation will be ongoing.

Program evaluation will utilize a mixed-methods approach, including surveys, focus groups and key informant interviews.

Evaluation will entail validity test of Texas Healthy Communities assessment tool.

Activity Status
Not Completed

Activity Outcome
This activity has not yet launched. The Program will be provided evaluation plan templates to the TXHC contractors, and will be provided a web-based training that will cover evaluation. The contractors will submit evaluation plans at the end of January 2015.

Reasons for Success or Barriers/Challenges to Success
Successes and Barriers will be discussed once this activity has been completed.

Strategies to Achieve Success or Overcome Barriers/Challenges
The TXHC Program will continue to work with contractors to build their evaluation plans.

Activity 4:
Sharing Successes
Between 07/2014 and 06/2015, DSHS staff will compile success stories and develop a publication highlighting communities' successes and best practices at the end of the grant year and will disseminate to the Texas Healthy Communities partners, the Texas Council on Cardiovascular Disease and Stroke, and the Texas Cardiovascular Disease and Stroke Partnership.
DSHS will convene a liaison meeting, including all Texas Healthy Communities liaisons and partners, to share successes, barriers, challenges, and best practices at the end of the grant year.

Activity Status
Not Completed

Activity Outcome
This is an ongoing activity. All of the TXHC contractors participate in monthly calls. Once the contractors have begun implementing the activities from their work plans they will report their progress, barriers, and successes during the monthly calls.

Reasons for Success or Barriers/Challenges to Success
This activity is still in progress. Successes and barriers will be discussed once this activity has been completed.

Strategies to Achieve Success or Overcome Barriers/Challenges
Strategies to achieve success will be discussed once this activity has been completed.

COPY OF EMAIL AS VERIFICATION OF WORK PLAN SUBMISSION

From: BGMIS Support [mailto:BGMIS@cdc.gov]
Sent: Tuesday, June 30, 2015 8:49 AM
To: Pearson,Amy (DSHS); David Tsao; Jacinta Bouvay; Pearson,Amy (DSHS); Sri Bodapati; Mark Hansey; Sharon Robertson; Latoya Donaldson; Tracey Coleman; Sharon Orum; Brownie Anderson; Ashley Martin; Michael Risner; Jennifer Forberg; Dagny Olivares
Subject: PHHS Block Grant Work Plan Submitted - Texas FY2015 Version 0 Revision 0

PHHS Block Grant Work Plan Submitted

State: Texas
Fiscal Year: 2015
Version: 0
Revision: 0
Submitted by: Amy Pearson
Date & Time: 6/30/2015 9:49 AM Eastern time

Comments to CDC Reviewer:

This is Texas' FY15 Work Plan for the Preventive Health and Health Services Block Grant (PHHSBG) for Federal Fiscal Year (FFY) 2014 (October 1, 2014 - September 30, 2015).
Should you have questions, please contact Amy Pearson, PHHS Block Grant Coordinator, at (512) 776-2028 or email @ amy.pearson@dshs.state.tx.us

To view this Work Plan from outside of CDC, click on the following link: http://nccd.cdc.gov/BGMIS

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Texas FY 2015
Preventive Health and Health Services
Block Grant

Work Plan

Original Work Plan for Fiscal Year 2015
Submitted by: Texas
DUNS: 807391511
Printed: 6/30/2015 9:49 AM

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CDC Work Plan ID: TX 2015 V0 R0
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Submitted on: 6/30/2015

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Executive Summary

This work plan is for the Preventive Health and Health Services Block Grant (PHHSBG) for Federal Year 2015. It is submitted by the Texas Department of State Health Services as the designated state agency for the allocation and administration of PHHSBG funds.

Funding Assumptions:
The total award for the FY 2015 Preventive Health and Health Services Block Grant is $6,166,855. This amount is based on a funding update allocation table distributed by CDC in the previous fiscal year.

Proposed Allocation and Funding Priorities for FY 2015:
Sexual Assault-Rape Crisis (HO IPV 40): $562,234 of this total is a mandatory allocation to the Texas Department of State Health Services which provides this funding to supports local sexual assault programs and one statewide program to develop and implement community and statewide based strategies and activities that support the primary prevention of sexual violence. These primary prevention efforts address the underlying causes of sexual violence and goes beyond awareness to include activities designed to change attitudes, beliefs and behaviors that allow sexual violence to occur.

Public Health System Assessment (HO PHI-14): $2,180,419 of this total will be utilized to support 60 Local Health Departments by strengthening local public health infrastructure through education and outreach; disease surveillance; mobilization of community groups to address local public health concerns; and development of policies to safeguard and protect local community health and safety.

Receipt of Evidence-Based Clinical Preventive Services (AHS-7), Community-Based Primary Prevention Services (ECBP-10), Older Adults' Confidence in Managing Their Chronic Conditions (OA-3) , and Tobacco Screening in Health Care Settings (TU-9) : $1,408,386 of this total will be utilized to ensure the continuation and expansion of the priority activities developed through the DSHS Community Transformation Grant (CTG) that are evidence-based strategies to reduce the impact of chronic diseases on the State of Texas and on individuals, families, and communities.

Community-Based Primary Prevention Services (ECBP-10):$1,455,354 will fund the Texas Healthy Communities (TXHC) Program which was established in 2003 by the DSHS Cardiovascular Disease Program and the Texas Council on Cardio-vascular Disease and Stroke with the help of public and private partners. The TXHC Program assists cities to assess their existing environments, implement changes in local environmental and policy infrastructure and adopt priority public health practices to reduce risk factors for cardiovascular disease (CVD), stroke, and other chronic diseases.

Administrative costs associated with the Preventive Health Block Grant total $560,462 which is 10% of the grant. Activities include: provision of legal services, personnel and accounting services, information technology services, office space, utilities, printing, phone, building and equipment maintenance supporting the operation of the PHHS Block Grant within the Texas Department of State Health Services.

The grant application is prepared under federal guidelines, which require that states use funds for activities directed toward the achievement of the National Health Promotion and Disease Prevention Objectives in Healthy People 2020.

Funding Priority: Under or Unfunded, State Plan (2015), Data Trend

Statutory Information

Advisory Committee Member Representation:
Advocacy group, County and/or local health department, Schools of public-health, State health department, State or local government

Dates:

Public Hearing Date(s):	Advisory Committee Date(s):
5/19/2015	6/18/2014
5/20/2015	3/24/2015
	5/12/2015

Current Forms signed and attached to work plan:

Certifications: Yes
Certifications and Assurances: Yes

BUDGET

Budget Detail for TX 2015 V0 R0	
Total Award (1+6)	$6,166,855
A. Current Year Annual Basic	
1. Annual Basic Amount	$5,604,621
2. Annual Basic Admin Cost	($560,462)
3. Direct Assistance	$0
4. Transfer Amount	$0
(5). Sub-Total Annual Basic	$5,044,159
B. Current Year Sex Offense Dollars (HO 15-35)	
6. Mandated Sex Offense Set Aside	$562,234
7. Sex Offense Admin Cost	$0
(8.) Sub-Total Sex Offense Set Aside	$562,234
(9.) Total Current Year Available Amount (5+8)	$5,606,393
C. Prior Year Dollars	
10. Annual Basic	$0
11. Sex Offense Set Aside (HO 15-35)	$0
(12.) Total Prior Year	$0
13. Total Available for Allocation (5+8+12)	$5,606,393

Summary of Funds Available for Allocation	
A. PHHSBG $'s Current Year:	
Annual Basic	$5,044,159
Sex Offense Set Aside	$562,234
Available Current Year PHHSBG Dollars	$5,606,393
B. PHHSBG $'s Prior Year:	
Annual Basic	$0
Sex Offense Set Aside	$0
Available Prior Year PHHSBG Dollars	$0
C. Total Funds Available for Allocation	$5,606,393

Summary of Allocations by Program and Healthy People Objective

Program Title	Health Objective	Current Year PHHSBG $'s	Prior Year PHHSBG $'s	TOTAL Year PHHSBG $'s
Community and Clinical Preventive Services	*AHS-7 Receipt of Evidence-Based Clinical Preventive Services*	$449,860	$0	$449,860
	ECBP-10 Community-Based Primary Prevention Services	$579,311	$0	$579,311
	OA-3 Older Adults' Confidence in Managing Their Chronic Conditions	$30,000	$0	$30,000
	TU-9 Tobacco Screening in Health Care Settings	$349,215	$0	$349,215
Sub-Total		**$1,408,386**	**$0**	**$1,408,386**
Local Health Departments	*PHI-14 Public Health System Assessment*	$2,180,419	$0	$2,180,419
Sub-Total		**$2,180,419**	**$0**	**$2,180,419**
Rape Prevention	*IVP-40 Sexual Violence (Rape Prevention)*	$562,234	$0	$562,234
Sub-Total		**$562,234**	**$0**	**$562,234**
Texas Healthy Communities Program	*ECBP-10 Community-Based Primary Prevention Services*	$1,455,354	$0	$1,455,354
Sub-Total		**$1,455,354**	**$0**	**$1,455,354**
Grand Total		**$5,606,393**	**$0**	**$5,606,393**

PROGRAMS

State Program Title: **Community and Clinical Preventive Services**

State Program Strategy

Goal: Implementation and expansion of evidence-based strategies to reduce the impact of chronic diseases on the State of Texas and on individuals, families, and communities.

Health Priorities: The health priorities of Community and Clinical Preventive Services include optimization of clinical preventive care through quality improvement strategies such as use of standardized clinical quality measures and training for integrated team care in Federally Qualified Health Centers (FQHCs); tobacco cessation through system enhancements that improve tobacco use screening, counseling, and QuitLine referral in clinical settings; and efforts to enhance community-clinical linkages through efforts to increase chronic disease training opportunities for Community Health Workers and develop strategies for improved coordination between clinical systems and community based resources such as chronic disease self-management programs.

Primary Strategic Partnerships: Strategic partnerships will continue with TMF Health Quality Institute, Texas Association of Community Health Centers (TACHC) and the University of Texas at Austin Tobacco Research and Evaluation Team for specified programmatic activities.

Evaluation Methodology: The Health Promotion and Chronic Disease Prevention Section at DSHS will dedicate a database administrator and evaluation specialist to coordinate all data reporting and develop evaluation plans for subcontractors' programmatic activities. Evaluation methods will include both qualitative and quantitative approaches, including process measures as well as health outcome data (e.g. tobacco cessation, diabetes and blood pressure control).

State Program Setting:

Community health center, Medical or clinical site, Other: Community resources (lay workers, CHWs, nonprofits)

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.
Position Name: Kristy Hansen
Position Title: Grant Coordinator III
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Name: Gerardo Rodriguez
Position Title: Program Specialist V
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Name: VACANT
Position Title: Data Base Administrator V
State-Level: 100% Local: 0% Other: 0% Total: 100%
Total Number of Positions Funded: 3
Total FTEs Funded: 3.00

National Health Objective: HO AHS-7 Receipt of Evidence-Based Clinical Preventive Services

State Health Objective(s):

Between 07/2014 and 12/2020, Expand quality improvement strategies to optimize provision of evidence-based clinical preventive services to vulnerable populations served by federally qualified health centers (FQHCs) throughout Texas.

Baseline:
39 current FQHC members are involved in the Texas Association of Community Health Centers (TACHC) health center control network

Data Source:
Texas Association of Community Health Centers will provide data on expansion of quality improvement activities.

State Health Problem:

Health Burden:
Texas leads the nation in the rate of uninsured, has marked health disparities affecting vulnerable populations, and suffers a significant burden of chronic diseases such as hypertension, cardiovascular disease and stroke, diabetes, and cancer, most of which can be attributed to modifiable risk behaviors. Health care delivery systems need to be optimized to provide appropriate evidence-based preventive and chronic disease management services, as well as develop and/or strengthen linkages to community resources for evidence-based health promotion, chronic disease management, and other community preventive strategies.

Target Population:
Number: 23,093,014
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 4,094,274
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: BRFSS, TACHC data on clinics' quality improvement activities

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Best Practice Initiative (U.S. Department of Health and Human Service)
Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $449,860
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
75-99% - Primary source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Clinical quality improvement
Between 10/2014 and 09/2015, Texas Association of Community Health Centers (TACHC) will increase the number of Federally Qualified Health Centers (FQHCs) using standardized clinical quality measures from 24 to **29**.

Annual Activities:
1. Clinical Innovation Specialist Training
Between 10/2014 and 09/2015, Specialist will begin training to enhance TACHC's ability to provide Team-based Care Training and Technical Assistance to federally qualified health centers in Texas

2. Add Immunizations to CQM Dashboard
Between 10/2014 and 11/2014, Add immunizations for children under 3 (UDS Childhood Immunization Measure) to the CQM dashboard.

3. Recruit 5 new centers to participate in the CQM dashboard
Between 10/2014 and 12/2014, Recruit five additional centers not currently in the HCCN to participate in the CQM dashboard.

4. Feasibility report to report outcomes by payor source
Between 10/2014 and 12/2014, Conduct investigation and develop a draft report on the feasibility of adding functionality in the CQM dashboard to delineate reported outcomes by payor source.

5. Complete OC3 Learning Collaborative
Between 10/2014 and 04/2015, Complete the 2014-2015 Optimizing Comprehensive Clinical Care (OC3) Learning Collaborative with participating centers documenting (a) plan to improve CQM dashboard measures and (b) meeting a minimum 50% score on the National Center for Quality Assessment (NCQA) Patient-Centered Medical Home 2011 Standards 1G (Care Team), 4B (Community Resources), 5B (Referral Tracking) and 5C (Care Transitions) or their 2014 equivalents.

6. Recruit new teams to the 2015 - 2015 OC3 Learning Collaborative
Between 10/2014 and 05/2015, Recruit 8-10 teams to participate in the 2015 - 2016 OC3 Learning Collaborative.

7. Increase functionality of CQM Dashboard
Between 10/2014 and 06/2015, Increase functionality of the CQM dashboard to include ability to stratify reported outcomes by race, ethnicity, and gender.

8. Review potential State Quitline interfaces
Between 10/2014 and 06/2015, Complete Technologic Scope and Capacity Review of potential State Quitline interfaces.

9. OC3 participants have documented baseline measures and NCQA PCMH Self-Assessment
Between 10/2014 and 07/2015, Ensure that OC3 Learning Collaborative participants have documented (a) Baseline CQM dashboard measures and (b) Baseline SCQA PCMH Self-Assessment (PCMH 2011 focus areas 1G, 4B, 5B, 5C, or 2014 equivalents)

10. Legal review of potential State Quitline interfaces
Between 10/2014 and 08/2015, Complete legal review of potential State Quitline interfaces.

11. New sites to be reverse engineered into the HCCN
Between 10/2014 and 09/2015, Recruit 4-5 new FQHCs to be reverse engineered into the TACHC Health Center Control Network

12. Increase CQM dashboard participation
Between 10/2014 and 09/2015, Make 40-44 existing FQHCs capable of CQM dashboard participation.

National Health Objective: HO ECBP-10 Community-Based Primary Prevention Services

State Health Objective(s):
Between 07/2014 and 12/2020, Engage community-based organizations and health care systems to develop and strengthen community-clinical linkages to improve health outcomes.

Baseline:
To be determined. Baseline will be based on an environmental scan of potential targeted communities; there are currently a few collaborative groups in a few Texas communities. A thorough assessment will be completed by TMF to determine appropriate groups and partners to link clinical and community partners in chronic disease prevention.

Data Source:
TMF will provide environmental scan of potential target Texas communities.

State Health Problem:

Health Burden:
Texas leads the nation in the rate of uninsured, has high poverty rates, and a significant burden of chronic diseases such as hypertension, cardiovascular disease and stroke, diabetes, and cancer, all of which can be attributed to modifiable risk behaviors. Health care delivery systems need to be optimized to provide appropriate evidence-based preventive and chronic disease management services, as well as develop and/or strengthen linkages to community resources for health promotion and chronic disease management.

Target Population:
Number: 26,059,203
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Disparate Population:
Number: 4,094,274
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific

Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: BRFSS, Steering Community data sources

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Best Practice Initiative (U.S. Department of Health and Human Service)
Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $579,311
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
75-99% - Primary source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Engaging a local coalition in Tyler
Between 10/2014 and 09/2015, TMF Health Quality Institute will establish **1** local coalition to facilitate and strengthen community-clinical linkages to build upon existing community resources and CHW networks and to provide structure to the community-clinical linkage.

Annual Activities:
1. Develop steering committee
Between 10/2014 and 09/2015, Develop a steering committee of 5-7 community and medical representatives to redesign the network of care.

2. Obtain and analyze baseline data
Between 10/2014 and 09/2015, Engage participating medical facilities to provide baseline data and work with remaining community representatives to work on data analysis and how to use data to connect with the medical providers.

3. Community meetings
Between 10/2014 and 09/2015, Host a minimum of six community meetings to provide updates on rapid cycle improvements.

4. 12 month report
Between 10/2014 and 09/2015, Have steering committee members prepare a report at the end of the 12 month period to document outcomes achieved, lessons learned, and recommendations for sustaining a steering committee.

National Health Objective: HO OA-3 Older Adults' Confidence in Managing Their Chronic Conditions

State Health Objective(s):

Between 07/2014 and 12/2020, TMF will enhance the capacity of community health workers in Texas to provide excellent patient-centered services for health promotion and chronic disease prevention.

Baseline:
To be determined (environmental scan of free curricula and tools for community health workers to educate communities about chronic disease prevention yielded no results).

Data Source:
Online research, CHW networks/association contacts, Agency for Health Care Research and Quality, American Public Health Association, Minnesota Community Health Care Worker Alliance, Rural Assistance Center Community Health Worker toolkit, and Texas CHW Certification program.

State Health Problem:

Health Burden:
Texas leads the nation in the rate of uninsured, has high poverty rates, and a significant burden of chronic diseases such as hypertension, cardiovascular disease and stroke, diabetes, and cancer, all of which can be attributed to modifiable risk behaviors. Health care delivery systems need to be optimized to provide appropriate evidence-based preventive and chronic disease management services, as well as develop and/or strengthen linkages to community resources for health promotion and chronic disease management.

Target Population:
Number: 7,413,634
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Disparate Population:
Number: 7,413,634
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: Online research, CHW networks/association contacts, Agency for Health Care Research and Quality, American Public Health Association, Minnesota Community Health Care Worker Alliance, Rural Assistance C

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Best Practice Initiative (U.S. Department of Health and Human Service)
Guide to Community Preventive Services (Task Force on Community Preventive Services)
National Guideline Clearinghouse (Agency for Healthcare Research and Quality)

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $30,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
75-99% - Primary source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Enhance CHW training to address chronic disease prevention
Between 10/2014 and 09/2015, TMF Health Quality Institute will develop **7** activities that will enhance educational opportunities for CHWs and lay health leaders to address chronic disease prevention.

Annual Activities:
1. CHW focus group
Between 10/2014 and 09/2015, Provide one focus group of CHWs to assess knowledge of chronic disease prevention and gather input on continuing education and tools needed to develop the skills to educate communities on chronic disease prevention and receive feedback on the CHW curriculum under development.

2. Develop chronic disease training modules
Between 10/2014 and 09/2015, Develop the chronic disease modules based on the CHW learning needs identified in the focus groups.

3. In-person CHW trainings
Between 10/2014 and 09/2015, Conduct two CHW trainings using the chronic disease modules developed.

4. Incorporate CD modules into existing programs
Between 10/2014 and 09/2015, Incorporate the Chronic Disease Modules into existing CHW training programs of identified CHW Training Institutions.

5. Webinars for CHWs
Between 10/2014 and 09/2015, Provide four webinars targeting CHWs/lay health leaders and educators to increase their knowledge about chronic disease prevention and share strategies to educate communities.

Objective 2:
Learning and Action Network
Between 10/2014 and 09/2015, TMF Health Quality Institute will maintain **1** Learning and Action Network (LAN) website including a resource center, events calendar, webinar registration and recordings, and allows for a subscriber email digest.

Annual Activities:
1. Functionality of LAN website
Between 10/2014 and 09/2015, Maintain the functionality of the LAN website, providing recorded webinar content, email digest capability, webinar registration, calendar, tools, and materials. Ensure website content is compliant with government laws and regulations in Section 508. Update website platform by transitioning from DNN 563 to DNN 7 as part of the maintenance.

National Health Objective: HO TU-9 Tobacco Screening in Health Care Settings

State Health Objective(s):

Between 07/2014 and 12/2020, Expand by 100 the number of clinical systems in Texas (hospital and clinic-based, as well as dental and mental health/substance abuse providers) implementing evidence-based tobacco cessation strategies, especially through use of an e-tobacco protocol incorporated into electronic medical records. This systems strategy will improve the delivery of effective tobacco screening, counseling, and referral to Quitline services, thereby improving rates of tobacco cessation and reducing the burden of tobacco-related diseases in Texas.

Baseline:
Current estimate of systems with fully implemented e-tobacco protocol in Texas are <20.

Data Source:
Texas Quitline maintains detailed records of clinical systems incorporating the e-tobacco protocol, and provides detailed reports of Quitline participants to the Texas Tobacco Prevention and Control Program. Participants can be tracked by referral source, so impact of this intervention in clinical systems can be quantified with electronic referral integration.

State Health Problem

Health Burden:
Overall, 23.9% of Texan adults smoke cigarettes or use smokeless tobacco, 22.9% of high school students use tobacco products, and 50% of Texan adults report second-hand smoke exposure (BRFSS, 2011). Each year, more than 24,000 Texans die from tobacco related causes making it the leading preventable cause of death. (*JAMA. 2004;291(10):1238-1245. doi: 10.1001/jama.291.10.1238)* This burden falls especially heavy on the low-socioeconomic status (i.e. annual income $25,000 or less, education level of high school diploma or less) Texans whose prevalence rates consistently are above state average (*2010 BRFSS*) and who often are without health care coverage (*2010 BRFSS, 34.4% of Texas smokers have no insurance*) and thus have limited access to care to treat tobacco related health issues. In addition, those who have substance abuse and mental health issues have prevalence rates three or more times higher than the general population (*DSHS CMBHS Reporting System*).

Target Population:
Number: 26,059,203
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 6,228,150
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state

Target and Disparate Data Sources: BRFSS, Quitline

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $349,215
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Start-up
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

Integration of eTobacco Protocol

Between 10/2014 and 09/2015, UT-Austin Tobacco and Research Evaluation Team will identify **15** medical/dental clinic or Electronic Health Record (EHR) systems to integrate the eTobacco Protocol.

Annual Activities:

1. Logic Model

Between 10/2014 and 12/2014, Complete creation of a logic model, based on the Coordinated Framework for Implementation Research (CFIR), to explore/describe the process of working to integrate the eTobacco Protocol into healthcare systems.

2. Outreach to medical clinic systems

Between 10/2014 and 09/2015, Provide outreach to clinic systems that have not yet integrated the eTobacco Protocol and offer technical assistance on implementing practice changes for tobacco screening, counseling, and referral.

3. Dental clinic outreach

Between 10/2014 and 09/2015, Provide outreach to three identified dental clinics to integrate the eTobacco Protocol into their electronic health records.

4. Motivational Interviewing Training

Between 10/2014 and 09/2015, Provide training in motivational interviewing to providers who have integrated the eTobacco Protocol into their electronic health records.

5. Outreach to EHR Systems

Between 10/2014 and 09/2015, Identifiy a minimum of two EHR systems to work with to establish the eTobacco Protocol as a standard process for each client.

6. Health Information Exchange concept

Between 10/2014 and 09/2015, Continue to develop the concept of integrating the eTobacco Protocol into a Health Information Exchange system.

State Program Title: **Local Health Departments**

State Program Strategy

Goal: The goal of the Division for Regional and Local Health Services (RLHS) of the Texas Department of State Health Services (DSHS) is to provide a coordinated system of public health services through local health departments and agency health service regions by ensuring the provision of the ten essential public health services.

As a public health priority for all Texans, the Texas Health and Safety Code, Chapter 121, Local Public Health Reorganization Act identified the Texas Department of State Health Service (DSHS) as one of several partners responsible for provision of essential public health services. The essential services are public health activities that ensure a healthy community at the local level. A priority for the state of Texas is to provide local health department funding in order to assure the provision of essential public health service to its citizens. To do so, DSHS and its health service regions must strengthen the statewide public health systems' ability to implement essential public health functions at the local level through increasing partnerships with current local health departments and establishing new local public health systems through collaborative processes. The RLHS division's overall strategy is to work with local health departments in establishing work plans based on community assessed public health essential service need. Work plans will identify and focus on current priority community health needs, using established state or national standards of performance, and identified activities to support the work plan based on best practices.

Health Priorities: Each PHHSBG funded local health department will be addressing essential public health service in their communities based on the 10 Essential Public Health Services. Local health department objectives will be developed to increase the community's ability to meet the gaps in service in order to build local capacity for public health.

Primary Strategic Partnerships: The RLHS division has established several external and internal partnerships throughout the state and nationally. Internal partners include the Center for Program Coordination, Family and Community Health Services, the DSHS Center for Health Statistics, Prevention and Preparedness programs. Strategic partners critical to accomplishing the divisions goal are current local health departments and districts, identified Local Health Authorities, the Texas Health Association, the Texas Health Institute, the Texas State System of Academic Schools of Public Health, affiliated non-profit public health agencies, and local stakeholders as defined by communities throughout the state.

Evaluation Methodology: Surveillance data will be used from local health department reports as they relate to meeting identified deliverables within specific work plan objectives. The RLHS division staff will evaluate completion of work plan objectives accomplished to meet essential public health service needs, DSHS programmatic goals, state wide identified public health priorities, and national public health performance standards such as Healthy People 2020.

State Program Setting:
Local health department

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: Chris Metting
Position Title: Contract Specialist III
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 1
Total FTEs Funded: 1.00

National Health Objective:	HO PHI-14 Public Health System Assessment

State Health Objective(s):
Between 10/2014 and 09/2015, the Texas Department of State Health Service will maintain the number of local public health agencies (59) working on locally defined goals for providing essential public health services.

Baseline:
59 Local Health Departments

Data Source:
DSHS Division for Regional and Local Health Services

State Health Problem:
Health Burden:
According to the Texas Department of State Health Services, Center for Health Statistics' 2012 data, Texas is still a minority majority state. This data shows that Texas has a non-Hispanic white population of 44.3 percent, a Hispanic or Latino population of 38.4 percent, a Black or African American population of 11.2 percent, and other populations of 5.8 percent. Access to healthcare is especially a problem among minorities, and according to the 2013 Texas Behavioral Risk Surveillance System Survey, 19.3 percent of Texans reported they could not see a doctor because of cost as compared to 15.9 percent, nationwide. Along the same lines for adults ages 19-64, 32 percent of Texans reported no health insurance coverage. This is significantly greater than the nation's 21 percent coverage for the same age group. Of Hispanic in Texans, 39 percent reported having no health insurance, compared to 22 percent of Blacks and 17 percent of Whites. There are 254 counties within the State of Texas classified as either urban, urban/rural, rural or frontier. Although a majority of Texans live in urban areas, over one half of the counties in the state are rural. According to the U.S. Bureau of the Census and the Office of Management and Budget, 177 of the 254 counties are non-metropolitan. Approximately 7.5 million people or 30 percent of the population live in these non-metropolitan areas and therefore, face the following barriers: lack of access to affordable health care, lack of transportation, little or no economic development, and limited fiscal resources.

PHHSBG are utilized to fund 59 LHDs, made up of city health departments, county health departments and public health districts serving a population base of 21,368,546.

Target Population:
Number: 21,368,546
Infrastructure Groups: State and Local Health Departments

Disparate Population:
Number: 21,368,546
Infrastructure Groups: State and Local Health Departments

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Best Practice Initiative (U.S. Department of Health and Human Service)
Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)
Model Practices Database (National Association of County and City Health Officials)
National Guideline Clearinghouse (Agency for Healthcare Research and Quality)

Other: Essential Services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems. Assuring the provision of essential public health service for all Texans is outlined in the Texas Health and Safety Code, Chapter 121, Local Public Health Reorganization Act. The passage of this Act identified the Texas Department of State Health Service (DSHS) as one of several partners responsible for ensuring this takes place. LHDs select one or more essential service in conjunction with an approved national, state, or industry standard to evaluate the essential public health services for FY

2015. Expectations are that public health systems through effective essential public health services begin to build consistency in service ultimately leading to a better quality of life.

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $2,180,419
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Assure Competent Workforce
Between 10/2014 and 09/2015, Local Health Departments who select this essential service will review **2** times per year workforce staff requiring licensure as part of their public health role within their respective programs to assure compliance.

Annual Activities:
1. Workforce Development
Between 10/2014 and 09/2015, Where needed, local health departments will provide their public health workforce access to staff development training and education, either live or online, on identified public health workforce needs.

Objective 2:
Develop Policies and Plans
Between 10/2014 and 09/2015, Local Health Departments who select this essential service will review **1** time per fiscal year their agency strategic plans and update any associated public health policies as needed.

Annual Activities:
1. Strategic Planning and Policy Development
Between 10/2014 and 09/2015, Based on annual reviews, local health departments will work with jurisdictional leaders, public health stakeholders, and community leaders in strategic planning and policy development around identified community public health priorities.

Objective 3:
Diagnose and Investigate
Between 10/2014 and 09/2015, Local Health Departments will review **1** time per year their local disease outbreak strategic plans to ensure local programs comply with CDC and DSHS state epidemiologic standards.

Annual Activities:
1. Disease Surveillance and Investigations
Between 10/2014 and 09/2015, Local Health Departments will semi-annually review local systems used in tracking of disease outbreaks in their jurisdictions, to include reporting and updating of appropriate data sources in accordance to local, state and federal guidelines.

2. Disease Surveillance Strategic Planning
Between 10/2014 and 09/2015, Local Health Departments will annually review disease surveillance strategic plans to assure compliance with DSHS and CDC standards, incorporating any needed improvements based on evaluation outcomes.

Objective 4:

Enforce Laws and Regulations

Between 10/2014 and 09/2015, Local Health Departments will conduct **1** annual review of the LHD strategic plans associated with environmental health and sanitation code enforcement activities in their jurisdiction to ensure plans are in accordance with state and federal health codes.

Annual Activities:

1. Code and Regulatory Enforcement

Between 10/2014 and 09/2015, Local health departments will develop semi-annual reports of all code enforcement monitoring and tracking activities to identify ongoing public health trends, and the regulatory activity used to enforce local public health codes.

Objective 5:

Evaluate Health Programs

Between 10/2014 and 09/2015, Local Health Departments will conduct **4** evaluations of PHHSBG work plans (1 per quarter) to assure program goals and objectives are on track for completion.

Annual Activities:

1. Program Evaluation and Assessment

Between 10/2014 and 09/2015, Local health departments will utilize the quarterly reporting process on PHHSBG funded program areas to evaluate and assess any needed changes to current goals or objectives, and implement changes where appropriate.

Objective 6:

Inform and Educate

Between 10/2014 and 09/2015, Local Health Departments who select this essential service to address will conduct **1** time per year a review of their public health education planning associated with programs across their agency to evaluate methods used for the dissemination and accuracy of information to identified stakeholders.

Annual Activities:

1. Public Health Education Initiatives

Between 10/2014 and 09/2015, Programs within the LHDs will annually review health education literature used for outreach and education campaigns reflecting current data and resource information.

2. Public Health Education Initiative

Between 10/2014 and 09/2015, Local health departments will gather local public health data and vital statistics associated with their jurisdiction to be shared with local lawmakers, commissioners courts, city or county public health advisory committees to educate them on health issues and or initiatives associated with the population they serve.

Objective 7:

Link People to Services

Between 10/2014 and 09/2015, Local Health Departments who select to address this essential service will conduct **1** time per year a review of program referral systems linking clients to providers or services in order to measure overall referral rates.

Annual Activities:

1. Resource Connectivity

Between 10/2014 and 09/2015, Local health departments will review annually client service referral directories are in place, whether these are through existing phone directories, or online client service databases to be used for linking stakeholders to local, state, or national public health services.

2. Resource Coordination and Collaboration
Between 10/2014 and 09/2015, Local health departments will annually evaluate their internal policies for client referrals and case management activities in population based service programs to identify inefficiencies or needed program changes.

Objective 8:
Local Health Department Accreditation
Between 10/2014 and 09/2015, Local Health Departments who select this essential service will develop **1** strategic plan for their agency in accordance to Public Health Accreditation Board guidelines related to preplanning for local public health accreditation.

Annual Activities:
1. Accreditation Pre-Planning and Development
Between 10/2014 and 09/2015, Local Health Departments establish a process for conduction system wide assessment on accreditation readiness through appointment of an accreditation coordinator who will oversee the process.

2. Activity 2 - Accreditation Pre-Planning and Development
Between 10/2014 and 09/2015, Local health departments will create plans for implementing pre-requisite steps in place outlined by the PHAB to evaluate their agency's readiness to move forward toward accreditation.

Objective 9:
Mobilize Partnerships
Between 10/2014 and 09/2015, Local Health Departments who select this essential service will review **1** time per year their community for potential stakeholders who contribute to or benefit from public health in order to increase the value of local public health.

Annual Activities:
1. Community Resource Management
Between 10/2014 and 09/2015, Local Health Departments conduct one strategic planning meeting with locally identified public health stakeholders and partners to review commonalities and resources in order to build collaborative approaches to preventing prevalent public health issues.

Objective 10:
Monitor Health Status
Between 10/2014 and 09/2015, Local Health Departments who select this essential service will evaluate **1** times per year the data used for their community health profile to ensure accuracy and that the data is readily available and in a usable manner for stakeholder planning.

Annual Activities:
1. Disease Outbreak Tracking
Between 10/2014 and 09/2015, Local Health Departments will establish semi-annual reports that track and record required jurisdictional program data submissions to state and federal guidelines that help create their local health status profiles.

2. Community Health Status
Between 10/2014 and 09/2015, Local Health Departments will act as a resource for local stakeholders and partners in conducting community health assessments based on documented public health need and use for local planning and health profiles.

Objective 11:

Research

Between 10/2014 and 09/2015, Local Health Departments who select this essential service will analyze **1** time per year research and best practices published by state local or federal partners for information that can be incorporated when appropriate into existing PHHSBG funded programs.

Annual Activities:

1. Public Health Research

Between 10/2014 and 09/2015, Local health departments will annually review public health programs for opportunities to collaborate with Texas public health academic institutions of higher education in order to promote research towards established best practices.

State Program Title: **Rape Prevention**

State Program Strategy

Goal: The Texas Department of State Health Services (DSHS) contracts with the Texas Office of the Attorney General (OAG) to administer the Preventive Health and Health Services (PHHS) Block Grant Sex Offense Set Aside funds. The OAG will use this funding to support statewide and community-based strategies and activities for the primary prevention of sexual violence. Funds will be awarded to sexual assault programs and one state sexual assault coalition for these purposes.

Health Priorities: Local PHHS Block Grant funded sexual assault programs will implement comprehensive primary prevention programs to address priorities identified in *Preventing Sexual Violence in Texas, A Primary Prevention Approach* (Plan), Amendment dated February 2015, using any one or more of the following approved activities or community change strategies. Approved activities include: Educational seminars; training programs for professionals; preparation of informational materials; and training programs for students and campus personnel designed to reduce the incidence of sexual assault at colleges and universities. Community change strategies include: Community mobilization, coalition building, policy education and social norms change.

The Plan Amendment, a revision of the original Plan, was completed by the Texas Primary Prevention Planning Committee (PPPC) in February 2015. The Plan Amendment identifies Texas specific risk factors for sexual violence, sets minimum standards for programming, identifies new outcomes, and provides additional guidance to PHHS Block Grant funded sexual assault programs on the implementation and evaluation of primary prevention strategies and activities. The state sexual assault coalition - Texas Association Against Sexual Assault (TAASA) - will use these funds to provide technical assistance and training to PHHS Block Grant funded local sexual assault programs on the implementation and evaluation of sexual violence primary prevention strategies; support efforts of the PPPC; and support local and statewide primary prevention efforts including but not limited to engaging men and youth in primary prevention efforts.

Primary Strategic Partnerships: Internal partnerships include the OAG Crime Victim Services Division (CVSD) staff which provides the programmatic guidance for this grant and the Grants Administration Division (GAD) staff who work closely with CVSD staff to develop the application kit used by sub-grantees to apply for funds, develop policy and procedures for awarding funds to sub-grantees, and serve as grant managers and grant monitors to sub-grantees ensuring compliance with the use of grant funds.

External partnerships include the following members of the PPPC along with OAG program staff - representatives from DSHS, TAASA, sexual assault programs, the Texas Council on Family Violence (TCFV) and community stakeholders. The PPPC was formed in 2007 to develop the Plan and guide the state's transition to a primary prevention approach to end sexual violence. The PPPC meets quarterly and currently provides guidance on the Plan's implementation and evaluation efforts.

Evaluation Methodology: PHHS Block Grant funded organizations will use pre-and post-tests, surveys, etc. to measure outcomes of interest. Measurement tools are currently being developed with the assistance of a professional evaluator and will be distributed to sexual assault programs for use.

State Program Setting:

Rape crisis center

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0
Total FTEs Funded: 0.00

National Health Objective: **HO IVP-40 Sexual Violence (Rape Prevention)**

State Health Objective(s):

Between 01/2000 and 12/2020, Reduce rapes or attempted rapes to 34 per 100,000 population

Baseline:
37.2 forcible rapes per 100,000 population in 2005. Forcible Rape, as currently defined in the Federal Bureau of Investigations (FBI)'s Uniform Crime Reporting (UCR) Program includes attempts or assaults to commit rape by force or threat of force. In 2013, the FBI began collecting data using the new definition of rape approved by the FBI Director in December 2011. Along with the new definition, the term "forcible" was removed from the UCR.

Data Source:
The source of data was the FBI, Uniform Crime Reports as prepared by the National Archive of Criminal Justice Data.

State Health Problem:

Health Burden:
In 2003, the OAG and TAASA funded a study entitled: *A Health Survey of Texans: A Focus on Sexual Assault.* The University of Texas (UT) at Austin in collaboration with the Public Policy Research Institute at Texas A & M University conducted the study, which measured the prevalence of sexual assault in Texas. Participants in 155 of the 254 Texas counties responded to a set of detailed questions about unwanted sexual experiences that may have occurred during three time periods: 1) before the age of 14; 2) between the ages of 14 and 17; and 3) at the age of 18 and over. The study revealed 13% of adult Texans have been sexually assaulted at some point in their lifetime. Only 18% of the victims reported their assault to law enforcement, and the proportion of sexual assault is much higher for females than males (one out of five females and one out of 20 males). Females in all age categories are at risk for sexual victimization. Nine percent of female Texans were assaulted before the age of 14, 7% between the ages of 14 to 17 and 10% at 18 or older.

In 2015, DSHS funded UT to do a follow-up survey on prevalence of sexual assault in Texas. Preliminary findings show an increase in rates of sexual assault to approximately 18.2% of adult Texans have been sexually assaulted at some point in their lifetime.

During the time period of September 1, 2013 – August 31, 2014, sexual assault programs reported providing services to 45,045 survivors from 254 counties. An analysis of data shows that of survivors served, 10% were male, 88 % were female and 2 % gender unknown, 60% were adults, 33% were children and 8 % age was unknown.

Cost Burden:
A 2011 study conducted by the Institute on Domestic Violence and Sexual Assault, at the University of Texas, Austin, entitled *Sexual Assault Needs Assessment in Texas*, estimates the state of Texas spends approximately $42.8 million on services for victims of adult sexual assault every year. The study indicates this estimate is conservative as it does not include "the cost for district attorneys' time spent investigating and prosecuting cases after police and sheriffs' investigations are completed, costs associated with patrol officers' initial response to an outcry, and unreimbursed hospital and Sexual Assault Nurse Examiners program costs, all of which simply cannot be estimated".

In FY 2013 the OAG awarded $5,039,751 to sexual assault programs throughout Texas to provide sexual assault related services and to the statewide coalition to provide technical assistance and support to sexual assault programs. Those services are detailed above in the Health Burden section.

Target Population:
Number: 6,044,840
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 4 - 11 years, 12 - 19 years, 20 - 24 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 6,044,840
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 4 - 11 years, 12 - 19 years, 20 - 24 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: Texas Department of State Health Services Population Projections Year 2015

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: The Prevention Guidelines System (Centers for Disease Control and Prevention).
Preventing Sexual Violence in Texas, A Primary Prevention Approach, Amendment dated February 2015.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $562,234
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Inform and Educate
Between 10/2014 and 09/2015, PHHS Block Grant funded sexual assault programs will increase the percent of knowledge of the factors that allow sexual violence to occur from baseline of 0 to **75% of participants who complete a pre-and post-test or some other outcome instrument will show an increase in knowledge of the factors that allow sexual violence to occur. Approximately 6% of all participants (2,500) will complete an outcome instrument**.

Annual Activities:
1. Approved Activities and Complementary Strategies
Between 10/2014 and 09/2015, PHHS Block Grant funded sexual assault programs will implement at least one comprehensive primary prevention program that includes activities at the individual, relationship and community levels that involve multiple sessions with the same audience. Programs will utilize the approved

activities and community change strategies (listed below). PHHS Block Grant funded organizations will conduct approximately 1,000 educational seminars and training programs for professionals reaching approximately 25,000 participants. Strategies and activities implemented will focus on reducing attitudes, behaviors, and norms supportive of sexual violence including: hyper masculinity, hostility towards women; unhealthy attitudes about sex and sexuality (consent0; association with sexually aggressive peers and delinquent peers; general tolerance of sexual violence within the community; societal norms that support sexual violence; and weak laws and policies related to gender equity. PHHS Block Grant funded sexual assault programs will use the Plan Amendment as a programmatic guide.

Approved activities include: Educational seminars; training programs for professionals; preparation of informational materials; training programs for students and campus personnel designed to reduce the incidence of sexual assault at colleges and universities; Community change strategies include: Community mobilization, coalition building, policy education and social norms change.

2. Increase Capacity
Between 10/2014 and 09/2015, TAASA and the OAG will work to increase capacity of local PHHS Block Grant funded sexual assault programs to implement and evaluate sexual violence primary prevention strategies. TAASA and the OAG will provide training and programmatic technical assistance to PHHS Block Grant funded sexual assault programs on implementing strategies and activities to address modifiable risk and protective factors for sexual violence and other topics.

Objective 2:
Inform and Educate
Between 10/2014 and 09/2015, Office of the Attorney General will increase the number of sexual assault programs that report an increase in participants' intent to engage in healthy relationship behaviors from 0 to **100% of sexual assault programs report an increase in participants' intent to engage in healthy relationship behaviors**.

Annual Activities:
1. Approved Activities and Complementary Strategies
Between 10/2014 and 09/2015, Between 10/2014 and 09/2015, PHHS Block Grant funded sexual assault programs will implement at least one comprehensive primary prevention program that includes activities at the individual, relationship and community levels that involve multiple sessions with the same audience. Programs will utilize the approved activities and community change strategies (listed below). PHHS Block Grant funded organizations will conduct approximately 1,000 educational seminars and training programs for professionals reaching approximately 25,000 participants. Strategies and activities implemented will focus on reducing attitudes, behaviors, and norms supportive of sexual violence including: hyper masculinity, hostility towards women; unhealthy attitudes about sex and sexuality (consent0; association with sexually aggressive peers and delinquent peers; general tolerance of sexual violence within the community; societal norms that support sexual violence; and weak laws and policies related to gender equity. PHHS Block Grant funded sexual assault programs will use the Plan Amendment as a programmatic guide.

Approved activities include: Educational seminars; training programs for professionals; preparation of informational materials; training programs for students and campus personnel designed to reduce the incidence of sexual assault at colleges and universities; Community change strategies include: Community mobilization, coalition building, policy education and social norms change.

State Program Title: **Texas Healthy Communities Program**

State Program Strategy:

Goal: The goal of the Texas Healthy Communities (TXHC) Program is to assist cities to assess their existing environments, implement changes in local environmental and policy infrastructure and adopt priority public health practices to reduce risk factors for cardiovascular disease (CVD), stroke, and other chronic diseases.

Health Priorities: The health priorities of the TXHC Program include physical activity promotion and access, promotion of and access to good nutrition, healthy school environments, healthy worksite environments, tobacco control and prevention, cardiac and stroke event response, and health care quality improvement.

Primary Strategic Partnerships: Primary strategic partnerships will include programs internal to DSHS, such as the School Health Program and the Tobacco Prevention and Control Program, in addition to local health departments, the Texas Council on Cardiovascular Disease and Stroke, the Texas Cardiovascular Disease and Stroke Partnership, and local community based organizations as appropriate.

Evaluation Methodology: Program evaluation will utilize a mixed-methods approach, including surveys, focus groups and key informant interviews. Evaluation will be conducted in collaboration with local health departments and led by the Office of Surveillance, Evaluation and Research within the Health Promotion and Chronic Disease Prevention Section at DSHS.

State Program Setting:

Community based organization, Local health department

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: Cecily Brea
Position Title: Program Coordinator
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Name: Debbie Warren
Position Title: Program Specialist
State-Level: 25% Local: 75% Other: 0% Total: 100%
Position Name: Jane Schwarz
Position Title: Program Specialist
State-Level: 25% Local: 75% Other: 0% Total: 100%
Position Name: VACANT
Position Title: Research Specialist
State-Level: 25% Local: 0% Other: 0% Total: 25%

Total Number of Positions Funded: 4
Total FTEs Funded: 3.25

National Health Objective: HO ECBP-10 Community-Based Primary Prevention Services

State Health Objective(s):

Between 10/2014 and 09/2015, Increase the capacity of local health departments to implement and sustain community systems and environmental changes to address one or more of the nine priority Texas Healthy Communities (TXHC) indicators.

Eight indicators include:
1. Physical Activity -Physical activity areas and opportunities are designated, safe, accessible, and promoted throughout the community
2. Nutrition -Healthy food options are accessible and promoted to all members of the community.
3. Breastfeeding -Mother-friendly worksites, birthing facilities, and hospitals are in place in the communities.
4. Schools-Public schools comply with all legislated components of a coordinated school health program and daily physical activity, and high schools offer an evidence-based health curriculum.
5. Worksites -Worksites wellness programs are in place for the majority of employees.
6. Tobacco- A comprehensive tobacco control program is in place that includes a 100 % smoke free city smoking ordinance.
7.Cardiac and Stroke Response- Defibrillators (Manual and/or Automated External) are available to first responders and the emergency system of care maintains a rapid response time for cardiac events. Stroke is treated as a medical emergency in the community and appropriate acute stroke treatment protocols are in place.
8. Healthcare Quality-Health Care Sites in the community promote primary and secondary prevention of CVD and Stroke. Health Care Sites promote hypertension and diabetes reporting.

Baseline:
0 health departments implementing community systems and environmental changes to address one or more of the eight priority Texas Healthy Communities (TXHC) indicators.

Data Source:
Texas Healthy Communities Assessment through web-based Performance Management and Tracking System (PMATS)

State Health Problem:

Health Burden:
Chronic disease is a major cause of death and disability in Texas. With an estimated population of more than 25 million, the second most populous state in the Union is becoming increasingly diverse, with approximately 38 percent of Texans identifying as Hispanic, 46 percent as white, and about 12 percent as African American in 2010. From 2000 to 2010, the Hispanic population in Texas increased by about 42 percent.[1] These factors, coupled with a high burden of chronic disease and major health disparities has created an immense public health challenge for the state:

- Cardiovascular disease (CVD) continues to be the leading cause of death in Texas, leading to 47,250 lives lost in 2011,1
- Nearly 30 percent of Texas adults report high blood pressure (HBP),
- Diabetes affects about 10 percent of the general adult population,
- Eight percent of Texans report cardiovascular disease,
- Five percent report prediabetes.[2]

While these chronic diseases are largely preventable through the reduction of such modifiable risk factors, relevant risk factors are also a major problem for Texas adults: 30 percent are obese, 50 percent are physically inactive, and 81 percent report consuming fewer than five fruit and vegetable servings per day.[2] In addition to the human consequences, the financial burden of chronic disease in Texas is immense. Total hospital charges for CVD and diabetes in Texas in 2010 exceeded 21 billion dollars.[3]
Young Texans are impacted by chronic disease risk as well. Data suggest 17 percent of Texas children and youth across grades 3-12 are at risk of becoming obese.[4] Childhood obesity prevalence is greater in both African-Americans and Hispanic children compared to whites; one in three Hispanic and one in four African-American 4th graders are estimated to be obese in Texas.[5] Among all high school students, 16 percent reported engaging in no physical activity.[6]

In Texas, African Americans, Hispanics, and persons of low socioeconomic status experience a particularly disproportionate burden of chronic disease including multi-morbidity. African Americans are four times as likely to report having diabetes or pre-diabetes, HBP and CVD as compared to whites, and Hispanics are twice as likely to report all three conditions.[2] Age-specific hospitalization rates for diabetes are twice as high among elderly (≥ 65 years) Hispanics than elderly whites.[3] Incidence rates indicate African Americans are at greater risk for CVD, diabetes, and blood pressure hospitalizations. Furthermore, education and income levels decrease as prevalence increases for all major chronic disease risk factors (obesity, high cholesterol, lack of fruit and vegetable consumption, lack of physical activity).[2]

References

1 Center for Health Statistics. Texas Department of State Health Services, 2011.
2 Center for Health Statistics. Texas Behavioral Risk Factor Surveillance System. Texas Department of State Health Services, 2011.
3 Texas Health Care Information Collection. Texas Hospital Discharge Data. Texas Department of State Health Services, 2011.
4 The Cooper Institute. FITNESSGRAM. Dallas, Texas.
5 University of Texas. School Physical Activity and Nutrition Survey. Texas Department of State Health Services, 2011.
6 Center for Health Statistics. Youth Risk Factor Surveillance System. Texas Department of State Health Services, 2011.

Target Population:
Number: 6,915,671
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Disparate Population:
Number: 6,915,671
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Specific Counties
Target and Disparate Data Sources: Center for Health Statistics, Texas Department of State Health Services.

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Community Preventive Services (Task Force on Community Preventive Services)
Model Practices Database (National Association of County and City Health Officials)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $1,455,354
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0

Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
75-99% - Primary source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Community Participation
Between 10/2014 and 09/2015, Texas Department of State Health Services and Local Health Department staff will increase the number of communities participating in the Texas Healthy Communities Program to complete community assessments and implement environmental and systems changes that address one of the nine priority Texas Healthy Communities Program indicators. from 0 to **20**.

Annual Activities:
1. Establish contracts
Between 10/2014 and 09/2015, DSHS staff will establish contracts with 20 communities, through local health departments or community-based organizations, to conduct the Texas Healthy Communities assessment and use results of the assessment to implement a targeted, evidence-based intervention(s) to address one or more of the 8 Texas Healthy Communities Program priority indicators.

2. Technical assistance
Between 10/2014 and 09/2015, DSHS staff will develop technical assistance plans for contractors that will identify areas for improvement based on the Texas Healthy Communities assessment. Plans will also recommend actions/interventions to address areas for improvement. Technical assistance plans will utilize evidence-based practices and guidelines. In addition to customized technical assistance plans, DSHS staff will conduct site visits and monthly calls to monitor program implementation and provide support.

3. Conduct evaluation
Between 10/2014 and 09/2015, DSHS staff will work with contractors to develop evaluation plans for targeted interventions and for the Texas Healthy Communities Program overall. Evaluation will be ongoing.

Program evaluation will utilize a mixed-methods approach, including surveys, focus groups and key informant interviews.

Evaluation will entail validity test of Texas Healthy Communities assessment tool.

4. Sharing Successes
Between 10/2014 and 09/2015, DSHS staff will compile success stories and develop a publication highlighting communities' successes and best practices at the end of the grant year and will disseminate to the Texas Healthy Communities partners, the Texas Council on Cardiovascular Disease and Stroke, and the Texas Cardiovascular Disease and Stroke Partnership. DSHS will convene a liaison meeting, including all Texas Healthy Communities liaisons and partners, to share successes, barriers, challenges, and best practices at the end of the grant year.

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name:	Stock Epinephrine Advisory Committee (SEAC)		
Number of Members:	10		
Committee Status (Ongoing or Inactive):	Ongoing	Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.	
Date Created:	6/1/2015	**Date to Be Abolished:**	N//A
Budget Strategy (Strategies) (e.g. 1-2-4)	B.1.2	**Strategy Title (e.g. Occupational Licensing)**	Women and Children's Health Services
Budget Strategy (Strategies)		**Strategy Title**	

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Education Code, Sec. 38.202
State Authority		
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$8,000	$12,000
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$8,000	$12,000

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$20,053	$20,353	$20,053
Number of FTEs	0.4	0.4	0.4
Other Operating Costs	$300	$0	$12,000
Total, Committee Expenditures	$20,353	$20,353	$32,053

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
555 - Federal Funds	$20,353	$28,353	$44,053
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year	0	3	3

Committee Description: Senate Bill 66, 84th Legislative Session, amends Chapter 38 of the Texas Education Code by adding Section 38.0152, allowing schools to adopt and implement policy for the possession, administration, and disposal and reporting of epinephrine auto-injectors utilized in the school district. In addition, it requires the commissioner of state health services to establish and appoint members to an advisory committee that will advise on the storage, maintenance, training, and planning required to be implemented by local school

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. - No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

The committee has not been appointed yet, so there is no meeting history at this time. It is expected that they will meet at the Texas Department of State Health Services, 1100 West 49th Street, Austin, Texas 78756. There is no requirement as to the frequency of meetings.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

Once the committee is appointed, it will advise the DSHS Commissioner on the storage, maintenance, training, and planning required to be implemented by local school districts who stock epinephrine.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

The committee has not been appointed at this time, so no advice has been received.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ?

Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

0.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Staff is currently soliciting applications from physicians and nurses wishing to serve on the committee. Staff will complete the appointment process and schedule a preliminary meeting to determine meeting frequency and assign tasks. Staff will assist in developing recommendations and present them to the DSHS Commissioner. Staff will play an ongoing role in developing a reporting system where schools submit information about their use of epinephrine to DSHS.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

The first committee meeting has not yet occurred.

7b. Do members of the public attend at least 50 percent of all committee meetings?

7c. Are there instances where no members of the public attended meetings?

8. Please list any external stakeholders you recommend we contact regarding this committee.

School districts affected by statute

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

9b. Please describe the rationale for this opinion.

The first committee meeting has not yet occurred.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

Yes

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

No

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Texas Council on Alzheimer's Disease and Related Disorders (TCAD)

Number of Members: 12 voting members; 5 non-voting members

Committee Status (Ongoing or Inactive): Ongoing

Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 1987 **Date to Be Abolished:** N/A

Budget Strategy (Strategies) (e.g. 1-2-4) A.3.1 **Strategy Title (e.g. Occupational Licensing)** Chronic Disease Prevention

Budget Strategy (Strategies) **Strategy Title**

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Texas Health and Safety Code, Chapter 101
State Authority	Admin Code	Title 25, Part 12, Chapter 801, Rule Section 801.1
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$579	$3,500	$3,500
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$579	$3,500	$3,500

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$53,205	$54,801	$54,801
Number of FTEs	1.0	1.0	1.0
Other Operating Costs	$29,347	$19,870	$21,699
Total, Committee Expenditures	$82,552	$74,671	$76,500

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	$83,131	$78,171	$80,000
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year 2 2 2

Committee Description:

Per Health and Safety Code, Chapter 101, Section 101.007, duties are:
• Recommend needed action for the benefit of persons with Alzheimer's disease (AD) and related disorders and their care givers.
• Disseminate information on services and related activities for persons with AD and related disorders to the medical and academic communities, care givers, associations, and the general public.
• Coordinate services and activities of state agencies, associations, and other service providers.
• Encourage statewide coordinated research.
• Prepare and submit a Biennial Report to the Governor, Lt. Governor, and Speaker of the House every even-numbered year of the Council's activities.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission.

No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

Per statute, the council meet at leasts twice each calendar year and at the call of the chairman, typically in Austin.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

The Council is required to provide a Biennial Report to the Governor, Lt. Governor, and Speaker of the House every even-numbered year of the Council's activities. The Council developed the 2010-2015 Texas Alzheimer's Disease State Plan.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

The Council made recommendations regarding state appropriated funds for Texas Alzheimer's Research and Care Consortium (TARCC), as mandated, for Alzheimer's disease research. The Council recommended that the 2010-2015 Texas Alzheimer's Disease State Plan be updated, and it is currently being updated.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ?

Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

1536.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Provide support for Council meetings (developing agenda, securing meeting space etc.), provide support in implementing and updating the state plan.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

All Council meetings are posted to in the Texas Register according to Open Meetings Act.

7b. Do members of the public attend at least 50 percent of all committee meetings?

Yes

7c. Are there instances where no members of the public attended meetings?

No

8. Please list any external stakeholders you recommend we contact regarding this committee.

Alzheimer's Texas; Baylor College of Medicine - Houston

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

Yes

9b. Please describe the rationale for this opinion.

The Council, established by statute as the state's advocate for persons with Alzheimer's Disease (AD) and those who care for them, continues to provide information and support to AD patients, their families, and long-term care providers. The legislatively mandated activities of the Council were incorporated into the 2010-2015 Texas State Plan on Alzheimer's Disease. The Council developed the Texas Alzheimer's Disease Partnership, a partnership of over 120 members, to create the Plan and actively engage in comprehensively addressing the burden of AD on a statewide, coordinated basis. Education Code, Chapter 154 (House Bill 1504, 76 Legislature, Regular Session, 1999) directed the Texas Council on Alzheimer's Disease and Related Disorders (Council) to establish a Consortium of Alzheimer's Disease Centers, later renamed the Texas Alzheimer's Research and Care Consortium (TARCC). TARCC is part of the state-funded Darrell K. Royal Texas Alzheimer's Initiative.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute? No

10b. Does the scope and language found in statute for this committee prevent your agency from responding to No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

N/A

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)? Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission? No

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

Meeting Minutes
Texas Council on Alzheimer's Disease and Related Disorders
Meeting Minutes – February 19, 2014
JJ Pickle Commons Learning Center
10100 Burnet Road
Austin, Texas 78758

The Texas Council on Alzheimer's Disease and Related Disorders met on Wednesday, February 19, 2014, at the JJ Pickle Commons Learning Center, 10100 Burnet Road, Austin, Texas 78758

Council Members Present	**Guests Present**
The Honorable Clint Hackney, Vice-Chair	Paula Grammas, PhD, Texas Tech HSC
Bonnie Curington, PhD, DSHS	George Perry, PhD, UTSA
Grayson R. Hankins	Diana Kerwin, MD
Susan Rountree, MD	Katie Wiechnicki, DSHS - HPCDP
Ronald DeVere, MD	Marcelo Kort, Lilly
Melissa L. Edwards	Lisa Glass, Ross Communications
Lisa B. Glenn, MD	Beth Lynn Maxwell, UT System
Deborah S. Hanna, Chair	James Crowson, Attorney General's Office
Rita Hortenstine	Denise Rose, TAMHSC
Patty Moore, PhD	Janice Knebl, UNTHSC
Robert Vogel, MD	Danny Jensen, UNTHSC
Laura DeFina, MD	Thomas Fairchild, UNTHSC
	Nancy Turco, Alzheimer's volunteer
Council Members Absent	
Carlos Escobar, MD	**Staff Members Present**
Kate Allen Stukenberg	Lynda Taylor, DSHS - HPCDP
Ray Lewis, DO	

1. Welcome/Call to Order/Roll Call/Excuse Absent Members

Ms. Debbie Hanna called the meeting to order at 8:35 am. Ms. Lynda Taylor certified roll, and a quorum was present. Members, guests and new members were welcomed and introduced.

Dr. Carlos Escobar and Ms. Kate Allen Stukenberg extended their apologies for not attending. Dr. Ray Lewis was also absent. Ms. Hanna requested that the absence of Dr. Escobar, Ms. Stukenberg and Dr. Lewis be excused. The Honorable Clint Hackney moved for the excused absence. Grayson R. Hankins seconded the motion. All were in favor.

2. Approval of Council Minutes from the August 28, 2013, Meeting

Ms. Hanna asked Council members to review the minutes from the August 28, 2013, meeting. Dr. Ron DeVere moved that the minutes be approved as presented. Ms. Melissa Edwards seconded the motion. All were in favor, and the August 28, 2013, meeting minutes were approved as presented.

3. DSHS Staff Changes

Ms. Hanna announced that Ms. Susan Ristine, the previous DSHS Alzheimer's Disease Program Coordinator had retired. Ms. Lynda Taylor was hired in November 2013 as the new Coordinator.

4. TARCC Consortium Director Introduction: Paula Grammas, PhD

Ms. Hanna introduced Paula Grammas, PhD, as the Consortium Director for the Texas Alzheimer's Research and Care Consortium (TARCC). Dr. Grammas reports directly to the Council.

The Texas Council on Alzheimer's Disease and Related Disorders (the Council) identified the need for permanent supervision of TARCC in order to expand its reach in developing programs and research. The Council conducted a search for a director in the summer of 2013.

Dr. Grammas comes to TARCC from the Texas Tech University Health Sciences Center, School of Medicine, where she served as the Executive Director of the Garrison Institute on Aging, Mildred and Shirley L. Garrison Chair in Aging, and Professor of Neurology. Previously, Dr. Grammas was the director of the Oklahoma Center for Neuroscience at the University of Oklahoma Health Sciences Center, the Presbyterian Health Foundation Endowed Chair in Neuroscience, and adjunct professor of cell biology, geriatrics, psychology and behavioral science at the University of Oklahoma Health Sciences Center. Dr. Grammas is originally from Long Island, NY.

The first TARCC Steering Committee meeting of the year will be on February 20, 2014.

5. Update on TARCC Activities

Dr. Grammas provided an overview of the current TARCC activities and the possibilities for expanding TARCC's reach. A priority is the promotion of statewide collaborations to include non-

TARCC institutions and younger researchers. There is a need to translate basic science research in order to "take research to the bedside." This investment in effort will create a bigger base for what TARCC wants to accomplish. More discussions are needed to determine where TARCC wants to be. The TARCC Steering Committee meeting will continue this discussion on February 20, 2014.

Dr. Grammas provided an update on the Texas Harris Alzheimer's Research Study.

6. Texas A&M Health Science Center Program and Research Initiative

Ms. Hanna introduced the Investigator Outreach Program in draft form as authored by Dr. Grammas and handed out a program concept paper. This program will be administered by Texas A&M University (TAMU). TAMU researchers are currently involved in TARCC activities. The goal is to develop a scientific core to be more prepared to participate in existing activities of TARCC that eventually will connect TARCC with public health efforts. Funds for 10 2-year grants will be awarded to equal $1,250,000. It is important to note that TAMU does not receive these funds for their own use but will manage the grant program that distributes these monies to colleges, universities and medical schools across Texas to conduct Alzheimer's research utilizing, to the maximum extent possible, the TARCC cohort.

Dr. Grammas described the program as a way to jumpstart research collaboration to further the understanding of Alzheimer's disease in many ways:

1. Provide opportunities for faculty
2. Foster involvement of younger faculty
3. Involve clinical & basic faculty
    a. Statewide reach of A&M (network and experience)
    b. Lots of effort for dissemination
4. Encourage dialogue on scientific research on AD
5. Prepare for a public approach down the road

Ms. Hanna stated that TAMU is accepting a big responsibility. TARCC has full support from the scientific community at A&M. This is a good first step in leveraging the strengths of TAMU and addressing a real need. The program will be open to researchers around the state who can utilize the cohort for their research.

Ms. Hanna asked for a motion to adopt the expenditure for the Texas A&M Health Science Center Investigator Outreach Program. The Honorable Clint Hackney moved to adopt this expenditure. Grayson R. Hankins seconded the motion. All were in favor, and the motion passed unanimously. A memorandum of understanding will be drafted by the summer.

Dr. Grammas thanked the Council.

7. External Advisory Committee Update

Dr. Grammas will work with the External Advisory Committee. Ron Petersen, MD, PhD, of Mayo Clinic serves as chair of this group of 5 distinguished scientists from across the US who come together every other year to evaluate the activities of TARCC. Meetings are conducted in person and by conference calls. Dr. Grammas and Dr. Petersen will establish time and location for the review meeting. The Council will receive a written report of the findings in the late fall.

8. Consideration and possible action with respect to Memorandum of Understanding distributing funds to TARCC member sites & TARCC Contract Update

Ms. Hanna provided an overview of the TARCC contractual activities over the past year. The agreements with the TARCC schools are actually memorandums of understanding (MOU). At the August 28, 2013, Council meeting, the Council received information on the costs for TARCC and the patient cohort for the period September 1, 2013, through August 31, 2015. James Crowson of the Attorney General's Office prepared the MOUs. The 2013 MOUs were sent to the schools and included only changes in dates and dollar amounts. The MOUs were the same in content as has been signed by the schools since first funding in 2005. A discussion resulted within the six schools regarding the Intellectual Property sections of Exhibit E. Five of the six TARCC schools came to an understanding regarding the objectionable sections, signed the MOUs and accepted the funds.

Following weeks of negotiation, The University of North Texas Health Science Center (UNTHSC) declined to sign the MOU. The standards of compromise were negotiated by attorney Beth Lynn Maxwell of the University of Texas System. Pursuant to an email dated February 7, 2014, from S. Michelle Williams, Associate General Counsel University of North Texas System, UNTHSC is withdrawing from TARCC effective September 1, 2013. This is binding on the Council, and the Council accepted the withdrawal, as stated by Ms. Hanna, with great regret. Ms. Hanna asked that the record reflect the Council is very proud of the work of UNTHSC and Dr. Sid O'Bryant, formerly of Texas Tech HSC but most recently associated with UNTHSC. UNTHSC, TARCC, and the Council will work on an agreeable transition.

Ms. Hanna asked for questions:

Dr. Vogel: Why did UNTHSC withdraw?

Ms. Hanna: There was a disagreement over language and the process for working it out. Five of the six member schools and their attorneys came to an agreement with the attorneys for UT System and the Attorney General's office.

Dr. Vogel: Will we lose Sid O'Bryant? He has done much to advance the science.

Ms. Hanna: I hope this is not final.

Mr. Hackney: Can they come back at a later time?

Ms. Hanna: They are part of our research family by statute. I am not even sure they can resign. I know they can choose to not participate. Please be very clear, the email I

distributed indicates they resigned and it came as a shock. We never asked them to leave. We hope that the disagreements can be worked out.

Mr. Crowson: UNTHSC could/would not continue with the language as it was written. They could be included in the future. It is a matter of working out the details.

Ms. Maxwell: The process clarified ideas.

Dr. Fairchild: (Steering Committee of UNTHSC)
Based on the regent's rules, they are not allowed to give away intellectual property. The withdrawal related only through the balance of this fiscal year. No funds were received for the new fiscal year. UNTHSC will continue to be active on the TARCC steering committee during this time.

Mr. Hackney: We should do something to get UNTHSC back in.

Ms. Maxwell: Campuses that work well together are committed to research and know that there are other things to continue working together on.

Ms. Hanna: Do you know why the resignation from UNTHSC was effective retroactively back to September 1, 2013?

Mr. Crowson: I do not.

Mr. Crowson: Intellectual property matters can be worked out. This is a disappointment.

9. Time and Date for Next Council Meeting

Ms. Hanna explained that if needed she would call an emergency meeting of the Council. The next planned meeting of the Council will occur in the fall of 2014.

10. Public Comment

There was no public comment.

11. Adjourn

There being no further business, the meeting was adjourned at 9:30 am.

Meeting Minutes
Texas Council on Alzheimer's Disease and Related Disorders
Meeting Minutes – February 25, 2015; 8:30 a.m.
JJ Pickle Commons Learning Center
10100 Burnet Road
Austin, Texas 78758

The Texas Council on Alzheimer's Disease and Related Disorders met on Wednesday, February 25, 2015, at the JJ Pickle Commons Learning Center, 10100 Burnet Road, Austin, Texas 78758.

Council Members Present	**Guests Present**
The Honorable Clint Hackney, Vice-Chair	George Perry, PhD - UTSA
Grayson R. Hankins	Katie Wiechnicki, DSHS - HPCDP
Ronald DeVere, MD	Thomas Fairchild, UNTHSC
Lisa B. Glenn, MD	Howard Gruetzner, N. Cent. TX Alz. Assoc.
Deborah S. Hanna, Chair	Monica Rodriguear, Baylor – ADMDC
Rita Hortenstine	Mimi Dang, MD – Baylor College of Med.
Patty Moore, PhD	Mark Kunik – Houston VAMC/BCM
Robert Vogel, MD	Janice Knebl – UNTHSC
Valerie J. Krueger	Robert Barber, PhD – UNTHSC
Toni Packard	Rachelle S. Doody – Baylor College of Med.
	Brandon Patterson – Silverado
Council Members Absent	Cerretha Rose – Realty Austin
Laura DeFina, MD	Matthew Lambert – TTUHSC
Carlos Escobar, MD	P. Hemachandra Reddy - TTUHSC
Kate Allen Stukenberg	Holly Palmer – ACC Occ. Therapy Asst. PR
Ray Lewis, DO	Natalya Price – ACC Occ. Therapy Asst. PR
Susan Rountree, MD	Elena Simens - ACC SOTA
Melissa L. Edwards	
Nancy Walker	**Staff Members Present**
	Lynda Taylor, DSHS - HPCDP

1. Welcome/Call to Order/Roll Call/Excuse Absent Members

Ms. Debbie Hanna called the meeting to order at 8:35 a.m. Ms. Lynda Taylor certified roll, and a quorum was present. Members, guests and new members were welcomed and introduced. Two new agency representatives were introduced: Valerie J. Krueger of Adult Mental Health Services, Department of State Health Services and Toni Packard of the Department of Aging and Disability Services.

2. Approval of Council Minutes from the February 19, 2014, Meeting

Ms. Hanna asked Council members to review the minutes from the February 19, 2014, meeting. Dr. Robert Vogel moved that the minutes be approved as presented. Mr. Grayson Hankins seconded the motion. All were in favor, and the February 19, 2014, meeting minutes were approved as presented.

3. DSHS Update

Patty Moore provided updates from the Texas Department of State Health Services.

- The DSHS Commissioner, Dr. David Lakey, has left the position. Kirk Cole is the Interim Commissioner.
- The Sunset Advisory Commission has released its recommendations regarding the health and human services (HHS) agencies. Their recommendation to date has been a consolidation of the agencies. There are still many unknowns at this point in time.
- The 84th Legislature is in session. There are two bills (one in the House, one in the Senate) to "clean up" language in existing statute.
- Budget:
    - The Alzheimer's Disease Program funding is intact.
    - The Health Promotion and Chronic Disease Prevention Section put forward four exceptional items: 1) Asthma Prevention and Control, 2) Potentially Preventable Hospitalization, 3) Diabetes Prevention and Control, and 4) Tobacco Prevention and Control.

4. DSHS Alzheimer's Disease Program update

Lynda Taylor stated that over the past year, the focus has been on activities that enhance the existing objectives of the State Plan instead of a major update to the entire Plan. Ms. Hanna and Ms. Taylor agreed that it is in the best interest of the State Plan moving forward to form committees and spend the next several months amending and refining our work plan.

5. TARCC update

Dr. Barber provided a brief update.

- Dr. Grammas was contracted as the director of TARCC. After several months in the position, she decided to return to Texas Tech. Her contract was terminated based on her request. The TARCC advisory board appreciates her efforts and wishes her well.

- Dr. Waring is part of the summer external advisory review. The last amount assigned for the TARCC budget was $9.23 million. Dr. Waring suggested that there should be regular meetings of the advisory committee through in-person meetings and conference calls. He also suggested that they involve more organizations.

- Texas A&M Health Science Center Program and Research Initiative
    - Texas A&M manages the $1.5 million awarded to Alzheimer's research.
    - Grant applications are due March 2.
    - Awards will be announced the end of April.
    - There are over 60 applicants.
    - The review is conducted out of state.
    - Letters of intent were received from all six TARCC institutions.
    - There are letters of intent for collaborative projects.

Debbie Hanna stated that the role of the steering committee needs clarification.

Clint Hackney requested Dr. Doody's perspective on TARCC. Dr. Doody stated that TARCC has grown into something to be proud of over the years. There is improved AD work in the institutions and improved collaboration. TARCC is known outside of Texas.

Dr. Fairchild agreed that TARCC is going well but that there is a need to stress the care aspect of TARCC. It is important to involve families in pushing forward and working with researchers. TARCC can extend its reach with researchers across the state.

6. Time and Date for Next Council Meeting

The next planned meeting of the Council is tentatively scheduled for August 2015.

7. Public Comment

There was no public comment.

8. Adjourn

There being no further business, the meeting was adjourned at 9:09 a.m.

Meeting Minutes
Texas Council on Alzheimer's Disease and Related Disorders
Meeting Minutes – August 25, 2015; 10:30 a.m.
Texas Department of State Health Services
1100 W. 49th St., Austin, TX 78756
Moreton Building, room M-653

The Texas Council on Alzheimer's Disease and Related Disorders (Council) met on Tuesday, August 25, 2015, at the Texas Department of State Health Services, 1100 W.49th St., Austin TX 78756.

Council Members Present	**Guests Present**
The Honorable Clint Hackney, Vice-Chair Lisa B. Glenn, MD Deborah S. Hanna, Chair Rita Hortenstine Patty Moore, PhD Valerie J. Krueger Toni Packard Laura DeFina, MD Kate Allen Stukenberg Melissa L. Edwards	Katie Wiechnicki, DSHS – Health Promotion and Chronic Disease Prevention (HPCDP) Roberto Rodriquez, DSHS - HPCDP Mack Harrison, DSHS – Office of General Counsel Nimisha Bhakta, DSHS - HPCDP Office of Surveillance, Evaluation and Research (OSER) Erin Wu, DSHS – HPCDP OSER Susan Ristine, Texas Alzheimer's Research and Care Consortium (TARCC)
Council Members Absent Carlos Escobar, MD Ray Lewis, DO Susan Rountree, MD Nancy Walker Grayson R. Hankins Ronald Devere, MD Robert Vogel, MD	**Program Staff Members Present** Lynda Taylor, DSHS - HPCDP

1. **Welcome/Call to Order/Roll Call/Excuse Absent Members**

   Ms. Debbie Hanna called the meeting to order at 10:35 a.m. Ms. Lynda Taylor certified roll, and a quorum was present. Members and guests were welcomed.

2. **Approval of Council Minutes from the February 25, 2015, Meeting**

   Ms. Hanna asked Council members to review the minutes from the February 25, 2015, meeting. Kate Stukenberg moved that the minutes be approved as presented. Rita Hortenstine seconded the motion. All were in favor, and the February 25, 2015, meeting minutes were approved as presented.

3. **Department of State Health Services (DSHS) Update**

   Dr. Patty Moore provided updates from the Texas Department of State Health Services.

   1. Chris Traylor was appointed Health and Human Services Commission (HHSC) Executive Commissioner replacing Dr. Janek.
   2. Kirk Cole was appointed Interim DSHS Commissioner replacing Dr. Lakey.
   3. The Sunset Commission recommended that DSHS, DADS, DARS, and DFPS be merged into HHSC. Senate Bill 200 contained language to do that. The bill leaves DSHS as an independent agency with continued oversight from HHSC. However, a number of DSHS administrative functions and programs will be merged into HHSC over the biennium. Legislative leadership, HHSC, and DSHS are working to determine those functions that will be left with a streamlined DSHS.

4. **Presentation on Texas data and barriers to population-level data collection on Alzheimer's disease**

   Dr. Moore stated that at the request of the Chair of the Texas Council on Alzheimer's disease and Related Disorders, the Health Promotion and Chronic Disease Prevention Section (HPCDPS) Office of Surveillance, Evaluation and Research (OSER) conducted preliminary exploration to determine the feasibility of creating a population data base for persons with Alzheimer's disease (AD) in Texas. Dr. Moore introduced Erin Wu from OSER to present the initial findings of this report.

   Ms. Wu provided a slide presentation regarding the following:

   - Population-level AD in Texas
     - Current and projected number of Texans
     - Hospital discharge rates and charges
     - Mortality rates
     - County-level prevalence among Medicare beneficiaries
     - Prevalence of comorbidities among Medicare beneficiaries
     - Healthcare utilization among Medicare beneficiaries

- Literature review on barriers to collecting population-level AD data
    - Incidence and prevalence data for Alzheimer's disease is difficult to find. The data available indicate that the number of Texans with AD is very likely higher than the numbers reflected in the data. There are many barriers to collecting population-level AD data.

5. Texas Alzheimer's Research and Care Consortium (TARCC) report on funding

Ms. Hanna stated that the Council, as the oversite body for TARCC, reviewed the TARCC budget bills introduced in the 84th Legislature. Ms. Hanna presented a document stating that the bills placed AD research funding as a special item of the University of Texas System (Senate Bill 2) and a special item of the University of Texas at Austin (House Bill 1), both in the same amount of $9,230,625.

To reconcile the difference, the conference committee retained the language of House Bill 1, which makes the University of Texas at Austin (UT Austin) TARCC's fiscal agent. Ms. Hanna and the Honorable Clint Hackney had no objections because the same amount of money was distributed.

6. University of Texas at Austin – TARCC membership

Ms. Hanna presented a letter from the President of UT Austin, Gregory L. Fenves, requesting membership in TARCC. In the letter, Mr. Fenves stated that the research and clinical activities at the university are directly related to the activities of TARCC and will be expanded with the establishment of the Dell Medical School.

Ms. Hanna presented a letter and curriculum vitae from John C. DeToledo, M.D., of the Texas Tech University Health Science Center requesting to be the Interim PI for the Lubbock TARCC site now that Chuang-Kuo Wu, M.D., has resigned.

Ms. Hanna asked for a motion to approve TARCC membership for the University of Texas at Austin and the appointment of John C. Toledo, M.D., as the Interim PI for the Lubbock TARCC site. Judge Hackney moved to adopt the motion. Rita Hortenstine and Laura DeFina, M.D., seconded the motion. All were in favor, and the motion passed unanimously.

7. TARCC 5-year review

Ms. Hanna referenced the Education Code, Chapter 154.008 (House Bill 1504 of the 76th Texas Legislative Session) requiring the Council to "review and evaluate the performance of the consortium participants and data coordinating center at least every five years."

Ms. Hanna described the process as follows:

The Council has utilized the services of an External Advisory Committee comprised of distinguished scientists to meet every other year and evaluate the cohort. The site performance review will differ in that it will be more robust and will include an evaluation of the Alzheimer's research efforts at all funded sites including an audit of the UTSW Tissue Bank, UTSW Data Center (data coordinating center), UTSW subcontract for GWAS, Investigator Grant Program (TAMHSC) and cohort.

- Drs. Doody and Barber will coordinate with Ms. Hanna on the steps necessary to identify processes and parties necessary to conduct this statutory site review.

Site Annual Reviews

The Scientific Manager MOU with UNTHSC provides that an annual site cohort review for each funded institution be performed by Dr. Barber. These reviews were discontinued but all agreed it is important for Dr. Barber to reinstitute a once per year visit to each site. Dr. Doody will assist Dr. Barber in designing the template for the annual site review. To the extent that financial matters and MOUs are part of the review, that function will be performed by Ashley Nemec, UT Austin.

8. TARCC budget

TARCC Cohort

Ms. Hanna presented the administrative budget summary for FYE2016 and FYE2017 and FYE 2016 budget summary for TARCC cohort sites.

Each TARCC Steering Committee members prepared the budget request for their site. The requested budgets were funded as requested. In 2016 the Steering Committee working through Dr. Doody will present their 2017 cohort maintenance budgets and additional items based on available funds.

Funded institutions:

- Baylor College of Medicine
- Texas Tech University Health Sciences Center
- University of North Texas Health Science Center
- University of Texas Southwestern Medical Center
- University of Texas Health Science Center San Antonio

Texas AMHSC does not participate in cohort enrollment.

Ms. Hanna asked for a motion to approve the FYE 2016 cohort maintenance budget. Clint Hackney moved to adopt the motion. Rita Hortenstine seconded the motion. All were in favor, and the motion passed unanimously.

TARCC 2-Year Budget

Ms. Hanna presented a 2-year TARCC administrative budget summary for FYE2016 and FYE2017.

Ms. Hanna suggested that the Council be open to an increase in the number of meetings each year to four so that matters concerning TARCC can be reviewed if necessary. UT Austin will use TARCC funds for meeting space and Council travel reimbursement for the two additional meetings each year.

Ms. Hanna stated that funds were available in the appropriation to begin planning for TARCC to address the statutory responsibility to address Alzheimer's care in Texas. Two hundred thousand dollars ($200,000) per year of the TARCC budget will be used for a Care Initiative. A group of four council members, including Rita Hortenstine, and Lynda Taylor, DSHS Alzheimer's Disease Program Coordinator, will create a plan for the initiative. This planning group will consult with Rachelle S. Doody, M.D., Ph.D., and C. Munro Cullum, Ph.D., and determine ways to collaborate with Texas A&M and the Texas Department of Aging and Disability (DADS) to reach the many counties of Texas through existing resources. For consideration is the national pilot model for dementia-friendly cities.

Ms. Hanna asked for a motion to approve the FYE 2016 and FYE 2017 TARCC administrative budget which includes the Care Initiative. Ms. Hortenstine moved to adopt the motion. Kate Stukenberg seconded the motion. All were in favor, and the motion passed unanimously.

Steve Waring, DVM, Ph.D., resignation

Ms. Hanna stated that Steve Waring, DVM, Ph.D., had resigned from the TARCC External Advisory Committee via email in June 2015 due to reasons of geography. Dr. Waring will not renew his contract with Texas A&M.

Steering Committee Interim Chair

Ms. Hanna recommended that Rachelle S. Doody, M.D., Ph.D., be appointed interim chair of the Site Review Steering Committee for two years.

Mack Harrison, general counsel for DSHS, stated that because the suggested appointment of Dr. Doody as interim chair was not on the meeting agenda, the motion could be challenged at a future time. In lieu of actually appointing Dr. Doody interim chair, Ms. Hanna suggested that Dr. Doody be assigned the tasks of interim chair until an appointment is made.

9. Time and Date for Next Council Meeting

Ms. Hanna said she would consider scheduling a meeting in the next couple of months and will discuss options with the Council members.

10. Public Comment

Ms. Hanna presented a letter on behalf of Dr. Ron Devere, who was not present at the meeting. Dr. Devere's letter described an example of the challenges that occur regarding legal guardianship for those with dementia. State agency representatives present at the meeting were welcomed to contact Dr. Devere for more information.

11. Adjourn

The meeting was adjourned at 12:04 p.m.

Putting the Pieces Together

A Comprehensive Plan for Addressing the Burden of Alzheimer's Disease in Texas

2010 – 2015 Texas State Plan on Alzheimer's Disease

TEXAS Department of State Health Services

Foreword

In July 2007, the Alzheimer's Study Group was established under the auspices of the Congressional Task Force on Alzheimer's disease and was charged with creating a National Alzheimer's Strategic Plan to address the "looming crisis" of Alzheimer's disease in the United States. In March 2009, the group released its report, *"A National Alzheimer's Strategic Plan: The Report of the Alzheimer's Study Group."* This report was the first national account of its kind, and provided core recommendations for addressing the current and future burden of Alzheimer's disease.

Similarly, development of a plan to advance statewide, coordinated action to address Alzheimer's disease in Texas became paramount as disease prevalence continues to climb, exacting huge human and economic burdens on state residents and resources. In March 2009, the Texas Council on Alzheimer's Disease and Related Disorders and the Department of State Health Services (DSHS) Alzheimer's Disease Program began formal discussions around development of the first, coordinated Texas state plan on Alzheimer's disease. A steering committee was formed, comprised of distinguished leaders and professionals working in the field of Alzheimer's disease. This committee was charged with identifying the plan's priority goals, while taking into account the Alzheimer's Study Group recommendations and unique issues facing Texas.

Five goals were identified as essential plan elements. These goals are believed to represent a comprehensive approach to addressing Alzheimer's disease in Texas: Science, Prevention and Brain Health, Disease Management, Caregiving, and Infrastructure. Each goal within this plan contains targeted actions that Texas needs to take to comprehensively address Alzheimer's disease.

To garner statewide input for plan development, partners were recruited, and the Texas Alzheimer's Disease Partnership (partnership) was officially formed; its first meeting was held in Austin, Texas, in June 2009. The partnership is comprised of individuals with diverse backgrounds from state, local and community level organizations; academic and research institutions; for-profit and non-profit sectors; businesses; the healthcare sector; and family members of individuals afflicted with Alzheimer's disease. The rich and varied experiences of partnership members provided the synergy and expertise that created a strategic blueprint for formulating and implementing a comprehensive and coordinated statewide plan.

It was determined that the scope and range of this process was sufficiently large enough to call for development of five committees that would address an assigned goal and/or field of focus. Each of the five Alzheimer's Association chapters in Texas were invited and agreed to chair and guide the actions of an assigned committee. The committees met on an ongoing basis to further refine objectives and strategies of their respective goals. Through their efforts, a myriad of voices and perspectives were incorporated into the process and laid the foundation for a working framework of informed and knowledgeable stakeholders.

This plan was designed to present an overview of the state of Alzheimer's disease in Texas, while providing realistic and thoroughly achievable actions and strategies that can be implemented over the next five years. The plan presents a compelling case and provides a clear roadmap for increased and coordinated action among all partners. It is hoped that this plan will benefit Texans by guiding statewide coordinated efforts to reduce the burden of this disease on Texas citizens and those who care for them. Some strategic efforts will be coordinated at the state level, but others can only be effectively coordinated at the local or organizational level. Success of this plan depends on all partners in all sectors and at all levels working collaboratively to achieve what one cannot accomplish alone.

Acknowledgements

The members of the Texas Council on Alzheimer's Disease and Related Disorders are to be recognized for their leadership role in the development of this plan and for their willingness to give of their time and expertise as they work to fulfill their charge to serve as the state's advocate for persons with Alzheimer's disease and those who care for them.

Ronald DeVere, MD
Austin

Carlos Escobar, MD
San Angelo

Carolyn Frazier, RN
Huffman

Frank Genco
Austin

The Honorable Clint Hackney,
Vice-Chair
Austin

Grayson Hankins, BS
Odessa

Debbie Hanna, Chair
Austin

Rita Hortenstine
Dallas

Melissa L. King
Houston

Ray Lewis, DO
Arlington

Angela Hobbs-Lopez, DO
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Mary Kenan-Owens, PsyD
Houston

Lilani Muthali, MD
Austin

Susan Rountree, MD
Houston

Winnie Rutledge, BS
Austin

Kate Allen Stukenberg
Houston

Robert A. Vogel, MD
Midland

State Plan Steering Committee Members:
- The Honorable Clint Hackney
- Debbie Hanna
- Rita Hortenstine
- Janice Monger
- Susan Ristine, MSHP
- Jennifer Smith, MSHP
- Mary Somerville
- Steve Waring, DVM, PhD

Alzheimer's Association Chapters in Texas generously gave their time and expertise to the development of this plan:

Capital of Texas Chapter
Austin

Greater Dallas Chapter
Dallas

Star Chapter
El Paso

North Central Texas Chapter
Fort Worth

Houston and Southeast
Texas Chapter
Houston

Plan Editors:
- Robert Barber, PhD
- David Biemer, PhD
- Mark Torres, EdD

DSHS staff played key roles in coordinating meetings and facilitating planning sessions:
- Lauri Kalanges, MD, MPH
- Sarah Kirk, MPH
- Weihua Li, MD, MPH
- Jane Osmond, MPH, RRT
- Susan Ristine, MSHP, Plan Coordinator/Writer
- Bobby Schmidt, MEd
- Rick Schwertfeger, MAT
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Center for Program Coordination,
Policy and Innovation:
- Mike Messenger, MPH

Plan Layout and Design:
- Veronica Primeaux
- ESO - Art Department

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At least 14 million baby-boomers, those born between 1946 and 1964, will develop Alzheimer's disease or a related disorder in their lifetime, doubling the number of persons with this disease today.

Executive Summary

Every 70 seconds, someone in the United States develops Alzheimer's disease. There are now more than 5.3 million Americans living with this disease, including 5.1 million Americans 65 and older and approximately 200,000 under 65 with younger-onset Alzheimer's disease. It is the seventh leading cause of death in the U.S. and fifth leading cause of death for those over 65. At least 14 million baby-boomers, those born between 1946 and 1964, will develop Alzheimer's disease or a related disorder in their lifetime, doubling the number of persons with this disease today. By mid-century, it is estimated that someone in the United States will develop Alzheimer's disease every 33 seconds, or 2,618 new cases of Alzheimer's disease every day or 955,636 new cases every year *(2010 Alzheimer's Disease Facts and Figures, Alzheimer's Association)*.

There is no cure for Alzheimer's disease and every person who develops this disease will die from its complications. Unlike other forms of dementia, it is progressive in nature and continues through cognitive and functional decline to total disability and death. The financial impact of Alzheimer's exceeds $172 billion annually. Its impact in suffering and anguish defies calculation. The primary at-risk factor for Alzheimer's disease is advanced age, but contrary to popular misconception, it is not a normal part of aging. More women than men have Alzheimer's disease, but this is a consequence of their longer life expectancy. There is a growing body of research indicating that African Americans and Hispanic Americans may be at higher risk. Increasing prevalence of Alzheimer's disease is related directly to increasing human life expectancy rates in the United States. A person with Alzheimer's disease or a related dementia will live an average of five to eight years after diagnosis, but may live as many as 20 years or more following onset of symptoms.

The impact of Alzheimer's disease presents many challenges that cannot be dismissed or ignored:

- Clinicians are challenged to treat individuals with Alzheimer's disease at the earliest stage possible to delay its progression, while also helping individuals remain independent for longer periods of time.
- Researchers are challenged to work towards Alzheimer's disease prevention and cure, while also finding ways to delay onset of symptoms until later in life.
- Caregivers are challenged to provide appropriate care and support to family members living with Alzheimer's disease, while also finding ways to manage competing financial, physical, and emotional needs.
- Prevention is challenged by the widely-held belief that declines in brain health and cognitive function are a normal part of aging, when in fact such declines may possibly be delayed and have the potential to be mitigated with early detection and treatment.
- Infrastructure is challenged to meet the societal and economic impact of Alzheimer's disease, while also providing optimal, coordinated care and support systems for affected individuals.

The 2010-2015 Texas State Plan on Alzheimer's Disease was developed in direct response to increasing rates of Alzheimer's disease. Plan objectives provide specific recommendations for addressing the burden of this devastating disease on Texans and those who care for them. Ongoing coordination, information and resource sharing, partnership development, and capacity building are essential for creating a sustained and resourced statewide system to promote and advance recommendations of this plan.

Goals of the Plan

Goal I: Texas will support Alzheimer's disease research.

Goal II: Texans will experience improved cognitive health throughout the life span.

Goal III: Texans with Alzheimer's disease will experience improved quality of life through better disease management.

Goal IV: Caregivers will experience enhanced levels of support through improved access to Alzheimer's disease/dementia care information and services.

Goal V: Texas will improve state and local capacity to address Alzheimer's disease.

Call to Action

Understanding the current and future burden of Alzheimer's disease in Texas and working collaboratively to implement the 2010-2015 Texas State Plan on Alzheimer's Disease is a pressing charge that cannot be taken lightly. Partners and stakeholders at local, state and regional levels are called upon now to adopt and incorporate activities outlined in this plan. By working together on a unified set of ambitious but thoroughly realistic and achievable goals and objectives, the effect of Alzheimer's disease across the state can be reduced and the quality of life of Texans with Alzheimer's disease and their families can be improved.

Introduction

Alzheimer's disease (AD) is a progressive and irreversible brain disorder that is characterized by a steady decline in cognitive, behavioral, and physical abilities severe enough to interfere with daily life. Hallmark symptoms of Alzheimer's disease are memory loss, disorientation, and diminished thinking ability followed by a downward spiral that includes problems with verbal expression, analytical ability, frustration, irritability, and agitation. With disease progression, physical manifestations include loss of strength and balance, inability to perform simple tasks and physical activities, and incontinence. As more of the brain is affected, areas that control basic life functions like swallowing and breathing become irreversibly damaged, leading to death. The course of Alzheimer's disease and rate of progression vary from person to person, ranging from an average of five to eight years to more than 20 years from onset of symptoms *(Texas Council on Alzheimer's Disease and Related Disorders, 2008 Biennial Report).*

Alzheimer's disease is the seventh leading cause of death in the United States and has an economic burden that exceeds $172 billion annually. Currently, 5.3 million people in the United States have Alzheimer's disease, including approximately 340,000 Texans. Nationally, Texas ranks third in Alzheimer's disease cases and second in Alzheimer's disease deaths. A new person develops Alzheimer's disease every 70 seconds, and current projections indicate that this rate will increase to one new case every 33 seconds by 2050. In 2009, there were an estimated 10.9 million unpaid caregivers of individuals with Alzheimer's disease in the United States, most of who were family members. These individuals were confronted day-in day-out with the enormous challenges of caring for a loved one with Alzheimer's disease. In Texas, 852,820 unpaid caregivers are providing care to an estimated 340,000 individuals with Alzheimer's — this equates to 971,191,823 hours of unpaid care at a cost of $11,168,705,965 per year *(2010 Alzheimer's Disease Facts and Figures, Alzheimer's Association)*.

> By 2050, without prevention or cure, individuals 65 and older with Alzheimer's disease is projected to reach between 11 and 16 million *(2010 Alzheimer's Disease Facts and Figures, Alzheimer's Association).*

Although Alzheimer's disease is not a normal part of aging, it is considered an age related disorder, affecting up to 13 percent of people 65 and older and increasing to 50 percent at 85 and older. These rates take on increasing significance with the U.S. population older than 65 expected to increase from its present 13 percent to 18 percent by 2025. It is estimated that the number of people 65 and older with Alzheimer's disease will reach 7.7 million in 2030, almost a 50 percent increase from the 5.3 million who are currently affected. By 2050, without prevention or cure, individuals 65 and older with Alzheimer's disease is projected to reach between 11 and 16 million *(2010 Alzheimer's Disease Facts and Figures, Alzheimer's Association).*

With the first of the 76 million baby boomers reaching 65 in 2011, Alzheimer's disease and other age-related diseases will rank among the leading causes of morbidity and mortality. This will have significant economic and human ramifications *(Texas Council on Alzheimer's Disease and Related Disorders, 2008 Biennial Report).*

While the exact cause of Alzheimer's is not yet known, most experts agree that the disease probably develops much like other chronic conditions and probably results from multiple risk factors. Since the greatest risk factor for Alzheimer's disease is increasing age, many scientists consider the emerging field of prevention an exciting research area. A growing body of evidence suggests that brain health is closely linked to overall heart health. Some data indicate that management of cardiovascular risk factors such as high cholesterol, overweight, diabetes, and high blood pressure may help delay declines in cognitive function. Additional research points to the significant role physical activity and diet play in maintaining lifelong cognitive health *(2010 Alzheimer's Disease Facts and Figures, Alzheimer's Association).*

Currently there is no treatment to stop the deterioration of brain cells in individuals with Alzheimer's disease. Five drugs are approved by the Food and Drug Administration (FDA) that temporarily slow worsening of symptoms for an average of six to 12 months, for about half the individuals who take them. Researchers have identified treatment strategies that may potentially change the course of Alzheimer's disease, and a number of experimental therapies are currently in clinical trials *(2010 Alzheimer's Disease Facts and Figures, Alzheimer's Association).*

Despite a lack of disease-modifying therapies, studies consistently show that active medical management of individuals with Alzheimer's disease significantly improves their quality of life through all disease stages. Active medical management includes appropriate use of available treatment options, effective management of coexisting conditions, and use of supportive services such as counseling and activity and support groups *(2010 Alzheimer's Disease Facts and Figures, Alzheimer's Association).*

The human toll of Alzheimer's disease on patients and the informal network of family and friends in charge of their care is inestimable. Of the more than five million Americans with Alzheimer's disease, approximately 76 percent live at home and receive most of their care from family members. Each caregiving experience presents its own special circumstances and challenges.

Alzheimer's disease exacts an enormous toll on the healthcare system, American businesses, families, and individuals. Until it can be prevented, controlled, and/or cured, the impact of Alzheimer's disease will only continue to intensify *(Texas Council on Alzheimer's Disease and Related Disorders, 2008 Biennial Report).*

In response to these challenges, this plan was developed to comprehensively address Alzheimer's disease in Texas, and contains goals, objectives and strategies essential to reducing the impact and burden of Alzheimer's disease in Texas.

Science

The aging population is dramatically increasing the incidence of Alzheimer's disease. More than 5.3 million Americans are already living with this disease, which is the seventh leading cause of death in the United States and the fifth leading cause of death for those over age 65. While other causes of death have been declining in recent years, those due to Alzheimer's disease have risen. Between 2000 and 2006, deaths due to heart disease, stroke, and prostate cancer declined by 12 percent, 18 percent, and 14 percent, respectively, whereas deaths attributable to Alzheimer's disease increased by 47 percent. By 2050, Alzheimer's disease is expected to strike nearly a million additional persons per year in the United States and affect an estimated 11 to 16 million Americans.

While these trends are similar in all states, the impact is particularly acute in Texas. Today, Texas ranks third in the nation (behind California and Florida) in the estimated number of Alzheimer's cases and second in the number of Alzheimer's disease deaths. According to the National Alzheimer's Association, 340,000 Texans will be living with Alzheimer's disease by the end of 2010. In addition, individuals providing care for Alzheimer's patients in Texas grew from 690,058 to 852,820 between 2005 and 2009. Most of these care providers are unpaid family members. The estimated total value of this unpaid care in Texas increased from $5.8 billion in 2005 to $11.2 billion in 2009, the second highest in the nation. Texas businesses are also impacted by Alzheimer's disease, losing over $14 billion annually in healthcare costs and lost productivity.

Therefore, there is a great need for Texas to develop an infrastructure equal to the challenge and capabilities commensurate with the state's increasing burden imposed by Alzheimer's disease and related disorders. This requires establishing a greater capacity in Texas to provide leadership in the global fight against Alzheimer's disease. The Texas Legislature made a significant investment in Alzheimer's disease research to begin meeting this challenge. The Texas Alzheimer's Research Consortium (TARC) was established in 1999 by the 76th Texas Legislature. This legislative action mandated the Texas Council on Alzheimer's Disease and Related Disorders (Texas Council) to establish a Consortium of Alzheimer's Disease Centers among four state institutions: Texas Tech University Health Sciences Center (Texas Tech), University of North Texas Health Science Center (UNTHSC), the University of Texas Southwestern Medical Center at Dallas (UT Southwestern), and Baylor College of Medicine (BCM).

> Texas-based Alzheimer's disease research benefits the state in many ways.

In 2005, Texas lawmakers approved the first appropriation for Alzheimer's disease research. This $2 million investment provided start-up funding for TARC. In 2007, the 80th Texas Legislature nearly doubled the state's initial investment in TARC making it possible to recruit 500 Texans with Alzheimer's disease and 300 healthy control participants into the Texas Harris Alzheimer's Study to participate in cutting edge biomedical research.

These study volunteers undergo a battery of tests and provide blood and DNA samples annually at TARC member sites. The resulting wealth of uniformly collected clinical, neurocognitive and laboratory data is

combined in the new centralized Texas Alzheimer's Data Bank, based at UT Southwestern. TARC also has used state funding to establish the first Texas bio-bank of stored blood, tissue and DNA to support current and future Alzheimer's disease research studies. Researchers across Texas are able to utilize these unique resources to answer specific questions about Alzheimer's disease, both now and in the future, as new information leads to new ideas.

In September 2008, the Texas Council voted to add the University of Texas Health Science Center at San Antonio (UTHSC-SA) to TARC. This addition, coupled with the 2009 state appropriation of $6.85 million, enabled TARC to begin recruiting a large number of Hispanic individuals into the Texas Harris Alzheimer's Study and extended TARC's reach to South Texas. Inclusion of underrepresented Hispanics significantly strengthens Texas Alzheimer's disease research efforts. More than one-third of Texans are Hispanic, and, according to the Texas State Data Center, Texas will become a majority Hispanic state between 2025 and 2035. With its sizeable Hispanic population, Texas is uniquely positioned to assume a national leadership role in this largely untapped area of Alzheimer's disease research.

There are important interactions between Alzheimer's disease and heart disease, diabetes and other health conditions that are common in Hispanics. In its report, Hispanics/Latinos and Alzheimer's Disease, the national Alzheimer's Association predicts that Alzheimer's disease and related dementias among Hispanics could "increase more than six-fold" to as many as 1.3 million by 2050—and calls this development "a looming but unrecognized public health crisis."

Hispanic participation in Alzheimer's disease research has historically been low across the nation. Texas is presented with the unique opportunity to assemble the nation's only large-scale, well-characterized group of Non-Hispanic and Hispanic Alzheimer's disease research participants with considerable genetic, blood, clinical and cognitive markers, making possible comparative research to advance detection, treatment and prevention of Alzheimer's disease. In addition to TARC's efforts at the UTHSC-SA, there are a number of projects in Texas that enroll Hispanic individuals for aging studies. For example, UTHSC-SA has also participated for many years in the San Antonio Longitudinal Study of Aging (SALSA). This study has tracked development of diabetes, heart disease and stroke in Hispanic research participants of all income levels. Having historical data on these participants' diabetes and related conditions makes their recruitment for Alzheimer's disease research all the more valuable. In addition to SALSA, Project Frontier, led by Texas Tech researchers, enroll Hispanic and rural Texans into a longitudinal study of aging. Furthermore, BCM has several projects underway to understand how to measure cognition in Spanish-speaking patients with Alzheimer's disease and how to understand those particular risks associated with the high rate of diabetes among Hispanics. These are but a few examples of the many projects across the state. In addition, both Texas Tech and UT Southwestern are using telemedicine technology to explore use of this cutting-edge research tool to expand diagnostic services to rural populations. These projects present important opportunities for collaboration between Texas researchers and institutions to capitalize on Texas' unique position to increase participation of underserved groups in Alzheimer's research.

Texas-based Alzheimer's disease research benefits the state in many ways that include, but are not limited to the following:

- **Advances in detection.** Using a

multi-disciplinary/translational approach, that includes blood biomarkers, genetic material, imaging and neurocognitive data, as well as psychological, neuro-psychological, behavioral and general medical information, Texas researchers are developing new methods for early Alzheimer's detection.

- **Ability to predict risk.** Recruitment and follow-up of normal elders, along with patients with Alzheimer's disease, will enable scientists to better understand factors leading to increased risk for this disease. TARC researchers have begun this process by looking at information on biomarkers, lipid metabolism, genetics and clinical testing as they relate to the disease. However, many more factors remain to be examined. Early identification of Alzheimer's disease risk will make it possible to create therapies to prevent or delay disease onset.
- **Better tracking of Alzheimer's disease progression.** By leveraging Texas' medical and university infrastructure, Texas-based scientists can identify individual differences among patients that influence the disease progression rate. Data gathered from these studies will help identify new therapies to slow its development and improve quality of life.
- **The best in personalized medicine.** Texas scientists can use advances created by these Texas-based research initiatives to develop new treatments that address a patient's individual Alzheimer's disease "profile," as defined by specific genetic, blood biomarker, general medical, behavioral, psychiatric, and other risk factors.
- **Advances in basic science.** While great progress has been made, researchers are still searching for definitive answers to questions about basic mechanisms of Alzheimer's disease. Advancing understanding of these mechanisms through basic research can benefit Texas by expanding scientific discovery and identifying additional treatment targets.

Sustaining a competitive edge in Alzheimer's research will benefit Texas. Ongoing research support will help Texas meet two of its four major goals for improving higher education by 2015. The Texas Higher Education Coordinating Board noted in its landmark report entitled "*Closing the Gaps: The Texas Higher Education Plan*" that the state's economy could be adversely affected unless steps are taken to create centers of excellence at the state's institutions of higher education and increase Texas' share of federal research funding, while also increasing competitive state-funded research grants.

A sustained investment in Alzheimer's disease research also increases Texas researchers' ability to leverage this commitment and obtain funding from the National Institutes of Health (NIH) as well as other public and private groups for both clinical research using human participants and basic laboratory research.

Texas' commitment to Alzheimer's disease research will foster scientific excellence at state health science centers and medical schools and promote innovative technologies that can potentially attract increased external economic investments in Texas. Evidence of this effect is already beginning. Since 2005, there has been a substantial increase in Alzheimer's disease research at the majority of Texas universities and health science centers. "Over the last five years, Texas-based investigators have continually increased their portion of highly cited Alzheimer's disease papers within the context of U.S. based Alzheimer's disease research as well as within the context of the global effort to better understand Alzheimer's disease" *(Aaron Sorensen, Scientometrics Editor, Journal of Alzheimer's Disease).*

Historically, most Alzheimer's disease research occurred at BCM and UT Southwestern. Building upon these anchors, a broad-based expansion of Alzheimer's disease research has occurred across Texas over the past five years. Texas now leads in a number of areas of research. Working together through TARC mechanisms can align and build a formidable research enterprise, increasing research funding and educational opportunities for all Texans. Boosting state capacity as a center for biotechnology and pharmaceutical development can positively impact hundreds of thousands of Texans with Alzheimer's disease.

Sustained support for Alzheimer's research makes Texas an attractive partner for national research projects and will attract more research funding to Texas. Texas has both private sector partnerships and the collaborative TARC structure necessary to begin streamlining transfer of research breakthroughs into drug trials and patented therapies to better treat Texans suffering from Alzheimer's disease. Sustaining momentum in Alzheimer's disease research is critical to addressing one of the largest public health challenges facing Texas and the nation, while enabling Texas to become a national leader. Achieving the Texas research goal to delay and ultimately prevent Alzheimer's disease, as recommended by the National Alzheimer's Study Group, requires a concerted focus on combining clinical and basic studies to yield effective treatments resulting from laboratory bench work. This approach will facilitate transfer of research discoveries into clinical practice improvements. While progress has been made toward this goal, researchers are still searching for definitive answers to questions about basic mechanisms of Alzheimer's. In order to accelerate basic scientific discovery and develop additional targets for treatment, Texas should encourage and support funding in all these areas.

Development of research programs that cut across disciplines is another approach needed to quicken discovery. For example, exploring potentially significant lifestyle modifications, such as diet and exercise alone, is insufficient — pharmacological and behavioral interventions must be integrated in order to develop therapies aimed at Alzheimer's disease prevention. Texas scientists, through collaboration between behavioral sciences and biomedical research, are developing prevention tools and interventions for those coping with Alzheimer's disease. This kind of multi-disciplinary research, typically not funded by national health and science foundations, offers significant opportunities to study disease progression and advance therapeutic strategies. Establishing outcome-oriented projects backed by appropriate funding mechanisms and active collaboration with other stakeholders is important. Working with a variety of stakeholders to clarify and streamline pathways for increasing preventive and risk-reducing therapies is a critical task.

Almost everyone knows someone whose life, including a lifetime of memories, has been unraveled by Alzheimer's disease. Continuing support of Alzheimer's research will position Texas as a leader in the race to find new ways to detect, delay, treat and ultimately prevent this devastating disease. The following objectives have been developed to strengthen Texas' commitment to continued Alzheimer's disease research.

GOAL I: Texas will support Alzheimer's disease research.

Objective 1: By August 31, 2015, increase funding to the Texas Alzheimer's Research Consortium to further understanding of the biology of Alzheimer's disease for improved early detection and novel approaches for prevention and treatment.

Rationale:

Increased funding for the TARC is critical to Texas' efforts to conduct Alzheimer's disease research and will result in a number of important initiatives. These funds will enable creation of an administrative core (a Translational Research Core) within TARC to conduct human clinical trials. This core would translate TARC discoveries into potential new therapies that would benefit Texans suffering from Alzheimer's. Although a large number of clinical trials have been conducted, virtually all have failed to produce effective therapies. TARC Translational Research Core is to find ways to speed up clinical trials of new drugs by identifying novel clinical and biological markers for disease that could be used to evaluate effectiveness of drugs being tested. These markers would also be useful for selecting patients who are more likely to benefit from the investigative treatment, thereby increasing trial sensitivity to demonstrate efficacy. In addition, increased funding could result in creation of a pilot grant program aimed at supporting academic Texas researchers conducting innovative clinical and basic research. These pilot grants will focus primarily on junior researchers and are intended to increase access and utilization of TARC resources by investigators at both TARC and non-TARC institutions.

Strategies:

1. Support efforts to increase funding by ten percent to maintain patient enrollment in the Texas Harris Alzheimer's Study.
2. Develop and distribute data and informational materials to inform potential funders about possible benefits of increased Alzheimer's disease research.
3. Make available detailed information regarding progress and discoveries made by TARC investigators.
4. Compile a compendium of ongoing state-funded projects and future TARC research efforts.
5. Present TARC's specific plan for translating basic scientific discoveries into improved methods for diagnosis, treatment, and prevention of Alzheimer's disease to the scientific community.
6. Create a state-level committee to identify Alzheimer's disease research priorities in Texas.
7. Improve targeted funding opportunities to increase interdisciplinary, multi-institutional collaborations in Alzheimer's disease research.

GOAL I: Texas will support Alzheimer's disease research.

Objective 2: By August 31, 2015, increase funding by 25% for non-TARC Alzheimer's disease research in Texas.

Rationale:

Additional funding is needed to expand non-TARC Alzheimer's disease research in Texas. Creation of an organized plan to acquire these funds is the first important step in achieving this objective. While these efforts will begin with NIH, the largest single source of medical research funding, additional public and private funding sources should be targeted.

Strategies:

1. Quantify the current level of research funding for Alzheimer's disease in Texas and prepare a comprehensive list of all active Texas-based Alzheimer's disease investigators, funded and non-funded.
2. Establish a system for Texas research institutions to annually report research projects and funding sources to the Texas Council on Alzheimer's Disease and Related Disorders.
3. Utilize available information to profile productivity of Alzheimer's disease research in Texas, relative to other states.
4. Develop a program to leverage resources among Texas investigators and affiliated researchers for joint applications for federal research funding through institutions such as the Veteran's Administration, Centers for Disease Control and Prevention, the Administration on Aging, the Agency for Healthcare Research and Quality, and the National Institutes of Health.
5. Create an on-line clearinghouse of external, non-state supported research funding opportunities available for any Texas researcher working in Alzheimer's disease and dementia.
6. Establish a research work group to identify funding sources to improve researchers' capacity to attract external research dollars.
7. Encourage development of Alzheimer's disease centers of excellence that can compete for federal support.
8. Promote private funding of Alzheimer's disease projects by disseminating research results of Texas-based scientists among lay communities.
9. Convene an annual forum for Alzheimer's disease researchers from across the nation to meet, discuss, and plan future collaborations.
10. Expand research areas and disciplines engaged in Alzheimer's disease research via funded, collaborative trans-disciplinary grant applications.

GOAL I: Texas will support Alzheimer's disease research.

Objective 3: By August 31, 2015, establish a minimum of two non-state funded research projects with special emphasis on the impact of Alzheimer's disease and cognitive aging on the state's underserved individuals, including African Americans, Hispanic Americans, Native Americans, and rural Texas seniors.

Rationale:

Hispanic Americans and African Americans, among other minorities, may be at increased risk for developing Alzheimer's disease at a younger age, possibly because many risk factors for Alzheimer's disease, such as high blood pressure, diabetes, and high cholesterol, are much more prevalent within these ethnic groups, who are also underrepresented in medical research. Although 20 percent of the nation resides in rural locations, there is very little information on occurrence of risk factors, presentation, and prevalence of Alzheimer's disease among rural elders. Different environmental exposures may lead to disproportionate risk among these elders. Texas' ethnic and geographic diversity provides a unique opportunity to address Alzheimer's disease among these under-served groups. There are ongoing Texas studies that can, and should, collaborate to begin systematic study of Alzheimer's disease among Hispanic-American, African American, and rural Texans. Use of telemedicine technology is but one example of expanding research and clinical services to these populations. Increased research funding will make it possible for Texas to expand its efforts and thereby assume a national leadership role in these Alzheimer's disease research areas.

Strategies:

1. Develop collaborative relationships between ongoing Texas-based health outcome studies already enrolling elderly ethnic minorities and medically underserved populations to facilitate recruitment of underserved individuals into aging and Alzheimer's disease specific studies.
2. Create and distribute appropriately tailored informational materials on aging and Alzheimer's disease research studies to underserved Texas communities for volunteer recruitment.
3. Expand use of telemedicine technology applications in research protocols to reach rural populations and communities.
4. Investigate collaborations with Latin-American, bi-national colleagues to embark in lifestyle risk assessment of Hispanics.

GOAL I: Texas will support Alzheimer's disease research.

Objective 4: By August 31, 2015, increase utilization of TARC's database by non-TARC Texas researchers to a minimum of three new projects per year.

Rationale:

TARC is a state asset. As such, resources developed through TARC must be shared with other Texas researchers interested in Alzheimer's disease research. Further, progress toward achieving TARC's goals can best be made by organizing, nurturing and promoting a greater interest in Alzheimer's disease research across the state. This can be realized only if medical as well as other Texas researchers are aware of TARC and available resources to further Alzheimer's disease research. Information distribution about TARC and its resources to Texas medical researchers is a priority.

Strategies:

1. Generate and distribute information describing available TARC data and procedures for requesting data for analysis.
2. Disseminate information to the Office of Research at each Texas-based university, including university media contacts, and selected personnel within institutions.
3. Create a working group/taskforce to interact with TARC's data coordinating center to ensure a user-friendly process for requesting and obtaining data.
4. Develop a Texas list of present and potential Alzheimer's disease researchers by institutions.
5. Assess the feasibility of establishing TARC-funded pilot research grants that support new Texas-based Alzheimer's disease research.
6. Develop a multi-institutional resource sharing system/database that promotes collaborative sharing of information and resources between researchers at all Texas institutions.
7. Identify researchers at existing TARC sites to serve as collaborators and/or mentors for non-TARC Texas-based junior researchers and those who may be new to Alzheimer's disease research.
8. Convene an annual statewide research symposium to highlight Alzheimer's disease research within Texas as well as promote collaboration and resource sharing.
9. Promote awareness of Alzheimer's disease research at academic institutions, hospitals and disease-related businesses.

GOAL I: Texas will support Alzheimer's disease research.

Objective 5: By August 31, 2015, advance one recommendation of the Alzheimer's Study Group Strategic Plan by encouraging Texas researchers to collaborate across the scientific spectrum of developmental science and basic research.

Rationale:

A disciplined and comprehensive strategy, backed with sufficient public and private investment, is essential for realizing this objective. By promoting research collaboration among institutions and across disciplines, Texas can accelerate the quest for improved diagnosis, treatment, and ultimately, prevention of Alzheimer's disease. These collaborations can only be achieved by integrating cognitive and behavioral research directed towards greater understanding of lifestyle, socioeconomic, psychological, and behavioral risk factors with currently existing biomedical research objectives. Actively supporting Texas researchers in obtaining public and private funding for projects that encourage, support, and promote research across the scientific spectrum of dementia research interventions is required.

Strategies:

1. Support increased funding for collaborative dementia research across Texas.
2. Develop and distribute data and informational materials to educate public corporations and policymakers about the need for interdisciplinary Alzheimer's disease research.
3. Develop an authoritative list of all active Alzheimer's disease researchers (including basic and clinical research, behavioral research, and cognitive investigators) and their affiliated research institutions.
4. Facilitate acquisition of funding by Texas researchers from the Veteran's Administration, Centers for Disease Control and Prevention, and other federal and private funding sources for multi-disciplinary and multi-institutional collaborative projects.
5. Develop, maintain, and distribute a compendium of ongoing funded Alzheimer's research projects, multi-institutional collaborations, and multi-disciplinary studies within Texas.

Prevention and Brain Health

Many adults believe that aging is a time of irreversible mental decline and that dementia is inevitable. Factually, declines in cognitive function do not necessarily correlate with the normal aging process. Much like physical health, cognitive health can be viewed along a continuum – from optimal functioning to mild cognitive impairment to severe dementia.

The human brain contains over 100 billion nerve cells (neurons) that work together in networks to perform specific functions. These networks have very specific purposes. Some are involved in forming new memories, recalling old memories, thinking and learning. Others are tasked with controlling the five senses and telling muscles when to move. Alzheimer's disease destroys brain cells, causing these networks to cease normal functioning. As these networks begin to fail, the brain is able to re-route networks to maintain function for a limited period of time. Progression of Alzheimer's disease will ultimately accelerate beyond the brain's ability to recover function.

> A person's physical health can now easily outlast his or her cognitive and mental abilities. Advancing age presents a classic paradox: people want to live as long as they can, but do not want to experience a decline in their cognitive abilities *(AARP's Educator Community).*

Alzheimer's disease typically unfolds slowly in patients. Therefore, it is easy to ignore until significant symptoms appear. By the time there are symptoms, treatments that exist may not alter the disease's course. While the ultimate solution to the Alzheimer's crisis is cure, there are steps that can be taken with hope of reducing cognitive decline. Promising prevention and brain health research is now focused on eliminating risk factors that are known to damage the brain, and increasing those behaviors which promote good brain health. Although there is no proven link between controlling these measures and cognitive performance for Alzheimer's disease prevention, the current body of research indicates a strong correlation between risk for Alzheimer's disease and conditions that damage the heart and/or blood vessels. These conditions include high blood pressure (hypertension), heart disease, stroke, diabetes and metabolic syndrome, elevated blood homocysteine, and high cholesterol *(2010 Alzheimer's Disease Facts and Figures, Alzheimer's Association)*.

Keeping physically, mentally and socially active have been hypothesized to be key factors in reducing one's risk of Alzheimer's disease. Just as Dr. Kenneth Cooper's theories about the positive relationship between aerobic exercise and higher levels of cardiovascular health have been validated throughout the past three decades, scientific studies are now demonstrating a positive relationship between prevention or treatment of risk factors and increased brain health. Researchers have suggested the beneficial effects of a Mediterranean-type diet – fruits, nuts, legumes, fish rich in omega-3 fatty acids, and olive oil as the major source of monounsaturated fat – in reducing the rate of cognitive decline as measured by the Mini-Mental Status Exam (MMSE) (Knopman, 2009). The Mediterranean type diet can also have a positive impact on lowering blood cholesterol, which can lead to better heart health.

Keeping the total cholesterol level below 200 also may reduce the risk of developing dementia later in life. A longitudinal study lasting over 40 years found that even borderline to moderately high cholesterol detected in forty year old individuals greatly increased the chances of having Alzheimer's disease or other dementias later in life. Persons with borderline cholesterol had a 52 percent higher risk of vascular dementia. While this study demonstrated a strong link between borderline to moderate cholesterol and risk for Alzheimer's disease and other dementias, the relationship between the two remains unclear. The implication is quite clear, however, reducing cholesterol through improved diet, lifestyle changes and physical activity improves your heart health and may reduce risk of Alzheimer's and other dementias (Solomon et al., 2009).

Medical technology has exponentially increased lifespan during the 20th century, from 46 to 78 years at present. Advances in medicine have led to cures and treatments of many diseases, such as cancer, heart disease, and tuberculosis. These diseases were not survivable a century ago. Yet, Alzheimer's disease and other dementias create problems on a scale never before imagined. A person's physical health can now easily outlast his or her cognitive and mental abilities. Advancing age presents a classic paradox: people want to live as long as they can, but do not want to experience a decline in their cognitive abilities *(AARP's Educator Community*).

Public health initiatives for improving early detection for many diseases have greatly improved the public's knowledge and access to routine screenings for various chronic conditions, such as high blood pressure and diabetes. Efforts to provide education on primary prevention, such as not smoking and proper nutrition and physical activity have added years to the American lifespan and enhanced quality of life in later years. However, a significant problem in the current healthcare system is a lack of coordination and payment for preventive healthcare.

Physicians and other primary care providers are presently not reimbursed to deliver appropriate preventive measures. Under current reimbursement methods, physicians and other primary care providers are paid for episodic treatment and management of disease states. Current reimbursement policy effectively discourages valuable between-visit care and support for people with dementia and their family caregivers.

Many primary care practitioners are not prepared to screen and diagnose Alzheimer's disease and other dementias. Some of these issues may stem from a lack of education and understanding of Alzheimer's disease and treatment options. Or, they may result from insufficient resources required to adequately provide a screening and diagnostics program. An obvious consequence is that larger numbers of people go without a proper diagnosis of Alzheimer's disease or other dementias at the earliest stage possible, when the patient is most likely to benefit from treatment.

Objectives and strategies that follow were designed to strengthen and advance awareness of the relationship between prevention and brain health fitness. These activities are developmental in nature, as there are no current established national or state performance measures from which to begin this work. It is believed that these recommendations will serve as a starting place for changing the way Texans think and behave regarding brain health.

GOAL II: Texans will experience improved cognitive health throughout the life span.

Objective 1: Ongoing, the Texas Alzheimer's Disease Partnership will submit proposals to the Behavioral Risk Factor Surveillance System to obtain Texas-specific data related to brain health fitness.

Rationale:

Having accurate surveillance data helps states measure the burden of disease, guide public health priorities, target interventions, and set healthcare policy. Surveillance data help us understand who is affected by a particular disease, what health behaviors may increase risk, and how this disease affects the person and his or her quality of life. In order to obtain data needed to assess brain health fitness, reliable surveillance is needed. The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and healthcare access primarily related to chronic disease and injury. Established in 1984 by the Centers for Disease Control and Prevention (CDC), the BRFSS is the largest telephone health survey in the world. BRFSS data is collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam, and more than 350,000 adults are interviewed each year (CDC).

At present, there are no state or national population-based measures for assessing brain health fitness. For years, the burden of cognitive impairment has been expressed in terms of incidence, prevalence, and mortality for dementias such as Alzheimer's disease. Therefore, taking the lead role on developing and implementing new surveillance measures to identify and provide baseline and trend data is essential. As outlined in the following strategies, a workgroup will be established to develop key recommendations relevant to brain health fitness surveillance as well as questions to include on BRFSS surveys. This objective serves as an important first step to increasing the number of measures to accurately describe brain health fitness.

Strategies:

1. Explore and secure funding sources to support BRFSS survey questions.
2. Establish a workgroup to identify, develop, or use existing standardized BRFSS questions.
3. Work with the Department of State Health Services to prepare and submit BRFSS proposals to BRFSS Coordinator.
4. Monitor status of BRFSS proposals and make necessary changes to questions based on feedback from BRFSS Coordinator.

GOAL II: Texans will experience improved cognitive health throughout the life span.

Objective 2: By August 31, 2015, increase resources needed to advance and elevate brain health fitness and prevention awareness and education efforts in Texas.

Rationale:

Texans are living longer with greater physical health status than ever before. This extension of physical vitality is marred by increased impairment in cognitive and mental abilities. The majority of Texans will suffer from declining brain health fitness with increasing age. But this condition may be able to be avoided. The potential for Texans to experience improved brain health fitness as they enjoy longer life spans must be anticipated now.

The brain is highly modifiable. New brain discoveries suggest that more can be done to strengthen brain health fitness than almost any other organ. Appropriate mental and physical activities can potentially offset some types of mental decline in later adulthood (Elias & Wagster, 2007). Even in Alzheimer's disease, it is possible to extend brain health fitness with early detection and early treatment (Chapman et al., 2005). The earlier brain health fitness is addressed, the greater the potential to make progress against sources of reduced mental activity such as: aging, chemotherapy, general anesthesia, silent strokes, and diseases that impair brain health – even Alzheimer's disease.

This initiative calls for a comprehensive effort to advance and elevate brain health fitness in Texas. Major resources are required and will involve partnerships across all segments of public and private society including corporate Texas, insurers, businesses promoting healthy aging, food industry, and pharmaceuticals and related resources. Through public education and other awareness programs, Texans can free themselves of the stigma and fears associated with assessments of brain health status and reduce the gap between brain health span and lifespan.

Strategies:

1. Identify and support funding opportunities to address and advance brain health fitness.
2. Establish a brain health fitness consortium to provide compelling data on emerging science and translation of research into practice.
3. Develop white papers to educate policymakers on brain health fitness.
4. Support efforts to increase funding and/or legislation for brain health fitness, prevention, awareness, and education.
5. Maintain brain health fitness partnership activities and convene bi-yearly meetings.

GOAL II: Texans will experience improved cognitive health throughout the life span.

Objective 3: By August 31, 2015, develop a compendium of targeted preventive brain health fitness screening recommendations and education for healthcare professionals in Texas to establish brain health fitness benchmarks and promote brain health fitness.

Rationale:

Medical research is confirming the connection between physical health and brain health. It is now known that a lifetime of healthy living has a direct impact on brain health. Just as physical exercise strengthens the body, mental activities strengthen brain health. Just as regular medical check-ups are the foundation for physical health, similarly, assessments of the brain are essential to brain health. Unfortunately, assessment of brain health is not a routine part of the lifestyle of even people who may otherwise be conscientious regarding health maintenance. The result is that by the time most individuals receive a diagnosis of deteriorating brain health fitness, significant, possibly preventable damage has already occurred.

Increasing public awareness of the potential to maximize brain health fitness and lessen cognitive decline with aging is a critical step. But more needs to be done by the medical community as well. It is imperative that primary care providers begin to screen baseline brain health fitness. Initial screening at 50 years of age provides an excellent benchmark. The following strategies address development of effective clinical tools and protocols for measuring brain fitness. These tools, when utilized as part of a regular plan of preventive healthcare, can significantly impact long-term preservation of memory, critical thinking, and decision-making.

Strategies:

1. Establish a workgroup to identify effective screening tools and brain health fitness recommendations for all Texans.
2. Create a compendium of identified screening tools and brain fitness recommendations.
3. Develop multimedia education programs to promote recommendations for healthcare professionals and the public.
4. Determine best processes for dissemination of screening tools and brain health fitness recommendations for healthcare professionals.
5. Establish brain health fitness continuing education credits for all healthcare professionals.

GOAL II: Texans will experience improved cognitive health throughout the life span.

Objective 4: By August 31, 2015, develop one web-based clearinghouse that provides comprehensive information and resources on Alzheimer's disease and overall brain health for the Texas public and healthcare sectors.

Rationale:

Individuals seeking health information often turn to the internet. Here they find no shortage of information. Literally, millions of articles and websites expound on different aspects of diseases, including Alzheimer's. This abundance of information, rather than being helpful, can actually be a source of confusion and uncertainty. News about Alzheimer's disease and brain health comes from two primary sources: scientific and non-scientific. Scientific information is published after a scientific study or research project. This information is useful and can help Texans understand why preventing Alzheimer's disease is important. Non-scientific information is generally anecdotal and although interesting may be inaccurate or misleading.

Telling the difference between scientific information and anecdotal information can be difficult. It is important that individuals have access to information about Alzheimer's disease that is accurate, science/evidence-based, and reliable. Consequently, creation of an internet-based Alzheimer's disease and brain health "clearinghouse" website that contains accurate, relevant and timely information is required. On this website, Texans will find information on: disease facts; prevention research and brain health fitness; treatment options; state and community resources; and frequently asked questions. The clearinghouse will be shaped by a team of information management and technical experts.

Strategies:

1. Establish a Clearinghouse Steering Committee to develop the conceptual framework, including vision, design, implementation, and evaluation plans.
2. Secure funding to support clearinghouse design, development, implementation, and evaluation.
3. Establish a workgroup to identify information and resources to be included within the clearinghouse.
4. Bring together technical experts to plan and implement clearinghouse technical aspects.
5. Establish an oversight/monitoring workgroup to update and assimilate new data into the clearinghouse bi-annually.

GOAL II: Texans will experience improved cognitive health throughout the life span.

Objective 5: By August 31, 2015, one annual assessment will be completed to measure the effectiveness, satisfaction, relevance, and utilization of the Texas Alzheimer's/brain health fitness clearinghouse.

Rationale:

In this era of technological advancement and instantaneous access to electronic information, an annual clearinghouse review will ensure that information contained is accessible, appropriate, and relevant to current concepts within the Alzheimer's/brain health field. A workgroup of experts across an array of disciplines will be established with the primary responsibility of completing an annual clearinghouse review and providing improvement recommendations.

Strategies:

1. Establish a workgroup to develop metrics for clearinghouse criteria, such as reach, relevance, access, best evidence, quality operations, adherence to budget/return on investment and other metrics as identified by the Clearinghouse Steering Committee.
2. Identify yearly assessment timelines and reporting mechanisms and initiate assessment action with the designated evaluative entity.
3. Develop an annual written assessment of findings and recommendations and present to the Clearinghouse Steering Committee.

GOAL II: Texans will experience improved cognitive health throughout the life span.

Objective 6: By August 31, 2015, increase the number of Texas organizations by one per year that will promote information on the relationship between brain health fitness and overall health in their programs' communications and activities.

Rationale:

Unfortunately, the general public remains uninformed of how physical health directly impacts cognitive health. This lack of awareness stems from unavailability of print and other materials designed to educate the public of this important relationship. Many barriers confront this public education effort. One of these is geographical. Texas is the second largest state in the nation. Reaching the far corners of this huge area will require efforts of multiple partners and stakeholders working collectively to create awareness. Texas is also an ethnically diverse state. Ensuring that content and means of informing this diverse public requires close alliances among representatives of all ethnic groups.

Members of the Texas Alzheimer's Disease Partnership will build an alliance with one organization per year to promote information on the relationship between brain health fitness and overall health in their programs' communications and activities. By targeting one key organization per year, the partnership can focus on maintaining a growing and stable relationship, ultimately ensuring long-term success. Joint collaboration and promotional efforts with various organizations around Texas will not only allow the partnership to reach and educate a larger population on brain health, but it will increase participation and awareness for future partner agencies as well. Strategies that follow call for a strategic effort to educate Texans of the critical interplay of a healthy lifestyle and cognitive abilities.

Strategies:

1. Identify organizations and programs to target (i.e. Texas Medical Association, Texas Nurses Association, Texas Academy of Family Physicians, Texas Nurse Practitioners).
2. Establish a development workgroup to identify and prepare materials for promotion to organizations (white papers, briefing papers, etc.).
3. Initiate meetings with organizations to discuss the importance and urgency of promoting current information on brain health fitness.
4. Secure participation for collaborative promotional efforts with organizations.
5. Maintain ongoing relationships with partner organizations and actively work to increase numbers of partner agencies.
6. Publish all materials, including slide presentations, to the Alzheimer's/brain health fitness clearinghouse for use by partnering organizations.

Disease Management

The term "disease management" grew out of managed care and generally refers to a range of activities focused on returning people with chronic illnesses to a healthier state and helping them to effectively deal with disease complications. More recently, the term has been used to encompass the whole system of coordinated healthcare interventions integrated into an overall continuum of care for the chronically ill. Effective and comprehensive Alzheimer's disease management on a statewide level will require rethinking previous disease management practices in an Alzheimer's disease setting. New approaches will be required, bringing together disease managers with all facets of disease management practices.

> Improved quality of life for persons with Alzheimer's disease can be achieved though an all-inclusive, statewide system of disease managers, employing better disease management practices and initiatives.

Redefining disease management as it relates to an Alzheimer's setting begins with identifying key players, such as those individuals and organizations that can most directly improve quality of life for people with Alzheimer's disease and their families. Primary stakeholders are those who are engaged in direct provision of healthcare related treatments and therapies, including the patient, family members and or primary caregivers, primary care physicians, specialists, researchers, and other healthcare workers. Secondary stakeholders are those who are similarly involved in providing treatment and services, and include noncaregiver family members, physician networks/organizations, related healthcare workers/networks/organizations, not-for-profit healthcare service providers, faith-based personnel, and law-enforcement and first responder personnel. The third level of disease managers includes employers, elected officials, healthcare insurance providers (public and private), the pharmaceutical industry, and the general public.

Improved quality of life for persons with Alzheimer's disease can be achieved though an all-inclusive, statewide system of disease managers, employing better disease management practices and initiatives. Alliances must be formed, and institutions, organizations, agencies, and private business must join together as a statewide disease-management team. The impact of Alzheimer's disease is far reaching, extending to all aspects of public and private enterprise. All sectors of society are invited to voluntarily participate in and/or support development and implementation of a comprehensive, statewide system of an enhanced and expanded Alzheimer's disease management initiatives in Texas.

The following objectives and strategies are comprehensive in scope and are designed to support effective disease management. Any initiative developed and implemented under a statewide plan will impact not only the patient with Alzheimer's, but also family members who are frequently the primary caregiver and generally considered to be the secondary casualties of Alzheimer's disease. These recommendations, when implemented, will elevate and advance comprehensive Alzheimer's disease management in Texas on an unprecedented level and provide a framework from which to evaluate present initiatives, launch future interventions, and provide for quantifiable improvements.

Goal III: Texans with Alzheimer's disease will experience improved quality of life through better disease management.

Objective 1: By August 31, 2015, Texas will increase by 1,000 the number of healthcare professionals who integrate clinical best practices into the early detection, diagnosis and pharmaceutical treatment of persons with Alzheimer's disease.

Rationale:

No treatment is available to slow or stop deterioration of brain cells in Alzheimer's disease. Five drugs are currently approved that temporarily slow worsening symptoms for on average, six to 12 months, and for about half of the individuals who take them. Despite current lack of disease-modifying therapies, studies consistently show that active medical management of Alzheimer's disease can significantly improve quality of life through all disease stages for individuals and their caregivers. Active management includes appropriate use of available treatment options, effective integration of coexisting conditions into the treatment plan, and use of supportive services such as counseling, activity and support groups, and adult day center programs.

It is recommended that clinical guidelines be developed in order to promote best practices for recognizing, diagnosing, and providing treatment to individuals with Alzheimer's disease or a related dementia. These guidelines should be targeted to primary healthcare professionals, including physicians, nurse practitioners, physician assistants, social workers, nurses, and other professionals providing primary care to patients with Alzheimer's and their families. Recommendations for management of associated neuropsychiatric symptoms and coexisting medical conditions often seen in persons with Alzheimer's disease will be incorporated into these guidelines. Patients with Alzheimer's disease often need concomitant medication for treatment of diverse central nervous system disorders associated with progressive brain dysfunction (Cacabelos). Suggestions for easily administered and scored appraisal tools will be incorporated when possible, as well as diagnostic and treatment pearls.

Strategies:

1. Establish a statewide workgroup to develop and disseminate best practices guidelines.
2. Identify educators to provide continuing medical and nursing education approved presentations on clinical best practices.
3. Work with speaker's bureau on outreach activities in rural areas.
4. Identify opportunities to present at local healthcare professional meetings (i.e. county medical societies, nursing district meetings).
5. Promote inclusion of best practices curriculum into medical schools, nurse practitioner and physician assistant programs.
6. Provide guidelines to medical schools and hospital education through Grand Rounds, continuing medical and nursing education.
7. Develop an on-line educational series for healthcare professionals.
8. Collaborate with a broad spectrum of professional organizations to promote guidelines at conferences and other functions.

Goal III: Texans with Alzheimer's disease will experience improved quality of life through better disease management.

Objective 2: By August 31, 2015, increase by 1,000 the number of persons with Alzheimer's disease who participate in new and experimental clinical/research trials in Texas.

Rationale:

Critical to Alzheimer's disease research is willingness on the part of persons with Alzheimer's disease, at various stages of disease progression, to voluntarily participate in clinical trials and studies. Prior to utilization of therapies or pharmacological interventions in clinical practice, rigorous testing is required. Clinical trials are vital to testing possible interventions to diagnose, prevent, treat and hopefully result in a cure for Alzheimer's disease. They require long-term observation and analysis in large groups and require broad participation by both persons with Alzheimer's disease and those who have not been affected. In order to be effective, clinical trials examine possible interventions to diagnose, prevent, treat, and hopefully cure the disease.

While the benefits of participating in clinical trials and studies are many, there continues to be a shortage of individuals who volunteer to participate. As seen in other disease aspects, a lack of awareness and access contributes to difficulty in recruiting research participants. New therapies and pharmacological interventions can only be confidently and safely applied in practice after they have undergone rigorous scientific testing. Therefore, promoting importance of clinical trials and also recruiting participants for study participation is an essential plan element.

Strategies:

1. Promote greater awareness of existing and new opportunities for participation in Alzheimer's disease-related clinical studies and trials to health and service-related entities.
2. Promote awareness of the Alzheimer's Association's "Emerging Med" website to establish a data base of clinical studies and trials that match patients to clinical trials based on survey information.
3. Ensure that volunteer recruiting activities and measures are published in multiple languages and formats with high degrees of cultural sensitivity.
4. Explore the potential of securing funding for subsidizing costs in providing clinical trials to patients who live in rural areas.
5. Investigate the possibility of obtaining funding to conduct a statewide awareness campaign on the value of clinical trials and studies.

Goal III: Texans with Alzheimer's disease will experience improved quality of life through better disease management.

Objective 3: By August 31, 2015, increase access to training and education programs for persons with Alzheimer's disease, their families, and caregivers to improve communication and management of the disease.

Rationale:

Critical to this objective is a dedication and commitment to providing accurate and reliable information about Alzheimer's disease to individuals and families so that they may, when properly informed about the disease and its impact on families, adopt and develop strategies to combat the many challenges presented by this disease. This will enhance their ability to lead more fulfilling, less dependent lives over longer periods of time, within constraints of disease symptoms and progression.

While a diagnosis of Alzheimer's disease is often devastating, families who are adequately informed about this disease, its symptoms and long-term progression can often better manage the illness and its impact. Without accurate information, persons with Alzheimer's disease and their families are limited in their capacity to make informed decisions regarding in-home care, legal matters, finances, and other critical issues. Increasing access to training and education is a critical component for the overall goal of enhancing disease management across the state.

While few families are adequately prepared for an Alzheimer's disease diagnosis, it is critical that greater efforts and resources be focused on provision of accurate and reliable disease information through multiple information dissemination venues. The process of informing and education should begin when a person is first diagnosed with Alzheimer's disease. Therefore, the number one support mechanism provided in fulfillment of this objective is providing accurate and reliable disease information and contact information for local and statewide sources of support and assistance.

Strategies:

1. Partner with state, local and community agencies to disseminate Alzheimer's educational materials to patients and families (physician offices, Area Agencies on Aging, faith-based organizations, Alzheimer's Associations, for profit and not-for-profit health services agencies, and social services providers serving the elderly).
2. Conduct research to identify, evaluate and deploy effective and efficient methods of providing Alzheimer's disease educational materials to individuals and families.
3. Explore potential funding sources to support a statewide media campaign on resources available to individuals with Alzheimer's disease and their family caregivers.
4. Establish protocols for state and local agencies and cross training to address needs of individuals and families impacted by Alzheimer's disease and related dementias.
5. Look into the feasibility of using large-scale public presentations, mass media outlets, information kiosks, and associated businesses (both public and private) as a way to increase training and educational opportunities.

Goal III: Texans with Alzheimer's disease will experience improved quality of life through better disease management.

Objective 4: By August 31, 2015, promote the integration of Dementia Care Practice Recommendations for persons with Alzheimer's disease/related dementias into 250 nursing homes and long-term care facilities in Texas.

Rationale:

Dementia is the most significant risk factor for institutionalization and currently there are more than 1.5 million Americans residing in nursing homes. The most common form of dementia is Alzheimer's disease and most of those institutionalized with dementia are of this type. This number is expected to more than triple by the year 2030. It is recommended that quality of life be improved by integrating Dementia Care Practice Recommendations (the Recommendations) for disease management within those facilities.

The Alzheimer's Association developed the Recommendations in 2006 for nursing homes and assisted living facilities. The Recommendations have been adopted by the U.S. Department of Health and Human Services. Several current resources include Acute Care of Vulnerable Elders study (ACOVE) recommendations, American Medical Directors Association (AMDA) clinical practice guidelines, the Texas Department of Aging and Disability Services (DADS) Quality Matters Web (QMWeb), the National Guideline Clearinghouse summary on dementia care practice recommendations for nursing homes, and the Center for Health Systems and Research and Analysis (CHSRA). Quality of life can be significantly improved by integrating the Recommendations for disease management within Texas nursing homes and long-term care (LTC) facilities.

Data supporting this objective include, but are not limited to the following:

- Dementia is the most significant risk factor for institutionalization.
- Alzheimer's disease is the most common form of dementia and accounts for 60 to 80 percent of persons with dementia.
- More than 1.5 million Americans with dementia reside in nursing homes and related facilities and are expected to more than triple by the year 2030.

Distribution of the Recommendations should be provided in multiple venues. Facilities identified as not currently integrating the Recommendations in their disease management plans should be strongly encouraged to do so. Facility administrative and professional medical staff will be advised of opportunities to participate in in-service training to help educate and maintain the Recommendations.

Collaboration with professional organizations will be encouraged as well as strong support to link dissemination of the Recommendations with continuing education credit efforts. The Recommendations will be posted along with hyperlinks on the Alzheimer's Association website and other websites. Ongoing and interim follow-up is suggested to determine any challenges that are encountered during implementation. Hence, continued support of facility integration efforts and working relations through collaborative efforts especially with professional organizations should be maintained over the years.

Strategies:

1. Survey nursing homes and LTC facilities to identify those facilities which are currently integrating the Recommendations into Alzheimer's/dementia disease management.

2. Review, identify, and promote approaches to effectively integrate the Recommendations within identified facilities.
3. Collaborate with facility administrative and professional medical staff on integration of the Recommendations.
4. Conduct interim survey to determine facility needs on integration of the Recommendations and provide assistance where needed.
5. Continue support of facility integration efforts and maintain working relationships through collaboration.
6. By early 2015, re-survey to determine the numbers of nursing homes and LTC facilities that have integrated the Recommendations and identify implementation challenges and report improvement suggestions.
7. Propose rules changes for integration of the Recommendations to the Department of Aging and Disability Services, if needed.

Objective 5: By August 31, 2015, Texas will promote Alzheimer's disease personal safety awareness, measures, and guidelines to 5,000 persons with Alzheimer's disease and their family members/caregivers.

Rationale:

Safety for all older Americans is of increasing concern. The elderly face many challenges, including falls, accessibility issues, and community hazards.
The Centers for Disease Control and Prevention estimate that 35-40 percent of adults 65 and older fall at least once each year. Persons affected with Alzheimer's disease have even greater safety concerns due to cognitive deficits. Individuals with Alzheimer's are also at greater risk for wandering, accidents in the home and community, and problems with driving. These individuals are found to be more prone to home injuries, mostly due to falling. One study showed that patients with dementia have a decreased awareness of danger. Consequently, safety concerns are frequently cited by caregivers as a reason for seeking institutional care. Since the extent of risk to Alzheimer's patients is not easily discernable, addressing these safety issues will allow them to lead healthier lives and remain in their community longer.

Strategies:

1. Partner with law enforcement agencies to increase awareness of safety issues (specifically wandering).
2. Investigate conducting a pilot project in a mid-sized city to train police force and first responders about the MedicAlert-Safe Return and Comfort Zone Programs.
3. Partner with Texas Area Agencies on Aging to increase safety awareness for patients with Alzheimer's.
4. Encourage physicians to incorporate safety in the patient treatment plan.
5. Identify and partner with other safety-related organizations to promote safety awareness and measures.

Caregiving/Caregivers

An estimated 76 percent of people with Alzheimer's disease live at home. Families are the caregiving heart and soul for the 5.3 million people in the United States whose futures have been so dramatically altered by this disease. In 2009, 10.9 million family members, friends and neighbors provided unpaid care for persons with Alzheimer's disease or other dementias. Current medical interventions may provide symptomatic relief, but cannot delay underlying Alzheimer's disease progression *(2010 Alzheimer's Disease Facts and Figures, Alzheimer's Association)*.

Currently more than 852,820 unpaid caregivers, mostly family members, confront overwhelming challenges daily with providing care for an estimated 340,000 Texans with Alzheimer's disease and other forms of dementia. Care provided for an Alzheimer's patient can be extremely stressful. Caregivers frequently become isolated, over-burdened and depressed. One study noted that a person providing care to someone with dementia is twice more likely to have a significant adverse experience than someone who cares for a person who isn't suffering dementia. The same study noted caregivers' frequent need for assistance in both providing direct care and in managing patient needs. Caregivers were also found to have more health problems than others do at their age due to the physical and emotional demands of caregiving. Caregiving is also known to have negative effects on employment, income and financial security.

As Alzheimer's progresses and cognitive decline ensues, individuals with this disease often experience changes in personality and behavior; while becoming increasingly dependent on others for their needs. On a daily basis, families must deal with loved ones with Alzheimer's disease who are unable to cooperate or are actively resistant to the array of active care services provided. *Families Care: Alzheimer's Caregiving in the United States 2004*, a report by the Alzheimer's Association and National Alliance for Caregiving, found that "Caregivers of persons with Alzheimer's disease and other dementias shoulder a particularly heavy burden of care. Compared with other caregivers, the type of care they provide is more physically and emotionally demanding and more time consuming, and it takes a heavier toll on work and family life."

> Families are the caregiving heart and soul for the 5.3 million people in the United States whose futures have been so dramatically altered by this disease.

Even if a person with Alzheimer's enters an assisted living facility or nursing home, family members maintain their caregiver status by overseeing medical care, legal and financial matters. Duration of Alzheimer's disease is typically five to eight years, but has been known to last over 20 years, making the toll on caregivers prolonged and difficult. The *2010 Alzheimer's Disease Facts and Figures* found that at any one time, 32 percent of family and other unpaid caregivers of people with Alzheimer's and other dementia had been providing help for five years or longer. In addition to the taxing demands of providing constant care, families caring for someone with Alzheimer's often experience great frustration in attempting to locate and access supportive community services. Primary caregivers

of those with Alzheimer's disease are often compelled to take on the job of care manager. Families and those with the disease ordinarily prefer home care, but are not always capable, knowledgeable or adequately skilled in planning, accessing and coordinating services. In part, this is because there is significant fragmentation in the service delivery system. Services vary greatly and are offered by both public and private agencies. Eligibility varies by program sponsor. Some programs have income criteria, some age criteria and others geographic exclusions. This is confusing to the average person and can be overwhelming for those already burdened with the continual care persons with Alzheimer's disease require.

Most often, families turn to their primary care physician for information about Alzheimer's disease, managing difficult and symptomatic disease behaviors, and identifying available community resources to help with caregiving tasks. Unfortunately, primary care physicians are often not able to meet the families' needs in securing medical information and support. Physicians try to convey needed information, but caregivers report it is not adequate to address their questions and concerns. Still the primary care physician and broader healthcare system can be instrumental with identifying and reaching Alzheimer caregivers and aiding them in accessing services.

Enhancing support for Alzheimer caregivers throughout Texas requires efforts on two fronts: (1) improving access to existing services and (2) developing new services to address gaps in state information, referral and service delivery systems. A brief evaluation of provider reach and effectiveness reveals some limitations. While key service providers reach thousands of Texans annually, consumer awareness of available services is still lacking. After families have identified needed services, they frequently state they could have used assistance months or even years before it was obtained.

Given Texas' geography, diversity of its population, and wide range of long-term needs for the growing number of Texans with Alzheimer's disease, focusing on access to a multitude of existing statewide resources becomes even more critical. Meeting needs of family caregivers is central to this plan. However, many Texans with Alzheimer's will spend some time in a residential care facility. Thus, needs of residential care staff must also be addressed.

Goal IV: Caregivers will experience enhanced levels of support through improved access to Alzheimer's disease/dementia care information and services.

Objective 1: By August 31, 2015, develop and promote recommendations for key Texas service providers that enhance current distribution practices of Alzheimer's disease/dementia care information and services.

Rationale:

A recent study employed Internet research methods and 2-1-1 resources across the state to identify major providers of Alzheimer information and services. This work was an initial step to: (1) identify major statewide providers, (2) determine services and protocols offered by these providers, and, (3) specify barriers to access. The statewide study found many existing strengths among providers of Alzheimer information and services. Forty-eight business and organizations were identified, offering a broad array of services and a variety of ways to access their services. The following key statewide providers were identified:

The Alzheimer's Association - the oldest and largest national voluntary health organization committed to combating Alzheimer's disease. The Association's mission is to eliminate Alzheimer's disease through research advancement; provide and enhance care and support for all affected; and, reduce risk of dementia through promotion of brain health. The Association carries out its mission through a federation of 76 chapters across the United States and there are five Alzheimer's Association chapters in Texas; autonomously incorporated and based in Austin, Dallas, El Paso, Fort Worth and Houston.

Area Agencies on Aging (AAAs) - AAAs work within their communities to help seniors, their family members and caregivers receive information and assistance on locating and accessing community services. There are 28 AAAs with their respective service delivery areas covering Texas and reporting to the Texas Department of Aging and Disability Services.

Aging and Disability Resource Centers (ADRCs) - ADRCs endeavor to be the first stop for questions about Texas aging and disability programs and services. Eight ADRCs in Texas work collaboratively with public and private service organizations and their collective service areas within 34 Texas counties. These providers were identified as important resources because of their professional interactions with agencies. Providers were found to frequently offer their services in multiple languages, particularly in Spanish as a secondary language, and a majority of providers interviewed indicated they are satisfied with caregiver services available in their communities. Two issues were immediately clear from this assessment of services for families and professional Alzheimer caregivers across the state: 1) caregivers do not know where to find information about services; and 2) information about caregiver services available throughout Texas is inconsistent and varies widely. Geographically, the state is covered by services provided through the five chapters of the Alzheimer's Association and the Area Agencies on Aging. Core services are similar among the five chapters but, some offer additional services not available statewide. Funding varies and services are locally determined among the Area

Agencies on Aging. Aging and Disability Resource Centers are relatively new in Texas and limited in their current geographic coverage. The Aging and Disability Resource Centers are emerging as a useful referral source and effective collaborator among local agencies. The committee's recommendation is to work with existing key providers to enhance service protocols, materials and distribution practices based on study findings. It is hoped that that key providers are receptive to a mutual effort to enhance statewide service delivery. A public or publicly funded entity may likely need to coordinate this task.

Strategies:

1. Establish a workgroup to identify key urban and rural organizations involved in the distribution of Alzheimer's disease information and services.
2. Work with organizations to identify current distribution practices.
3. Assess caregivers on their experiences in obtaining access to needed information and services.
4. Develop recommendations to enhance protocols for distribution of Alzheimer's disease and dementia care information/services.
5. Present findings and recommendations to key Texas service providers.
6. Collaborate with service providers to promote and implement recommendations.
7. Adapt or develop new materials to enhance protocols as needed.
8. Promote technical assistance as needed.

Goal IV: Caregivers will experience enhanced levels of support through improved access to Alzheimer's disease/dementia care information and services.

Objective 2: By August 31, 2015, identify and engage the support of a minimum of 20 non-traditional partners in disseminating educational materials and resources that foster public awareness of Alzheimer's disease and services available through the Alzheimer's Association.

Rationale:

Families often do not know where to find needed information and services, even when resources are available. Current efforts focus on effectiveness of service providers in reaching their targeted audience. This initiative adds further value by expanding outreach efforts to additional community partners. Non-traditional partners such as businesses or other entities primarily focused on non-Alzheimer's services would be invited to go beyond the network of health and social service providers. Non-traditional partners bring extensive infrastructure resources to publicize or promote some aspect of Alzheimer's information and services, preferably on a statewide basis. Non-traditional partners are those who could help reach caregivers at atypical points of contact. This will be particularly helpful in reaching caregivers who are not already connected to any health or social service provider. The five Texas-based Alzheimer's Association chapters have regional and satellite offices throughout the state. As part of a national organization, the Alzheimer's Association offers a toll-free 24/7 telephone helpline. This availability ensures a knowledgeable professional is always available to respond to immediate questions and concerns from caregivers. The Association also has a wide array of quality educational materials available in print and on-line about Alzheimer's disease and caregiving issues. It is recommended that the Alzheimer's Associations play a key role in forging non-traditional partnerships where possible, on a statewide basis. Other traditional and non-traditional partners will be needed to promote collaborations and secure needed funding.

Strategies:

1. Identify non-traditional partners with statewide reach to disseminate materials and resources. Such partners may include utility companies, code enforcement officers, public safety officials, billboard companies, banks, public/private businesses, agricultural extension offices, and others.
2. Adapt or develop educational materials and resources that support the education message.
3. Where practicable, establish formal agreements with partners (based on size of organization and level of commitment), which may include subsidizing printing of materials, disseminating educational materials and resources to customers, educating employees about Alzheimer's signs and symptoms and sources of support for persons with Alzheimer's.
4. Expand collaboration and connectivity among non-traditional partners and Alzheimer's Associations in Texas.
5. Monitor the Alzheimer's Association 1-800 telephone helpline to identify and evaluate increases in referrals from non-traditional entities.
6. Maintain partnerships through in-person meetings, conference calls, and other means.

Goal IV: Caregivers will experience enhanced levels of support through improved access to Alzheimer's disease/dementia care information and services.

Objective 3: By August 31, 2015, streamline consumer information on rules and regulations governing assisted living and nursing home facilities providing dementia care in Texas.

Rationale:

Confusion exists when navigating the network of Texas long-term care services. While there is much information on Alzheimer's disease/dementia, it is not always easy to find, and the content's accuracy and validity varies widely among service providers. Streamlining information related to long-term care is vital to consumers when faced with challenges of choosing long-term residential care for a family member. Consumers need accurate and timely information on a variety of topics surrounding Alzheimer's disease care and long-term care placement options.

To make an informed placement decision, consumers need a basic understanding of what assisted living is, how this type of care differs from skilled nursing, and regulations and standards of each. Therefore, streamlining information and developing more uniform materials on long-term care options is critical to this objective.

Partners and stakeholders are called to work together to identify consumer needs around long-term care, develop appropriate materials, and design a comprehensive distribution network. While most of this information exists in various forms, efforts should be centered on compiling information in a standardized format with consistent delivery and dissemination practices. The following strategies are recommended to begin this process and help consumers with navigating long-term care placement when their family member can no longer be cared for at home.

Strategies:

1. Establish a workgroup to identify and collect educational materials on long-term care services for consumers.
2. Assess and evaluate accuracy and uniformity of materials.
3. Collaborate with long-term care organizations to identify opportunities and develop recommendations for improving and streamlining materials.
4. Work with organizations on materials revision/development and dissemination.
5. Identify funding mechanism(s) to support needed development/dissemination costs.
6. Disseminate materials to consumer organizations and their stakeholders.

Goal IV: Caregivers will experience enhanced levels of support through improved access to Alzheimer's disease/dementia care information and services.

Objective 4: By August 31, 2015, require by rule, increased role-appropriate dementia care training requirements of all staff working in any licensed facility housing persons with Alzheimer's disease/dementia.

Rationale:

In the 25-year period (2000 to 2025) Texas will experience a 74 percent increase in individuals 65 and older living with Alzheimer's disease. With this increase, the need to ensure quality care for people with Alzheimer's disease becomes increasingly important. This issue needs to be addressed not only in Texas, but across the country, particularly in residential care settings.

Nationally, 69 percent of all nursing home residents have some degree of cognitive impairment. Of these, nursing home records indicate approximately 47 percent of residents are diagnosed with Alzheimer's disease or another dementia. As for assisted living residents, studies indicate that 45-67percent have Alzheimer's or another dementia. It is undeniable that people with dementia often turn to residing in assisted living and nursing facilities, as physical and mental declines associated with this disease invariably lead to need for such supportive care. Currently, dementia specific training requirements in Texas range from zero to twelve hours annually, depending on the type of facility:

- Facilities licensed as assisted living are not required to provide any training in dementia care.
- Certified Alzheimer's assisted living facilities are required to provide 12 hours of dementia care training annually.
- Licensed nursing homes are required to provide one hour of dementia care training annually.
- Nursing homes certified for care of persons with Alzheimer's must have four hours of annual continuing education in Alzheimer's disease or related disorders.

Research shows that dementia care training directly correlates to factors impacting patient quality of care. In a study involving 124 nursing facilities in Minnesota, nursing assistants who received more dementia-specific training experienced an increase in knowledge and skills needed to work more effectively with dementia residents. An increase in knowledge and skills also positively impacted workers' job satisfaction and reduced turnover (Grant). In another study on dementia care in assisted living settings, it was found that dementia-specific training provided caregivers (direct care staff) "with the skills to insure resident safety, comfort and quality of life," (McKenzie). These studies highlight many positive benefits resulting from an increase in dementia care training in residential care facilities: increased staff confidence and job satisfaction; less turnover; and most importantly, higher quality of care for residents.

According to the Paraprofessional Healthcare Institute, "Good training ensures that direct-care workers can perform their jobs with competence and confidence. When workers feel well-prepared for their jobs, research shows that they are more likely to stay on the job," (PHI). As indicated in these studies, there is a cascade affect that comes with increased dementia care training. It not only results in better care for residents but also in another matter of

critical importance – reducing staff turnover. The high turnover rate among frontline staff in long-term care poses serious concerns not only as a workforce issue, but as a policy issue, as well; staff turnover is expensive. According to a 2004 report from Institute for the Future of Aging Services, direct turnover cost is conservatively estimated at $2,500 per incident. Direct costs include the cost of separation, vacancy, replacement, training and increased worker injury. In addition, there are also indirect costs such as productivity losses, penalties resulting from reduced service quality, lost client revenues from losing clients to other agencies and poor morale.

The long-term care industry is not alone in shouldering the burden of these direct and indirect costs. The financial impact on federal, state and local government is staggering. Turnover costs taxpayers roughly $2.5 billion annually. These negative impacts are further compounded by lower quality care for consumers and higher injury-related medical costs for workers. As author and labor economist Dorie Seavey notes, “Elders pay the heaviest cost of all, in quality of care they receive from too few, too new or temporary staff.” With the numbers of Texans with Alzheimer’s disease and other dementias living in assisted living and nursing facilities, it is imperative that the state work to raise the bar for dementia caregiver staff training requirements for all residential care settings.

Strategies:

1. Provide a detailed body of evidence-based data to justify and support increased dementia care training.
2. Present information on the need, evidence and benefit of dementia care training to appropriate policy makers and organizations.
3. Identify and make contact with residential care trade associations and appropriate regulatory agencies to establish partnering relationships.
4. Send out a comprehensive call for partners to collaborate on development of training recommendations.
5. Establish a formal workgroup to develop training curricula, based on roles and functions within facilities.
6. Work with appropriate entities to obtain legislative support of rules revisions as required.
7. Seek cooperation with appropriate rule-making entities for rule enactment.
8. Disseminate dementia care training curricula to affected licensed facilities.
9. Collaborate with appropriate entities to support implementation of training requirements.

Goal IV: Caregivers will experience enhanced levels of support through improved access to Alzheimer's disease/dementia care information and services.

Objective 5: By August 31, 2015, partner with at least one Texas healthcare system or group of primary care physicians to pilot test an evidence-based approach to identification, assessment and support of Alzheimer's disease caregivers within healthcare settings.

Rationale:

One-quarter of all hospitalized patients 65 and older have Alzheimer's disease or another form of dementia (Maslow). Compared to the general hospital population, those with dementia are often older, have a higher burden of chronic illness, and are at higher risk of nursing home placement (Bynum). Chronic illness coupled with dementia contributes to complexity of patient care and increases care burdens on family caregivers. Disease management is especially challenging for the patient and caregiver during care transitions: hospital to home (Jerant, Bayliss). Lack of communication during care transitions between different settings puts the patient at risk for medication errors, unrecognized worsening of disease symptoms, incomplete understanding of discharge instructions, and lack of coordinated follow-up with an outpatient provider (Coleman). Rapid hospital readmission following a hospital discharge is linked to patient inability to self-manage chronic illnesses, adequately report symptoms, and actively participate in their own care. Even though readmissions may seem as separate, acute events, readmissions have been shown to be associated with nursing home placement, a consequence that older adults prefer to avoid (Bishop, Mattimore). Placing a loved one in a nursing home introduces stresses and burdens not only on the patient but also on the patient's caregiving family (Nolan).

Since individuals with dementia are compromised in their ability for self-care, family caregivers are critical for preventing negative outcomes following hospitalizations, including nursing home placement, and are essential to daily management of the patient's chronic illnesses (Bynum). Caring for a family member with dementia can, however, lead to decreased quality of life and an increase in depressive symptoms in caregivers. Caregiving can also be detrimental to one's health (Schulz, Haley, Kiecolt-Glaser, Pruchno, and Vitaliano) and, if associated with burden, leads to higher rates of caregiver mortality (Schulz). In Texas, 852,820 unpaid caregivers provide care valued at $11.2 billion in uncompensated care making Texas the second highest in the nation in costs.

Evidence-based interventions are available to address risks associated with care transitions of older adults and to address negative consequences associated with caring for a loved one with dementia. Translation of one such evidence-based intervention, REACH II Intervention, has been implemented within Scott & White's integrated healthcare system in Texas to become the Scott & White Family Caregiver Program (S&W FCP). In 2007, Scott & White Healthcare created the S&W FCP, with funding from the Rosalyn Carter Institute/Johnson & Johnson Caregivers Program. The project was refunded in September 2008 for an additional year. The goal of this project is to identify high-risk patients and provide effective support to family caregivers by providing nursing staff developmental instruction, integration of caregiving risk appraisal measures

(REACH II RAM) into standard practices of care, and a family support program that coordinates hospital-based interventions and community-based formal supports services. The project targets individuals with dementia who are hospitalized, as this is a time in which the patient and family caregiver are at high risk for poor outcomes, including institutionalized long-term care for the patient and high levels of stress for the family caregiver.

To facilitate successful implementation, use of existing information technology was leveraged within the S&W healthcare system. Furthermore, collaboration occurred with the nursing staff, nurse educators, and nurse managers to facilitate integration within existing nursing protocols. To date, the S&W FCP has identified 1,702 Alzheimer's or dementia patients. Of these, 100 caregivers (23 percent) were enrolled in the S&W FCP. Caregiver burden, stress and patient problem behaviors significantly decreased and care recipient safety significantly increased during follow-up.

The healthcare system is frequented by patients with dementia, and provides an ideal contact point for caregivers who would otherwise remain anonymous in the community. Caregivers may also be more apt to receive care and treatment during the high stress of hospitalization (Schulz, Covinsky). Implementing an evidence-based program for caregivers within a healthcare system made up of numerous clinics and hospitals, and comprised of healthcare providers across all settings (physicians, nurses, social workers, and discharge planners) increases potential identification for caregivers and increases the program's value. Consequently, this plan proposes initiating a pilot project, similar to or modeled after the S&W FCP. By supporting caregivers during these critical times, it is hoped that their burden and stress will be lessened, and the patient's risk of hospitalizations or poor outcomes will be greatly decreased.

Strategies:

1. Establish a translational research work-group to explore opportunities for implementing an evidence-based caregiver support program into a large healthcare system or within a group of primary care physicians in Texas.
2. Promote integration of Alzheimer's disease caregiver support services into Texas healthcare system(s), providers and other healthcare-related organizations.
3. Encourage partnerships between Alzheimer's disease support service organizations, such as Alzheimer's Associations and local Area Agencies on Aging and healthcare systems to facilitate caregiver access to support services.
4. Identify potential sources of financial support for healthcare systems or physicians who provide support services to Alzheimer's disease caregivers (e.g., Centers for Medicare and Medicaid Services (CMS) demonstration projects, CMS waivers, Medicaid Waiver programs).

Infrastructure

Improving capacity means enhancing a community's ability to better identify needed resources and meet their needs and to participate more fully in society. Capacity can be defined as an organization's ability to successfully apply skills and resources toward identified goals. Capacity permits organizations to do their work, and is often closely linked to another term — infrastructure. In its broadest sense, infrastructure is viewed as those parts of a system that organize, inform, and support efforts of a group, organization or community in achieving its goals.

Improving and strengthening Texas' capacity to address Alzheimer's disease is essential to improving the health of Texans and creation of effective formal and informal partnerships are vital to this objective. The vast scope of Alzheimer's issues requires a multi-disciplinary system that includes community-based organizations, academia, state and local governments, along with for-profit and not-for-profit healthcare service industry. Partners and stakeholders at all levels are encouraged to identify where their organization fits into a coordinated effort to reduce the burden of Alzheimer's disease on Texans and volunteer their participation where it will best meet plan objectives.

In Texas, there are many formal and informal networks of concerned professionals representing public, private and civil sectors committed to dealing with the problems associated with Alzheimer's disease. Among these individuals and organizations, there is no lack of enthusiasm or dedication to the task. Weaving these parts together toward a coordinated effort is therefore a major step towards improving state capacity to address Alzheimer's disease in Texas. The 2010-2015 Texas State Plan on Alzheimer's Disease was developed to begin that coordinated, mobilization process of engaging all of Texas in collectively addressing Alzheimer's disease.

> Improving statewide capacity will require a coordinated, collaborative effort among all partners, at all levels, and within all sectors. Existing partnerships will need to be reinforced, new partnerships with planning agencies and public officials will need to be developed, and media organizations will need to be engaged in ways not previously used.

Improving statewide capacity will require a coordinated, collaborative effort among all partners, at all levels, and within all sectors. Existing partnerships will need to be reinforced, new partnerships with planning agencies and public officials will need to be developed, and media organizations will need to be engaged in ways not previously used. Progress in the battle against Alzheimer's disease can best be achieved through an infrastructure that links resources in an informed and coordinated manner.

The five objectives that follow are designed to strengthen infrastructure in key areas. Some strategies were designed to engage the media industry in a more active role and brings to the table extensive resources for public education and promotion of state plan initiatives. A diverse community consortium

will take the lead in developing educational materials for elected officials to provide them with information on which to base public policy decisions. These efforts will yield initial benefits as follows:

- More effective concentration of partners/ stakeholder's collective energies, resources, knowledge bases, and innovations.
- Attraction of important new resources and skill sets added to an already impressive mix of talent.
- Greater visibility to the overall effort as partnerships expand.
- Most importantly, achievement of an overall sense of coherence and unity.

Another set of initiatives is geared towards ensuring that information is relevant, accurate, and timely. Information enhances collaboration and enables education, facilitates an open, free exchange of experiences among professionals, and promotes planning innovations. Conducting a large scale effort for a five-year period as called for in the 2010-2015 Texas State Plan on Alzheimer's Disease requires organization. A key element is centralizing coordination at the Texas Department of State Health Services. In this way, a single, central body becomes the primary conduit for fostering and convening partnerships and networks, orchestrating efforts across multiple agencies and organizations, tracking progress, and measuring the impact against established goals.

Centralizing focus and accountability at the state level has another benefit. Too often, goals are looked at as discrete, disconnected parts with little understanding of their interrelatedness. While progress or slowdowns in one area are rarely viewed as impacting others, practitioners all too often experience the end result of this disconnect. A statewide approach, therefore, greatly reduces the possibility of scarce resources being uncoordinated and expenditures of time, money and resources being exhausted. This perspective enhances efficiency as the entire landscape of the campaign against Alzheimer's disease is monitored and managed. The result is a state-level impetus fully capable and resourced to sustain efforts over time. The following section lays out specific objectives and strategic actions designed to develop a solid infrastructure for a comprehensive and coordinated approach to addressing Alzheimer's disease in Texas.

Goal V: Texas will improve state and local capacity to address Alzheimer's disease.

Objective 1: By August 31, 2015, increase communications, collaborations, and coordination among statewide partners to implement state plan activities.

Rationale:

Strengthening partner and stakeholder relations and reaching out to form new partners is essential to statewide plan implementation. Effective collaborative efforts by partners and stakeholders will provide new resources and skills that will sustain the synergy that fosters continued plan implementation.

Strategies:

1. Identify opportunities to increase partnerships with stakeholders to strengthen and expand state plan implementation.
2. Continue to expand and advance the Texas Alzheimer's Disease Partnership to impact change in Texas.
3. Develop a consortium to spearhead public official education on Alzheimer's disease and promote policies and plans that support it.
4. Identify opportunities to foster partnerships with planning areas (i.e., Governor's State Planning Regions) for plan implementation.
5. Engage the media in state plan implementation activities via town hall meetings, press releases, and other events.

Objective 2: By August 31, 2015, convene one annual, in-person partnership meeting to review progress made on state plan implementation and identify priority areas for future action.

Rationale:

While ongoing information sharing provides tools for a clearer understanding of common interests, it must be accessible and timely to be useful. Coordinated information sharing is one strategy to enhance exchange of experiences, successes, and barriers to plan implementation.

Strategies:

1. Identify funding sources to support and coordinate partnership meetings and activities.
2. Establish a workgroup to assist with meeting planning coordination and logistics.
3. Explore use of web-based technology to increase meeting accessibility and participation.
4. Collaborate with partners to identify and increase statewide information sharing and reporting.
5. Develop reporting mechanisms to document progress in implementing initiatives (e.g. survey monkey, semi-annual progress reports).
6. Promote ongoing communication and collaboration among partners and stakeholders to advance the Texas Alzheimer's Disease Partnership (e.g., list serves, newsletters).

Goal V: Texas will improve state and local capacity to address Alzheimer's disease.

Objective 3: By August 31, 2015, improve statewide monitoring and surveillance of Alzheimer's disease in Texas.

Rationale:

Projections indicate that the Alzheimer's disease burden is expected to significantly increase in coming years. This will have a profound impact on families, healthcare systems, and state resources. For states to plan for the rapidly growing population of persons with Alzheimer's disease, reliable information about the demographics and needs of Texans who are coping with Alzheimer's disease is needed. To more accurately describe the impact of Alzheimer's disease in Texas, it is proposed that investigation, development, and implementation of surveillance measures to better assess the true burden of this disease in Texas begin now.

Strategies:

1. Create a statewide, multi-disciplinary group to identify Alzheimer's disease data and surveillance gaps in Texas.
2. Collaborate with partners to identify ongoing data needs, collection methods, reporting formats, and funding sources.
3. Continue to assimilate current data, monitor trends, track programs and policies, and recommend actions for improvement.
4. Support ongoing use of the Texas Behavioral Risk Factor Surveillance System to collect and analyze Alzheimer's disease data.
5. Disseminate data and encourage partners/stakeholders to promote Alzheimer's disease data collection in their program activities.

Objective 4: By August 31, 2015, develop one comprehensive, state sanctioned web-based repository that contains the most current information on prevention, risk factors, disease management, translational research and science, and family caregiver resources.

Rationale:

A key component of infrastructure is development and maintenance of a comprehensive web-based repository of Alzheimer's disease/dementia-related information. Emerging information in the field of Alzheimer's is at an all time high, and technology offers an unprecedented ability to access information in a timely manner. Therefore, consolidating this information into one accessible location and maintaining its accuracy will provide valuable resources to professionals and non-professionals alike.

Strategies:

1. Form a workgroup to identify information and resources for inclusion in the repository.
2. Identify opportunities for web-based collaborations with other organizations.
3. Pursue potential funding sources for design, development, implementation, and ongoing maintenance of the repository.
4. Establish a volunteer-based oversight/monitoring workgroup to recommend bi-annual repository updates.
5. Promote the repository to partners and stakeholders for use in their organizations.

Goal V: Texas will improve state and local capacity to address Alzheimer's disease.

Objective 5: By August 31, 2015, increase by 20 the number of organizations that include activities outlined in the 2010-2015 Texas State Plan on Alzheimer's Disease into their organizational programming.

Rationale:

Increasing numbers of agencies and organizations that include this plan's activities into their strategic planning will foster a resourced, capable, statewide infrastructure that increases the visibility of Alzheimer's disease in Texas. Through additional visibility and knowledge about Alzheimer's, a broader spectrum of partners and stakeholders will be encouraged to actively identify where their respective resources and potential contribution to better address Alzheimer's disease statewide and subsequently participate in its implementation.

Strategies:

1. Identify new and cost-effective ways to promote and disseminate the plan.
2. Identify system-level organizations and programs for state plan sponsorship.
3. Initiate meetings with state, local, and regional organizations to promote the state plan in fostering a comprehensive and coordinated approach to addressing Alzheimer's disease in Texas.
4. Facilitate formal and informal participation in joint collaborative promotional efforts with all appropriate organizations.
5. Maintain ongoing relationships with Texas organizations and actively work to increase the number that access and utilize the plan.
6. Encourage partners and partnerships to promote the plan in their program's activities and communications.

Invitation to Participate

If you are interested in joining the partnership as it moves forward on implementation of the 2010-2015 Texas State Plan on Alzheimer's Disease, please refer to staff contact information at:

www.dshs.state.tx.us/alzheimers/default.shtm.

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Executive Summary

Texas Council on Alzheimer's Disease and Related Disorders

Alzheimer's disease (AD) is the fastest-growing health threat in the country.[1] Out of the more than 5 million Americans with AD, 330,000 of those individuals are Texans.[2] The Texas Council on Alzheimer's Disease and Related Disorders (Council) was established in 1987 to serve as the State's advocate for persons with AD, their caregivers, and related professionals. HB 1066, 70th Legislature, Regular Session, 1987, requires the Council to submit to the Governor, Lt. Governor, Speaker of the House of Representatives, members of the Texas Legislature, the Long-Term Care Coordinating Council for the Elderly, and board, a Biennial Report of activities and recommendations.

This report documents highlights from fiscal years 2013 and 2014.

Progress in the Council's Work

During the past two years, the Council:

- Assisted the Texas Legislature with implementation of recommendations from House Resolution 1978 (82nd Regular Session, 2011), a joint interim study on the overall economic and systemic impact of Alzheimer's disease through 2017.
- Began to update the *Texas State Plan on Alzheimer's Disease* for 2015-2020.
- Published and disseminated the first Texas guidelines for the early detection, diagnosis, and pharmacological treatment of AD.
- Coordinated the activities of the Texas Alzheimer's Disease Partnership, a volunteer group of more than 150 individuals who actively advance the state plan and promote awareness of AD in Texas.
- Advanced strategies within the *2010-2015 Texas State Plan on Alzheimer's Disease.*
- Directed state-appropriated funds to the Texas Alzheimer's Research and Care Consortium (TARCC), as mandated, for AD research in Texas.

[1] Global Burden of Disease Study 2010, *Lancet*, 2012.
[2] Alzheimer's Association. *Alzheimer's Disease Facts and Figures 2014*.

Council Recommendations, FY 2015-2016

The Council has identified the following priority issues for the next biennium:

- Sustain and support ongoing research efforts to identify modifiable risk factors to help delay the onset of, prevent, and/or cure AD.

- Increase collaborative AD research among Texas researchers.

- Advance Texas' infrastructure and capacity to be commensurate with the state's increasing burden of AD through creating both public and private innovative partnerships.

- Optimize the system of care and support for AD caregivers.

- Update the *Texas State Plan on Alzheimer's Disease* for 2015-2020 to reflect the importance of evidence-based approaches to prevention and treatment.

- Continue to engage in strategic collaboration with Texas researchers, clinicians, directors of AD research centers and centers on aging, medical schools, medical professionals, state public health experts, and community partners.

Introduction

Statutory Requirement

Pursuant to HB 1066, 70th Legislature, Regular Session, 1987, which was codified in §101.010, Texas Health and Safety Code, "before September 1 of each even-numbered year, the council shall submit a biennial report of the council's activities and recommendations to the governor, lieutenant governor, speaker of the house of representatives, members of the legislature, Long-Term Care Coordinating Council for the Elderly, and board."

The report highlights the Council's activities as members discharge their legislative mandate by:

- Recommending needed action for the benefit of persons with AD and related disorders and their caregivers.

- Encouraging public and private family support networking systems for primary family caregivers.

- Disseminating information on services and related activities for persons with AD and related disorders to the medical and healthcare community, the academic community, primary family caregivers, advocacy associations, and the public.

- Actively participating in and making recommendations to interagency workgroups that promote successful aging for Texans.

- Encouraging research to benefit victims of AD and related disorders.

- Facilitating coordination of state agency services and activities relating to victims of AD and related disorders.

Background

Creation of the Council

Recognizing the growing problem of age-related neurodegenerative diseases, the 70th Texas Legislature passed House Bill 1066 in 1987 (Chapter 101, Texas Health and Safety Code), creating the Texas Council on Alzheimer's Disease and Related Disorders. The Council was established to serve as the State's advocate for persons with AD, their caregivers, and related professionals.

Specifically, the Council increases awareness of AD and its impact on Texans, participates as a strategic partner and coordinating body for statewide education, provides supervision and direction on state research activities related to AD, and supports policies and programs that benefit people with AD and their caregivers.

Council Activities

Awareness and Education

Websites

DSHS maintains a website containing information on AD, warning signs, diagnosis, treatment, legal and financial issues, options for care, and information on licensed nursing and assisted living facilities certified for AD care. Council meeting agendas and minutes, and helpful toll-free phone numbers and internet links are also available on the DSHS Alzheimer's Disease Program's website at www.dshs.state.tx.us/alzheimers/default.shtm.

Under the supervision of the Council, TARCC maintains a website with information and updates on research activities, information on TARCC institutions and committees, publications, research recruitment opportunities, contact information, and AD statistics and resources. This website can be accessed at http://www.txalzresearch.org/.

Toll-Free Helpline

Since its inception in 1987, the Council has worked to develop a growing awareness of the tremendous impact AD and related disorders have on individuals, families, and society. DSHS maintains a toll-free information helpline (1-800-242-3399) to provide information, support, and referrals to local community services.

Advocacy

The Council, in its continued efforts to advocate on behalf of individuals with AD and their families, provides guidance to community and state agencies on program and policy development.

Statewide Strategic Planning

Recognizing that AD is a growing public health concern, the Council and the DSHS Alzheimer's Disease Program began formal work in 2009 on the development of the *2010-2015 Texas State Plan on Alzheimer's Disease*, the first comprehensive state plan to address the current and future burden of AD on our state. Knowing that this work would require partners and stakeholders from state, local, and community level organizations; academic and research institutions; for-profit and non-profit sectors; businesses; the healthcare sector; and family members of individuals afflicted with AD, the Council and DSHS formed the Texas Alzheimer's Disease Partnership. This partnership is a volunteer group comprised of individuals with diverse backgrounds and rich and varied experiences, which provided the synergy and expertise to create a strategic blueprint for formulating and implementing a comprehensive and coordinated statewide plan for Texas. The state plan will be updated over the next fiscal year and will reflect the importance of evidence-based approaches to prevention and treatment.

In February 2013, the Council and the DSHS Alzheimer's Disease Program, with the help and review of many dedicated volunteers of the Texas Alzheimer's Disease Partnership, developed and released AD management guidelines titled *Clinical Best Practices for the Early Detection, Diagnosis, and Pharmaceutical and Non-Pharmaceutical Treatment of Persons with Alzheimer's Disease*. These guidelines were developed and peer-reviewed by a group of AD experts working to meet the disease management objectives of the *2010-2015 Texas State Plan on Alzheimer's Disease*. The hope is that these guidelines will help improve the quality of life of those living with this disease and those who provide care to them. These guidelines can be accessed at *Clinical Best Practices for the Early Detection, Diagnosis, and Pharmaceutical and Non-Pharmaceutical Treatment of Persons with Alzheimer's Disease*.

Partnership Development

Meeting the challenges of caregiving requires many resources. The Council, in its efforts to coordinate, collaborate, and support AD-related services and programs throughout the state, is engaged in developing partnerships with service organizations, health organizations, commissions, and aging-related agencies. Council members and DSHS staff serve on boards as well as advisory and planning committees to guide the direction and promotion of programs designed to assist individuals with AD and their caregivers. The caregiver support activities of the Texas Department of Aging and Disability Services (DADS), the Texas Respite Coalition, the Silver Alert Program, and the Aging Texas Well Advisory Committee are examples of ongoing collaborations and support. DADS and its 28 Area Agencies on Aging (AAAs) form a statewide network to provide comprehensive information and services for caregivers. The Council assists DADS by serving as a resource, providing referrals, and marketing caregiver activities through the DSHS website.

Coordinated Alzheimer's Disease Research

Darrell K. Royal Texas Alzheimer's Initiative

In October 2012, Council members unanimously voted to rename all funded AD efforts under their purview to the Darrell K. Royal Texas Alzheimer's Initiative. This initiative is committed to fostering excellence in research through the legislatively-mandated TARCC; addressing the burden of AD in Texas through statewide strategic planning; promoting collaborative research projects among Texas AD researchers; and coordinating/supporting other state-funded activities as they relate to AD.

Conclusions

Council Recommendations, FY 2015-2016

As the state's appointed advocate for persons with AD, their caregivers, and related professionals, the Council respectfully submits the following recommendations:

1. **Coordinated Alzheimer's Disease Research**
   The Council requests continued recognition and support of coordinated statewide research, as was demonstrated by the Texas Legislature when it passed House Bill 1504, 76th Legislature, 1999, (Chapter 154 of the Texas Education Code) establishing the Texas Consortium of Alzheimer's Disease Centers. The Consortium, later named Texas Alzheimer's Research and Care Consortium (TARCC) by the Council, provides Texas with the infrastructure for sharing vital AD research and clinical outcomes. It provides a framework for expanding and expediting the search for answers about the causes, methods to delay onset and stop disease progression, and eventual prevention and cure of AD.

2. **Increased Collaborative Research among Texas AD Researchers**
   Increasing collaboration in AD research across public, private, state, and federal sectors that cut across disciplines is needed to quicken discovery. Behavioral modifications, such as diet and exercise, and pharmacological interventions must be integrated in order to develop therapies aimed at AD prevention. This type of multi-disciplinary research, typically not funded by national health and science foundations, offers significant opportunities to study disease progression and advance therapeutic strategies. The Council supports using outcome-oriented research projects backed by appropriate funding mechanisms and active collaboration among Texas researchers to identify preventions and therapies.

3. **Continued Support for Quality Long-Term Care**
   The Council supports maintaining or increasing current levels of nursing-facility eligibility for people with cognitive impairments, specifically AD and other related dementias. The Council requests maintaining or increasing Resource Utilization Groups (RUGS), based on the level of need, to accommodate higher levels of reimbursement for facilities that care for persons with cognitive impairments.

4. **Expanded Community-Based Programs and Services**
   The Council recommends expansion and optimization of home and community-based programs and services for individuals with AD and their caregivers. The Council recommends the expanded availability of affordable respite care, training for caregivers, and other resources to maintain the integrity of the family caregiving system. Elimination of the Community Alzheimer's Resources and Education program left a significant gap in these services for families who need them most. Because family caregivers provide most care, expanding these resources will afford caregivers much needed services to assist them in caring for their loved ones with AD.

5. **Update the *Texas State Plan on Alzheimer's Disease* for 2015-2020**
   The Council recommends that the state plan be updated to reflect the importance of evidence-based approaches to prevention and treatment. The activities outlined in the current state plan will be enhanced for 2015-2020 to reflect the increasing need to coordinate caregiver support and evidence-based public health information that covers the many aspects of AD. The 2015-2020 state plan will provide the strategic blueprint that, when fully implemented, will enable Texas to better address the complex issues associated with the increasing prevalence of this disease. Texas requires greater capacity to address the huge economic and human toll AD places on our valuable resources and citizens. Limited and competing resources must be carefully directed at comprehensive and coordinated statewide strategic planning. The state of Texas must remain proactive in the face of the burgeoning epidemic of AD.

6. **Engage in Strategic Collaborations**
   The Council recognizes the importance of establishing and maintaining collaborative relationships with experts in AD. The Council and the DSHS Alzheimer's Disease Program will continue to engage in strategic collaboration with Texas researchers, clinicians, directors of AD research centers and centers on aging, medical schools, medical professionals, state public health experts, and community partners.

Appendix A: Council Roster

The Texas Council on Alzheimer's Disease and Related Disorders (Council) is composed of 17 members including 12 voting members who are appointed by the Governor, Lieutenant Governor, and Speaker of the House. Five non-voting members represent the Health and Human Services Commission (HHSC), Department of State Health Services (DSHS), and Department of Aging and Disability Services (DADS).

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Appendix B: Coordinated Alzheimer's Disease Research

Texas Alzheimer's Research and Care Consortium (TARCC)

TARCC, established and supervised by the Council, is part of the state-funded Darrell K. Royal Texas Alzheimer's Initiative. The Texas Legislature made history in 2005 by approving the first state-level appropriation for AD research in the nation. This initial $2 million investment provided start-up funding for TARCC, a collaborative research effort without precedence in Texas. The Council, by statute, established a consortium of AD centers among four of Texas' leading medical institutions: Texas Tech University Health Sciences Center (Texas Tech), University of North Texas Health Science Center (UNTHSC), the University of Texas Southwestern Medical Center at Dallas (UT Southwestern), and Baylor College of Medicine (BCM). In 2007, the Texas Legislature nearly doubled the state's initial investment in TARCC. This made it possible to recruit 500 Texans with AD and 300 healthy control subjects into the Texas Harris Alzheimer's Study to participate in cutting-edge biomedical research. Participants regularly undergo a battery of tests and provide annual blood and DNA samples at TARCC member sites. The resulting uniformly-collected clinical, neurocognitive, and laboratory data is combined in the centralized Texas Alzheimer's Data Bank based at UT Southwestern. Participants are assigned a unique number at the TARCC site when enrolled. Central data are de-identified in a HIPAA-compliant manner.

TARCC has established the first Texas bio-bank of stored blood, tissue, and DNA to support current and future AD research studies. Researchers across the state are able to utilize these unique Texas resources to answer specific questions about AD, both now and in the future, as new information leads to new ideas. In 2008, the Council expanded the reach of AD research into South Texas by adding the University of Texas Health Science Center – San Antonio to TARCC. This move, coupled with the 2009 state appropriation of $6.85 million, enabled TARCC to begin including a large number of Hispanic individuals into the Texas Harris Alzheimer's Study. One third of Texans are Hispanic, and according to the Texas State Data Center, Texas will become a majority Hispanic state between 2020 and 2035. The inclusion of underrepresented Hispanics significantly strengthens AD research efforts in Texas and uniquely positions Texas to assume a national leadership role in this largely untapped area of AD research. Funding for the fiscal year 2014/2015 biennium was increased to $9.2 million and will allow TARCC to expand its research efforts. Through Council action in January 2013, Texas A&M University Health Science Center was added as the sixth member of TARCC.

TARCC'S Current Research Objectives

Collaboration among TARCC institutions has resulted in a unique resource, the Texas Harris Alzheimer's Research Study. This resource includes data and biological samples gathered from more than 2800 participants diagnosed with AD or mild cognitive impairment, as well as from healthy controls. A novel and important strength of TARCC is the longitudinal nature of this study, where patients are followed annually, and standardized clinical, neuropsychiatric, genetic, and blood biomarker data are collected. Analysis of the longitudinal data set enables TARCC investigators to model changes in cognitive function over time, allowing identification of factors that affect not only risk, but disease progression. The inclusion of individuals diagnosed with

mild cognitive impairment is useful for understanding the sequence of neurodegenerative changes that occur as AD develops. Current research objectives being examined are described below.

- **Identify** genetic factors that affect the development of AD in Hispanic and non-Hispanic Europeans. Hispanics are the fastest-growing ethnic group in Texas and are projected to represent a majority of the state's population by 2020. Very little is known about AD in this population. TARCC is an invaluable resource to state and national AD research efforts because of the genetic and biomarker material collected from a large number of Hispanics.

- **Discover** the underlying biochemical factors and cellular mechanisms that affect disease progression. Identifying the specific cellular and biochemical changes linked to disease progression will shed light on how AD develops and could lead to the development of new drugs and therapies that will improve quality of life of patients with AD and may also diminish the risk of developing this disease.

- **Expand** enrollment into the Texas Harris Alzheimer's Research Study of individuals diagnosed with probable AD and mild cognitive impairment. As scientific progress moves forward, there is an emphasis on developing early markers to identify those individuals most at risk for AD. Expanding the Texas Harris Alzheimer's Research Study to include a large number of participants with probable AD and mild cognitive impairment will provide new insights into the development of the disease and suggest tools for early diagnosis as well as highlight novel therapeutic options.

TARCC's research activities are reviewed by an external advisory committee comprised of five internationally recognized leaders in AD research who ensure that TARCC adheres to the highest quality research standards and pursues a direction with the greatest potential to break new ground in AD research.

TARCC Achievements

Each TARCC site recruits individuals who are diagnosed with AD, mild cognitive impairment, or healthy aging controls. Blood samples of TARCC participants undergo advanced analyses of proteins, metabolic, and genetic data. Demographic information, clinical histories, and neuropsychological functioning are also assessed. To date, TARCC has enrolled 2857 participants, of which 1824 are currently active, into the Texas Harris Alzheimer's Research Study. Active participants include 462 patients with a primary diagnosis of AD, 909 cognitively normal individuals, and 453 subjects with mild cognitive impairment. These numbers include 818 Hispanic individuals. Given this impressive success and current patient accrual rates, TARCC is ahead of schedule to meet its target of active participants by August 2015.

All blood samples are sent to the University of Texas Southwestern Medical Center for processing, DNA extraction, handling, and storage in TARCC's dedicated bio-banking facility. This facility is also responsible for preparing and shipping samples for all laboratory analyses. Tracking of all tissue samples through all steps is facilitated by the software program Freezerworks to ensure this valuable resource is maintained for current research interests as well

as for future projects that require stored DNA, whole blood, plasma, and serum on a cohort of well-characterized individuals.

TARCC researchers have been highly productive, producing cutting-edge science and reporting important scientific discoveries. In the past biennium, TARCC researchers have published more than two dozen important papers in high-profile AD journals. These studies provide novel insights into how AD develops as well as how this disease could be effectively treated. A brief summary of these studies is presented below.

- **Improving diagnosis of AD in rural populations.** TARCC scientists published a study in the Journal of Alzheimer's Disease that described a new marker derived from neuropsychological tests that was characterized in subjects participating in the TARCC research study. The data derived from this study could help with AD diagnosis in rural or other underserved populations without ready access to state-of-the-art neurology care.

- **Validating new blood test for diagnosing AD.** TARCC researchers have developed a novel blood test for Alzheimer's that uses state-of-the-art microarray analysis of serum proteins to predict disease.The data generated suggests a novel biomarker algorithm is highly sensitive and specific for correctly classifying AD. TARCC investigators have received $640,000 from the National Institutes of Health to further validate these findings.

- **Identifying links between cardiovascular risk factors and AD.** Increasing research evidence suggests that cardiovascular risk factors play a role in the development of AD. In particular, inflammatory proteins, which are elevated in response to cardiovascular risk factors, have been implicated in AD development. TARCC researchers are at the forefront of defining how inflammatory proteins can be used for diagnosing AD as well as how they may be targeted for therapeutic intervention.

- **Inclusion of Texas A&M University Health Science Center (TAMUHSC) in TARCC.** The inclusion of TAMUHSC into TARCC has expanded new scientific avenues in AD research. TAMUHSC faculty are currently studying AD development and working on markers for earlier detection, as well as testing specific drugs to prevent or eliminate the disease. Research also is being conducted on the impact of lifestyle and the environment on health and disease.

An Early Return on the State's Investment

The creation of TARCC has set a collaborative-model standard for scientific endeavors statewide. The synergy of six institutions bringing clinicians and scientists together to focus on AD has resulted in enhanced research output and increased research infrastructure devoted to AD. These accomplishments are critical to Texas' role as an emerging leader in AD research.

TARCC-based AD research benefits the state by contributing to new advances in AD diagnosis, risk assessment, and therapeutic interventions.

- **New advances in AD diagnosis.** Using a multidisciplinary/translational approach, that includes blood biomarkers, genetic material, imaging, and neurocognitive data, as well as

psychological, neuropsychological, behavioral, and general medical information, Texas researchers are working to develop new methods for early detection of AD.

- **New approaches to risk assessment.** TARCC scientists are using advances created by Texas-based research initiatives to develop new treatments that address a patient's individual AD "profile," as defined by specific genetic, blood biomarkers, and general medical, behavioral, psychiatric, and other risk factors.

- **New insights into therapeutic interventions.** While great progress has been made, researchers are still searching for definitive answers to questions about the basic mechanisms underlying AD. TARCC researchers are at the forefront of defining how inflammatory proteins can be used for diagnosing AD as well as targeted for therapeutic interventions. Advancing greater understanding of these mechanisms through basic research can benefit Texas by expanding the pipeline of scientific discovery and identifying additional targets for treatment.

Appendix C: Alzheimer's Disease Background

Alzheimer's Disease - An Urgent National Health and Research Priority

The Burden of AD

AD is an age-related, progressive and irreversible brain disease characterized by a steady decline in cognitive, behavioral, and physical abilities severe enough to interfere with daily life. Hallmark symptoms of AD are memory loss, disorientation, and diminished thinking ability followed by a downward spiral that includes problems with verbal expression, analytical ability, frustration, irritability, and agitation. As the disease progresses, physical manifestations include loss of strength and balance, and the inability to perform simple tasks and physical activities. As cognitive and functional abilities decline, individuals are rendered totally dependent on others for all of their care. As more of the brain becomes affected, areas that control basic life functions like swallowing and breathing become irreversibly damaged, eventually leading to death. Currently, there is no effective prevention, treatment, or cure for AD. New criteria and guidelines for diagnosing AD were proposed and published in 2011, recommending that AD be considered a disease that begins well before the development of symptoms.[3]

AD affects over 5 million Americans today - 330,000 of those individuals are Texans. It is the sixth leading cause of death in the U.S. and has an economic burden of $214 billion annually. Texas ranks fourth in the number of AD cases and second in the number of AD deaths. A new person develops AD every 67 seconds, and current projections indicate that this rate will increase to one new case every 33 seconds by 2050. According to the 2014 Alzheimer's Association, Women and Alzheimer's poll, women are the epicenter of AD. Nearly 3.2 million of the estimated 5 million with AD are women, and women are more likely to have other dementias.[4]

In 2013, there were an estimated 15 million unpaid caregivers in the U.S., most of whom were family members. In Texas, 1.3 million unpaid caregivers provided care to the 330,000 individuals with AD in 2013. This equates to 1.5 billion hours of unpaid care at a cost of $18.5 billion per year.[5] Total payments for healthcare, long-term care, and hospice care for individuals with AD and other dementias are projected to increase from $214 billion in 2014 to $1.2 trillion in 2050 (in 2014 dollars).[6]

Progress Through Research and Advocacy

Research continues to expand our understanding of the causes of, treatments for, and prevention of AD.[7] Scientists have identified genetic and biological changes that occur with AD, allowing them to pinpoint possible targets for treatment. Advances in pharmacologic treatment may stabilize and delay progression of AD symptoms. This delay in progression helps contain costs

[3] Alzheimer's Association. *Alzheimer's Disease Facts and Figures 2014*.
[4] Alzheimer's Association. *Alzheimer's Disease Facts and Figures 2014*.
[5] Alzheimer's Association. *Alzheimer's Disease Facts and Figures 2014*.
[6] Alzheimer's Association. *Alzheimer's Disease Facts and Figures 2014*.
[7] National Plan to Address Alzheimer's Disease, U.S. Department of Health and Human Services, 2012.

associated with medical and long-term care, eases caregiver burden, and allows the individual with AD the opportunity to participate more fully in life and postpone inevitable dependency.

Public Health Challenge and Research Priority

AD is a major public health and research challenge because of its detrimental effects on the health and well-being of the nation's population. Because there is no cure for AD, the importance of early detection becomes even more critical - the earlier the diagnosis is made, the more likely the individual may respond to treatment. Despite its importance, significant barriers remain to early detection. A missed or delayed diagnosis of AD can lead to unnecessary burdens on the individual and their caregivers.

Ongoing research efforts to find causes and identify risk factors to delay onset and prevent and cure AD are imperative. As methodologies are refined, scientists and clinicians will be able to investigate and understand the earliest pathological and clinical signs of AD – perhaps 10 to 20 years before a clinical diagnosis is made. Drug development to block the progression of symptoms and eventually prevent AD is critical to decreasing disability and death, containing healthcare costs, and protecting individuals and families.

Increased support for individuals with AD and their caregivers is crucial. Stakeholders must continue to advocate for community and home-based care and community supports for caregivers, because these programs afford caregivers the assistance they need to help care for their loved ones at home.

Expediting statewide, coordinated action to address AD in Texas remains critical as the prevalence of the disease continues to climb, exacting huge human and economic burdens on Texas citizens and resources. The *2010-2015 Texas State Plan on Alzheimer's Disease* makes a compelling case for increased and coordinated statewide action and provides a clear roadmap for addressing the significant issues AD imposes on Texas. Continued implementation of the state plan will greatly benefit Texans by guiding the state in its efforts to reduce the burden of AD on our citizens and those who care for them.

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Texas Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Texas Council on Cardiovascular Disease and Stroke (TCCVDS)

Number of Members: 11 voting members; 3 non-voting agency representative members

Committee Status (Ongoing or Inactive): Ongoing

Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 9/1/1999 **Date to Be Abolished:** N/A

Budget Strategy (Strategies) (e.g. 1-2-4): A.3.1 **Strategy Title (e.g. Occupational Licensing):** Chronic Disease Prevention

Budget Strategy (Strategies): **Strategy Title:**

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Chapter 93, Health & Safety Code
State Authority	Admin Code	25 TAC, Sec. 1051.1
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$4,172	$5,000	$5,000
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$4,172	$5,000	$5,000

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$8,860	$8,860	$8,860
Number of FTEs	0.2	0.2	0.2
Other Operating Costs	$8,500	$10,000	$10,000
Total, Committee Expenditures	$17,360	$18,860	$18,860

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	$21,532	$23,860	$23,860
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year

Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
4	4	4

Committee Description: Develop a plan to reduce the morbidity, mortality, and economic burden of cardiovascular disease and stroke in Texas. Conduct health education, public awareness, and community outreach. Coordinate activities among agencies to improve access to treatment. Develop a database of recommendations for treatment and care. Collect and analyze information related to cardiovascular disease and stroke.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

Council meets quarterly in Austin. The statute requires the Council to meet at least quarterly.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

Developed (and will update in 2016) an effective and resource-efficient plan to reduce the morbidity, mortality, and economic burden of cardiovascular disease (CVD) and stroke in Texas addressing all required components (1-10). (Texas Plan to Reduce Cardiovascular Disease and Stroke 2013-2017. Publication Number: 81-11195); Advises the legislature on recommendations to develop and maintain a state-wide system of quality education services for all persons with CVD and stroke; Collaborates with the Governor's EMS and Trauma Advisory Council, the American Stroke Association, and other stroke experts to make recommendations to the department for rules on the recognition and rapid transportation of stroke patients to health care facilities capable of treating strokes 24 hours a day and recording stroke patient outcomes.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

Council members recommended a list of heart attack and stroke data elements to be included in the Rider 67/Heart Attack and Stroke Data Collection Initiative. These recommendations were adopted by DSHS. The Council recommended the development of a hospital recognition program. DSHS has adopted the recommendation and will implement in FY17.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ? Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees? No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015? 250.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Providing support for quarterly Council meetings (developing agenda, securing meeting space, etc.), providing support for Council sub-committee meetings and activities and convening the Council and supporting the development of the state plan.

6. Have there been instances where the committee was unable to meet because a quorum was not present? Yes

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

All Council meetings are posted to in the Texas Register according to Open Meetings Act.

7b. Do members of the public attend at least 50 percent of all committee meetings? Yes

7c. Are there instances where no members of the public attended meetings? No

8. Please list any external stakeholders you recommend we contact regarding this committee.

American Heart Association; Governor's EMS and Trauma Advisory Council; Texas Heart Attack Coalition; Regional Advisory Councils

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals? Yes

9b. Please describe the rationale for this opinion.

The Council has met its mission as outlined in statute. Additionally, the Council provided recommendations during the 83rd and 84th legislative sessions regarding stroke and heart attack systems of care funding (Rider 97 and Rider 67 respectively). The Council has been integral in the implementation of activities related to Rider 97 and 67 during Fiscal Years 2014-2016.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute? No

10b. Does the scope and language found in statute for this committee prevent your agency from responding to No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

The council provides valuable stakeholder input that the agency uses to implement its policies and programs.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

Texas Council on Cardiovascular Disease and Stroke

Texas Department of State Health Services

1100 W 49th Street, Austin, TX 78756

Moreton Building, Room 100

Saturday, February 7, 2015

Meeting Minutes

1.	**Call to Order** The meeting of the Texas Council on Cardiovascular Disease and Stroke (TCCVDS) was called to order at 1:00 pm by Neal Rutledge, MD, Chair.
2.	**Roll Call** **Council members present:** Pam Akins JD, Suzanne Hildebrand, Bob Hillert MD, Floristene Johnson MS, RD/LD, Diane Himmel, LPC, Suzanne Monsour, Roberto Rodriguez MD, Neal Rutledge MD **Members absent:** Lisa Glenn, Paula Gomez, Michael Hawkins MD, Cheryle Locke, Ann Quinn Todd RN, MSN **Guests:** Lisa Hutchison (Chair, Texas Cardiovascular Disease and Stroke Partnership), Robert Wozniak MD (Governor's EMS and Trauma Advisory Council Cardiac Care Committee and Texas Heart Attack Coalition), Kaitlyn Murphy (American Heart Association Senior Government Relations Director for Texas), Steven Warach MD PhD (Lone Star Stroke Consortium), Cherie Boxberger (American Heart Association Senior Director of Quality and System Improvement) **Other DSHS representatives present:** Suparna Bagchi MSPH, DrPH, Carleigh Baudoin MPH, Nimisha Bhakta, Cecily Brea MEd, Patty Moore, PhD, Katie Wiechnicki RN, MPH
3.	**Approval of Minutes** **Motion to approve** meeting minutes from February 8, 2014 and November 7, 2014 by Ms. Akins **Seconded** by Ms. Hildebrand **Motion carried**
4.	**Presentations, Reports and Updates** **<u>Comments from the Chair</u>** • Dr. Rutledge reported that there are three vacant Council positions, including the Licensed Physician in Primary Care, Consumer Member, and Registered Nurse • Diane Himmel, LPC, was introduced as the new Department of Assistive and Rehabilitative Services (DARS) representative to the Council, replacing Jan Skinner • Dr. Rutledge reported that the Council's report was distributed to each legislator and that it has been well received. • Dr. Rutledge stated that the Council now has a budget account to accept and spend funds on heart disease and stroke initiatives

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State Agency Updates

- **Department of State Health Services (DSHS):** Dr. Rodriguez shared that Commissioner Dr. David Lakey left the agency at the end of January and that Kirk Cole is the interim Commissioner. Dr. Rodriguez stated that legislative session is underway and currently all of the proposed exceptional items for the DSHS Health Promotion and Chronic Disease Prevention Section are still intact. House and Senate finance committee hearings are upcoming, and Sunset hearings are ongoing.
    - Dr. Rutledge asked whether DSHS would move under Health and Human Services Commission through the proposed Sunset recommendation for reorganization. Dr. Rodriguez confirmed that that is the recommendation and stated that those conversations are still in progress and nothing further is known at this time.

- **Department of Aging and Disability Services (DADS):** No report.

- **Department of Assistive and Rehabilitative Services:** Ms. Himmel shared highlights from the agency's 2014 annual report. Dr. Hillert asked for the rate of eligible stroke patients who return to work. Ms. Himmel stated that she will provide that information to the Council.

Standing Reports

- **Cardiovascular Disease and Stroke Partnership:** Ms. Hutchison introduced herself as the new Chair of the Partnership. Ms. Hutchison stated that the Chair position is now a two-year term to allow for more work to be done. The Partnership is changing its goals to support the Council with a heavy focus on prevention. Ms. Hutchison shared that the Partnership will host a conference call at the end of this month and a face to face meeting will take place in May.

- **Governor's EMS and Trauma Advisory Council (GETAC) Cardiac Care Committee:** Dr. Wozniak stated that the GETAC Cardiac Care Committee met in November. Recommendations and priorities discussed at the November meeting included: requiring STEMI as a reportable disease in Texas; providing a framework for STEMI systems of care; promoting pre-hospital STEMI data collection and continuing hospital data collection; identifying ways to improve funding for pre-hospital response to STEMI; reviewing the landscape of STEMI in Texas, including less mature systems or STEMI referring hospitals; and promoting regional reports for Regional Advisory Councils.

- **Texas Heart Attack Coalition:** Dr. Wozniak stated that this Coalition is a group of individuals representing a variety of disciples to raise the level of heart attack care through legislation. The Coalition supports efforts to provide funding and attention to improve heart attack care.
    - Dr. Hillert asked if the Coalition's focus is on a Regional Advisory Council-driven approach; Dr. Wozniak responded that their focus is on improving pre-hospital heart attack care and response.

- **American Heart Association (AHA):** Ms. Murphy stated that the AHA advocacy work is divided into three areas: tobacco control, obesity prevention and improving systems of

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care. In tobacco prevention, AHA is working on local smoke-free initiatives in Fort Worth, Irving, Denton, Waco and Lubbock. The AHA is advocating for DSHS exceptional item numbers one and nine, which would increase the state's tobacco prevention funding. In obesity prevention, AHA is supporting a healthy vending initiative for state agencies, a healthy food financing initiative, a coordinated school health initiative, and shared use promotion. For improving systems of care, AHA is supporting stroke and STEMI data collection through the maintenance or increase of funding for this initiative.

- Dr. Hillert asked whether there will be challenges to gains made in creating healthy school environments with Susan Combs leaving her position. Ms. Murphy responded that it is a loss to lose an advocate but that Ms. Combs continues to engage in committees related to coordinated school health.
- Ms. Johnson asked for an update on the Million Hearts® initiative, which was provided by DSHS staff, Ms. Baudoin.
- Dr. Hillert asked whether AHA is involved in the Texas Heart Attack Coalition's proposal to fund Regional Advisory Councils to improve systems of care. Ms. Murphy responded that AHA is involved in the THAC but that the specific proposal is not one of AHA's main priorities. Ms. Murphy stated that AHA would work with partners to try to support the proposal.
- Ms. Monsour asked whether AHA's proposal to improve systems of care includes involving local hospitals to coordinate with local EMS. Ms. Murphy responded that this was not included in the current proposal but that AHA could look into it. Dr. Hillert stated that this coordination is critical to the Mission: Lifeline program but it is a major challenge in rural systems. Ms. Monsour added that coordination in rural systems can be very successful.
- Dr. Rutledge asked whether AHA has a map of the distribution of smoke-free cities and smoking prevalence in Texas. Ms. Murphy responded that she could get the map from Smoke Free Texas to share with the Council.
- Ms. Akins asked for an update on CPR in schools. Ms. Murphy responded that CPR in schools is currently be implemented in most schools across Texas but that some schools have had challenges because of scheduling issues. Ms. Murphy stated that she could provide more updates to the Council.

- **Lone Star Stroke Consortium:** Dr. Warach shared a written report with the Council on updates and plans for next year including the continuation of three approved studies, consideration of additional studies, expanding the network in rural settings to include regional hubs, and including a broader group of patient advocacy groups. Two hubs are currently actively enrolling patients in an international clinical trial, CLOTBUST-ER; enrollment is anticipated to be complete this summer.
  - Dr. Hillert asked what percentage of the $4.5 million was used on organizational administrative costs and how much additional research money has the effort generated beyond the $4.5 million. Dr. Warach responded that activities were not started until late in the fiscal year due to contractual delays so that most funding spent to date has been on start-up and administrative costs. The CLOTBUST-ER study does leverage the network to bring in funding from a device company. One of the long-term goals is to leverage this network with NIH StrokeNet network to look at clinical trials across the nation.
  - Ms. Hildebrand asked for a breakdown of how the $4.5 million has been spent to date, including start-up and administrative costs. Dr. Warach responded that the

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University of Texas (UT) System as the fiscal agent would have that data and Dr. Warach will discuss that with UT. Ms. Hildebrand clarified whether there have been any additional funds brought into the Consortium to date; Dr. Warach responded that there is funding for the CLOSTBUST-ER study and funding from Genentech to pilot a study on new technology.

- Dr. Rutledge asked whether teleneurology is in place in all of the hubs and spokes. Dr. Warach responded that teleneurology is in place at most of the sites but not all, due to contracting delays with the spokes. Dr. Warach stated that he could provide the exact number to the Council.
- Dr. Rutledge asked what the maintenance for teleneurology units costs. Dr. Warach stated that units vary in cost by vendor but estimated a unit cost of $20,000 to $25,000 and a couple of thousand dollars per year in maintenance. Dr. Warach said that he could provide a more specific estimate.

- **Chronic Care Subcommittee:** Ms. Johnson reported that Dr. Rutledge led a conference call meeting of the subcommittee this week. Ms. Johnson listed two chronic care priorities of the Council's legislative report, including a Texas Speech Remediation Program and a DARS Stroke Program. Ms. Johnson also discussed a potential reward program for stroke rehabilitation centers, hosting a stakeholder meeting for caregivers and rehabilitation center staff to discuss needs related to chronic care for stroke, developing a document related to the need for stroke resources especially during discharge planning, and better integrating stroke resources into existing DADS website resources for caregivers.
  - Dr. Rutledge asked whether the Council had any suggestions on how to convene a stakeholder group to get feedback on chronic care needs for stroke. Ms. Hildebrand offered to connect the Council to social workers with the Stroke Support Program at the University Hospital in San Antonio.

- **Governor's EMS and Trauma Advisory Council (GETAC) Stroke Committee:** Dr. Rutledge stated that the Committee made recommendations on three issues: 1) to use the Brain Attack Coalition's guidelines for the state certification of Level III (stroke ready) hospitals; 2) to move from a time-based approach for stroke transport plans to a severity grade-based approach; and 3) hours and materials for stroke education for first responders and EMS personnel.

DSHS Heart and Stroke Program Staff Updates

- **DSHS Heart Disease and Stroke Program:** Ms. Baudoin gave an overview and update on the 1305, Prevention and Control grant from the Centers for Disease Control and Prevention, which funds the Heart Disease and Stroke Program, the Diabetes Program, School Health Program, and the Community and Worksite Wellness Program through a joint work plan to reduce the burden of heart disease, diabetes and obesity. Ms. Baudoin reported on four specific activities including: 1) a contract with the North Texas Regional Extension Center to provide technical assistance to health systems on the use of electronic health records and health information technology to improve the quality of care for patients with high blood pressure and diabetes; 2) collaboration with TMF Quality Improvement Organization and North East Texas Public Health District to increase blood pressure control through the use of home blood pressure monitors in DSHS Health Service Region 4/5N; and 3) hosting a Grand Rounds session in April on using health information

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technology to improve blood pressure and diabetes control.

- Dr. Hillert asked whether the Program purchased Behavioral Risk Factor and Surveillance System surveys this year. Ms. Baudoin responded that this year's survey will include the Actions to Control Blood Pressure module and core questions related to hypertension control.
- Dr. Hillert asked whether data from previous years is available. Ms. Baudoin responded that DSHS has just received the 2013 data files and can present that data at the next Council meeting.

- **Rider 97:** Dr. Rodriguez stated that the first analysis of hospital level data is complete. The stroke and heart attack hospital performance measure reports have been uploaded to the Texas Heart Disease and Stroke Program website. The link to these reports has been shared with stakeholders including Rider 97 data consultants, American Heart Association, hospitals, the Regional Advisory Councils, Governor's EMS Trauma Advisory Council, and the Texas Council on Cardiovascular Disease and Stroke. Quarter 3 regional and hospital data is currently being analyzed and reports are anticipated to be finalized and shared with stakeholders in March. The Program is continuing to increase participation in the initiative with about 50 hospitals participating in the cardiac report and 41 hospitals participating in the stroke report. The Program will continue to work with the Council on marketing the initiative to hospitals.
  - Dr. Rutledge requested that DSHS provide printed reports for the upcoming GETAC meetings.

Presentations (available upon request)

- Texas Healthy Community Program by Ms. Brea
  - Dr. Rutledge requested that DSHS include a map of the Texas Healthy Communities color-coded by award level on the Program website
  - Dr. Hillert suggested coordinating Texas Healthy Communities Program efforts with Million Hearts® and Regional Advisory Council activities
- Rider 97 Data by Dr. Rodriguez and Dr. Bagchi
  - Dr. Hillert asked about the number patients receiving endovascular treatment. Dr. Bagchi and Dr. Rodriguez responded that this will be included in the next report.
  - Dr. Rutledge requested a copy of slides and reports for the upcoming GETAC meetings.
  - Dr. Hillert shared that there needs to be a focus on pre-hospital systems of care. Dr. Rodriguez reported that the Program is also collecting pre-hospital data from Regional Advisory Council through quarterly surveys and reports on this data are on the Program website.
- Caruth 2 by Ms. Boxberger
  - Dr. Rutledge asked for the amount of the Caruth grant and how much funding AHA contributed. Ms. Boxberger responded that the original Caruth grant was $3.5 million of all Caruth funding and Caruth 2 is $5.1 million over three years including $2 million from AHA funders and $3.1 million from Caruth.
  - Dr. Rutledge asked what the target area for Caruth 2 is. Ms. Boxberger responded that the main counties are Dallas, Tarrant, Denton and Collin and that the television market extends a bit beyond that.

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	▪ Dr. Rutledge suggested using a study done in Beaumont as a comparison. ▪ Dr. Hillert suggested that the Program integrate the campaign into Texas Healthy Communities and that AHA make the ads available free of charge.
7.	**Other Discussion/Public Comment** Dr. Wozniak noted that many STEMI patients never make it to the hospital, and therefore are not reflected in the data. Dr. Wozniak also noted that the data in the reports are from hospitals who are volunteering to share their data. Dr. Wozniak asked whether the Council could implement a mandate for hospitals to report their data. Dr. Hillert reported that hospitals will be mandated to report trauma data, including heart attack and stroke data, in 2016. Dr. Hillert suggested determining existing and future reporting requirements from regulating agencies. Dr. Rodriguez stated that DSHS welcomes Council's recommendations on how to increase participation in the data collection initiative. Dr. Rutledge suggested stressing data security and anonymity and exploring whether a list of non-participating hospitals could be shared. Dr. Hillert stated that competition through a recognition program may be a way to encourage participation.
9.	**Adjournment** **Motion to adjourn** by Dr. Rutledge **Seconded** by Dr. Hillert **Motion carried**

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Meeting Minutes

Texas Department of State Health Services
1100 W 49th Street, Austin, TX 78756
Moreton Building, Room 100
Saturday, August 1, 2015

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1. **Call to Order**

   Time: 1:05 PM
   By: Neal Rutledge, MD, Chair

2. **Roll Call**

   Members Present: Lisa Glenn (Department of Aging and Disability Services, DADS), Paula Gomez, Marcie Wilson Gonzalez, Suzanne Hildebrand, Bob Hillert, Diane Himmel (Department of Assistive and Rehabilitative Services, DARS), Floristene Johnson, Sherron Meeks, Roberto Rodriguez (Department of State Health Services, DSHS), Neal Rutledge, Kyle Sheets, and Shilpa Shamapant
   Quorum Reached: ☒Yes ☐No
   Members Absent: Michael Hawkins and Cheryle Locke
   Action on Absences: N/A
   Motion to Approve Moved By:
   Seconded By:
   Carried? ☐Yes ☐No

3. **Approval of [Previous Date] Meeting Minutes**

   Comment: Since there was not a quorum at the May 1st Council meeting, no business was conducted and minutes were not taken.
   Motion to Approve Minutes from February 7, 2015 Moved By: Bob Hillert
   Seconded By: Suzanne Hildebrand
   Carried? ☒Yes ☐No

4. **Chair's Address, State Agency Updates, Standing Reports, DSHS Report and Presentations/Other Reports**

   - **Comments from the Chair:** Dr. Rutledge welcomed the new Council Members:
     - Marcie Wilson Gonzalez
     - Kyle Sheets
     - Sherron Meeks
     - Shilpa Shamapant

Dr. Rutledge provided a brief summary of the 84th Texas Legislative Session outcomes and proposed dates for the Council Meeting in 2016. The Council will vote on the following dates at the November 1st Council Meeting:

- Saturday, February 6, 2016
- Friday, May 6, 2016
- Saturday, August 6, 2016
- Friday, November 4, 2016

- **State Agency Updates**
  - **Department of State Health Services (DSHS)**: Dr. Rodriguez provided an overview of the 84th Texas Legislative Session and the Sunset Report; agencies are working to implement passed legislation and address Sunset recommendations.
  - **Department of Aging and Disability Services (DADS):** No report.
  - **Department of Assistive and Rehabilitative Services**: Ms. Himmel provided a one-page report on vocational rehabilitation for stroke disability. Ms. Himmel reported that in 2013, 104 cases were successfully closed, and in 2014, 132 cases were successfully closed. Ms. Himmel will provide further clarification on the vocational rehabilitation report at the Council's request. Ms. Himmel noted that table headings were confusing and prefers to have her office re-run a new query that could include the information from our fiscal year 2015. Ms. Himmel would like the council to provide questions for DARS to develop a standardized query to run at the end of each fiscal year.
- **Standing Reports**
  - **Cardiovascular Disease and Stroke Partnership:** Lisa Hutchinson, Chair of the Texas Cardiovascular Disease and Stroke Partnership, provided updates. Ms. Hutchison stated the Partnership has not met since the last Council meeting. The next Partnership meeting will be held by conference call on August 7th from 10am-11am. The Partnership is working on reestablishing its organizational structure and reengaging its members. Current activities include developing an inventory of partner resources and activities, a manual for the Partnership, and a resource directory.
  - **Governor's EMS and Trauma Advisory Council (GETAC) Cardiac Care Committee:** No report.
  - **Texas Heart Attack Coalition:** No report.
  - **American Heart Association (AHA):** Kaitlyn Murphy reported that the American Heart Association is focusing on local smoke-free initiatives. Waco passed a comprehensive smoke-free ordinance in July 2015, and Denton went smoke-free a month ago. AHA will focus on identifying opportunities for obesity prevention and workplace legislation. AHA plans to target corner stores and healthy food

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store initiatives that will address obesity prevention. AHA will also work with municipalities to address nutrition and healthy vending initiatives.

- **Lone Star Stroke Consortium:** Dr. Steve Warach reported that Lone Star Stroke Consortium will continue with its four active projects and will develop additional projects for the upcoming year. Future priorities include involving more rural hospital systems and identifying external funding sources.

  Dr. Warach provided information on the NIH StrokeNet Clinical Trial in Houston. UTHSC Houston was named the Regional Coordinating Center for the new NIH StrokeNet clinical trials network. Lone Star Stroke Consortium plans to submit an application for the AHA's Go Red for Women Research Network.

  Ms. Hildebrand requested itemized accounting of expenditures from last biennium, a copy of the University of Texas System and DSHS contract from both last biennium and the upcoming biennium, the functions of Lone Star Stroke employees, and the number of study participants in the trials.

  Dr. Warach proposed the Lone Star Stroke Consortium coordinate its annual meeting with the TCCVDS, November 6th meeting. The Council agreed with the proposal.

- **Chronic Care Subcommittee:** Ms. Johnson provided an update on the Chronic Care Subcommittee. The Chronic Care Subcommittee has not met since the last Council meeting. Committee members expressed interest in developing a resource directory specific to caregivers for the DADS website. There was a discussion about holding a stakeholder conference focusing on caregivers at a regional location.

- **DSHS Reports**
  - Ms. Eichner gave an overview and update on the 1305 Prevention and Control grant from the Centers for Disease Control and Prevention. Ms. Eichner reported on three contracts for Fiscal Year 2016 and the home self-blood pressure monitoring project.
    1. North Texas Regional Extension Center is continuing to work with physician practice groups on the use of electronic health records and health information technology to improve the quality of care for patients with high blood pressure and diabetes.
    2. Texas Pharmacy Association will work with community pharmacists in Northeast Texas to promote hypertension control activities.
    3. Area Health Education Center, at the University of Texas Medical Branch, will provide continuing education on the use of clinical support tools and

protocols for diagnosing patients with hypertension and improving medication adherence.

Dr. Hillert requested the amount for each of the contracts. Ms. Eichner provided an estimated amount for each contract.

- **Rider 97:** Ms. Granado provided an update on the Heart Attack and Stroke Systems of Care Summit: A Focus on Quality Improvement through the Heart Attack and Stroke Data Collection Initiative that was held on July 24, 2015. Erin Wu and Suparna Bagchi, with the Office of Surveillance Evaluation and Research (OSER), presented the Hospital Annual Report on Stroke and ST-Elevation Myocardial Infarction (STEMI).
  - 55 hospitals provided heart attack data and 47 hospitals provided stroke data.
  - The Council recommended that DSHS contact and present the data to the RACs at a GETAC.
  - The Council discussed a plan to enhance communication with the RACs and agreed to appoint a RAC liaison to attend the Council meetings.
  - Dr. Rutledge would like DSHS to consider a hospital recognition program.
  - Ms. Meeks would like to have data on stroke functionality at 90 days post stroke included in DSHS reports, if feasible.
- **Texas Healthy Communities:** Ms. Brea stated the Texas Healthy Communities workshop was held on July 31, 2015. At the workshop, contractors were provided with resources and shared success stories. Joanna Patterson, with Wichita Falls Wichita Falls/Wichita County Public Health District, and Paula Botsford, with Angelina County/Cities Health District, shared their success stories with the Council. Ms. Brea provided an update on the Texas Healthy Communities and reported that DSHS will contract with 20 communities for Fiscal Year 2016. Eighteen communities are receiving a second round of funding and DSHS is contracting with two new communities.

5. Other Discussion/Public Comment

None

6. Adjournment

Motion to Adjourn Moved By: Suzanne Hildebrand
Seconded By: Sherron Meeks
Carried? ☒Yes ☐No

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Meeting Minutes

Texas Department of State Health Services
1100 W 49th Street, Austin, TX 78756
Moreton Building, Room 100
Friday, November 6, 2015

1. ## Call to Order

Time: 1:03 p.m.
By: Neal Rutledge, MD, Chair

2. ## Roll Call

Members Present: Lisa Glenn (Department of Aging and Disability Services, DADS), Marcie Wilson Gonzalez, Michael Hawkins, Suzanne Hildebrand, Bob Hillert, Floristene Johnson, Cheryle Locke, Sherron Meeks, Roberto Rodriguez (Department of State Health Services, DSHS), Neal Rutledge, Kyle Sheets, Shilpa Shamapant
Quorum Reached: ☒Yes ☐No
Members Absent: Paula Gomez and Diane Himmel
Action on Absences: Approved excused absences

3. ## Approval to Align 2016 Council Meetings with Governor's EMS and Trauma (GETAC) Advisory Council Meetings

Comment: Suzanne Hildebrand suggested alignment of two of the Council Meetings with the GETAC meetings. Council members agreed that it is a good idea. All council members are in favor and no members are opposed.

Motion to approve aligning two Council Meetings with GETAC Meetings Moved By: Bob Hillert
Seconded By: Sherron Meeks
Carried? ☒Yes ☐No

4. ## Approval of Meeting Dates for 2016

Comment: The Council approved the following meeting dates:
Friday, February 12, 2016*
Saturday, May 7, 2016
Friday, August 26, 2016*
Saturday, November 5, 2016
*Meetings are aligned with the 2016 GETAC Meetings

Motion to approve dates for 2016 meetings: Neal Rutledge
Seconded By: Bob Hillert
Carried? ☒Yes ☐No

5. **Approval of August 1, 2015 Meeting Minutes**

Comment: Diane Himmel submitted a request for revision to the August 1st meeting minutes to reflect the following: Ms. Himmel noted the table headings (from the vocational rehabilitation report) were confusing and will have her office create a new report that could include information from Fiscal Year 2015. Ms. Himmel would like the Council to provide questions for DARS to develop a standardized query to run at the end of each fiscal year.

Dr. Rutledge recommended referral of Diane Himmel's request to the Chronic Care Subcommittee for their review and recommendations.

Motion to Approve Minutes from August 1, 2015 Moved By: Bob Hillert
Seconded By: Shilpa Shamapant
Carried? ☒Yes ☐No

6. **Approval of Authorization**

Background: To prepare for the implementation of Rider 67 and the expansion of the Heart Attack and Stroke Data Collection Initiative: authorizes a Council members to provide DSHS with a list of recommended data elements to collect through the Heart Attack and Stroke Data Collective Initiative.

Dr. Rutledge made a motion to create a subcommittee for the Heart Attack and Stroke Data Initiative. The subcommittee will convene by conference call and come up with a list of data elements by the end of the year.

The following council members volunteered to be on the subcommittee – Dr. Rutledge, Sherron Meeks, Marcie Wilson-Gonzalez and Bob Hillert.

Motion to Approve Authorization of a Data Collection Subcommittee Moved By: Bob Hillert
Seconded By: Shilpa Shampant
Carried? ☒Yes ☐No

7. **Chair's Address, State Agency Updates, Standing Reports, DSHS Report and Presentations/Other Reports**

- **Comments from the Chair**: Dr. Rutledge reported that the Rider 67 project will be valuable to the gap analysis and the DSHS contracts are moving towards using the

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NEMSIS database to collect pre-hospital data for STEMI and stroke. Data will continue to be collected through the RACs contracts. Dr. Hawkins asked about collecting non-STEMI data and suggested DSHS look at the number of hospital admissions to identify other types of heart attacks.

Dr. Rutledge discussed the duties of the Council being that the Council makes recommendations to DSHS and the legislature.

- **State Agency Updates**
  - **Department of State Health Services (DSHS)**: Dr. Rodriguez provided an update on the transition and transformation of HHSC. While DSHS remains a separate agency, many of the functions will be transitioned to HHSC. There are a variety of workgroups working on a transition plan and there will also be a process for public input.

    Dr. Rodriguez shared with the Council that an abstract submitted by Dr. Mark J. Alberts and Nimisha Bhakta, manager of the DSHS Office of Surveillance, Evaluation, and Research (OSER), has been accepted for the 2016 International Stroke Conference.

    Dr. Rutledge asked how the Council can support DSHS with identifying and supporting funding opportunities. Dr. Rodriquez reported that the agency is always looking at funding opportunities and welcomed the Council's support. Dr. Rodriquez mentioned that among the Legislative interim charges there is a focus on chronic conditions and that DSHS will look to the Council for further guidance.
  - **Department of Aging and Disability Services (DADS):** No report.
  - **Department of Assistive and Rehabilitative Services**: No report.

- **Standing Reports**
  - **Cardiovascular Disease and Stroke Partnership:** Brandy Lee, Co-Chair of the Texas Cardiovascular Disease and Stroke Partnership, provided updates on activities for the Partnership. Activities included the development of a Partnership Overview Guide, Membership Directory, and reorganization of the four goal committees. A complete update was provided to Council members as meeting materials. The Partnership will meet next via conference call on Monday, February 1, 2016.
  - **Governor's EMS and Trauma Advisory Council (GETAC) Cardiac Care Committee:** No report.
  - **Texas Heart Attack Coalition:** No report.
  - **American Heart Association (AHA):** Kaitlyn Murphy provided information on obesity prevention initiatives and work at the local level on smoke free ordinances. The City of Austin allocated $400,000 for obesity initiatives, including $150,000 on corner store projects. A smoke free ordinance was upheld in Port

Lavaca, and there is interest in North Texas and the Rio Grande Valley in passing smoke free ordinances. Ms. Murphy noted that without state-wide legislation, Texas will not be a smoke free state.

- **Lone Star Stroke Consortium:** Dr. Steve Warach reported that the Lone Star Stroke Consortium submitted its annual report to DSHS in August, hosted its annual meeting on November 6th, and provided updates on the ongoing four studies. The full recording of the annual meeting will be posted on the Lone Star Stroke Consortium (www.lonestarstroke.org). The Lone Star Stroke Consortium is submitting an application for the American Heart Association's Go Red for Women Research Network for the Center Grant to study Women's Health Issues.

  Dr. Warach addressed a request by Ms. Hildebrand from the August 1st Council Meeting. Ms. Hildebrand requested itemized accounting of expenditures from last biennium, a copy of the University of Texas System and DSHS contract from both last biennium and the upcoming biennium, the functions of Lone Star Stroke employees, and the number of study participants. Dr. Warach provided information on the functions of Lone Star Stroke employees, the number of study participants, and referred to DSHS for a copy of the Fiscal Year 2015 and 2016 contracts and an itemized accounting of expenditures.

- **Chronic Care Subcommittee:** Ms. Shamapant provided an update from the October 7th conference call to discuss hosting a Stroke Caregivers Conference in May 2016 in conjunction with Stroke Awareness Month. The conference will target stroke survivors and their caregivers and possible topics include respite care, stroke education, the recovery process, and counseling/ peer support groups. A meeting summary of the October 7th conference call was provided to Council members.

- **DSHS Reports - A summary of DSHS, Heart Disease and Stroke Program updates was provided to Council Members**
  - Ms. Eichner gave an update on and overview of the 1305 Prevention and Control Grant from the Centers for Disease Control and Prevention. Ms. Eichner announced that DSHS was awarded a $150,000 grant by the Association of State and Territorial Health Officials. This grant supports Texans to achieve blood pressure control through a state-wide learning collaborative. DSHS is partnering with three local health departments in Northeast Texas to implement project activities, and working with state partners to expand into other regions. Ms. Eichner reported on three contracts (North Texas Regional Extension Center, Texas Pharmacy Association, and Area Health Education at the University of Texas Medical Branch) for Fiscal Year 2016 and the home self-blood pressure monitoring project.
  - **Heart Attack and Stroke Data Collection Initiative:** Ms. Granado provided an update on activities for the Heart Attack and Stroke Data Collection Initiative,

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including outreach efforts to increase hospital participation and presentation on the Initiative at Texas Hospital Association Quality and Patient Safety Conference. Ms. Granado noted that project staff is analyzing data and education information received from the Regional Advisory Councils (RACs) during the last two contract years. Reports will be made available on the Texas Heart Disease and Stroke Program website and shared with the Council, project data consultants, American Heart Association, hospitals, Regional Advisory Councils, and the Governor's EMS Trauma Advisory.

- **Texas Healthy Communities:** Ms. Brea provided an update on the Texas Healthy Communities Conference and activities for Fiscal Years 2015 and 2016. Contractors submitted work plans and the program will be developing a success story document. For Fiscal Year 2016, the Texas Healthy Communities will contract with 20 communities. Eighteen communities are receiving a second round of funding and DSHS is contracting with two new communities. Ms. Brea introduced Rachel Coughlin as the new staff member for the Healthy Communities Program.

8. **Other Discussion/Public Comment**

- **American Heart Association (AHA) – Larissa DeLuna**

On November 4th AHA launched the Guideline Transformation and Optimization This is a three year, $6 million dollar initiative and the first goal is to increase the survival rate of non-STEMI heart attacks.

AHA is focusing on developing model Cardiac Prevention guidelines and a recognition program for implementing guidelines. Resources and tools for patients include MyLife Check, Heart 360, Check Change and Control, and an online patient support network. AHA is also expanding Mission Lifeline to focus on non-STEMI, developing an EMS recognition program, working on a hypertension algorithm for Stage I and II patients in cardiac rehabilitation, and has released new resuscitation guidelines.

- **Sanofi Health Care Company – Debbie Lopez**

Ms. Lopez made a presentation on hyperlipidemia. Ms. Lopez provided statistics on hyperlipidemia, information on LDL guidelines, studies and trials on statin drugs and outcomes.

- **It's Time Texas – Kristen Nussa, Director of Community Programs**

It's Time Texas is a new social change organization. The mission of the organization is to create a social change to reverse the obesity epidemic by providing programs targeting individuals, families, communities and organizations. Ms. Nussa highlighted the Community Challenge program, sponsored by HEB, creating competition for active living among communities of the same size.

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- **Other Discussion:** There was a discussion among Council Members on the education of using 911 rather than personal vehicle for someone who is having a heart attack or stroke, and the five signs and symptoms of stroke. Dr. Rutledge asks that Council members come up with recommendations for further discussion.

9. **Adjournment**

Motion to Adjourn Moved By: Suzanne Hildebrand
Seconded By: Sherron Meeks
Carried? ☒Yes ☐No

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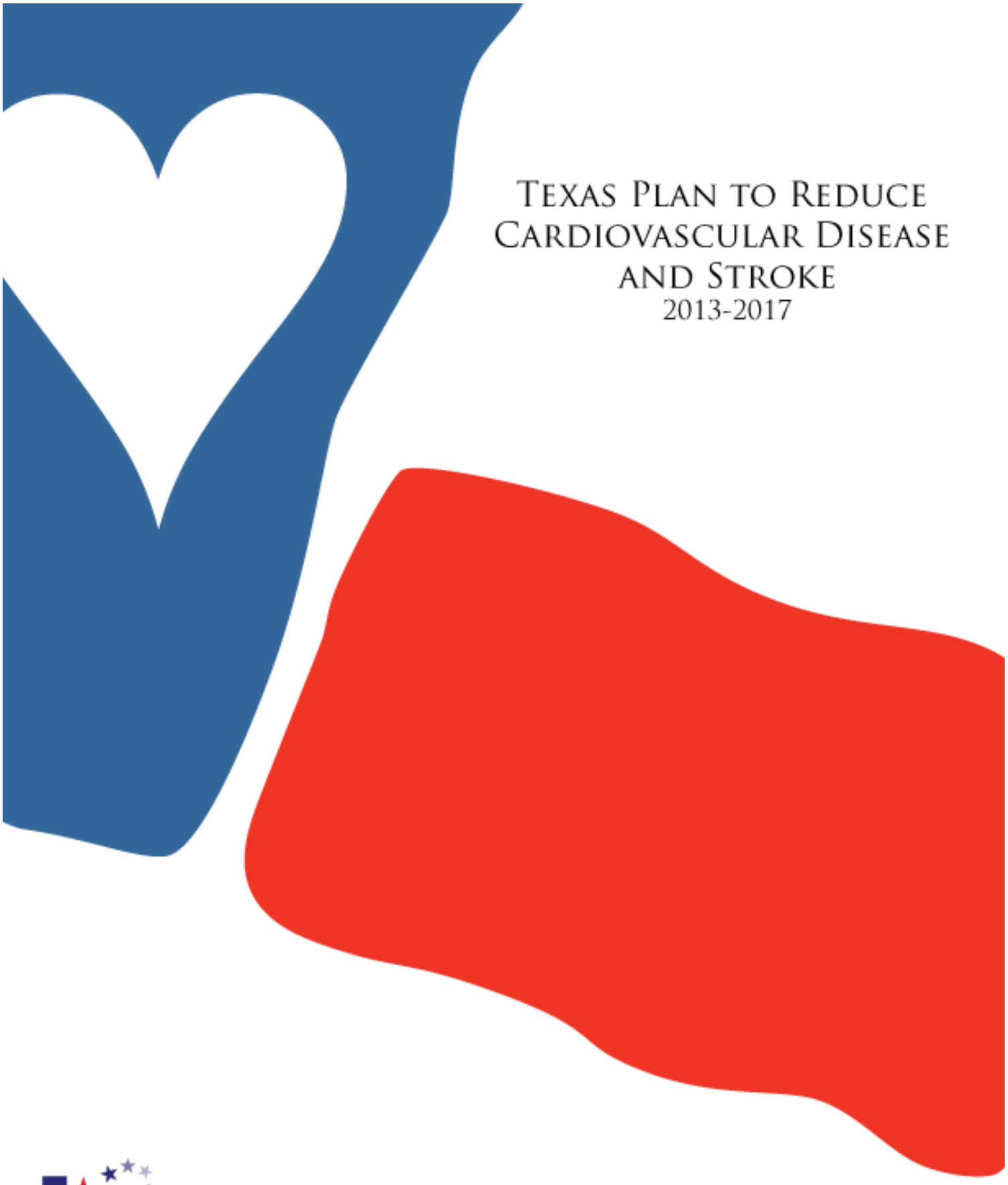
Texas Plan to Reduce Cardiovascular Disease and Stroke

2013-2017



TEXAS
Department of
State Health Services

Foreword

The fourth edition of the *Texas Plan to Reduce Cardiovascular Disease and Stroke* (*Plan*) provides a set of goals and strategies for addressing heart disease and stroke in Texas. The 2013 *Plan* has been updated with the help of community stakeholders from across the state and a group of experts representing state and community-level public health agencies, the health care industry, worksite wellness professionals, the non-profit and academic sectors. These stakeholders provide a wide range of local and organizational perspectives. Their efforts helped identify heart disease and stroke prevention, detection, and treatment priorities to address in Texas.

The *Plan* provides an overview of the current state of cardiovascular disease and stroke in Texas and identifies priority objectives for organizations to incorporate into their strategic plans. The *Plan* includes summary of findings from the heart disease and stroke prevention system assessment, as well as information on mortality, morbidity, prevalence, and related risk factors.

Many strategies will be coordinated at the state level, but others can only be effectively implemented at the local or organizational level. The success of this *Plan* and of heart disease and stroke prevention efforts in Texas requires partners in all sectors and at all levels to work collaboratively.

The Texas Council on Cardiovascular Disease and Stroke was established by the Legislature and its members are appointed by the Governor. The Council continues to work with stakeholders to implement the *Plan* and promote the mission of the Council: that is, "to educate, inform and facilitate action among Texans to reduce the human and financial toll of cardiovascular disease and stroke."

The Texas Cardiovascular Disease and Stroke Partnership, a group of dedicated stakeholders from all across Texas, has worked diligently to provide information and expert advice on the development of this updated *Plan*. The Partnership's Steering Committee is committed to the *Plan*'s successful implementation and invites you to join in its efforts to reduce heart disease and stroke in Texas.

The Cardiovascular Disease and Stroke Program of the Texas Department of State Health Services' Health Promotion and Chronic Disease Prevention Section provides technical assistance, training and consultation on the development of policy and environmental change strategies to decrease risk factors for heart disease and stroke and encourage Texans to establish a heart and stroke healthy lifestyle. The Program works collaboratively with the Texas Council on Cardiovascular Disease and Stroke and the Texas Cardiovascular Disease and Stroke Partnership to educate, inform and facilitate action among Texans to reduce the human and financial toll of cardiovascular disease and stroke.

Please use this *Plan* for developing your own cardiovascular disease and stroke program objectives. Implement the evidence-based strategies described in this report to bring about improved cardiovascular and brain health for all Texans. Your participation in and adoption of the strategies outlined in this *Plan* are critical to the success of this collaborative effort.

Acknowledgements

This *Plan* was updated through joint planning meetings and coordination among organizations participating in the Texas Cardiovascular Disease and Stroke Partnership, the Texas Council for Cardiovascular Disease and Stroke, and the Cardiovascular Disease and Stroke Program of the Texas Department of State Health Services.

A number of staff from the Department of State Health Services played key roles in coordinating meetings, facilitating planning, and writing and editing drafts of the *Plan*.

Health Promotion and Chronic Disease Prevention Section &

Cardiovascular Disease and Stroke Program

Rosemary Ang, MS, MT – Epidemiologist

Maria Benedict - Program Specialist

Nimisha Bhakta, MPH - Epidemiologist

Cecily Brea, MEd – Program Specialist

Brett Spencer – Statewide Wellness Coordinator

Julie Stagg, MSN, RN, IBCLC, RLC – State Breastfeeding Coordinator

Tom Stephan, BA, MFA - Information Specialist

Lucina Suarez, PhD - Acting Assistant Commissioner - Prevention and Preparedness Services Division

Katie Wiechnicki, RN, MPH – Program Coordinator and Plan Writer

Members of the **Texas Council on Cardiovascular Disease and Stroke** contributed their time and expertise to fulfill their charge with maintaining and implementing a cardiovascular disease plan for the state of Texas.

Pam Akins, JD

Lisa Glenn, MD

Paula Gomez (Incoming member 2012)

Michael Hawkins, MD

Suzanne Hildebrand (Incoming member 2012)

Bob Hillert, MD, FACC, FACP, FAHA

Deanna Hoelscher, PhD, RD, LD, CNS (Departing member 2012)

Floristene Johnson, MS (Incoming member 2012)

Ann Quinn Todd, RN, MSN, NE-BC, FAHA

J. Neal Rutledge, MD, FACR

Jan Skinner, MPH

Thomas Tenner, Jr, PhD

Louis West, LFACHE

Members of the **Texas Cardiovascular Disease and Stroke Partnership** also contributed their time and expertise to the *Texas Plan to Reduce Cardiovascular Disease and Stroke* update process. A list of the Partnership Steering Committee members can be found in Appendix III.

The majority of data for the *Plan* were obtained from the Center for Health Statistics, Texas Department of State Health Services.

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Executive Summary

Cardiovascular disease (CVD) and stroke are the number one and number three causes of death in Texas.[4] However, these chronic diseases are largely preventable through the reduction of modifiable risk factors. Prevalence, as well as CVD and stroke-related morbidity and mortality rates, can be reduced by: increased physical activity; good nutrition; tobacco cessation; control of high blood pressure, high blood cholesterol and diabetes; and reduction of overweight and obesity.

The Texas Plan to Reduce Cardiovascular Disease and Stroke 2013 update (*Plan*) was developed through collaboration between the Texas Council on Cardiovascular Disease and Stroke and the Texas Cardiovascular Disease and Stroke Partnership. It provides a set of goals, objectives, and strategies for reducing morbidity and mortality related to heart disease and stroke in Texas.

The *Plan* is modeled after the Coordinated Chronic Disease State Plan Framework and outlines a comprehensive strategy through four overarching focus areas. The focus areas include Strategies that Support/Reinforce Healthy Behavior; Community-Clinical Linkages Enhancements; Health Systems Interventions; and Surveillance and Epidemiology. Each focus area consists of a goal and accompanying objectives and strategies that tend to be cross-cutting.

Goals of the 2013 *Plan* include*:*

- **Strategies that Support/Reinforce Healthy Behavior:** To establish and promote environments that support the prevention of heart disease and stroke through healthy eating, physical activity, and tobacco-free lifestyles for all Texans, with an emphasis on access to resources and priority populations.
- **Community Clinical Linkages Enhancements:** To promote partnerships between clinical and community groups in Texas to provide enhanced and coordinated patient care.
- **Health Systems Interventions:** To promote capacity and infrastructure changes within the health delivery system to effectively prevent, treat, and manage heart disease and stroke for all Texans.
- **Surveillance and Epidemiology*:** To collect comprehensive heart disease and stroke data that are readily available to assess, monitor, and describe the burden of heart disease and stroke in Texas.

  *Note: Surveillance and epidemiology strategies are included in all *Plan* objectives to provide data to monitor progress in priority areas and towards targets.

Thirty sets of objectives, grouped by common desired outcomes, were identified for the *Plan*. The objectives reflect Healthy People 2010 and 2020 objectives for improving the health of the nation and are specific to heart disease and stroke priorities in Texas. The *Plan* includes objectives that are largely measurable through existing data sources and are deemed realistic and attainable through coordinated efforts and effective use of available resources.

The Texas Cardiovascular Disease and Stroke Partnership, the Texas Council on Cardiovascular Disease and Stroke, and the Cardiovascular Disease and Stroke Program of the Texas Department of State Health Services will collaborate to implement evidence-based strategies to achieve identified targets by the year 2017.

Call to Action

Stakeholders at all levels, including state, regional or community, should be knowledgeable about CVD and stroke, as well as the diseases' impact on individuals' well-being and economic and societal well-being in Texas. We urge you to use this *Plan* to determine the role and direction that your organization decides to assume as part of a unified, coordinated effort to reduce premature death from CVD and stroke, as well as to improve the quality of life for Texans.

Help empower healthy Texans for a lifetime!

Introduction

Cardiovascular disease (CVD) and stroke are the number one and number three causes of death in Texas.[4] Together, heart disease and stroke account for nearly three of every ten deaths in the state.[4] In addition to the human consequences, the financial burden of CVD and stroke in Texas is substantial. Hospitalization charges related to CVD and stroke amounted to nearly $20 billion in 2010[5], and the following trends suggest this problem will continue to worsen in the future:

- The aging of the population will remain an important factor as older adults reach ages where CVD and stroke are the most prevalent.
- The incidence of morbid obesity in Texas is rising; nearly one in three Texans is obese, and two-thirds of Texans are overweight.[3]
- Health care, school, and work environments are not keeping pace with the need for healthier food choices and a community environment conducive to increasing physical activity and access to healthy food options.
- Medical costs associated with CVD and stroke are on the rise due to an increase in per capita health care spending; total direct health care costs related to CVD are expected to triple by 2030, and direct health care costs related to stroke are expected to increase by 238 percent over the next 20 years.[30]

In response to these challenges, the Texas Cardiovascular Disease and Stroke Partnership (Partnership) was created to work in collaboration with the Texas Council on Cardiovascular Disease and Stroke and the Cardiovascular Disease and Stroke Program of the Texas Department of State Health Services (DSHS) to update and implement a statewide plan for addressing CVD and stroke in Texas.

The 2013 *Texas Plan to Reduce Cardiovascular Disease and Stroke (Plan)* not only reflects a new set of goals, objectives, and strategies related to improving cardiovascular and brain health in Texas but includes key implementation activities identified by the Centers for Disease Control and Prevention (CDC) as essential to implementing a comprehensive public health strategy (see Figure 1):

- **Communicating Effectively:** The Texas public health community should effectively communicate the urgency and promise of preventing heart disease and stroke and their risk factors through public information and education utilizing appropriate technology to reach underserved populations.
- **Promoting Strategic Leadership**: State and local governments, public health agencies, and community leaders should foster effective leadership and partnerships to prevent heart disease and stroke by strengthening existing relationships with partners and forging new ones with other partners.
- **Taking Action**: Community leaders in Texas should take action to promote desirable social and environmental conditions and promote partnerships to effectively translate current knowledge into successful outcomes.

- **Strengthening Capacity**: State and local governments, public health agencies, and community leaders must work to build local and statewide capacity to address the health and wellness of Texans by expanding partnerships and utilizing resources in a more coordinated and effective way.
- **Evaluating Impact**: Resources should be dedicated to developing new data systems, expanding and standardizing existing data sources, and effectively monitoring health indicators related to CVD and stroke to monitor progress made with interventions implemented.
- **Advancing Policy**: Critical policy issues must be addressed, and effective public policy should be implemented to ensure resources are available, the environment is conducive to the health and wellness of Texans, and all citizens have access to quality preventive services and treatments.
- **Promoting Regional and Global Partnerships**: State and local governments, public health agencies, and community leaders in Texas should engage in partnerships to effectively use resources for optimal outcomes related to cardiovascular health promotion and CVD prevention.[1]

Figure 1: Process of Effective Implementation of a Comprehensive Public Health Strategy

Effective implementation of comprehensive public health strategies begins with effective communications and continues through an iterative process involving strategic leadership, action, strengthening capacity, evaluating impact, advancing policy, and building partnerships.

The State of Cardiovascular Disease and Stroke in Texas

Cardiovascular disease (CVD) refers to a group of diseases that targets the heart and blood vessels. It is the result of complex interactions among a variety of factors including: multiple inherited traits, environmental factors, diet and exercise, body mass index, blood pressure, cholesterol levels, and tobacco use. Its etiology suggests that CVD is largely preventable; and, when diagnosed early, disease symptoms and risk factors can often be mitigated with lifestyle changes and/or treatment with medication. Common forms of CVD include high blood pressure, coronary heart disease, stroke, and congestive heart failure.

A major cause of CVD is atherosclerosis, a general term describing the thickening and hardening of the arteries. It is characterized by deposits of fatty substances, cholesterol, and cellular debris on the inner lining of an artery. The resulting buildup is called plaque, which can partially or completely block a vessel and may lead to heart attack or stroke. The most prevalent forms of heart disease and stroke are ischemic heart disease and ischemic stroke. These two forms are caused by narrowed or blocked arteries resulting in reduced blood supply to the heart or brain. This *Plan* focuses primarily on these two types of CVD.

According to the American Heart Association (AHA), over 82 million, or one out of every three Americans, have one or more types of CVD.[2] In 2010, about 1.5 million Texas adults ages 18 years and older reported that they had been diagnosed with heart disease or stroke.[3,4]

Cardiovascular disease continues to be the number one cause of death in Texas and in the United States (U.S.).[4,6] Over 2,200 Americans die from CVD each day.[2] An estimated 30.5 percent of all deaths in Texas in 2010 were due to CVD.[4]

However, progress has been made. From 2000 to 2010, age-adjusted mortality rates (number of deaths per 100,000 people) due to CVD in Texas and the U.S. steadily declined. The death rate associated with CVD in Texas declined 30.7 percent during this ten year period. Factors affecting this decline include more effective medical treatment and an increasing emphasis on controllable risk factors.[2, 6]

While mortality rates have declined, the financial burden associated with CVD continues to grow. Together, heart disease and stroke are the number one group of conditions draining health care resources, costing more than any other diagnostic group. According to the AHA, the estimated direct and indirect costs of CVD in the U.S. for 2008 was $297.7 billion, and the cost of CVD is projected to triple from 2010 to 2030.[2]

Diseases of the Heart

In Texas, diseases of the heart claimed over 38,090 lives in 2010.[4] Heart disease has been the leading cause of death in Texas since 1940 and currently accounts for more than one in four (22.9%) deaths. Diseases of the heart include acute rheumatic fever, chronic rheumatic heart diseases, hypertensive diseases, and ischemic heart diseases. The *Plan* focuses primarily on ischemic and hypertensive heart diseases, which account for 73 percent of deaths from heart disease in Texas and much of the financial burden. Hospital charges for ischemic heart disease in Texas in 2010 exceeded $6 billion.[5]

The first appearance of heart disease, often presenting as cardiac arrest, can be sudden and devastating, but cardiac arrest can be reversed if treated within a few minutes. Optimal treatment to restore a normal heartbeat occurs through electric shock to the heart (defibrillation) within three to five minutes. With every minute that passes without cardiopulmonary resuscitation (CPR) and defibrillation, the chance of survival is reduced by seven to 10 percent.[7] For this reason, bystander recognition of the signs and symptoms of cardiac arrest and an immediate call to 911 are critical to improve patient outcomes. In 2009, while 85.9 percent of Texans

recognized 911 as the first emergency response option for heart attack and stroke, only 11.8 percent of Texas adults could correctly identify all signs and symptoms of a heart attack.[3]

In the event of cardiac arrest, CPR and use of an automated external defibrillator (AED) should begin immediately. The availability of AEDs is becoming more widespread as many municipal and state governments are instituting mandates for AED programs in public sites such as schools, shopping malls, and other public places. New recommendations for CPR performed by bystanders include high quality chest compressions by pushing hard and fast in the middle of the chest with minimal interruptions.[8] Education to promote the rapid recognition of the signs and symptoms of cardiac arrest and stroke, calling 911, and promotion of CPR training and AED availability are a major focus of public education and training in the 2013 *Plan*.

What is defibrillation?

Most sudden cardiac arrest is caused by ventricular fibrillation (VF), an abnormal heart rhythm. Ventricular fibrillation prevents the heart from pumping blood effectively. Defibrillation is the treatment for VF. Defibrillation delivers an electric shock to the heart that can stop VF and allow the heart to resume a normal rhythm and pump effectively.[7]

Stroke

Stroke is the third leading cause of death in Texas and the fourth leading cause of death in the nation. Over the past decade, the death rate from stroke in Texas declined by approximately 32.6 percent (from 66.6 percent in 2000 to 44.9 percent in 2010).[2,6] Many more people are surviving strokes but not without consequences. Stroke can leave a range of disabilities from loss of speech to paralysis of limbs and other neurological impairments, making stroke a leading cause of long-term disability and a major economic burden in terms of health care cost and lost productivity.[2] The estimated direct and indirect costs of stroke in the U.S. for 2010 was $53.9 billion.[30] Total hospital charges for stroke in Texas in 2010 exceeded $2.7 billion.[5]

Fortunately, stroke is preventable. When treated immediately, the damage can be minimized. Timely treatment requires early recognition of signs and symptoms and rapid response. The Behavioral Risk Factor Surveillance System (BRFSS) survey conducted in Texas in 2009 showed that only 21.1 percent of adults in Texas could correctly identify all stroke signs and symptoms (see Table 1).[3]

In addition to early recognition of stroke signs and symptoms by the public, early and appropriate medical intervention is critical to increase survival and reduce risk of disability. Unfortunately, stroke care in many communities remains inadequate and fragmented, hindered by lack of expertise and coordination within the stroke system of care.[8] One of the goals in the *Plan* is to support ongoing efforts to improve systems of care that target stroke in Texas.

Table 1: Recognition of Signs and Symptoms of Stroke in Texas, 2010

Symptoms of Stroke	% of Respondents who Recognized Symptoms of Stroke
Sudden confusion, trouble speaking or understanding	94.9
Sudden trouble seeing in one or both eyes	87.8
Sudden numbness or weakness of the face, arm or leg	97.2
Sudden trouble walking, dizziness or loss of balance and coordination	93.5
Sudden severe headache with no known cause	77.4
Recognized all 5 signs and symptoms	21.1

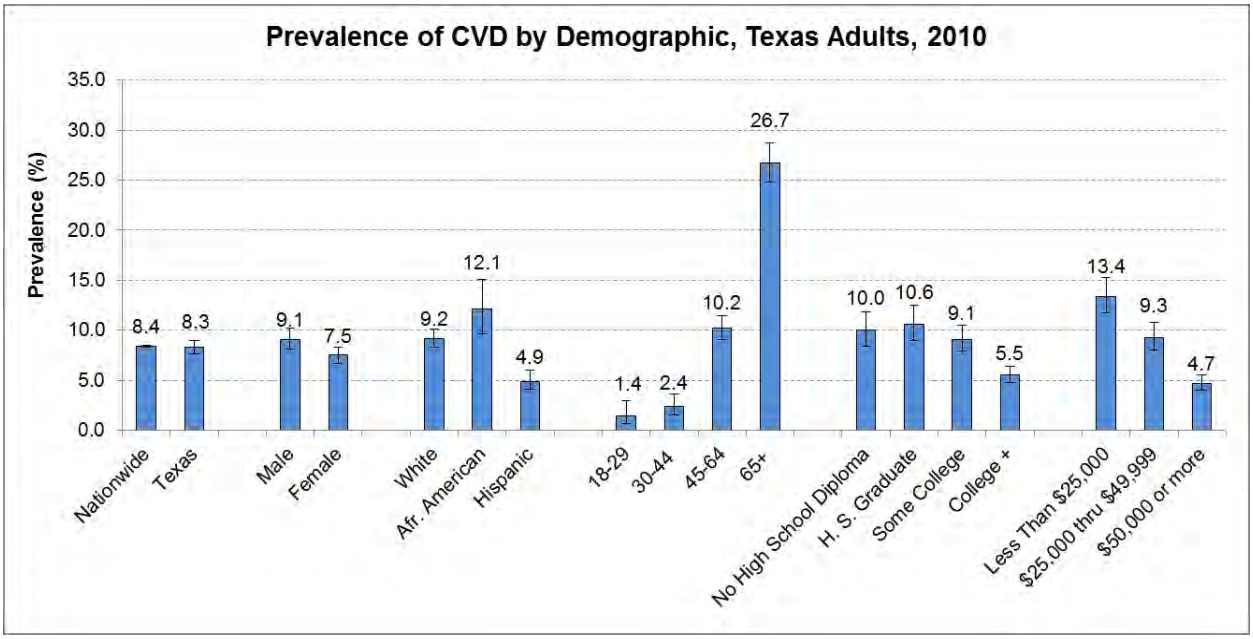
Data source: BRFSS, Center for Health Statistics, TDSHS, 2010

Disparities in Cardiovascular Disease and Stroke

High Risk Populations

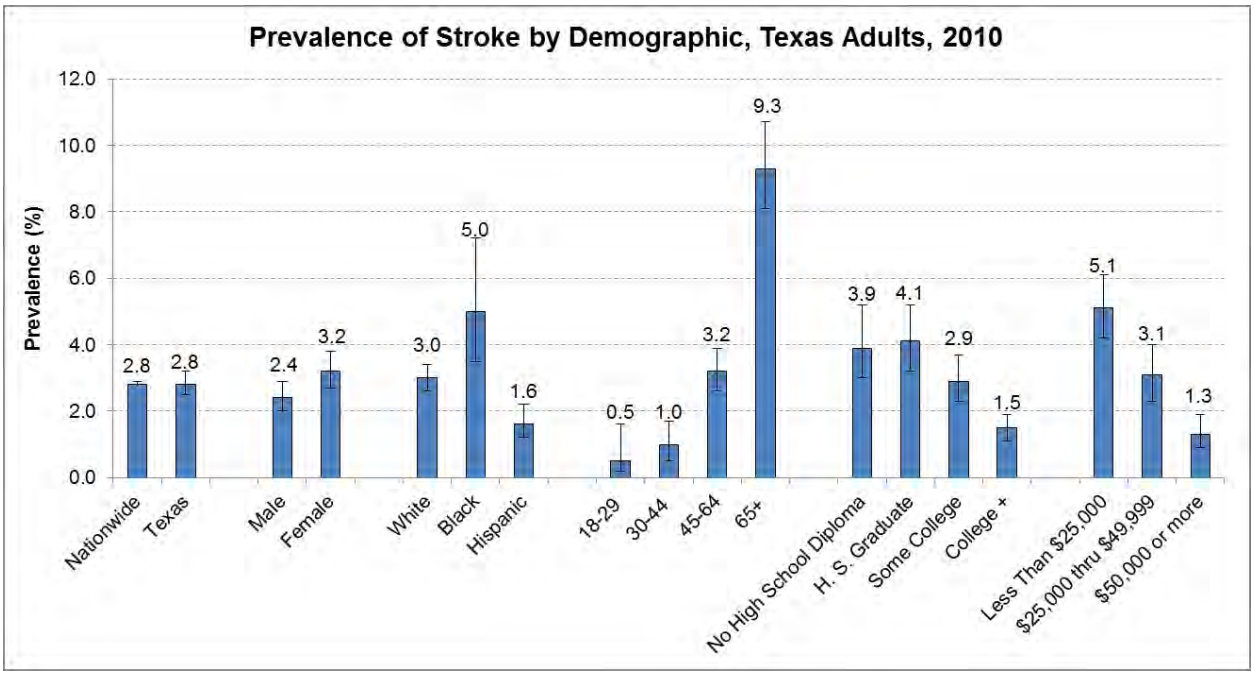
Significant disparities exist among Texans with CVD, stroke, or related risk factors. In general, there is a higher prevalence of CVD and stroke among Texans who are older (especially those ages 65 years and older), earn a lower income, have received less education, are African American, and have multiple risk factors (see Figures 2 and 3).

Figure 2: Prevalence of CVD by Demographic, Texas Adults, 2010



Data source: BRFSS, Center for Health Statistics, TDSHS, 2010

Figure 3: Prevalence of Stroke by Demographic, Texas Adults, 2010



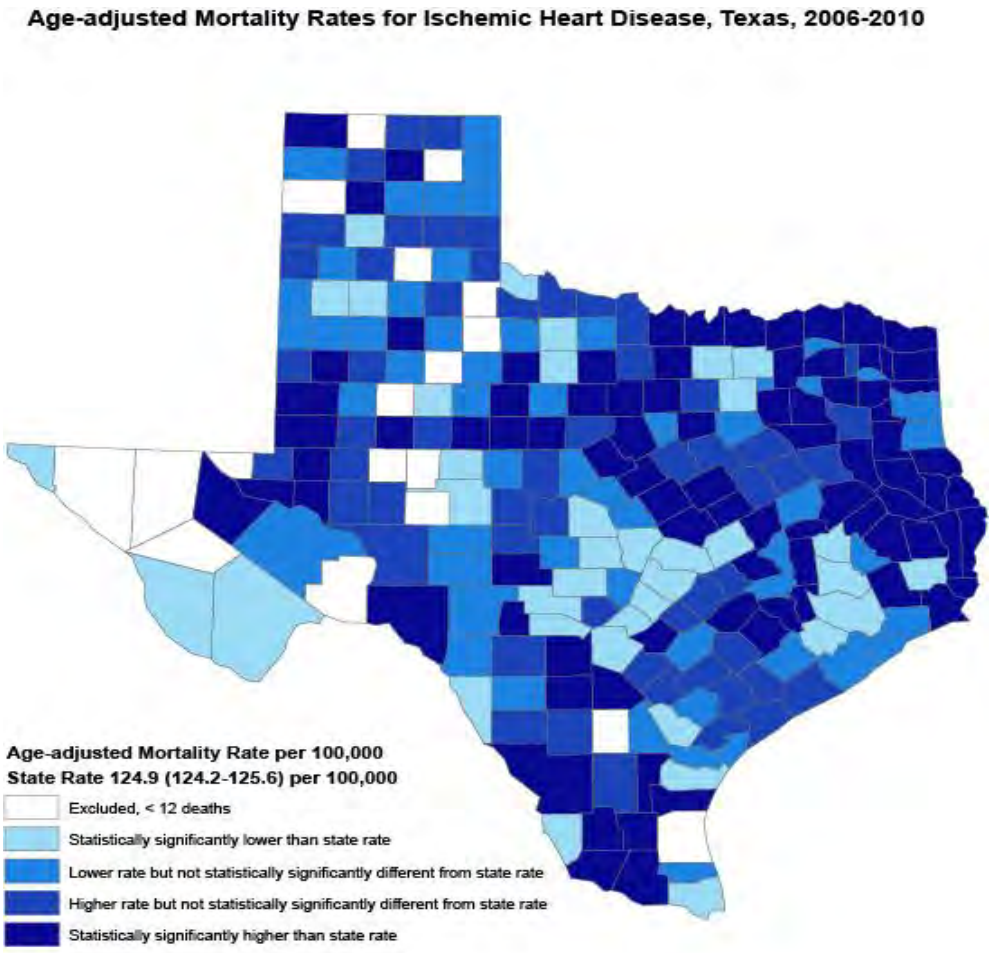
Data source: BRFSS, Center for Health Statistics, TDSHS, 2010

In addition, there is a higher risk of death from CVD and stroke among these at-risk individuals. While CVD and stroke mortality rates have generally declined for most populations, disparities persist. Between 2006 and 2010, ischemic heart disease mortality rates among Whites, African Americans, and Hispanics showed significant decline. However, the highest mortality rate from CVD and stroke still occurs in the African American population, both in Texas and in the U.S. In Texas, the 2010 age-adjusted mortality rate for ischemic heart disease among African Americans was 132.9 per 100,000 compared to 118.5 per 100,000 for Whites and 94.9 per 100,000 for Hispanics.[4]

In 2010, the age-adjusted mortality rate for stroke among African Americans was 1.3 times higher than Whites (60.0 per 100,000 versus 44.7 per 100,000), 1.6 times higher than Hispanics (60.0 per 100,000 versus 38.0 per 100,000), and 1.8 times higher than other ethnic groups (60.0 per 100,000 versus 34.2 per 100,000) in Texas.[4]

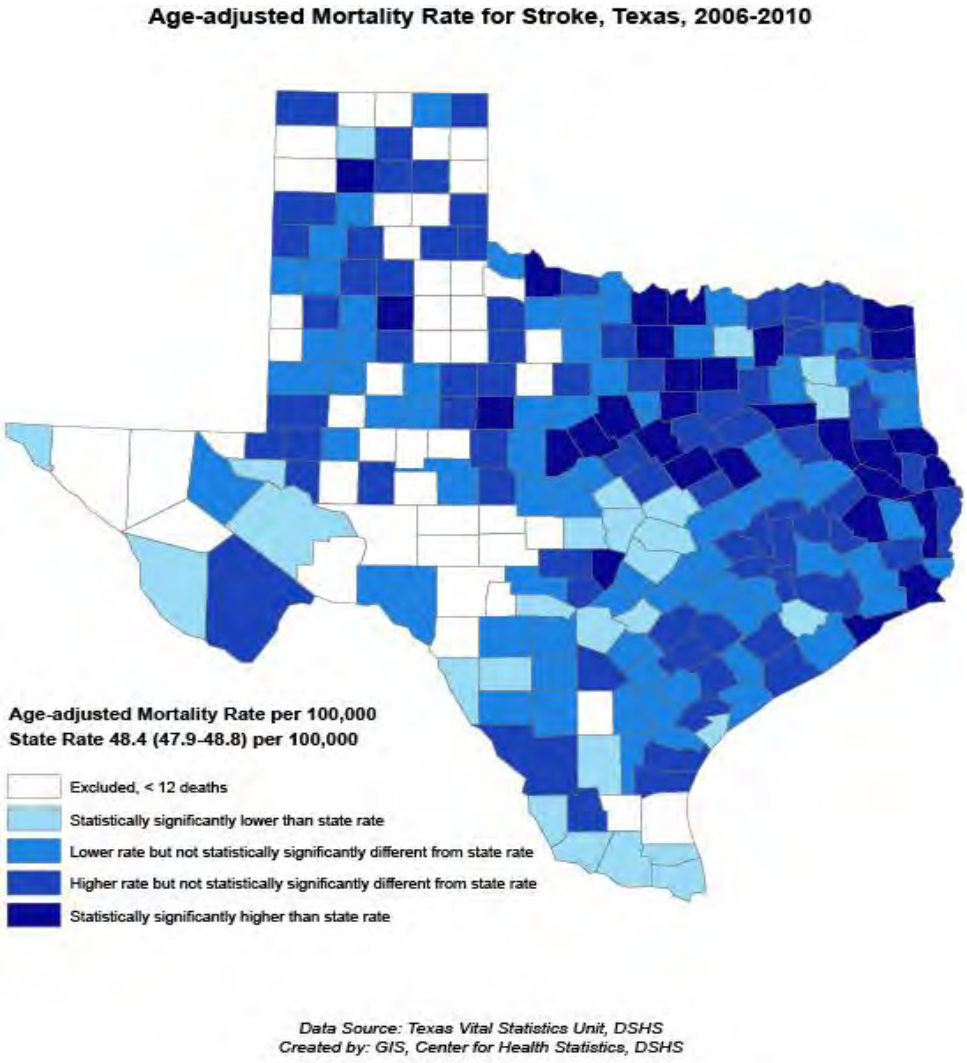
Geographic differences in mortality rates associated with ischemic heart disease and stroke among Texas urban, rural, and border regions are attributed to demographic differences. The highest age-adjusted mortality rates associated with heart disease are concentrated in East and Northeast Texas and the border region. The highest age-adjusted mortality rates associated with stroke are concentrated in Northeast Texas (see Figures 4 and 5).

Figure 4: Age-adjusted Mortality Rates for Ischemic Heart Disease by County, Texas, 2006-2010



Data Source: Texas Vital Statistics Unit, DSHS
Created by: GIS, Center for Health Statistics, DSHS

Figure 5: Age-adjusted Mortality Rate for Stroke by County, Texas, 2006-2010

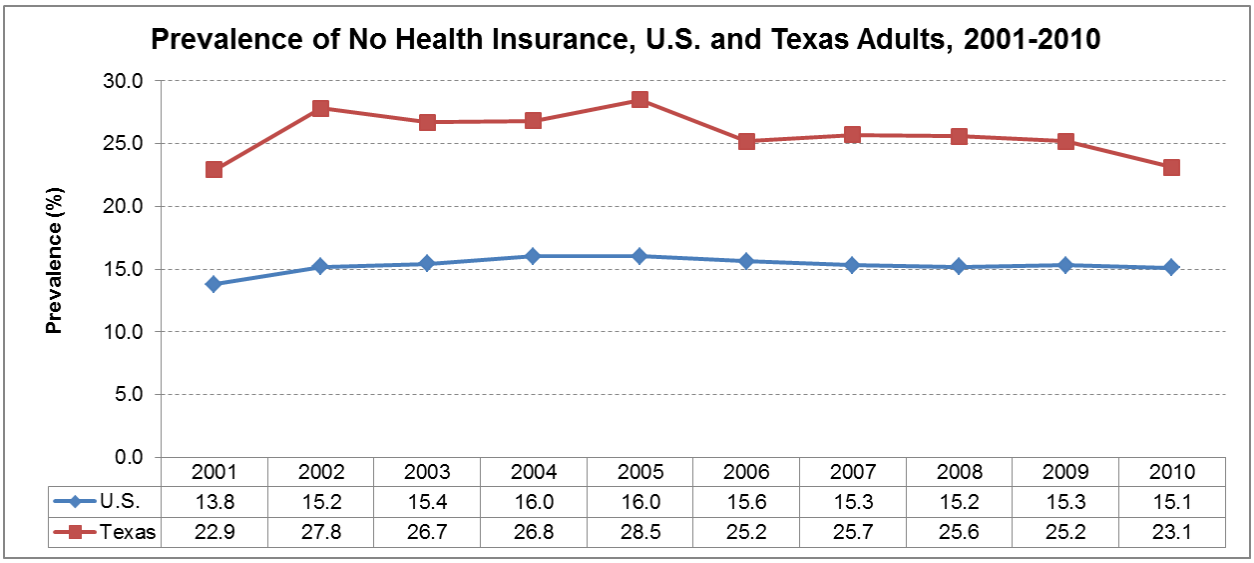


Access to Care

Barriers to accessing care include, but are not limited to: cost of care; geographic location; lack of insurance; language barriers; and not having a usual source of primary care. Populations that have decreased access to care may be referred to as *underserved*. Among Texans ages 18 years and older who have CVD or stroke in 2010, 14.8 percent stated that they did not have any type of health care coverage; 20.55 percent could not see a doctor due to the cost; and 26.1 percent did not have a routine checkup within the past year.[3]

Texas has consistently had a higher rate of health uninsurance compared to the U.S. (see Figure 6).[9] Compared to other states, Texas currently ranks lowest for the number of residents who have health insurance.[9] According to Texas BRFSS 2010, Public Health Service Regions along the border and in East Texas have particularly high rates of uninsurance (see Figure 7). Hispanics (46.2%) and African Americans (25.3%) are significantly more likely to lack health care coverage than Whites (11.6%). Younger Texas adults are more likely to be uninsured than older Texans, and Texans with lower education levels and lower annual income have a greater likelihood of being uninsured (see Figure 8).[3]

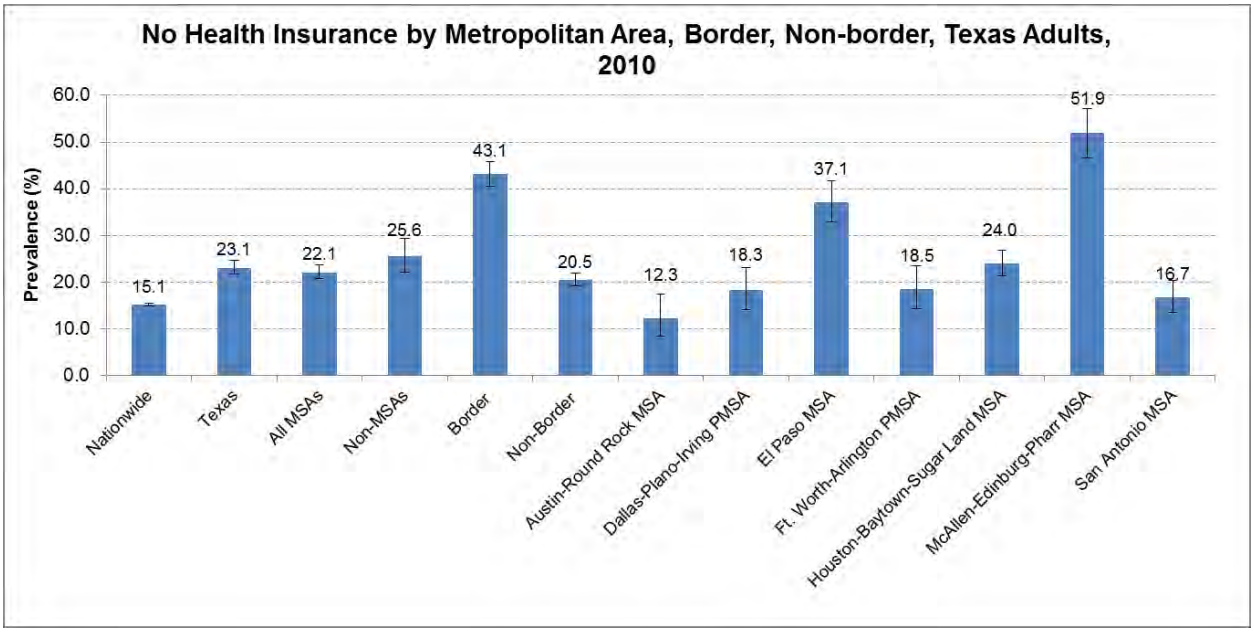
Figure 6: Prevalence of No Health Insurance, U.S. and Texas Adults, 2001-2010



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
U.S.	13.8	15.2	15.4	16.0	16.0	15.6	15.3	15.2	15.3	15.1
Texas	22.9	27.8	26.7	26.8	28.5	25.2	25.7	25.6	25.2	23.1

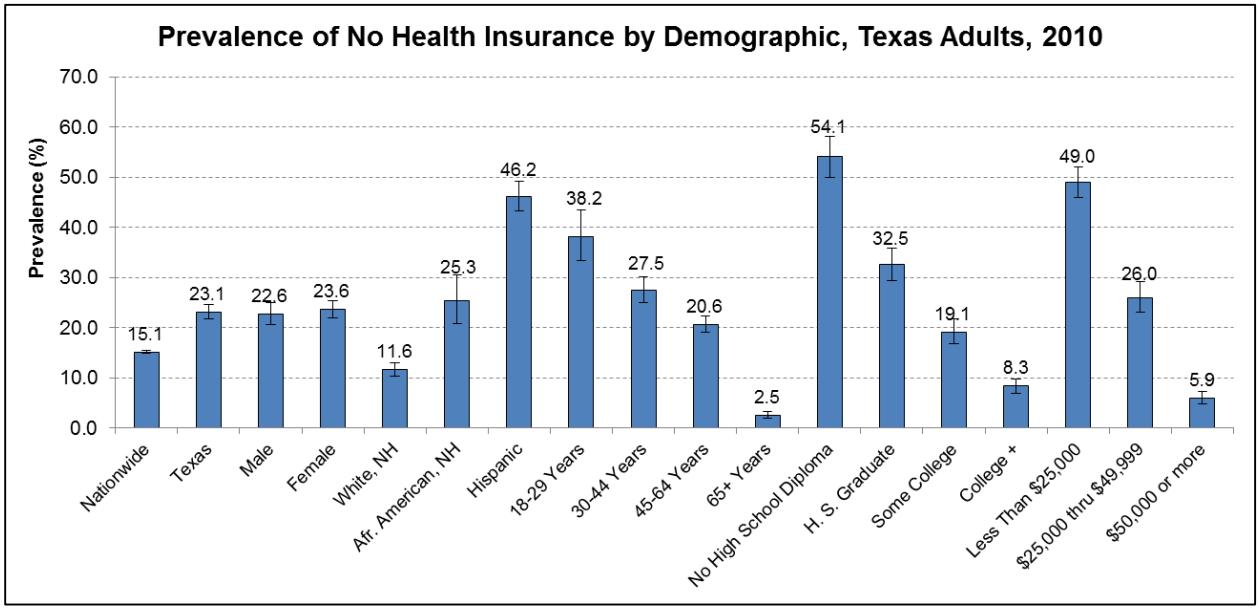
Data Source: BRFSS, Center for Health Statistics, TDSHS, 2010

Figure 7: No Health Insurance by Metropolitan Area, Border, Non-border, Texas Adults, 2010



Data source: BRFSS, Center for Health Statistics, TDSHS, 2010

Figure 8: Prevalence of No Health Insurance by Demographic, Texas Adults, 2010



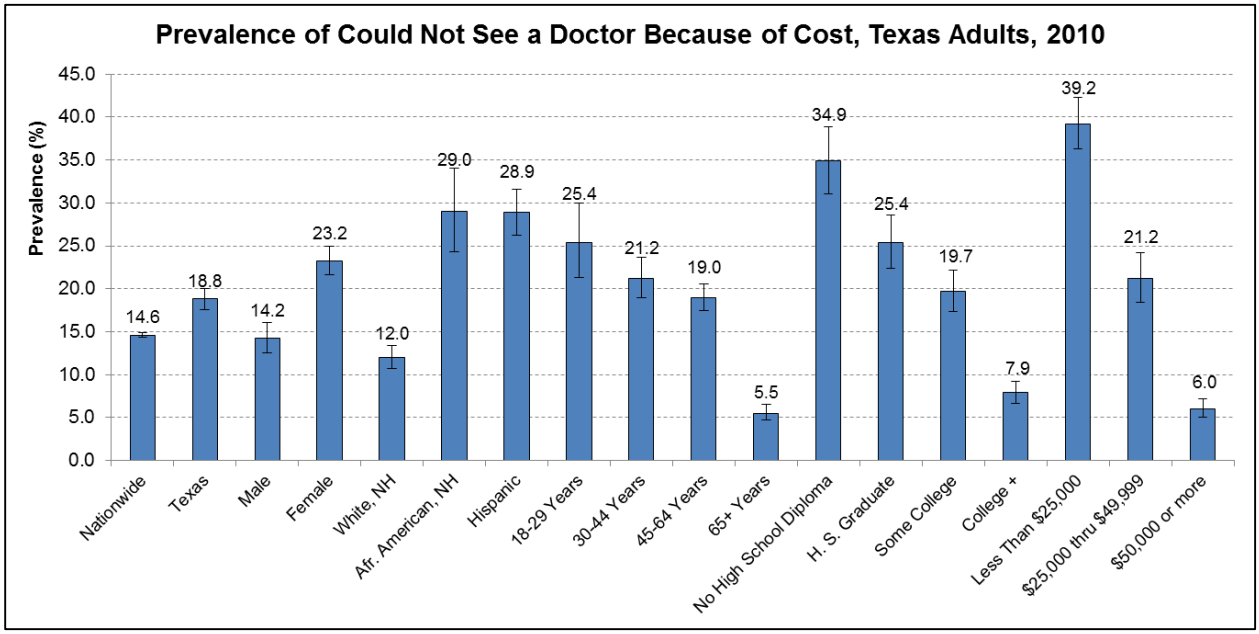
Data source: BRFSS, Center for Health Statistics, TDSHS, 2010

Secondary prevention of CVD and stroke relies on the early detection and management of risk factors such as high blood pressure, high blood cholesterol, diabetes, and obesity. Not having a usual source of primary health care is a barrier to secondary prevention. In 2010, Texas (38.9%) had significantly higher rates of adults who had not had a routine health check-up within the past year compared to the national average (31.9%).[3]

Cost is often a barrier to accessing routine health care, even for those with insurance. Texas (18.8%) had a significantly higher rate of adults who could not see a doctor in 2010 due to cost compared to the national average (14.6%). Females had significantly higher prevalence for inability to see a doctor due to cost than males. Hispanics (29.0%) and African Americans (28.9%) had a higher prevalence for inability to see a doctor due to cost than Whites (12.0%). Adults in the younger age groups had significantly higher prevalence for inability to see a doctor due to cost than those over 65 (see Figure 9).[3]

Access to long term care, including nursing home care, home health care, adult day care, assisted living, and hospice care is a critical and growing concern for all Americans as the number of elderly people continues to rise. Victims of both cardiac events and strokes often require post-hospital rehabilitation, and stroke victims left with disabilities require long term help to perform activities of daily living. Financial barriers and limited availability of services restrict access to these services. Addressing access to health care for all Texans will require system-wide policy changes.

Figure 9: Prevalence of Could Not See a Doctor Because of Cost, Texas Adults, 2010



Data source: BRFSS, Center for Health Statistics, TDSHS, 2010

Addressing Health Disparities

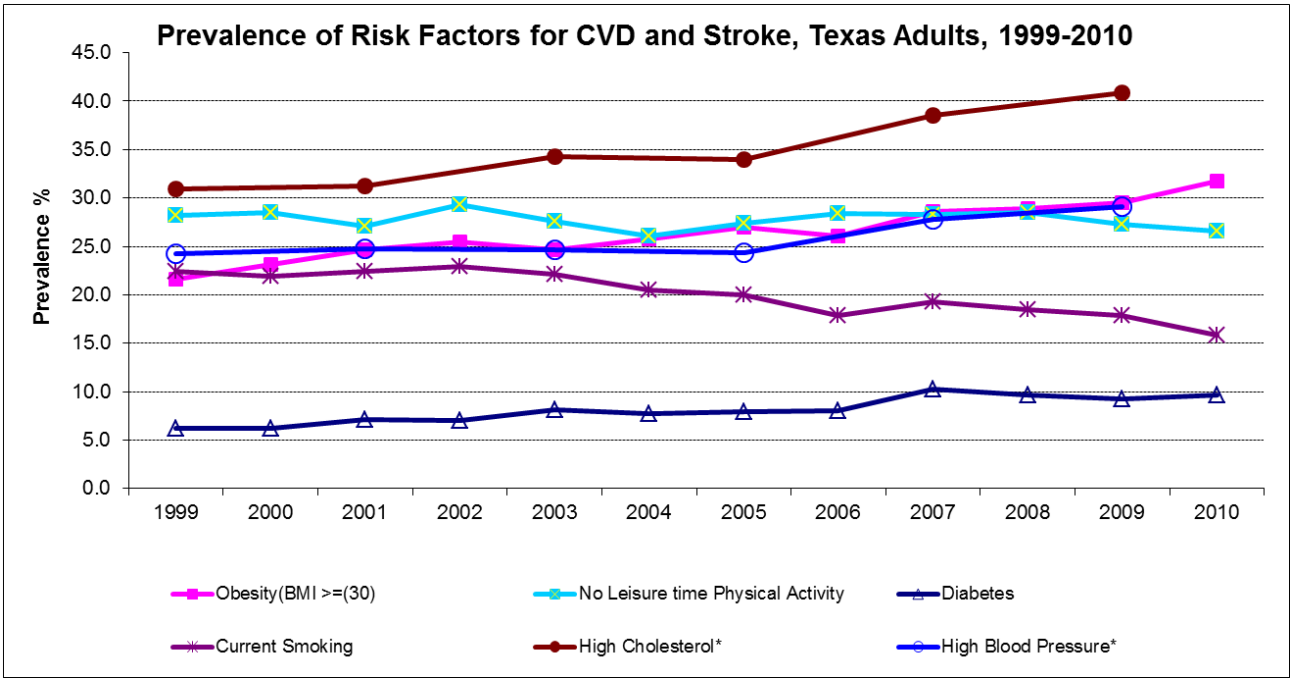
Addressing disparities in morbidity and mortality from CVD, stroke, and related risk factors must be a priority for all stakeholders working in these areas. The 2013 *Plan* includes a new objective related to identifying health disparities and at-risk populations. In addition, new strategies promote culturally appropriate communication in health care settings, use of non-traditional partners such as community health workers in health programming and health care settings, and access to underserved populations. Addressing disparities through the implementation of culturally competent, evidence-based strategies that effectively reach priority populations is a focus of the *Plan*.

Improving access to care for high risk populations and the underserved should be a priority for all programs working to reach Texans for the prevention, diagnosis, and treatment of CVD and stroke and related risk factors.

Risk Factors for Cardiovascular Disease and Stroke

There are several major risk factors that increase a person's chance of developing CVD. Many of these risk factors are modifiable through primary prevention measures such as eating a healthy diet, engaging in regular physical activity, maintaining a healthy weight, and avoiding tobacco use and exposure. Others are modifiable through secondary prevention measures such as treating and controlling high blood pressure and high cholesterol, weight loss for overweight and obese individuals, and tobacco cessation for smokers. Though modifiable, many risk factors for CVD and stroke in Texas have been on the rise over the past decade (see Figure 10).

Figure 10: Prevalence of Risk Factors for CVD and Stroke, Texas Adults, 1999-2010



An examination of the trends in modifiable risk factors over the past decade in Texas demonstrates an increase in the prevalence of high cholesterol, obesity, diabetes, and high blood pressure. Rates of individuals getting no leisure time physical activity have remained relatively level. Smoking rates have decreased since 1995, and while data showed an increase in the estimated number of adults who smoke from 2006 to 2007, a decreasing trend was observed from 2007 to 2010.[3]

* Data not available for 2010

Data source: BRFSS, Center for Health Statistics, TDSHS, 2010

High Blood Pressure

High blood pressure, also known as hypertension, affects one in three Americans, or more than 76 million people in the U.S.[2] In 2009, about three out of ten (29.1%) Texas adults reported that they had been diagnosed with high blood pressure.[3] Hypertension rates for those ages 65 and older are over 60 percent. As the population ages, the prevalence of high blood pressure will increase unless broad and effective preventive measures are implemented.[2]

In addition to physical consequences, high blood pressure is costly for the nation and the state. The total annual direct and indirect cost of high blood pressure to the U.S. economy in 2008 was $50.6 billion.[2] In Texas in 2010, hospital charges for high blood pressure exceeded $1 billion.[5]

High blood pressure can be caused by many different medical conditions, including chronic kidney disease, primary aldosteronism, renovascular disease, coarctation of the aorta, and thyroid or parathyroid disease; however, many risks for high blood pressure are modifiable.[10] Obesity, excessive alcohol consumption, smoking, lack of physical activity, and a diet high in sodium are all risk factors for high blood pressure.[31]

The relationship between blood pressure and the risk for CVD is well established and independent of other risk factors. High blood pressure is a factor in 69 percent of first-time heart attacks, 77 percent of first-time strokes,

and 74 percent of heart failures.[2] The higher the blood pressure, the greater the risk for heart attack, heart failure, and stroke. Blood pressure is classified according to systolic and diastolic readings as normal, pre-hypertension or hypertension stages one or two (see Table 2).The presence of pre-hypertension signals the need for increased education and lifestyle changes to prevent the onset of hypertension.[10]

Table 2: Blood Pressure Classification

Blood Pressure Classification		
Blood Pressure Classification	**Systolic (mmHg)**	**Diastolic (mmHg)**
Normal	< 120	And < 80
Prehypertension	120-139	Or 80-89
Stage 1 Hypertension	140-159	Or 90-99
Stage 2 Hypertension	≥ 160	Or ≥ 100

Adapted from The 7th Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure, DHHS, 2003

Adoption of a healthy lifestyle is critical for the prevention of high blood pressure and is an integral part of the management of hypertension. Lifestyle changes include weight reduction, adoption of the Dietary Approaches to Stop Hypertension (DASH) eating plan, sodium reduction, physical activity, smoking cessation, and moderation of alcohol consumption. Combinations of lifestyle modifications can achieve the best results.[10]

Unfortunately, in many cases lifestyle modifications alone are not enough to control high blood pressure. Antihypertensive therapy, frequently with the use of two or more drugs, is often necessary. Antihypertensive therapy has been associated not only with excellent results in controlling high blood pressure but with reductions in the incidence of stroke, heart attack, and heart failure. Lifestyle modifications can enhance the effects of drug therapy and contribute to lower cardiovascular risk.[10]

However, even the most effective therapy may fail to control hypertension if the patient does not or cannot adhere to prescribed medication regimens and adopt healthy lifestyle changes. It is important for clinicians to understand cultural differences, individual beliefs, and socioeconomic barriers to following recommendations and to use a patient-centered strategy to achieve mutual goals.[10] Promoting provider adherence to hypertension guidelines through provider training and education, in addition to cultural competency training, may be another key step to increasing high blood pressure control.[32]

High blood pressure control is a priority in the 2013 *Plan* and will be a major focus of work in the future for the Cardiovascular Disease and Stroke Program and the Texas Cardiovascular Disease and Stroke Partnership.

High Blood Cholesterol

About four out of ten (40.9%) Texas adults in 2009 had been diagnosed with high blood cholesterol, a major risk factor for heart disease.[3] Research indicates that elevated low density lipoprotein (LDL) cholesterol, low high density lipoprotein (HDL) cholesterol, and elevated triglycerides are each independent risk factors for CVD. [11] Classifications of LDL, HDL, and total cholesterol and triglycerides are outlined in Table 3.

Current guidelines from the National Cholesterol Education Program (NCEP) recommend a fasting lipoprotein profile (total cholesterol, LDL, HDL, and triglyceride) be measured every five years for adults 20 years and older. Adherence to screening guidelines by health care providers and making patients aware of their cholesterol levels are critical components of efforts to reduce high cholesterol.[11]

Table 3: Classification of LDL, Total, HDL Cholesterol and Triglycerides (mg/dL)

Classification of LDL, Total, HDL Cholesterol and Triglycerides (mg/dL)	
LDL Cholesterol	**Classification**
<70	Therapeutic option for very high risk patients
< 100	Optimal
100-129	Near optimal/above optimal
130-159	Borderline high
160-189	High
> 190	Very high
Total Cholesterol	
< 200	Desirable
200-239	Borderline high
≥ 240	High
HDL Cholesterol	
< 40	Low
≥ 60	High
Triglycerides	
< 150	Normal
150-199	Borderline high
200-499	High
≥ 500	Very high

Adapted from Third Report of the National Cholesterol Education Program Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults, 2001 and the 2004 Update

Reducing risk associated with high blood cholesterol involves reducing lifestyle risk factors such as obesity, physical inactivity, a diet high in saturated fats, excess alcohol consumption, and tobacco use. A diet high in

carbohydrates (more than 60 percent of energy intake), certain diseases, certain drugs, and genetic causes are also associated with abnormal lipoproteins.[11]

In addition to therapeutic lifestyle changes, treatment with medication therapy may be indicated. LDL lowering drug therapy has been shown to be very effective in reducing risk for CVD.[11] Adherence to NCEP guidelines by both patients and providers is key to achieving success in managing cholesterol levels and reducing risk for CVD. The NCEP Expert Panel recommends use of multi-disciplinary methods involving the patient, providers, and the health care delivery system to achieve population level effectiveness for primary and secondary prevention of high cholesterol.[11] Increasing the proportion of adults who have been screened for high cholesterol within the past five years and decreasing the proportion of adults with high non-HDL cholesterol levels are objectives of the 2013 *Plan*.

Diabetes

Diabetes, a major risk factor for CVD, is a group of diseases marked by high levels of blood glucose and includes Type 1, Type 2, gestational, and other types resulting from various medical conditions. People with Type 1 diabetes must monitor and control their blood glucose level through insulin administration. Those with Type 2 diabetes can often control their blood glucose through diet, exercise, and oral medication.[12]

It is estimated that nearly 26 million people in the U.S. have diabetes, seven million of whom are still undiagnosed.[12] The prevalence of diabetes in Texas has increased over the past decade from 6.2 percent of the population in 2000 to 9.7 percent in 2010.[3] African Americans (16.5%) have a significantly higher prevalence of diabetes in Texas, compared to Whites (8.2%) and Hispanics (11%). However, as the Hispanic population in Texas continues to increase, it is estimated that by 2040, Hispanics will comprise the majority of diabetes cases.[35] Diabetes prevalence also increases significantly with age, increasing sharply at age 45 and above.

Diabetes negatively affects the risk of cardiac events in addition to cardiac outcomes. Adults with diabetes have heart disease mortality rates two to four times higher than adults without diabetes, and the risk for stroke is two to four times greater with diabetes. In fact, two out of three people with diabetes die from heart disease or stroke. Due to the relationship between diabetes and CVD, diabetes management is complicated and involves not only control of blood glucose but also of blood pressure and cholesterol levels. Diabetes Self-management Education (DSME) involves providing people with the tools to develop problem-solving and coping skills to manage diabetes on their own. DSME is integral to good outcomes and a high quality of life.[12]

The Texas Diabetes Council, established by the Texas Legislature, is charged with developing and implementing a state plan for diabetes treatment, education, and training. *Changing the Course: A Plan to Prevent and Control Diabetes in Texas, 2012-2013* (*Diabetes Plan*) identifies five priorities: advancing public policy; evaluating the impact of diabetes in Texas; promoting comprehensive programs for the prevention of diabetes; increasing public awareness, promoting community outreach and diabetes education; and improving diabetes care and prevention of complications by health care professionals. The Diabetes Prevention and Control Branch of the Texas DSHS undertakes and sponsors a number of key activities that support the five priorities of the *Diabetes Plan*.[13] An objective of the 2013 *Texas Plan to Reduce Cardiovascular Disease and Stroke* is to reduce the death rate from CVD and stroke among those with diabetes.

Tobacco Use and Exposure to Second Hand Smoke

Tobacco remains the single most preventable cause of death and disease in the U.S. today. Tobacco use is a major risk factor for heart disease and stroke.[14] From 2000-2004, 32.7 percent of smoking-attributable death was caused by CVD.[33] The CDC estimates that tobacco use costs the country $96 billion in direct medical care expenses and $97 billion in lost productivity each year.[14]

In Texas, adult smoking rates decreased significantly from 2007 (19.3%) to 2010 (15.8%).[3] The Texas high school smoking rate in 2011 (high school students who reported smoking cigarettes on one or more days during the past 30 days) was 17.4% compared to the Healthy People 2010 goal of 16%.[15] So while Texas has seen improvements, there is still progress to be made.

Exposure to secondhand smoke is also causally associated with CVD. According to the CDC, involuntary exposure to secondhand smoke in home or work environments increases the risk of heart attack by 25-35 percent. Each year in the U.S., 46,000 non-smokers die from CVD related to secondhand smoke.[16] Many Texas communities are working to adopt or have already passed smoke-free ordinances that reduce exposure to secondhand smoke in public places, including bars and restaurants. However, 57 percent of the municipal Texas population is still not covered by smoke-free policies across five focal settings, including municipal worksites, private worksites, restaurants, bars in restaurants, and bars not in restaurants.[45]

Tobacco-related health disparities are reflected in unequal prevention and treatment of tobacco use, disproportionate incidence, disparate morbidity and mortality, and inadequate access to resources. Members of certain racial/ethnic minority groups, people with low socioeconomic status, and people with lower levels of education are at higher risk for tobacco use and exposure to secondhand smoke and experience more tobacco related illness and death.[34] In Texas, young adults between 18 and 29 (23.6%) had significantly higher smoking prevalence than older adults (30-44 years, 14.2%; 45-64 years, 17.6%; 65 and older, 8.5%). Males (18.3%) had higher smoking prevalence than females (13.4%), and Whites (17.0%) and African Americans (18.3%) had higher smoking prevalence rates than Hispanics (13.7%), although this was not statistically significant.[3]

Investments in state level, evidence-based prevention programs have produced significant reductions in cigarette consumption, demonstrating the need for fully funded statewide tobacco prevention programs at CDC-recommended levels. Tobacco control in Texas is underfunded with 0.3 percent of the $1.9 billion collected yearly in Texas from tobacco settlement funds and tobacco taxes invested in comprehensive community level programs. This spending level places Texas 39th among the states for tobacco prevention program funding.[17]

The Texas Cancer Council, which became the Cancer Prevention and Research Institute of Texas (CPRIT) in 2007, is charged with implementing the *Texas Cancer Plan* and published the *Texas Tobacco Control Plan 2008, A Statewide Action Plan for Tobacco Prevention and Control in Texas*.[34] Partners from across the state and many community level stakeholders are actively working to reduce tobacco use in Texas. Reducing tobacco use among youth and adults and reducing exposure to secondhand smoke are objectives of the 2013 *Plan*.

Overweight and Obesity

The prevalence of overweight and obesity in Texas and the U.S. has been on the rise for the past few decades. In fact, obesity rates among children have tripled and rates among adults have doubled.[18] In 2010,

two out of three (66.6%) Texas adults were overweight or obese. Males (73.5%) had a significantly higher overweight and obesity rate than females (59.2%). Among racial/ethnic groups, Hispanics (74.3%) and African Americans (73.7%) had significantly higher rates for obesity and overweight compared to Whites (62.9%). Persons ages 45-64 (72.6%) are significantly more overweight or obese than those ages 18-29 (49.8%) or older than 65 (65.4%).[3]

A survey of high school students conducted in 2011 found that 16 percent of students were overweight (at or above the 85th percentile but less than the 95th percentile for body mass index[18]), and 19 percent of males and 11.9 percent of females were obese (at or above the 95th percentile for body mass index[18]). Hispanic students, followed by African American students, had higher rates of overweight than Whites at 18.4 percent, 17.8 percent, and 12.4 percent respectively.[15]

Heart disease, stroke, high blood pressure, high cholesterol, diabetes, cancer, respiratory problems, and arthritis are among the health consequences of overweight and obesity. Risk factors for heart disease such as high cholesterol and high blood pressure are more prevalent in children and adolescents who are overweight or obese.[18]

In addition to contributing to poor health outcomes, obesity harms the economy. According to the CDC, total direct and indirect medical expenses related to obesity were a staggering $147 billion in 2008.[19] The Texas Comptroller estimates that obesity cost Texas businesses $9.5 billion in 2009, and if obesity rates among the Texas workforce continue to increase, obesity could cost Texas businesses $32.5 billion in 2030.[39]

Overweight and obesity classifications are determined by body mass index (BMI), a ratio of body weight (kg) to height (m)^2. Overweight is defined, in adults, as a BMI between 25 and 29.9. Obesity in adults is defined as a BMI of 30 or higher. In children, overweight is defined as between the 85th and 95th percentile for BMI for age and sex specific percentile, and obesity is defined as 95th percentile and higher. [18]

The Surgeon General's *Vision for a Healthy and Fit Nation* identifies, as a national priority for immediate action, the need for the nation to take an informed, sensitive approach to communicate with and educate the American people about health issues related to overweight and obesity. While personal behaviors and choices related to diet and physical activity do affect health outcomes including obesity, focus on changing the social and physical environments allows individuals and communities to have opportunities to make healthy choices that lead to positive health outcomes.[18]

Research has shown that childhood obesity, even among underserved populations, can be reduced by finding and using opportunities for comprehensive obesity prevention and control efforts that involve community programing, school health programs, nutrition and physical activity programs for adults, and advertising campaigns.[44] The Nutrition, Physical Activity, and Obesity Prevention Program at DSHS has worked with partners from across the state to produce *Updates for the Strategic Plan for the Prevention of Obesity in Texas 2008 (Update).* The *Update* is intended to provide direction and focus as Texans move forward with implementation of the *Strategic Plan for the Prevention of Obesity in Texas: 2005-2010 (Obesity Plan).* The *Update* identifies 19 key targets from the *Obesity Plan* and 55 indicators that will be used to track progress as partners across Texas work to address obesity as a public health issue; create opportunities to choose lifestyles that promote healthy weight; implement policies and environmental changes that support healthful eating and physical activity; and decrease obesity rates through the dissemination of evidence-based

practices.[20] Reducing the proportion of adults and youth who are overweight or obese is an objective of the *Texas Plan to Reduce Cardiovascular Disease and Stroke*.

Unhealthy Eating

Nutrition plays an important role in an individual's overall health and quality of life. A diet high in calories, saturated or trans fats, cholesterol, sodium, and/or sugar contributes to poor health. Whereas a diet high in fruits and vegetables leads to better health outcomes.[21]

For reducing risk of CVD and stroke, the American Heart Association encourages individuals to know their daily caloric intake to ensure calories eaten do not exceed calories burned through daily physical activity and consuming nutrient rich foods that are high in vitamins, minerals, fiber, and other nutrients but low in calories.[21]

Americans are encouraged to eat a variety of foods, including:

- Vegetables and fruits (at least 4.5 cups a day)
- Unrefined whole grains
- Low fat dairy products, lean meats, poultry, and fish, including oily fish high in omega-3 fatty acids
- Limited amounts of salt, sugar, saturated fats, trans fats, and cholesterol [21]

The 2013 *Plan* focuses on three of the Healthy People 2020 objectives for improving nutrition related to CVD and stroke: fruit and vegetable consumption and sodium intake.

A NOTE ON BREASTFEEDING

Breastfeeding benefits extend into adulthood, and have shown positive outcomes for mothers and infants, in addition to children and adults who were breastfed as infants. Studies have shown that women who breastfed for 7-12 months were less likely to have hypertension, diabetes, and hyperlipidemia later in life and were less likely to develop cardiovascular disease later in life.[22] Breastfeeding also has been associated with higher levels of HDL-c and lower BMI in adulthood.[42] Studies have shown that children who were not breastfed experience higher average blood pressure and cholesterol, and adults who were not breastfed as infants have significantly higher average cholesterol levels than their breastfed counterparts. [43]

In 2009, Texas (76.2%) had a similar prevalence of eating fruits and vegetables fewer than five times per day compared to the nation (76.3%). Males (80.8%) had a significantly higher prevalence of low fruit and vegetable consumption than females (71.8%), and there was no statistically significant difference among racial/ethnic groups.[3] Poor eating habits are often established during childhood, so resources should be directed toward initiatives that affect children's nutrition. Only 18.5 percent of Texas high school students in 2011 reported eating five or more servings of fruits and vegetables per day. African American (21.0%) and Hispanic (20.2%) students were more likely to report they had eaten five or more servings of fruits and vegetables per day for the past seven days than White students (14.8%), but the difference was not statistically significant. Male high school students (21.2%) were significantly more likely to report they had eaten five or more servings of fruits and vegetables per day for the past seven days than female high school students (15.6%).[15]

Dietary sodium reduction is a cornerstone in managing high blood pressure. Excessive sodium intake is a proven risk factor for high blood pressure, which can lead to cardiovascular events .[23] The 2010 Dietary Guidelines for Americans recommends reducing sodium intake to no more than 2,300 mg per day for the

general population and no more than 1,500 mg per day for those who are at a higher risk for cardiovascular events.[23] A popular, evidence-based approach to reducing hypertension is the Dietary Approaches to Stop Hypertension (DASH) eating plan. A 1,600 mg sodium DASH eating plan has effects similar to single drug therapy for treating high blood pressure.[10] Reducing the amount of sodium in manufactured/packaged and restaurant-prepared foods has become a national initiative to reduce daily intake of sodium by Americans.[23]

To meet national and state objectives for good nutrition, the CDC recommends a public health approach that includes continued surveillance and strategies that support and reinforce healthy behavior and address barriers. Interventions that increase public awareness, effectively motivate individual behavior change, and increase access to affordable healthy foods should be promoted. Related strategies include health care provider recommendations, school-based initiatives, faith-based and culturally appropriate programs, and access to community gardens and farmer's markets.[24] Objectives to increase the proportion of youth and adults who report eating fruits and vegetables five or more times per day and who report currently taking measures to reduce sodium intake are a focus of the 2013 *Plan*.

Lack of Physical Activity

Regular physical activity is associated with reduced risk for chronic disease and a healthier, longer life. Cardiovascular benefits of regular physical activity include lower risk for heart disease, high blood pressure, stroke, abnormal blood cholesterol and triglycerides, diabetes, and obesity.[25]

Despite the benefits, most Texans, like most Americans, are sedentary. In 2010, the proportion of Texas adults who reported no participation in leisure time activity (26.7%) was significantly higher than the national average (24.4%). Females (29.9%) were significantly less likely to participate in leisure time activity compared to males (23.4%). African Americans (32.6%) and Hispanics (32.3%) had a significantly higher prevalence of no leisure time activity than Whites (23.0%). Persons over the age of 65 (32.9%) were significantly less likely to participate in leisure time activity than other age groups.[3]

Lack of physical activity has contributed to a sharp increase in childhood obesity over the past 20 years.[18] In 2011, too few Texas high school students reported being physically active for at least 60 minutes per day on five or more days during the past week (44.5%). Males were significantly more likely to be active (53.6%) than females (35.1%), while Hispanic students were less likely to be active (39.6%) compared to Whites (50.4%) and African Americans (47.8%).[15]

The U.S. Department of Health and Human Services recommends that adults do 150 minutes of moderately intense exercise per week or 75 minutes of vigorous exercise. Youth recommendations are 60 minutes daily of moderately intense to vigorous activity. Adults should also engage in muscle-strengthening exercise two or more days per week for additional health benefits.[25] Only 48.1 percent of Texans 18 and older participated in moderate physical activity in 2009.[3] Children and adolescents should have at least 60 minutes of moderate physical activity a day, with at least three days a week of vigorous physical activity. Children and adolescents should also do physical activity that involves muscle-strengthening and bone-strengthening at least three days of the week.[25]

Interventions that have shown success in promoting physical fitness include: limiting screen time for youth, establishing policies for physical activity in child care and school settings; creating physical activity curricula based on national standards; establishing worksite wellness programs that promote physical activity by offering incentives, designated exercise areas, safe walking paths and stairwell programs; supporting health care provider reminders related to physical activity screening and education; building infrastructure for safe walking

and biking in the community; and improving access to public transportation.[18] The 2013 *Plan* includes objectives to increase the proportion of adults and youth who engage in regular physical activity.

Systems of Care

The early detection and effective treatment of already-established CVD is crucial. Monitoring, tracking, and making improvements, where needed, within the systems of care in Texas are priorities in the 2013 *Plan*. Information and data regarding the general public's knowledge of early warning signs and symptoms of heart attack and stroke events, the development and implementation of screening and treatment guidelines and protocols, and the quality and equity of long term care are needed in order for Texas policy makers, agency and organizational leaders, and community level practitioners to better understand the issues and challenges Texas faces in reducing mortality and morbidity from heart attack and stroke.

The benefits of rapid identification and treatment of heart attack and stroke are clear. Early treatment of heart attack reduces heart muscle damage and early treatment of stroke can minimize functional disability. As therapies become increasingly more effective, rapid implementation of therapies has become critical to improving patient outcomes.[37] Strategies for improving patient outcomes include developing and implementing clinical practice guidelines and protocols that reflect accepted standards of care and providing education and training for emergency department personnel.

The systems of care targeting cardiac and stroke events can be classified as the emergency health care system or pre-hospital care; the stroke system of care; the heart system of care; and the public health system. While each of these systems has a unique role, coordination among the systems of care is of utmost importance to ensure efficient and effective, high-quality care.

Emergency Health Care System (Pre-hospital care)

For both a stroke event and a cardiac event, rapid diagnosis and treatment can mean the difference between recovery, disability, or death. Healthy People 2020 has set developmental objectives for increasing the proportion of persons who have access to rapidly responding pre-hospital emergency services and the proportion covered by basic life support or advanced life support.[36]

In Texas, the average Emergency Medical Services (EMS) response time for a suspected cardiac event in 2008 was approximately 8.5 minutes from the time the call was received to the time EMS arrived on the scene, and the average delivery time was nearly 39.7 minutes from the time the call was received to the time EMS arrived at the destination, generally a hospital. For a suspected stroke, the average EMS response time was approximately 11.0 minutes and the average delivery time was 42.3 minutes.[37]

Response times varied across Public Health Service Regions (HSR). Some Regions demonstrated improvement in response time between 2007 and 2008 while others did not. The average EMS response times for cardiac arrest in HSR 11 increased from 7.6 minutes in 2006 to 13.4 minutes in 2008, and the average EMS response time for stroke increased from 8.8 minutes in 2006 to 27.7 minutes in 2008. [37] (Note: These numbers are likely underestimations as the Texas EMS/Trauma Registry did not receive medical-related calls from all participating EMS providers in Texas.[37])

A 2010 survey conducted of EMS in 200 cities in America identifies the need for improvements in the emergency health care system from the time a 911 call is placed until the patient is delivered to the hospital.

Other identified issues within the emergency system of care include service cutbacks related to decreased tax funding and an increasing number of uninsured patients; use of emergency medical dispatch protocols; use of electronic patient care records; use of transport protocols for designated cardiac or stroke centers; lack of protocols for use of thrombolytics; and community CPR and public access defibrillator programs.[26] The emergency health care system, in coordination with the stroke, cardiac, and public health systems of care, will need to address these current issues moving forward to provide high-quality, efficient care.

The Stroke System of Care

Many areas of Texas are currently underserved with regard to stroke facilities that are able to effectively diagnose, treat, and manage stroke patients. DSHS designates Texas stroke facilities as either *comprehensive*, *primary* or *support* facilities, based on services provided. Services may include acute stroke care, supportive care and transport, and comprehensive stroke care including the full range of stroke treatments, rehabilitation, and long term care.

The Cardiovascular Disease and Stroke Program and Texas Cardiovascular Disease and Stroke Partnership, in consultation with the DSHS Office of EMS and in collaboration with the American Heart Association (AHA) and the American Stroke Association (ASA), developed the Stroke Public Education Toolkit -2010. This initiative aimed to impact timely care to patients, reduce the burden of stroke, and improve survival outcomes through public education campaigns (see Appendix I). Continuing to improve and expand the stroke system of care in Texas is a focus of the 2013 *Plan*.

The Heart System of Care

The heart system of care ranges from acute care to rehabilitation services. Many areas of Texas also are underserved with regard to such capacity for cardiac care, even though early treatment and continued management is crucial. Patients who receive artery opening therapy within the first or second hour after the onset of heart attack symptoms experience significant reductions in disability and death.[37] An AHA initiative for ST elevation myocardial infarctions (STEMI), called Mission: Lifeline, focuses on increasing the number of patients with timely access to quality care. According to the AHA, about 250,000 people a year experience STEMI. About 30 percent of those people do not receive percutaneous coronary intervention (PCI) or thrombolytic therapy, and of those who do receive PCI, only 40 percent receive PCI within the timeframe recommended by AHA. Less than 50 percent of patients receive thrombolytic therapy within the recommended timeframe, and 70 percent of patients who are not eligible for thrombolytic therapy do not receive PCI, which is the only other option to restore blood flow to occluded arteries.[28]

STEMI vs. NSTEMI

ST-elevation myocardial infarction (STEMI) is a heart attack that happens as a result of total coronary artery blockage. Because of the occlusive nature, there is a high risk of death and disability with STEMI. A non ST-elevation myocardial infarction (NSTEMI) may occur when an artery is partially blocked and therefore severely reducing blood flow through that artery. The fastest way to differentiate a STEMI and NSTEMI event is through an electrocardiogram (ECG). [28]

In addition to STEMI events, guidelines for treating non ST-elevation myocardial infarction (NSTEMI), are not routinely followed in all patients, and therefore NSTEMI outcomes are not as positive as they should be based on current scientific knowledge.[38] Therefore, appropriate utilization of treatment for cardiovascular events and improving and expanding the heart system of care in Texas is a key objective of the 2013 *Plan*.

Public Health System

Throughout its history, DSHS has funded and supported numerous statewide and community level initiatives to reduce CVD and stroke. DSHS continues to address CVD and stroke as a public health issue through the CDC-funded Cardiovascular Disease and Stroke Program. In addition, the program supports the Texas Council on Cardiovascular Disease and Stroke and the Texas Cardiovascular Disease and Stroke Partnership.

A systems approach that focuses on building capacity for state and local efforts to implement population-based interventions has been and will continue to be a priority for the Cardiovascular Disease and Stroke Program. The Cardiovascular Disease and Stroke Program and statewide Partnership are pursuing population-based, capacity-building strategies, including: monitoring CVD and stroke; supporting collaboration among partners; coordinating available services and resources; expanding reach and improving quality of care; connecting partners to evidence-based interventions; and working to reduce health care disparities. The 2013 *Plan* includes objectives related to those efforts and aims to increase the capacity for state and local entities to implement the *Plan*.

Framework for Action

The Texas Framework for Heart Disease and Stroke (Framework) has undergone a dramatic change since 2008. The new Framework is modeled after the Coordinated Chronic Disease State Plan Framework and outlines a comprehensive strategy for the *Texas Plan to Reduce Cardiovascular Disease and Stroke* through four domains or focus areas (see Figure 11). Domains include *Strategies that Reinforce/Support Healthy Behavior*, *Health Systems Interventions*, *Community-Clinical Linkages Enhancements*, and *Surveillance and Epidemiology*. Each focus area contains a goal and accompanying objectives and strategies that tend to be cross-cutting with many similar aims. The *Strategies that Support/Reinforce Healthy Behavior* focus area contains policy or environmental approaches to achieving health behavior changes. The *Clinical-Community Linkages Enhancement*s focus area contains strategies that promote partnerships between clinical groups and community supports to improve patient health. The *Health Systems Interventions* focus area contains strategies that aim to improve the way health care systems in the state detect, manage and control heart disease and stroke through changes in capacity and infrastructure. Lastly, the *Surveillance and Epidemiology* domain comprises objectives and strategies that aim to provide enhanced data and information for purposes of monitoring trends and progress, raising awareness, increasing knowledge, and ultimately decision-making. In an effort to move towards a more coordinated approach to CVD and stroke , as well as to chronic disease, the 2013 objectives and strategies tend to be cross-cutting through the four focus areas.

The Framework also demonstrates which sectors, partners, and organizational resources frame the *Plan*. Identified sectors include worksites, schools, communities, and health care settings. Inputs include the Texas Council on Cardiovascular Disease and Stroke, the Texas Cardiovascular Disease and Stroke Partnership, the Cardiovascular Disease and Stroke Program, and national and state partners. Organizational resources include the Texas Department of State Health Services, the Health Promotion & Chronic Disease Prevention Section, and the Division for Preparedness and Disease Control.

As the framework suggests, when four broad approaches (*Strategies that Support/Reinforce Healthy Behavior, Health Systems Interventions*, *Clinical-Community Linkages Enhancements* and *Epidemiology and Surveillance*) are fully and effectively implemented, a heart healthy, stroke-free Texas can be realized.

A Model for Action

In addition to a framework, a logic model is a tool for graphically representing the relationships between a program's activities and its intended effects, the assumptions that underlie expectations, and the context in which the program will operate.[29] Figure 12 depicts a logic model that represents the critical entities that are needed for successful *Plan* implementation; major activities that will take place, especially those involving the coordinated efforts of the Partnership; concrete outputs that will be generated along the way; and expected short, intermediate, and long term outcomes.

Figure 11: Framework for a State Plan to Reduce Heart Disease and Stroke

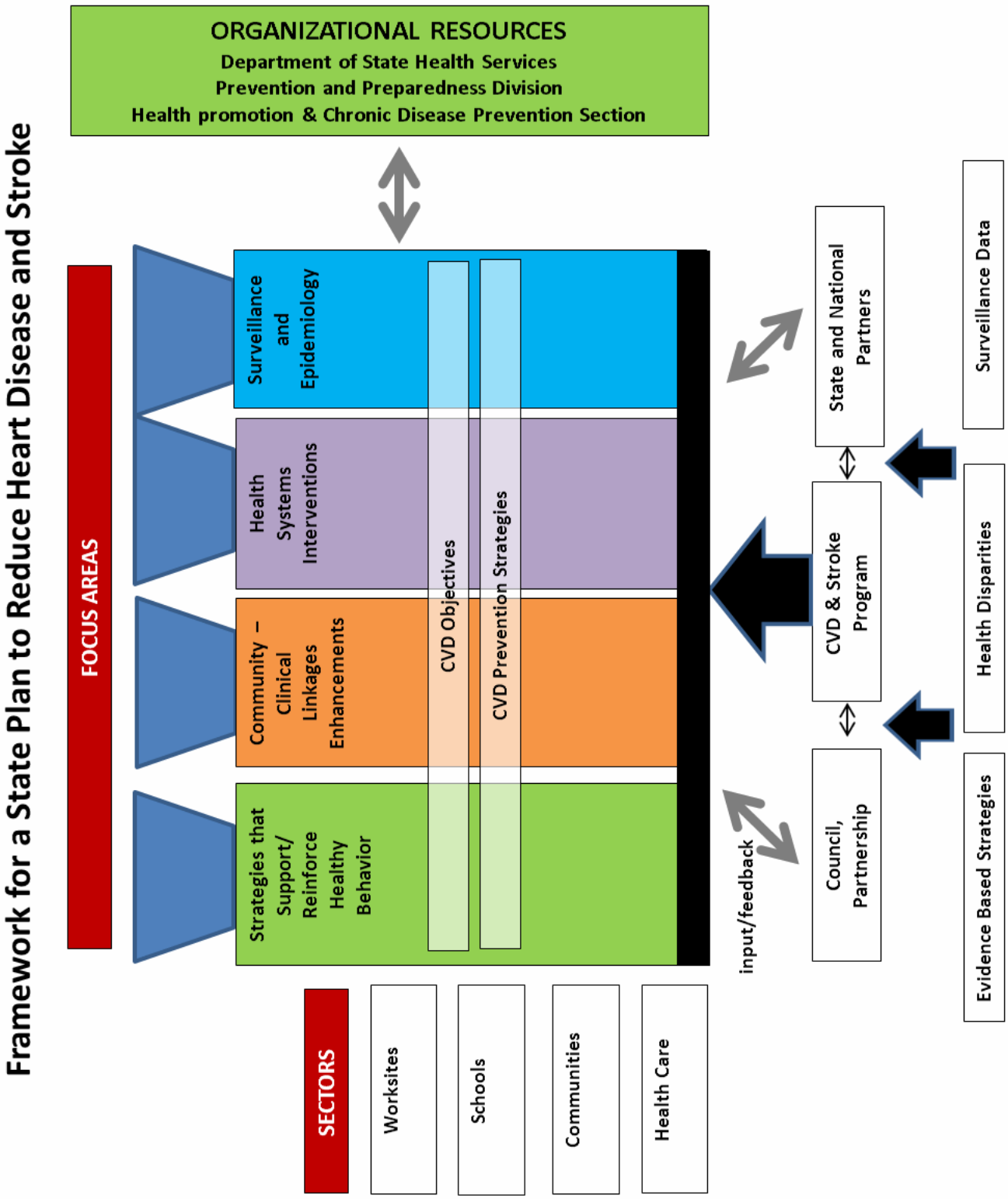
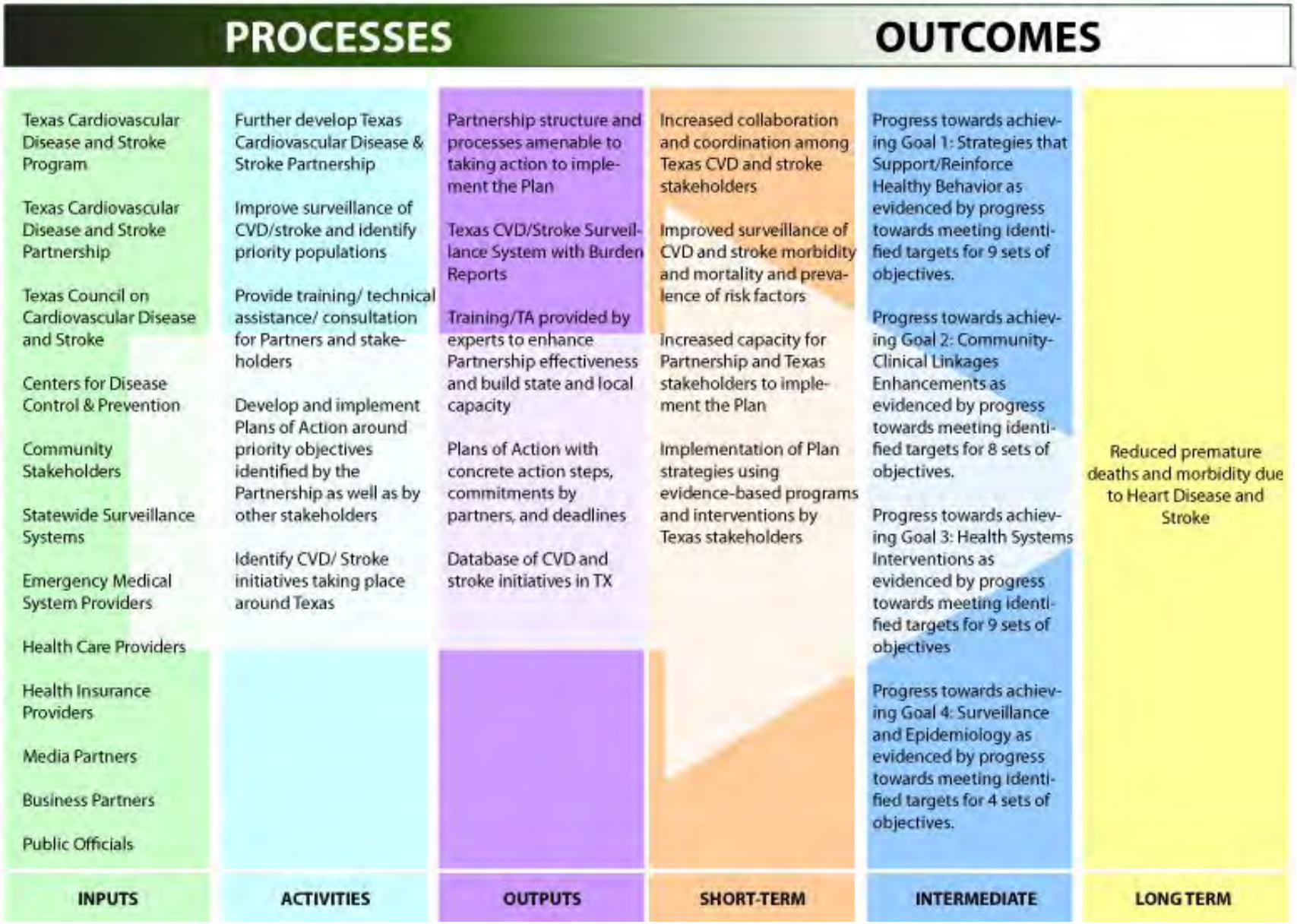


Figure 12: Logic Model

Texas Plan to Reduce Cardiovascular Disease and Stroke 2013 – 2017 Logic Model



Texas Goals, Objectives and Strategies 2013 – 2017

The *Texas Plan to Reduce Cardiovascular Disease and Stroke* (*Plan*) identifies a set of goals and objectives, and proposes evidence-based, best practice, or promising strategies to approach these objectives. Some strategies are cross-cutting, and so address more than one objective. When objectives apply to multiple focus areas, they are listed within a primary focus area and the additional applicable focus areas are denoted with an asterisk. Many of the objectives are taken directly from the national Healthy People (HP) 2010 and 2020 objectives for improving the health of the nation. Progress in meeting these objectives can be measured using established health indicators and existing data collection sources.

In some cases, the objectives are related to improving the systems of care in Texas and building capacity for local and statewide cardiovascular and brain health efforts. These objectives are not measurable using established health indicators and therefore are labeled as "developmental." Stakeholders taking action in these areas should identify indicators for monitoring and reporting success early on.

Goal: *A statement of a long term expected outcome.*

Objective*: A short-term, measurable change that, when accomplished, will help in reaching the goal.*

Strategy: *A relatively broad approach to achieving an objective.*

SMART *Objectives should be* ***S****pecific,* ***M****easurable,* ***A****ttainable,* ***R****ealistic and* ***T****ime-bound.*

For many strategies, there may be specific evidence-based or best practice programs or interventions already in existence. See Appendix I for a list of existing, evidence-based or promising programs/resources. Stakeholders should seek and use existing, evidence-based programs when they exist and, when they do not, should develop new interventions using theory based approaches and good evaluation techniques.

Stakeholders in Texas working on cardiovascular and brain health should be able to identify where their efforts fit within this *Plan*. Individuals and organizations will determine how their mission plays a part in implementing the *Plan* and will identify what actions they are taking or will take in the future to implement identified strategies. Partners' action planning around strategy implementation will serve to further efforts toward achieving short-term objectives and long-term goals. Working together, stakeholders in Texas can achieve progress in reaching these goals and, ultimately, in reducing premature death and improving quality of life for Texans with heart disease and stroke.

Key to Symbols

Objectives also have SS but not in key

SE: The strategy is supported with **S**trong **E**vidence and recommended by the Guide to Community Preventive Services or the U.S. Preventive Services Task Force

SE-Other – Supported with **S**trong **E**vidence by the indicated agency

EUR: The **E**vidence to support the effectiveness of the strategy is currently **U**nder **R**eview (as of June 2008)

R: The strategy is **R**ecommended by the Guide to Community Preventive Services, the U.S. Preventive Services Task Force, or the CDC

Goal 1: Strategies that Support/Reinforce Healthy Behavior

***To establish and promote environments that support the prevention of heart disease and stroke through healthy eating, daily physical activity, and tobacco-free lifestyles for all Texans, with an emphasis on access to resources and priority populations*.**

Objective 1.1: By June 30, 2017 increase the proportion of adults who engage regularly in moderate physical activity for at least 150 minutes per week by 5% (HP 2020)

Objective 1.1.1: By June 30, 2017, reduce the proportion of adults who engage in no leisure-time physical activity by 5% (HP 2020)

Implement community-wide campaigns (SE)

Promote worksite physical activity programs (SE)

Create/enhance access to places for physical activity such as parks, trails, bike lanes, and sidewalks combined with information outreach (SE)

Objective 1.2: By June 30, 2017, increase the proportion of youth grades 9-12 who have been physically active for a total of 60 minutes per day on five or more days per week by 5% (HP 2020)

Encourage school-based physical education, define physical education requirements for schools, and educate about existing policy concerning physical education requirements (SE)

Improve/implement community wide campaigns (SE)

Develop collaborations among community partners working to increase youth physical activity levels (non-family social support) (SE)

Objective 1.3: By June 30, 2017, increase the proportion of adults 18 and older who report eating fruits and vegetables five or more times per day by 5% (HP 2010)

Objective 1.3.1: By June 30, 2017, increase the proportion of youth grades 9-12 who report eating fruits and vegetables five or more times per day by 5% (HP 2010)

Enhance access to healthy foods (R - National Prevention Council) and reduce access to unhealthy foods at worksites and in community and school-based settings (SS)

Provide information about produce that includes price and easy preparation ideas (SS)

Encourage eligible youth to participate in the National School Lunch Program (SE - USDA)

Implement recognition programs for schools meeting standards (R - U.S. Department of Agriculture)

Objective 1.4: By June 30, 2017, reduce the proportion of adults who report a BMI (height and weight self-report) equal to or greater than 25 Kg/m2 by 5% (HP 2020)

Objective 1.4.1: By June 30, 2017, reduce the proportion of youth grades 9-12 who report a BMI (height and weight self-report) equal to or greater than the sex and age specific 95th percentile from CDC growth charts by 5% (HP 2020)

Implement multi-component interventions aimed at diet, physical activity, and cognitive change at worksites and in other settings (R)

Research evidence-based programs for maintaining healthy BMI in college-age adults (SS)

Implement community interventions that increase access to affordable healthy foods and places to be physically active (SE)

Educate about physical education curricula in schools (SE)

Expand coordinated school health requirements through grade 12 (R)

Educate about the benefits of existing and enhanced physical activity, nutrition, and coordinated school health strategies for all grades (SS)

Objective 1.5: By June 30, 2017, reduce the proportion of youth grades 9-12 who report ever using any type of tobacco on one or more days by 10% (HP 2020)

Objective 1.5.1: By June 30, 2017, reduce the proportion of youth grades 9-12, who report using cigarettes in the past 30 days by 10% (HP 2020)

Objective 1.5.2: By June 30, 2017, reduce the proportion of youth grades 9-12 who report using smokeless tobacco products in the past 30 days by 10% (HP 2020)

Objective 1.5.3: By June 30, 2017, reduce the proportion of youth grades 9-12 who report using cigars in the past 30 days by 5% (HP 2020)

Educate about the use of evidence-based tobacco programs that include educational, clinical, and social strategies with the goal of tobacco and smoke-free environments (SE)

Use peer-involved campaigns (SS)

Implement multi-component campaigns that include use of mass media, school and community prevention campaigns, and tobacco and smoke-free environments (SE)

Educate about ordinances that prohibit sale of tobacco to minors (SE)

Provide health care provider counseling (SE)

Objective 1.6: By June 30, 2017, reduce the proportion of adults who smoke cigarettes by 10% (HP 2020) *Also Health Systems Interventions

Objective 1.6.1: By June 30, 2017, reduce the proportion of adults who use smokeless tobacco products by 5% (HP 2020)

Objective 1.6.2: By June 30, 2017, reduce the proportion of adults who smoke cigars (Developmental) (HP 2020)

Promote health care provider screening and counseling (SE)

Promote counseling among pediatricians to promote cessation and prevention efforts in pregnant women and mothers (SE)

Implement multi-component campaigns that include use of mass media, education, school and community prevention campaigns, and tobacco cessation (SE)

Educate about smoke-free environments in public places, including worksites (SE)

Support interventions that increase the unit price for tobacco products (SE)

Objective 1.7: By June 30, 2017, reduce exposure to secondhand smoke by 5% (HP 2020) *Also Health Systems Interventions

Educate about community policies for smoke-free public spaces, including worksites (SE)

Educate about existing tobacco and smoke- free environments (SE)

Develop grass roots coalitions to work on smoke-free environments (R)

Promote counseling among pediatricians to promote cessation and prevention efforts in pregnant women and mothers (SE)

Encourage state hospital licensure requirements to require smoke-free campuses (SS)

Promote smoke-free school requirements (R)

Objective 1.8: By June 30, 2017, increase proportion of Texans who report currently taking measures to reduce sodium intake (Developmental)

Educate about procurement practices that limit sodium in government purchased food, worksites, and schools (SE - Institute of Medicine)

Promote availability of lower sodium food options (fresh produce) (R)

Promote expansion of consumer information and labeling initiatives for sodium (e.g., point of purchase warning labels) (SE - Institute of Medicine)

Collaborate with business coalitions to promote healthy workplace programs and environments that help lower sodium intake (R)

Collaborate with food manufacturers, restaurant associations, and schools to promote sodium reduction (SE-Institute of Medicine)

Promote the Dietary Approaches to Stop Hypertension eating plan (DASH) (SE - U.S. Department of Health and Human Services)

Objective 1.9: By June 30, 2017, reduce the proportion of adults 18 and older with high blood pressure by 5% (HP 2020)

Increase the number of worksites that have physical activity and nutrition programs or best practice wellness programs, strategies, and environmental supports that reduce risk factors related to high blood pressure (SE)

Implement community level programs promoting healthy eating, physical activity, smoking cessation, and healthy weight (SS)

Work to decrease sodium content in restaurant and manufactured foods (SS)

Goal 2: Community - Clinical Linkages Enhancements

To promote partnerships between clinical and community groups in Texas to provide enhanced and coordinated patient care.

Objective 2.1: By June 30, 2017, increase the proportion of persons at risk for or with cardiovascular disease who are aware of resources regarding disease management (Developmental)

Continue to enhance web-based resources that promote evidence-based material for patients (R), including the Texas Cardiovascular Disease and Stroke Partnership web-site

Partner with health promotion experts to develop culturally appropriate communication (SS)

Work through community networks to share information and resources (R)

Objective 2.2: By June 30, 2017, collaborate with the Governor's EMS and Trauma Advisory Council (GETAC) to increase resources available to advance prevention efforts and improve the Texas heart and stroke system of care (Developmental)

Increase collaboration and create synergy, and leverage existing resources among Texas stakeholders (R)

Use existing data to educate stakeholders about issues (R)

Continue to advance the power and commitment of the Texas Cardiovascular Disease and Stroke Partnership to impact change in Texas (R)

Objective 2.3: By June 30, 2017, increase access to cardiovascular disease and stroke prevention, early detection, and treatment services for underserved populations (Developmental)

Objective 2.3.1: By June 30, 2017, increase access to cardiovascular disease and stroke prevention, early detection, and treatment services for rural populations (Developmental)

Objective 2.3.2: By June 30, 2017, increase access to cardiovascular disease and stroke prevention, early detection, and treatment services for populations in poverty (Developmental)

Objective 2.3.3: By June 30, 2017, increase access to cardiovascular disease and stroke prevention, early detection, and treatment services for the uninsured population (Developmental)

Expand the cardiovascular health care system to include non-traditional partners that can assist in improving access to care (R)

Promote the use of community health workers (R)

Promote appropriate cultural competency trainings for the health care work force (R - AHRQ)

Promote the creation of new community health centers and expanded services at existing community health care centers (R - U.S. Department of Health and Human Services)

Objective 2.4: By June 30, 2017, increase the proportion of adults who are aware of the early warning signs and symptoms of heart attack and stroke and the importance of calling 911 if a heart attack or stroke is suspected by 10% (HP 2020)

Promote the use of evidence-based public education programs tailored to appropriate audiences (R)

Partner with Emergency Medical Services, 911 authorities, state agencies, and non-profits to serve as conduits for information dissemination (R)

Promote media campaigns to increase knowledge of early warning signs of heart attack and stroke and how to respond (SS)

Objective 2.5: By June 30, 2017, increase the proportion of out-of-hospital cardiac arrests in which appropriate bystander and emergency medical services were administered (Developmental) (HP 2020)

Provide community based group training in CPR and the use of AEDs (SS)

Support the establishment of evidence-based, CPR/AED programs in schools (R - American Heart Association)

Promote AED placement policies for businesses, restaurants, and other community settings (R -American Heart Association)

Objective 2.6: By June 30, 2017, increase the proportion of adults who are taking at least two preventive actions (for example: changing eating habits, exercising, reducing sodium intake, taking

medications) who are at risk for or who have cardiovascular disease, including stroke by 5% *Also Health Systems Interventions

Implement community outreach and worksite programs promoting healthy eating (for example the DASH eating plan), physical activity, smoking cessation, and healthy weight (SS)

Identify, disseminate, and promote utilization of evidence-based guidelines for hypertension diagnosis, treatment, and management (R)

Promote the availability of health plans that cover/include appropriate screenings and incentives to identify, reduce, and treat high blood pressure (SS)

Encourage health care practices to use team-based care that includes a multidisciplinary team of health care professionals (SS)

Promote health care system level solutions that use practitioner and patient reminders and medical records flags (R)

Work with third party payers to reimburse for high blood pressure management (SS)

Increase access to primary health care and affordable medications for underserved populations (R)

Assess and address barriers to compliance with physician recommendations and prescribed medications (R)

Objective 2.7: By June 30, 2017, increase the number of Heart and Stroke Healthy communities in Texas from 31 to 34 *Also Health Systems Interventions and Strategies that Support/Reinforce Healthy Behavior

Promote the implementation and monitoring, by Texas cities, of Heart and Stroke Healthy City (HSHC) Recognition Program indicators (R)

Increase connections between regional or local advisory groups or partnerships and regional resources to promote sharing of resources and improving initiatives related to cardiovascular disease and stroke prevention (SS)

Expand collaboration and connectivity among health related organizations (SS)

Objective 2.8: By June 30, 2017, increase communication and collaboration between system partners, including the Department of State Health Services, and Texas communities. (Developmental) *Also Strategies that Support/Reinforce Healthy Behavior

Continue to advance the commitment of the Texas Cardiovascular Disease and Stroke Partnership to impact change in Texas (SS)

Explore the use of web casts to share progress and emerging information (SS)

Support the Texas Cardiovascular Disease and Stroke Partnership to spearhead stakeholder education about heart disease and stroke and education about policies and plans that support cardiovascular health and wellness (SS)

Goal 3: Health Systems Interventions

To promote capacity and infrastructure changes within the health delivery system to effectively prevent, treat, and manage heart disease and stroke for all Texans.

Objective 3.1: By June 30, 2017, increase the proportion of adults with high blood pressure whose blood pressure is under control (< 140/90) by 5% (HP 2020)

Promote implementation of screening guidelines by health care professionals for the early detection and treatment of high blood pressure (SE)

Promote the availability of health plans that cover/include appropriate screenings and incentives to identify, reduce, and treat high blood pressure (SS)

Encourage health care practices to use team-based care that includes a multidisciplinary team of health care professionals (SS)

Promote health care system level solutions that use practitioner and patient reminders and medical records flags (R)

Work with third party payers to reimburse for high blood pressure self-management training (SS)

Increase access to primary health care and affordable medications for underserved populations (R)

Promote Chronic Disease Self-Management Training for health care providers (R)

Promote the use of community health workers in treating patients with high blood pressure (R)

Promote team-based care for improving blood pressure control (SE)

Objective 3.2: By June 30, 2017, reduce the death rate from cardiovascular disease and stroke in persons with diabetes by 10% (HP 2020) *Also Community Clinical Linkages Enhancements

Promote partnerships with the Diabetes and Coordinated Chronic Disease programs (R)

Promote risk reduction for cardiovascular disease and stroke in persons with diabetes (R)

Promote the use of clinical practice guidelines and an integrated approach for managing persons with diabetes to reduce risk for cardiovascular disease and stroke (R)

Improve access to care for underserved populations (R)

Encourage third party payers to cover chronic disease self-management (SS)

Promote Chronic Disease Self-Management Training for health care providers (R)

Promote the use of community health workers in treating patients with high blood pressure (R)

Promote team-based care for improving blood pressure control (SE)

Objective 3.3: By June 30, 2017, increase the proportion of adults who have high blood pressure who take aspirin, as advised by a health care professional, to reduce the chance of a heart attack and/or stroke (Developmental) (HP 2020)

Promote provider adherence to recognized prevention guidelines regarding the use of aspirin therapy (R)

Encourage utilization of electronic health records and flags for providers (SS)

Objective 3.4: By June 30, 2017, increase the proportion of adults who have had their blood cholesterol screened within the preceding five years by 5% (HP 2020) *Also Strategies that Support/Reinforce Healthy Behavior

Promote implementation of screening guidelines by health care professionals for the early detection and treatment of lipid disorders (R)

Include screening for total lipid panel in worksite wellness programs (R)

Encourage provision of incentives for routine physical exams that include cholesterol screening (SS)

Objective 3.5: By June 30, 2017, reduce the proportion of adults with high blood cholesterol levels by 5% (HP 2020) *Also Strategies that Support/Reinforce Healthy Behavior

Objective 3.5.1: By June 30, 2017, reduce the proportion of adults with high non-HDL blood cholesterol levels (Developmental)

Implement community outreach programs promoting healthy eating and physical activity (SE)

Promote the availability of health plans that cover/include appropriate screenings and incentives to identify, reduce and treat lipid disorders (SS)

Increase the number of worksites that have evidence-based wellness programs, policies, and environmental supports that contribute to the reduction of high cholesterol and other risk factors related to heart disease and stroke (SS)

Objective 3.6: By June 30, 2017, increase the proportion of adults 18-75 who had an LDL-c level of less than 100mg/dL during the measurement year, after discharge for an acute cardiovascular event by 15% *Also Community Clinical Linkages Enhancements

Emphasize the need to increase access to primary health care and affordable medications for underserved populations (R)

Promote implementation of screening guidelines by health care professionals (SE)

Promote the availability of health plans that cover/include appropriate screenings and incentives to identify, reduce, and treat high LDL-c (SS)

Educate health care practices about the benefits of using team-based care that includes a multidisciplinary team of health care professionals (SS)

Promote health care system level solutions including electronic health records, practitioner and patient reminders, and medical records flags (R)

Educate third party payers about the benefits of reimbursing for cholesterol management (SS)

Assess and address barriers to compliance with physician recommendations and prescribed medications (SS)

Objective 3.7: By June 30, 2017, increase utilization of appropriate therapeutic treatment interventions and application of clinical practice guidelines for treating patients with cardiovascular disease and stroke events (Developmental)

Partner with Governor's EMS and Trauma Advisory Council to expand EMS statewide treatment protocols (R - American Heart Association)

Where appropriate, provide evidence-based, interactive health care professional education regarding protocols and guidelines for the early detection, treatment, and long-term management of cardiovascular disease and stroke patients (SS)

Identify and address barriers (cost, access, etc.) to routine utilization of therapeutic interventions and clinical practice guidelines (SS)

Promote improved EMS response and delivery times (SS)

Promote implementation of clinical practice guidelines among emergency health care system personnel (SS)

Promote the monitoring and assessment of quality of care provided (R - AHRQ)

Continue support of statewide STEMI initiative (R - American Heart Association)

Seek opportunities to create incentives for health care system partners to address quality of care issues (SS)

Promote team-based care for improving blood pressure control (SE)

Objective 3.8: By June 30, 2017, increase the proportion of adult heart attack and stroke survivors who receive outpatient cardiac and stroke rehabilitation following discharge (Developmental) (HP 2020)

Promote awareness of rehabilitation benefits among providers to increase referral rates (SS)

Encourage health care practices to implement outpatient appointment systems (i.e. through discharge order sets) to schedule patients for rehab appointments prior to discharge (SS)

Create a comprehensive list of cardiac and stroke rehabilitation centers in Texas (R - American Heart Association)

Promote mandated reimbursement of outpatient cardiac rehabilitation by third party payers through insurance reform (R - American Heart Association)

Objective 3.9: By June 30, 2017, increase the number of Texas DSHS recognized stroke facilities from 92 to 100 that can provide multiple levels of stroke care to meet the full continuum of stroke care from EMS activation to outpatient rehabilitation and support.

Promote increased access to recognized stroke centers, through telemedicine and other means (R - American Heart Association)

Support efforts to establish regional stroke committees (R - American Stroke Association)

Provide assistance for hospitals working to become certified primary stroke centers (R - American Stroke Association)

Work with hospitals, especially in medically underserved areas, to move towards achieving higher levels of stroke care (R - American Stroke Association)

Continue to support efforts to adopt and implement protocols for stroke transport (R - American Stroke Association)

Continue support of statewide stroke system of care (R - American Stroke Association)

Goal 4: Surveillance and Epidemiology

To collect, analyze, and disseminate comprehensive heart disease and stroke data that are readily available to assess, monitor, and describe the burden of heart disease and stroke in Texas. *Note: Surveillance and epidemiology is embedded in all of the State Plan objectives in order to inform priority areas and targets.

Objective 4.1: By June 30, 2017, improve statewide monitoring and surveillance of emergency health care system information (Developmental)

Work collaboratively with stakeholders and partners to identify data needs, existing collection methods, and reporting formats in addition to barriers (SS)

Continue to support the assimilation of current available data, monitoring trends, evaluation of programs and policies, and recommendation of improvements (R)

Objective 4.2: By June 30, 2017, increase Texans' accessibility to data related to heart disease and stroke (Developmental)

Identify and develop new, available data sources for CVD surveillance as feasible (R)

Produce updated products (i.e. burden reports, etc.) on the most current data as is feasible (R)

Dialogue with Data Users Group and Partnership to assess satisfaction with current data use access (IE)

Monitor number of web-site hits and number of products created and/or disseminated to assess the general public's accessibility to data (IE)

Identify and create new opportunities for data sharing among partners (R)

Objective 4.3: By June 30, 2017, improve data linkages to utilize available data to enhance the assessment of the burden of disease and risk factors in Texas (Developmental)

Continue to assimilate current available data and monitor trends (R)

Work collaboratively with stakeholders and coordinated chronic disease efforts to assess data needs, improve collection methods, and refine reporting formats (SS)

Educate about policy development that encourages data coordination and collection necessary for effective surveillance (IE)

Objective 4.4: By June 30, 2017, utilize surveillance data to identify health disparities and populations at risk to guide policies and programs that will address needs (Developmental)

Continue to assimilate current available data and monitor trends (R)

Work collaboratively with stakeholders and coordinated chronic disease efforts to assess data needs, improve collection methods, and refine reporting formats (SS)

Continue to support inclusion of new and existing heart disease, stroke, and risk factor modules in the Behavioral Risk Factor Surveillance System as feasible (IE)

Promote the systematic evaluation of existing surveillance modules

Assessing Progress

Many objectives of the 2013 *Plan* are taken directly from Healthy People 2020 and are measurable using existing surveillance data. A few objectives still reflect Healthy People 2010 because existing data sources have not been updated to reflect Healthy People 2020 for those specific measures. Data sources are described in Appendix II.

Some objectives are related to improving the infrastructure and processes that support cardiovascular health and wellness in our communities, and are labeled "developmental." Indicators for measuring these objectives' success have not been identified or baseline data is not yet available.

Targets for 2017 were set by analyzing trends for the past five years and estimating a reasonable change that with focused efforts could be achievable. Progress is expected to be made for most objectives. However, only through the coordinated efforts of partners and the availability of adequate resources and funding that all *Plan* objectives will be met.

Texas Benchmark Indicators, Baselines, and 2017 Targets

Long-term Goal: Reduce premature death from heart disease and stroke.				
Benchmark Indicators	**Baseline**			**2017 Target (Target Setting Method)**
	Data Source	**Measure**	**Year**	
Age adjusted mortality (per 100,000) for ischemic heart disease	TX Vital Statistics	113.3	2010	102.0 (10% improvement)
Age adjusted mortality (per 100,000) for stroke	TX Vital Statistics	44.9	2010	40.4 (10% improvement)

Goal 1: To establish and promote environments that support the prevention of heart disease and stroke through healthy eating, daily physical activity, and tobacco-free lifestyles for all Texans, with an emphasis on access to resources for priority populations.

Benchmark Indicators	Baseline			2017 Target (Target Setting Method)
	Data Source	Measure	Year	
1.1: Proportion of adults who engage regularly in moderate physical activity for at least 150 minutes per week (HP 2020)	BRFSS	48.1%	2009	50.5% (5% improvement)
1.1.1: Proportion of adults who engage in no leisure-time physical activity (HP 2020)	BRFSS	26.6%	2010	25.3% (5% improvement)
1.2: Proportion of youth grades 9-12 who have been physically active for a total of 60 minutes per day on 5 or more days per week (HP 2020)	YRBSS	44.5%	2011	46.7% (5% improvement)
1.3: Proportion of adults 18 and older who report eating fruits and vegetables 5 or more times per day (HP 2010)	BRFSS	23.8%	2009	25.0% (5% improvement)
1.3.1: Proportion of youth grades 9-12 who report eating fruits and vegetables 5 or more times per day (HP 2010)	YRBSS	18.5%	2011	19.4% (5% improvement)
1.4: Proportion of adults who report a BMI (Height and weight self-report) equal to or greater than 25 kg/m^2 (HP 2020)	BRFSS	66.6%	2010	63.3% (5% improvement)
1.4.1: Proportion of youth grades 9-12 who report a BMI (height and weight self-report) equal to or greater than the sex and age specific 95th percentile from CDC growth charts (HP 2020)	YRBSS	15.6%	2011	14.8% (5% improvement)
1.5: Proportion of youth grades 9-12 who report using any type of tobacco on one or more days (HP 2020)	YRBSS	Any type tobacco 22.9%	2011	20.6% (10% improvement)
1.5.1: Proportion of youth grades 9-12 who report using cigarettes in the past 30 days (HP2020)	YRBSS	Cigarettes 17.4%	2011	15.7% (10% improvement)

Goal 1: (continued) To establish and promote environments that support the prevention of heart disease and stroke through healthy eating, daily physical activity, and tobacco-free lifestyles for all Texans, with an emphasis on access to resources for priority populations.

Benchmark Indicators	Baseline			2017 Target (Target Setting Method)
	Data Source	Measure	Year	
1.5.2: Proportion of youth grades 9-12 who report using smokeless tobacco products in the past 30 days (HP 2020)	YRBSS	Dip/chew 6.2%	2011	5.6% (10% improvement)
1.5.3: Proportion of youth grades 9-12 who report using cigars in the past 30 days (HP 2020)	YRBSS	Cigars/ Cigarillos 16.0%	2011	15.2% (5% improvement)
1.6: Proportion of adults who smoke cigarettes (HP 2020)	BRFSS	Cigarettes 15.8%	2010	14.2% (10% improvement)
1.6.1: Proportion of adults who use smokeless tobacco products (HP 2020)	BRFSS	Smokeless Tobacco 3.2%	2010	3.0% (5% improvement)
1.6.2: Proportion of adults who smoke cigars or other tobacco products (excluding cigarettes, snuff or chewing tobacco) (HP 2020)	BRFSS	Not available		To be determined
1.7: No exposure to secondhand smoke (HP 2020)	BRFSS	85.4% in the home 78.2% in public places	2009	89.7% (5% improvement) 100% (smoke-free state)
1.8: Proportion of adults who report currently taking measures to reduce sodium intake	Potential Data Source: BRFSS	Not		To be determined
1.9: Proportion of adults 18 and older with high blood pressure (HP 2020)	BRFSS	29.1%	2009	27.6% (5% improvement)

Goal 2: To promote partnerships between clinical and community groups in Texas to provide enhanced and coordinated care.

Benchmark Indicators	Baseline			2017 Target (Target Setting Method)
	Data Source	Measure	Year	
2.1: Proportion of person at risk for or with cardiovascular disease who are aware of resources regarding disease management	Potential Data Source: BRFSS	Not available		To be determined
2.2: Resources available to advance prevention efforts and improve the Texas heart and stroke systems of care	Developmental	Not available		To be determined
2.3: Access to cardiovascular disease and stroke prevention, early detection, and treatment services for underserved populations	Developmental	Not available		To be determined
2.3.1: For rural populations	Developmental	Not available		To be determined
2.3.2: For populations in poverty	Developmental	Not available		To be determined
2.3.3: For uninsured populations	Developmental	Not available		To be determined
2.4: Proportion of adults who are aware of the early warning signs and symptoms of heart attack and stroke; and the importance of calling 911 if a heart attack or stroke is suspected (HP 2020)	BRFSS	Heart attack – 11.8% Stroke – 21.1% First call 911 – 85.9%	2009	10% increase in all areas
2.5: Proportion of out-of-hospital cardiac arrests in which appropriate bystander and emergency medical services are administered	Potential Data Sources: NHIS, CDC, NCHS	Not available		To be determined

Goal 2: (continued) To promote partnerships between clinical and community groups in Texas to provide enhanced and coordinated care.

Benchmark Indicators	Baseline			2017 Target (Target Setting Method)
	Data Source	Measure	Year	
2.6: Proportion of adults with high blood pressure who are taking at least 2 actions (for example: losing weight, participating in physical activity, reducing sodium intake, taking meds as prescribed) (HP 2010)	BRFSS	84.6%	2009	88.8% (5% improvement)
2.7: Number of Heart and Stroke Healthy communities in Texas	DSHS	32	2012	37
2.8: Increase communication and collaboration between system partners, including The Texas Cardiovascular Disease and Stroke Partnership, DSHS and Texas communities	Potential Data Sources: DSHS	Not available		To be determined

Goal 3: To promote capacity and infrastructure changes within the health delivery system to effectively prevent, treat, and manage heart disease and stroke for all Texans.

Benchmark Indicators	Baseline			2017 Target (Target Setting Method)
	Data Source	Measure	Year	
3.1: Proportion of adults with high blood pressure whose blood pressure is under control (HP 2020)*	HEDIS*	51.1%	2011	53.7% (5% improvement)
3.2: Death rate (per 100,000) from cardiovascular disease in persons with diabetes (HP 2020)	VS	342.4	2010	308.2 (10% improvement)

3.3: Proportion of adults who have high blood pressure who take aspirin, as advised by a health care professional, to reduce the chance of a heart attack and/or stroke (HP2020)	Potential Data Source: BRFSS	Not available		To be determined
3.4: Proportion of adults who have had their blood cholesterol checked within the preceding 5 years (HP 2020)	BRFSS	72.0%	2009	75.6% (5% improvement)
3.5: Proportion of adults who report having high blood cholesterol (HP 2020)	BRFSS	40.9%	2009	38.9% (5% improvement)
3.5.1: Proportion of adults who report having high non-HDL blood cholesterol levels	Developmental	Not available		To be determined
3.6: Proportion of adults 18-75 who had an LDL-c level of less than 100 mg/dL during the measurement year and the year prior, after discharge for an acute cardiovascular event*	HEDIS*	42.9%	2010	49.3% (15% improvement)
3.7: Utilization of appropriate therapeutic treatment interventions and application of clinical practice guidelines for treating patients with cardiovascular disease and stroke events	Developmental	Not available		To be determined
3.8: Proportion of adult heart attack and stroke survivors who receive outpatient cardiac and stroke rehabilitation following discharge	Potential Data Source: BRFSS	Not available		To be determined
3.9: Number of Texas DSHS recognized stroke facilities that can provide multiple levels of stroke care to meet the full continuum of stroke care from EMS activation to outpatient rehabilitation and support	DSHS	92	2012	100

Goal 4: To collect comprehensive heart disease and stroke data that are readily available to assess, monitor, and describe the burden of heart disease and stroke in Texas.

Benchmark Indicators	Baseline			2017 Target (Target Setting Method)
	Data Source	Measure	Year	
4.1: Statewide monitoring and surveillance of emergency health care system information (Developmental)	Potential Data Source: Texas EMS surveillance system	Not available		To be determined
4.2: Accessibility to data related to heart disease and stroke (Developmental)	Potential Data Source: Data Users Group Survey	Not available		To be determined
4.3: Data linkages to utilize available data to enhance the assessment of the burden of disease and risk factors in Texas (Developmental)	Potential Data Source: Data Users Group Survey	Not available		To be determined
4.4: Utilization of surveillance data to identify health disparities and populations at risk to guide policies and programs that will address needs (Developmental)	Potential Data Source: Data Users Group Survey	Not available		To be determined

***Note: HEDIS data reflects a population of HMO members, adults 18-85 years of age with hypertension [41]**

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Appendix I – Resources for Action

The following organizations provide public and professional education, programs, and resources for cardiovascular disease and stroke. This is not intended to be an exhaustive list but provides a sampling of what is already available from credible sources. Before selecting and using any program, seek information regarding the efficacy or adaptability of the program for your intended population.

American Heart Association/American Stroke Association – www.americanheart.org

- Get With the Guidelines – hospital guidelines for heart disease and stroke
- Acute Stroke Treatment Program – hospital-based guide for primary stroke centers
- Power to End Stroke – public awareness campaign that embraces and celebrates African Americans
- Mission: Lifeline – guidelines for timely STEMI treatment for health care providers
- Heartsaver AED – workplace training program
- Go Red For Women – public awareness campaign
- Go Red Por Tu Corazón – public awareness campaign for Hispanic women
- CPR Anytime – general public training program
- Heart 360 – patient portal to track and manage heart health

Centers for Disease Control and Prevention – www.cdc.gov

- Guide to Community Preventive Services – guide to evidence-based practices
- Heart Healthy and Stroke Free – creating social environment changes
- Weight Management Research to Practice Series – evidence-based approaches
- Successful Business Strategies to Prevent Heart Disease and Stroke Toolkit – making the business case
- Promoting Physical Activity: A Guide for Community Action
- Million Hearts – campaign to prevent 1 million heart attacks and strokes in five years by coordinating national efforts

Texas Department of State Health Services – www.dshs.state.tx.us

- Diabetes and Disparities: A Plan to Prevent and Control Diabetes in Texas, 2008-2009
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- Updates for the Strategic Plan for the Prevention of Obesity in Texas 2008
    - www.dshs.state.tx.us/obesity/default.shtm
- Cardiovascular Disease and Stroke Program – www.dshs.state.tx.us/wellness/default.shtm
    - Stroke Public Education Toolkit - www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589959927
    - Heart and Stroke Healthy City Recognition Program - www.dshs.state.tx.us/wellness/hshcrp.shtm
- Building Healthy Texans – http://www.wellness.state.tx.us/physical_activity.htm
    - Active for Life Online – group physical activity program
    - Company Health and Wellness – ideas for building employee awareness and participation in physical activities
    - TEXERCISE – statewide fitness campaign developed by the Texas Department of Aging and Disability Services (DADS)
    - Five A Day – community fruit and vegetable promotion program
    - Lighten Up Texas – worksite weight loss team competition
    - Maintain No Gain – maintaining weight over the holidays
    - Skyscraper Climb – worksite physical activity
    - Walk Across Texas! - http://walkacrosstexas.tamu.edu/
- Long Live Texans – longlivetexans.com

Brain Attack Coalition - www.stroke-site.org/

- Guidelines and resources for stroke initiatives

Department of Health and Human Services - http://www.hhs.gov

- Healthy People 2020 www.healthypeople.gov/
- Agency for Healthcare Research and Quality – http://ahrq.gov
- National Heart, Lung and Blood Institute – www.nhlbi.nih.gov
    - Hearts N' Parks Community Mobilization Guide: Obesity and heart disease education initiative
    - Your Guide to Lowering Your Blood Pressure With DASH
    - Healthy Heart, Healthy Homes
    - Hypertension Guidelines - www.nhlbi.nih.gov/guidelines/hypertension/

- Cholesterol Guidelines - www.nhlbi.nih.gov/guidelines/cholesterol/index.htm

National Stroke Association - www.stroke.org

- Information and resources for stroke initiatives

Wellness Councils of America - www.welcoa.org/

- Workplace wellness resources

Texas Education Agency Approved Coordinated School Health Programs

- Bienestar Health Program - Office Phone: 210-533-8886
  Toll Free: 1-866-676-7472 - Web site: www.sahrc.org

- CATCH
  Telephone: 512-346-6163
  Web site: www.sph.uth.tmc.edu/catch/

- The Great Body Shop
  Telephone: 800-782-7077
  Web site: www.thegreatbodyshop.net/

- SPARK + Healthy and Wise by Caprock Press
  Telephone: 800-383-1927
  Web site: www.caprockpress.com/ or www.sparkpe.org

Bridges to Excellence - www.bridgestoexcellence.org/

- Quality improvement program for the health care industry

Chronic Disease Self-Management Program - http://patienteducation.stanford.edu/programs/cdsmp.html

- Patient oriented program for self-management of chronic disease

American Pharmacists Association Foundation -
www.pharmacist.com/AM/Template.cfm?Section=Project_ImPACT

- Project ImPACT - practice model for pharmacists to improve patient outcomes

Appendix II – Data Sources

BRFSS - The Texas Behavioral Risk Factor Surveillance System, initiated in 1987, is a federally and state funded telephone survey conducted on a monthly basis of 500 randomly selected Texas households to collect data on lifestyle risk factors contributing to the leading causes of death and chronic diseases. As a primary source for comprehensive statewide data on preventive health practices and health risk behaviors, BRFSS is an important tool for decision-making throughout DSHS and the public health community. Public and private health authorities at the federal, state, and local levels rely on BRFSS to identify public health problems, design policy and interventions, set goals, and measure progress toward those goals.

YRBSS - Youth Risk Behavior Surveillance Survey monitors priority health-risk behaviors and the prevalence of obesity and asthma among youth and young adults. The YRBSS includes a national school-based survey conducted by the Centers for Disease Control and Prevention and state, territorial, tribal, and local surveys conducted by state, territorial, and local education and health agencies and tribal governments.

VS - Texas Vital Statistics provides records for births or deaths that have occurred in Texas from 1903 to the present. Vital statistics refers to demographic data on births, deaths, fetal deaths, abortions, marriages, and divorces. At the Department of State Health Services, vital statistics functions are distributed within two organizational units: the Center for Health Statistics (CHS) and the Vital Statistics Unit (VSU). The Data Management team within CHS is responsible for developing, analyzing, and distributing public health data derived from records of vital events. The team also responds to statistical data requests and develops the Texas Vital Statistics Annual Report.

HEDIS - The Health Plan Employer Data and Information Set consists of standardized performance measures designed for comparing the quality of care of managed care organizations.

As reported by the *State of Managed Care Quality (2004),* this tool is used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HEDIS® is developed and maintained by the National Committee for Quality Assurance (NCQA), a private non-profit organization committed to assessing, reporting, and improving the quality of care provided by organized health care delivery systems.

Texas EMS/Trauma Registry - The Texas EMS/Trauma Registry is a legislatively mandated program responsible for collecting, analyzing, and disseminating information on emergency medical services runs and the occurrence of trauma in Texas including spinal cord injuries, traumatic brain injuries, and submersion injuries. EMS providers and acute care hospitals, designated to provide trauma care, must report trauma cases to the EMS/Trauma Registry. The EMS/Trauma Registry uses information on injuries to investigate the causes of injuries, their distribution, health outcomes, and associated costs. Local communities and providers rely on the data from the EMS/Trauma Registry to evaluate the trauma system in Texas and to plan injury prevention programs.

Appendix III – Texas Partnership Steering Committee

The following people/organizations have all generously contributed their time to the development of this *Plan* as members of the Texas Cardiovascular Disease and Stroke Partnership.

Thomas Alexander, MD
Heart Clinic of Corpus Christi

Maria Benedict
Texas Department of State Health Services

Cecily Brea
Texas Department of State Health Services

John Brink
Memorial Health System of East Texas

Genny Carrillo-Zuniga, MD, MPH, MSPH, ScD
Texas A&M Health Science Center

Berta Cavazos, BSW, CTR
Texas Department of State Health Services

Melissa Cole, MS, CHES
Williamson County and Cities Health District

Chelsea Couch
Texas Department of Aging and Disability Services

Kinnie Douglas
Nacogdoches Memorial Hospital

Kay Durilla, RN
Abilene-Taylor County Public Health District

Cheryl Dykes, RN
Memorial Hermann, The Woodlands

Vince Fonseca, MD, MPH, FACPM
Intellica Corporation

Tara Frease, RHIA
TMF Health Quality Institute

Luby Garza-Abijaoude, MS,RD, LD
Texas Department of State Health Services

Carol Gaskamp, PhD, RN, CNE
University of Texas at Austin

Madeline Gil
TMF Health Quality Institute

Tom Guidry, PharmD, BCPS
Pfizer

Katie Karaffa
Christus Spohn Health System

Nora Martinez, MPH, IBCLC, RLC
City of Laredo Health Department

Tod Marvin
American Heart Association

Sherron Meeks, TN, MPAL
Midland Memorial Hospital

Remmy Morris
Seton Family of Hospitals

Donald Nicholson, MEd
Texas Department of State Health Services

Vivian Nowazek, PhD, MSN, RN, BC, CNS, CCRN
University of Houston Victoria

Terri Pali
Texas Public Health Association

Emily Parsons, RN
Texas Department of State Health Services

Bettie Peebles-Beckworth, MEd
Texas Health and Human Services Commission

Holly Riley
Texas Department of Aging and Disability Services

George Roberts, FACHE
Northeast Texas Public Health District

Shilpa Shamapant
Austin Speech Labs

Tim Smith, RN, EMT-P
Covenant Medical Center

Brett Spencer
Texas Department of State Health Services

Thomas Tenner, Jr., PhD
Texas Tech University Health Sciences Center School of Medicine

Amber Haig, MS, CHES
Denton County Health Department

Becky Heinsohn, BS, RN, CPQH
TMF Health Quality Institute

Bob Hillert, Jr., MD
Texas Council on Cardiovascular Disease and Stroke

Tiffani Johnson
Waco-McLennan County Public Health District

Ian Kahn
Austin Parks and Recreation

Sherry Wachtel, RN, MSN, CNS
Christus Spohn Health System

Maricela Wilson, RN, BSN
Seton Family of Hospitals

Carol Winick
American Heart Association

Appendix IV - Invitation to Participate

As the Partnership continues to work together to implement the 2013 *Plan*, membership representation that reflects the diversity of CVD and stroke stakeholders and the populations and communities impacted by CVD and stroke in Texas will be an important factor.

If you and your organization can join the Partnership as it moves forward with taking concrete action to implement the 2013 *Plan*, please visit the Partnership web page at

http://www.dshs.state.tx.us/heart/Texas-Cardiovascular-Disease-and-Stroke-Partnership.aspx

TEXAS
Department of
State Health Services

Texas Department of State Health Services

Cardiovascular Disease and Stroke Program

P.O. Box 149347
Austin, Texas 78714-9347

Phone: (512) 776-7111

http://www.dshs.state.tx.us/heart/

Publication Number: 81-11195

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name:	Texas Diabetes Council (TDC)		
Number of Members:	14		
Committee Status (Ongoing or Inactive):	Ongoing	Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.	
Date Created:	6/5/1983	**Date to Be Abolished:**	N/A
Budget Strategy (Strategies) (e.g. 1-2-4)	A.3.1	**Strategy Title (e.g. Occupational Licensing)**	Chronic Disease Prevention
Budget Strategy (Strategies)		**Strategy Title**	

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Health and Safety Code, Chapter 103
State Authority	Admin Code	25 TAC. Chapter 651
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$9,374	$10,000	$19,200
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$2,440	$2,440	$2,500
Total, Committee Expenditures	$11,814	$12,440	$21,700

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$48,014	$48,014	$48,014
Number of FTEs	0.9	0.9	0.9
Other Operating Costs	$250	$250	$250
Total, Committee Expenditures	$48,264	$48,264	$48,264

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	$60,078	$60,704	$69,964
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year	4	4	4

Committee Description:

The Texas Diabetes Council addresses issues affecting people with diabetes and advises the Legislature on legislation that is needed to develop and maintain a statewide system of quality education services for all people with diabetes and healthcare professionals who offer diabetes treatment and education. Chapter 1358 of the Texas Insurance Code requires that the commissioner, in consultation with the Texas Diabetes Council, by rule shall adopt minimum standards for coverage provided to an enrollee with diabetes. In conjunction with developing each state plan described in Section 103.013, Health and Safety Code, the council shall conduct a statewide assessment of existing programs for the prevention of diabetes and treatment of individuals with diabetes that are administered by the commission or a Health and Human Services agency, as defined by Section 531.001, Government Code. As part of the assessment, the council shall collect data regarding:
(1) the number of individuals served by the programs;
(2) the areas where services to prevent diabetes and treat individuals with diabetes are unavailable; and
(3) the number of healthcare providers treating individuals with diabetes under the programs.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

The Texas Diabetes Council holds regular meetings on the fourth Thursday of January, April, July and October at 1:00 p.m. at the Texas Department of State Health Services, 1100 West 49th Street, Austin, Texas 78756. Committee and subcommittee meetings are scheduled on Wednesday evenings preceding the quarterly meeting, as well as the morning of the quarterly meeting. Per statute, the committee is required to meet at least quarterly.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

The Texas Diabetes Council (TDC) produces a Statewide Assessment of Existing Programs for the Prevention and Treatment of Diabetes, and has provided input on other legislatively required Health and Human Services Commission reports found online at http://www.dshs.state.tx.us/diabetes/preports.shtm. The TDC Health Care Professional Advisory Committee develops minimum standards for diabetes care for regulated health plans in Texas, as well as a number of treatment guidelines and algorithms for use in health care professional education which comprise the TDC Diabetes Tool Kit, found online at www.tdctoolkit.org. This TDC committee also meets quarterly to update these guidance documents and develop ways of promoting TDC recommendations.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

The Texas Diabetes Council has identified four opportunities for addressing prevention and treatment of diabetes in Texas along with priority activities in the Statewide Assessment of Existing Programs for the Prevention and Treatment of Diabetes. Recommendations focus on expanding Diabetes Self-Management Education programs for persons diagnosed with diabetes, increasing availability and reimbursement for the National Diabetes Prevention Program, assessment of Texas Medicaid Transformation Waiver (1115 waiver) programs addressing diabetes, and enhancing diabetes prevention services for women with gestational diabetes served by Texas Medicaid. These recommendations have been incorporated in work plans of the DSHS Diabetes Prevention and Control Program, and are ongoing topics of HHSC work groups addressing the availability and quality of diabetes services offered by Texas Medicaid.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ? Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees? No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015? 1872.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Four positions in the Diabetes Prevention and Control Program staff the Texas Diabetes Council as well as two committees and two subcommittees appointed by the TDC Chair. Staff develop meeting agendas with the chair of each committee/subcommittee, develop meeting guidelines, invite speakers and maintain minutes. Staff is responsible for producing final work products of the TDC including medical treatment guidelines and algorithms, legislative reports, and correspondence with stakeholders. Staff maintains a website dedicated to TDC work products (www.tdctoolkit.org), and promote TDC products at conferences and meetings of healthcare professionals and stakeholders.

6. Have there been instances where the committee was unable to meet because a quorum was not present? Yes

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

Texas Diabetes Council Meetings (quarterly and committee/subcommittee meetings) are open meetings posted in the Texas Register. Agendas are also posted at texasdiabetescouncil.org. Time is allocated for public comment at each quarterly meeting, and an application form is made available to individuals or organizations wishing to obtain a presentation time slot at a quarterly meeting. In addition to Governor-appointed members, the chair of the TDC has appointed committees to address specific charges of the TDC, which allows diabetes experts from across the state to participate directly in developing work products.

7b. Do members of the public attend at least 50 percent of all committee meetings? Yes

7c. Are there instances where no members of the public attended meetings? No

8. Please list any external stakeholders you recommend we contact regarding this committee.

American Diabetes Association, Texas Chapter of the American Association of Clinical Endocrinologists, American Association of Diabetes Educators, Texas Diabetes Institute (San Antonio)

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

Yes

9b. Please describe the rationale for this opinion.

The Texas Diabetes Council has played a key role in developing and assessing state law related to insurance coverage for persons with diabetes, a center of excellence for diabetes treatment and education in Texas, care of students with diabetes in school, risk assessment for type 2 diabetes among youth, support for diabetes self-management education and public information related to diabetes. Membership of TDC committees and subcommittees volunteer their time to develop content for state websites devoted to diabetes professional education and assist the state Diabetes Prevention and Control Program in implementing programs and initiatives related to diabetes prevention and management.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

Yes

10b. Does the scope and language found in statute for this committee prevent your agency from responding to

No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

Texas Diabetes Council committee and subcommittee members are active DSHS partners in developing educational content and state initiatives to address diabetes prevention and treatment. The stakeholder relationships forged through the TDC would need to be developed by another means or potentially purchased should the TDC be discontinued in order to maintain DSHS goals and objectives related to diabetes prevention and treatment.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

Meeting Minutes

Texas Diabetes Council

July 23, 2015 1:00 p.m.
Texas Department of State Health Services Room M-100
1100 West 49th Street
Austin TX 78756

1. **Call to Order**, Victor H. Gonzalez, MD, Chair

2. **Roll Call**, Curtis Triplitt, PharmD, CDE, Secretary
   Victor H. Gonzalez, MD, Chair
   Arthur E. Hernandez, PhD, NCSP, NCC
   Maria Duarte-Gardea, PhD, RD, LD
   John Griffin, Jr., JD
   Carley Gomez-Meade, MD
   Alicia Garcia
   Jason Michael Ryan
   Lisa Golden
   Roberto Rodriguez, MD
   Lisa Glenn, MD
   Rajendra Parikh, MD

   Quorum reached

3. **Action on Absences**

   a. Victor H. Gonzalez, MD, Chair made a motion to excuse the absences of Gene Bell, Dora Rivas, and Don Yarborough. The motion passed.

4. **Approval of April 2015 Meeting Minutes**

   a. A motion to approve the April 2015 Meeting Minutes passed.

5. **Chair's Address and Report**

   a. Dr. Gonzalez reported on a busy Legislative Session. Increased appropriations for DSHS diabetes programs fared well at the beginning of Session, but failed to pass. Dr. Gonzalez noted a sense of cooperation among state agencies and the Council to address programmatic areas that can improve the lives of persons with diabetes.

      The TDC and committees will continue to work toward this goal. The TDC should remain integrated in the planning process, using the resources gathered to answer questions related to diabetes management in Medicaid and other state agency programs. The TDC will continue to integrate its work with the work that goes on at the agency level. The Advocacy and Outreach Committee is poised to work with leadership at DSHS. Continued communication will help improve diabetes care for those served by state programs. Dr. Gonzalez encouraged committee/subcommittee

chairs to meet with state agency leadership to determine how agency programs can best be served by the TDC and begin to prepare for the next Legislative Session.

6. Presentations

Health and Human Services Commission Rider 84: Texas Medicaid and Texas Diabetes Council Coordination and Report

Alexander Melis, MSSW
Senior Policy Analyst
Acute Care Policy Development
Texas Medicaid/CHIP Division
Texas Health and Human Services Commission

Mr. Melis reported that Rider 84 provides an opportunity for HHSC to look at screening for diabetes and referral to DSME across Medicaid and state agency programs. HHSC seeks to start the report as early as possible. The rider specifically calls for HHSC and TDC to work jointly.

Existing legislation already requires HHSC to consult with the TDC regarding services offered persons with diabetes under Medicaid fee-for-service and managed care.

For Rider 84, the TDC should communicate where it sees opportunities for coordination. HHSC also has internal workgroups to address some of the issues related to diabetes. An outline of the report required by Rider 84 has not yet been developed, so an initial meeting with some of the state staff and council members may be appropriate to outline the process for developing the report. This template could also be used for future reports

John Griffin clarified areas where the TDC can help. After HHSC identifies existing efficiencies and inefficiencies in how diabetes is managed through Medicaid and state agency programs, the TDC can provide a strategic standpoint: What do we think are the barriers to improving screening rates for diabetes? What are our hypotheses on how to increase enrollment in DSME?

Dr. Gonzalez agreed with that approach and discussed forming a subcommittee.

John Griffin pointed out that the expertise of the TDC can provide initial thoughts on why screening rates are low and why Medicaid recipients are not receiving DSME.

Dr. Gonzalez suggested an electronic survey to get a baseline.

Alex Melis stated that HHSC can pull together a lot of information, but needs to know as soon as possible what kind of information is needed going forward.

Dr. Hernandez suggested that information on where data comes from would be helpful to promote data accuracy. He asked for a reminder about a DSME-focused study.

Richard Kropp discussed market research that the Diabetes Prevention and Control Program is doing, including surveys of patients who have attended DSME programs. A survey of AADE members and other diabetes educators was also conducted. This fall, physicians will be interviewed regarding their DSME referral practices. A report should be available around January.

Alex Melis recommended distributing managed care performance measures related to diabetes care and definitions. Council input is needed as soon as possible and meeting prior to the next quarterly meeting in October would be beneficial to meeting deadlines.

Dr. Gonzalez requested that a meeting to discuss TDC input be scheduled within the next two weeks.

Richard Kropp discussed the work the Medical Professionals Advisory Committee completed related to recommendations for disease management under Medicaid managed care. Their work should be the basis for next steps in assessing practices related to diagnosis and referral to DSME. The Medical Professionals Committee ended their recommendations with a request that the TDC be informed of any opportunities for quality improvement projects that assessed outcomes of DSME and disease management provided by Medicaid MCOs. This is an ongoing process.

The TDC's assessment of state agency programs serving persons with diabetes, conducted in coordination with development of the TDC state plan/call to action is also a resource for determining which HHSC programs have a role in impacting overall care of persons with diabetes.

7. **Executive Director's Report**, Richard Kropp

   a. Luby Garza and Sister Phyllis Peters completed a DEEP Training in McAllen and certified 30 trainers to conduct DSME based on the curriculum. The training was held on June 16-18 at South Texas College School of Nursing and Allied Health Sciences, McAllen, Texas
   b. Luby Garza exhibited TDC professional education materials at the annual meeting of the Texas Chapter of the American Association of Clinical Endocrinologists, July 31-August 1, Hyatt Regency in Austin
   c. The American Association of Diabetes Educators will hold its annual conference in New Orleans August 4-8. CDC Director of Diabetes Translation, Ann Albright will be a keynote speaker. Ardis Reed, TMF Health Quality Institute, will discuss efforts to expand DSME in Texas.
   d. Legislative Update: The Diabetes Prevention and Control Branch completed analysis for 23 bills related to abstinence education and school health issues, and provided analysis and support for exceptional item funding of $7.6 million to support diabetes prevention and management programs, which was not included in the final budget. Moving forward, the Branch will assist in implementing a new advisory council to assist the Commissioner of Health to establish rules for school anaphylaxis

policy that guides the storage, maintenance and use of epinephrine auto-injectors on school campuses and at school events, and continue to implement state abstinence education programming. Related to diabetes, two riders were included in the final appropriations act that require consultation of the Texas Diabetes Council.

e. 2015 Assessment of Existing Programs for the Prevention and Treatment of Diabetes: Rita Ortega is currently collecting agency data submissions for the 2015 Assessment of Existing Program for the Prevention and Treatment of Diabetes required by Section 103.131 of the Health and Safety Code. The Texas Diabetes Council is required to submit this report by November 1 of each odd-numbered year.
f. Assessment of DSME in Texas: Through CDC 1305 grant funding, the DPCP has contracted with a marketing research firm to develop a report on obstacles and opportunities for DSME in Texas involving the American Association of Diabetes Educators, the American Diabetes Association, TMF Health Quality Institute, and community-based diabetes programs. Six focus groups were conducted in June in the Lower Rio Grande Valley, Austin, and Dallas.
g. Campaign to Increase Participation in DSME and Diabetes Prevention: In addition to the TDC's ongoing Diabetes Prevention Campaign featured at preventtype2.org, 1305 funding will be used to promote the AADE and ADA's efforts to increase discussion of risk for diabetes and diabetes management, and referral to education by physicians.

The current TDC assessment of state agency programs is posted online and the executive summary serves at the TDC call to action. This report will be due again in November 2015. In order to provide guidance to state agencies working on rider reports and provide TDC input for the revised state agency assessment report, the TDC agreed to schedule a special meeting prior to the October quarterly meeting. Staff will poll members for their availability at the end of September or first week in October and schedule the meeting accordingly.

Richard Kropp introduced Dana Jepson, Government Affairs for the Employee Retirement System of Texas (ERS). Ms. Jepson noted that ERS had recently learned of Rider 14 related to an economic analysis of providing a diabetes prevention program to state employees. Ms. Jepson discussed statistics on prevalence of diabetes among the current and retired state employee population and indicated that any guidance on how to define the population of state employees with prediabetes would be useful, as well as information on how a diabetes prevention program could be operationalized.

8. **Health Care Professionals Advisory Committee**, Craig Spellman, DO, PhD, FACE

a. Dr. Curtis Triplitt presented the Lipid Algorithm for Type 1 and Type 2 Diabetes Mellitus in Adults. This item is a non-action consideration until the first PCSK9 inhibitors are approved.
b. **ACTION ITEM:** Dr. Triplitt presented the Glycemic Control Algorithm for type 2 diabetes mellitus in adults, last updated in 2008. Emphasis was placed on early dual therapy, MOA, and the SGLT2 class was added.

There was a motion to accept the Glycemic Control Algorithm. The motion passed.

c. The Health Care Professionals Advisory Committee recommended a non-action consideration of a future update on immunizations for the Diabetes Practice Recommendations for Children and Adults. Further consideration is still needed to include pediatric as well as adult recommendations, possibly separating into two separate documents.
d. Dr. Gonzales recommended an additional topic for consideration: diabetic retinopathy screening.

9. **Outcomes Advisory Subcommittee**, Maria Duarte-Gardea, PhD/Arthur Hernandez, PhD

a. Dr. Hernandez highlighted discussion of Riders 14 and 84. The Outcomes Advisory Subcommittee recommended that the TDC establish a subcommittee to provide guidance regarding these two riders.

The committee discussed a special workgroup for riders. Dana Jepson, ERS Government Affairs, stated ERS covers more than half a million people in the state. There is a high incidence of diabetes among those insured by ERS due to the fact that state employees tend to be an older population. Diabetes affects about 9 percent of those served by ERS and the prevalence is higher among spouses (15 percent). DADS has the highest prevalence of diabetes among the state agency populations. Prediabetes is harder to quantify based on claims. There is potentially a very large group that can't be identified. About 20 percent of adult medical cost is diabetes, which is close to 3 billion per year.

Ms. Jepson said that communication is difficult. ERS doesn't know if employees read the newsletter communication, let alone dependents. People are not required to take a health risk assessment.

John Griffin asked to have a draft of the Statewide Assessment emailed to members to edit by October 8.

10. **Advocacy and Outreach Committee**, John Griffin, JD

a. John Griffin reported that Rita Ortega described the background and progress of the DSME assessment project and Klause Madsen talked about the Changing Diabetes Initiative – a three-year project to study people living with diabetes in urban areas.
b. Advocacy and Outreach discussed the issue of school nutrition. TDC could contribute to the Partnership for a Healthy Texas which establishes positions on school nutrition in Texas
c. ADA update on advocacy: New school bill passed in Hawaii means 40 states have legislation to help students who manage diabetes at school.
d. The FAA announced that it will no longer discriminate against pilots who use insulin. People with insulin-dependent diabetes can now get a commercial driver's license in Texas through a federal exemption program. Gonzalez wrote a letter, dated May 26, 2015, asking Texas DPS to update their website to reflect the change. There was not a formal response, but the website now has a prominent link to the diabetes waiver program.

The council discussed other areas where information on the diabetes waiver exemption would be helpful.

11. Program reports

a. **Public Information and Education**, Jimi Ripley-Black reported on the Diabetes Self-Management Education campaign.
b. **Community Diabetes Projects**, Carol Filer, MS, RD, LD discussed two reports. One is process data. Some CDPs provided outcomes for individual projects. The other is information on outcomes from 2012-2014.

12. Agency reports

a. State agency representatives did not have further updates to provide other than those discussed earlier in the meeting.

13. Member announcements

a. TDC members discussed ways to use social media to increase diabetes prevention and management. Richard Kropp will consult with legal staff regarding ability of TDC members to engage in social media as Texas Diabetes Council members.
b. Dr. Gonzalez thanked Dr. Duarte for agreeing to be the new Secretary of the TDC.
c. Dr. Gonzalez noted that, as new medical schools open in the state, the TDC will be presented with new opportunities to make curriculum recommendations related to diabetes.

14. Public comment - no public comment received.

15. Adjournment

a. Motion to adjourn at 4:02 pm

Meeting Minutes

Texas Diabetes Council

October 22, 2015 1:00 pm
Texas Department of State Health Services Room T-607
1100 West 49th Street
Austin TX 78756

1. **Call to Order**, Victor H. Gonzalez, MD, Chair

2. **Roll Call,** John Griffin, Jr., JD
   Victor H. Gonzalez, MD, Chair
   Maria Duarte-Gardea, PhD, RD, LD
   Jason Michael Ryan
   Don E. Yarborough
   Lisa Golden
   Roberto Rodriguez, MD
   Lisa Glenn, MD

   Quorum was not reached. Committee members in attendance can discuss but not vote on action items.

3. **Action on Absences**

   a. There cannot be action items without a quorum. Discussion focused on how to improve attendance.

4. **Approval of July 2015 Meeting Minutes**

   a. The July 2015 meeting minutes could not be approved without a quorum.

5. **Chair's Address and Report**

   a. Dr. Gonzalez reported on the special meeting on October 2, 2015, to work on the Statewide Assessment.

   b. Since then, Dr. Gonzalez has met with the Texas Medical Association (TMA) and discussed challenges related to Medicaid coverage. All parties involved are interested in improving delivery of care. The best approach is to demonstrate cost-cutting measures. Between now and next summer, when the Legislative agenda for 2017 develops, there will be a focus on improving Medicaid delivery. Hopefully the TDC can convince the Legislature that Diabetes Self-Management Education (DSME) is something they should look at and invest in.

   c. TMA has been good about helping support those types of measures. They don't have a specific program yet but are considering topics to address. They have also been talking about potential routes the TDC may take and are interested in hearing from the Advocacy and Outreach Committee.

6. **Presentations**

Introduction to Cities Changing Diabetes
Klaus Kroyer Madsen, MPH
Local Project Lead for Cities Changing Diabetes in Houston

Dr. Faith Foreman, Assistant Director, Houston Health Department, will attend the January meeting.

Sixty-four percent of those with diabetes live in urban areas. As more people move to urban areas, the concentration of people with diabetes will increase. Lifestyle changes upon moving to urban areas include a longer commute, less exercise, and not eating as well. Novo Nordisk wants to understand what urban diabetes means for diabetes detection and management. Over the past year, an assessment project has been conducted

Rule of Halves Framework – An estimated 382 million people worldwide have diabetes. Numbers are better in the US: 70-75 percent diagnosed in US. Half of people with diabetes are diagnosed. Only half who are diagnosed receive care. Only half of those receive treatment. Of those, only half achieve desired outcomes.

Houston has conducted a vulnerability assessment. A summit to discuss findings will be held November 10.

Questions to answer include:

- "What are the driving factors behind the growing rise of diabetes?"
- "What are new interventions, solutions?"
- "What funding is available to assist in addressing the issue?"

Houston Health Department and partners have formed a coalition to address three phases of the initiative: mapping, sharing, and action. The mapping phase has just been completed. The action phase begins November 10. Work group meetings, in in the fall will develop initial projects with sustainability in mind – funded beyond 2017. The goal is to have several sustainable projects funded by this time next year. These projects can provide valuable insight to the TDC regarding diabetes in urban areas.

7. **Executive Director's Report**, Richard Kropp

TDC Meeting on October 2, 2015
The TDC held a special meeting on October 2 to review the Statewide Assessment of Existing Programs for the Prevention and Treatment of Diabetes and discuss riders passed during the 84th Legislature related to identifying efficiencies in screening for diabetes and referral to DSME across state agency programs, and determining prevalence of prediabetes among state employees and reporting on impact of offering a diabetes prevention program for state employees.

- An edited version of the statewide assessment was emailed to TDC members, including a summary of edits discussed at the meeting.
- Alex Melis, HHSC, reviewed quality indicators for Medicaid managed care contracts and discussed process for reviewing additional quality measures. HHSC will repeat the survey of Medicaid Managed Care Organizations developed by the TDC Medical Professionals Advisory Subcommittee to assess how MCOs are conducting DSME across plans.

Additional questions were suggested from an Ohio health plan survey developed to assess how health systems are identifying women who have had gestational diabetes and whether they are receiving post-partum counseling that addresses their risk for type 2 diabetes.

- Dr. Stephanie Gruss, team lead for the National Diabetes Prevention Program, joined the meeting via teleconference to update the TDC and guests regarding progress in implementation of the National Diabetes Prevention Program.
    - Nationally, 38 sites have achieved CDC recognition indicating their ability to achieve lifestyle changes proven to reduce risk for type 2 diabetes. Persons who are 55 and older are achieving the greatest benefit from participation in diabetes prevention programs.
    - Attendees from Employees Retirement System of Texas (ERS) and United Health discussed lack of data regarding prevalence of prediabetes among state employees. Some type of biometric assessment would be needed to develop an accurate estimate. Texas does have an estimate of prediabetes prevalence in the adult population based on BRFSS survey results, but these are considered to be an under-estimate.
    - CDC is developing a return on investment calculator that can be used by employers to estimate costs savings resulting from diabetes prevention, which should be available in early 2016.
    - The American Medical Association may also be releasing a calculator soon.
    - CDC will be working with Medicaid managed care organizations through grants to state Medicaid programs to make diabetes prevention program participation a covered benefit. Funded states will work to operationalize the benefit through their Medicaid programs. Specific tools are being developed to assist state Medicaid programs that should be available this fall.
    - CPT codes related to prediabetes are found in the diabetes prevention tool kit developed by the CDC and AMA.
    - A number of online providers of the NDPP are also available. Omada Health has developed the “Prevent” application, which has demonstrated results in achieving weight loss related to diabetes prevention. It may be useful to discuss implementation and results with other states that are offering prevention programs through online providers.

Community Diabetes Education Programs Announced

The Texas Diabetes Prevention and Control Program currently contracts with four organizations to:

- Increase opportunities for physical activity and better nutrition
- Increase access to ADA-recognized and/or AADE-accredited diabetes self-management education and support
- Improved capacity of a Community Diabetes Education Program (CDEP) advisory board to design, implement, and engage in program quality improvement of diabetes interventions
- Increase public and provider knowledge of the symptoms, risk factors and target goals of diabetes, pre-diabetes and gestational diabetes, and the importance of physical activity and healthy eating in preventing, delaying, or managing diabetes and it’s complications

Sites include:

- El Paso Diabetes Association
- Houston Health Department

- Northeast Texas Public Health District
- Wichita Falls/Wichita County Public Health District

Carol Filer and Ashley Doyle have completed an assessment of site technical assistance needs and are working on an upcoming training in Austin to address reporting requirements.

Potentially Preventable Hospitalization Contractor Meeting Held in September
The Diabetes Prevention and Control Program presented state and national resources for diabetes prevention and control to newly selected contractors addressing potentially preventable hospitalizations in Texas.

Since 2008, the Texas Department of State Health Services (DSHS) has educated communities and policymakers on the impact of the following adult PPH conditions:

- Diabetes Complications
- Chronic Obstructive Pulmonary Disease (COPD)
- Asthma
- Hypertension
- Congestive Heart Failure (CHF)
- Angina (without procedures)
- Dehydration
- Bacterial Pneumonia
- Urinary Tract Infection (UTI)

In 2013, adult Texans received approximately $8.9 billion in hospital charges for 230,458 hospitalizations for the above PPH conditions combined. The average hospital charge for these hospitalizations was $38,090.

DSHS requested $3.4M in new funding from the 84th Texas Legislature to expand the Adult PPH Initiative, originally funded in 2011, from 13 to 27 counties in FY16/17. However, the Legislature did not provide new funding to expand the initiative.

As a result, DSHS will attempt to maintain PPH intervention activities in 13 counties in FY16/17: Angelina; Brooks; Ector; Grayson; Limestone; Orange; Polk; Red River; San Augustine; Tom Green; Trinity; Victoria; and Walker County. DSHS will use $2M in the agency's biennial base budget for the Adult PPH Initiative to fund intervention activities in these 13 counties focusing on congestive heart failure, COPD and diabetes.

Luby Garza and Richard Kropp presented educational resources of the Texas Diabetes Council, CDC, and National Diabetes Prevention Program. Luby described the Diabetes Education and Empowerment Program and opportunities to train community health workers to implement the curriculum in communities. Breda Ortiz with TMF Health Quality Institute presented on the "Everyone with Diabetes Counts" initiative and opportunities for communities to work with TMF to expand opportunity for persons with diabetes to participate in DSME.

ADA Advocacy Training in San Antonio and Dallas:
Veronica De La Garza worked with local ADA chapters and national advocacy staff to conduct two day-long trainings in San Antonio and Dallas in October to educate local volunteers about how to talk to legislators about ADA advocacy agenda items such as funding for the Special Diabetes Program, funding for the CDC Division of Diabetes Translation and funding for the National Diabetes Prevention

Program. Richard Kropp presented the legislative history of the Texas Diabetes Council and current legislative priorities in Dallas on October 9, along with presentations by advocacy leads that worked to promote Medicaid expansion during the 84th Legislature.

Texas Academy of Family Physicians
Richard Kropp will exhibit TDC professional education materials at the Texas Academy of Family Physicians annual session to be held in the Woodlands on November 13 and 14.

8. **Health Care Professionals Advisory Committee/Medical Professionals Advisory Subcommittee**, Luby Garza

    a. There was not a quorum, so action items were not passed – Lipid algorithm, vaccine section of the minimum standards of care/flowsheet

    b. The flowsheet was complicated because new vaccines are recommended for people who are immune-compromised: Pneumovax and Prevnar. The CDC Advisory Committee on Immunization Practices recommended a schedule that has become so extended that the group decided to do an immunization section separate from the flowsheet (expand to two pages). The group will use CDC's recommendations from the latest Morbidity and Mortality Weekly Report (MMWR); however, recommendations continue to change. Staff will the seek input of the DSHS immunization program and state advisory group.

    c. Next meeting: Members will discuss and review insulin algorithms and finalize and get approval for the lipid algorithm and vaccine flowsheet.

9. **Outcomes Advisory Subcommittee**, Maria Duarte-Gardea, PhD

    a. There was not a quorum, so action items were not passed.

    b. Presentation on HMO Recognition Program - discussed indicators. HEDIS measures addressed by the recognition program are those related to ABCs (A1c, Blood Pressure and Cholesterol). Members discussed whether there is interest in changing this methodology but decided to continue the same procedure for recognition. HMOs to be recognized will be provided to the TDC at the January meeting. Members suggested that the online listing of HMOs receiving recognition also include a listing or link to those that are not recognized so that performance can be compared.

    c. Efforts to promote referral to DSME and Diabetes Prevention Programs: A future project of the subcommittee may include mapping of sites offering diabetes prevention in Texas. Waiver (1115) projects offering DSME could also be mapped. Not all diabetes-related waiver projects focus on DSME, so it would be useful to determine which do.

    d. Outcomes proposed a motion for the TDC to support federal legislation that expands reimbursement for DSME to CDEs and others offering DSME. Also support the bill that would support offering the NDPP to Medicare recipients.

    e. Jason Ryan will review the legislation and propose a motion.

10. Advocacy and Outreach Committee, John Griffin, JD

a. The DSME market research and evaluation project is in its early stages.

b. Joan Colgin forwarded the joint position statement on DSME that describes cost effectiveness of DSME for reference in the TDC reports.

c. The committee expressed that the TDC's Assessment Report is ready to move forward.

d. John Griffin discussed progress regarding FAA legal challenges.

e. More "Safe at Schools" victories are occurring across the nation. The latest court cases address issues with separate schools for children with diabetes and other disabilities. Nearly 40 states now have protection for kids attending schools where unlicensed diabetes care assistants are required. The October 2015 Diabetes Care published on how children with diabetes should be cared for in a school setting.

f. A new insulin is on the market or soon available that may help patients with interrupted doses and offers protection from a missed dose.

g. No action item other than TDC approval of the assessment report as soon as possible.

11. Program reports

a. **Public Information and Education**, Jimi Ripley-Black reported on the Diabetes Self-Management Education campaign.
b. **Community Diabetes Projects**, Carol Filer, MS, RD, LD, and Ashley Doyle, MPH, reported on the Community Diabetes Education Projects.

12. Agency reports

a. A job posting has been issued for the DSHS Commissioner. State agency representatives did not have further updates to provide other than those discussed earlier in the meeting.

13. Public comment

a. Patricia Haney talked about the care of her insulin-dependent son in hospitals and rehabilitation facilities.

14. Adjournment

a. Motion to adjourn at 3:15 pm

Meeting Minutes

Texas Diabetes Council

January 28, 2016 1:00 pm
Texas Department of State Health Services Room M-100
1100 West 49th Street
Austin TX 78756

1. **Call to Order**, Victor H. Gonzalez, MD, Chair

2. **Roll Call**, Curtis Triplitt, PharmD, CDE, Secretary
   Victor H. Gonzalez, MD, Chair
   Maria Duarte-Gardea, PhD, RD, LD
   Jason Ryan
   Dora Rivas, MS, RD, SNS
   Rajendra Parikh, MD
   Lisa Golden
   Roberto Rodriguez, MD
   Lisa Glenn, MD

   Quorum reached.

3. **Action on Absences (Action Item):** There was a motion to excuse the absences of Arthur Hernandez, John Griffin, Don Yarborough, Carley Gomez-Meade, Alicia Gracia, and Gene Bell. There was a motion to remove Gene Bell from excused absences. Both motions passed. Excused absences were approved for Arthur Hernandez, John Griffin, Don Yarborough, Carley Gomez-Meade, and Alicia Gracia.

4. **Approval of July 2015 and October 22, 2015 Meeting Minutes (Action Item):** Jason Ryan moved to approve both the July and October 2015 meeting minutes. The minutes were approved.

5. **Chair's Address and Report**

   a. Dr. Gonzalez noted that appointment of new members by the Governor's Office is expected to occur soon.

   b. He commended the relationships that the council has developed with other agencies, particularly HHSC.

6. **Presentations**

Cities Changing Diabetes Initiative - Houston
Faith Foreman, Dr. P.H., MPH, LVN
Assistant Director, Houston Health Department
Klaus Krøyer Madsen, MPH
Stakeholder Engagement Consultant, Cities Changing Diabetes Houston

Real Appeal Virtual Lifestyle Intervention Program
Diabetes Prevention Among State Employees
UnitedHealthcare, third-party administrator for HealthSelect of Texas℠

Surveillance of Texas Community Diabetes Projects Using
Program Management and Tracking System (PMATS) Data
Nimisha Bhakta, MPH
Office of Surveillance Evaluation and Research
Health Promotion and Chronic Disease Prevention Section
Texas Department of State Health Services

7. **Executive Director's Report**, Richard Kropp

   a. As follow-up to the October 2nd meeting to assist Texas Medicaid and the Employee Retirement System of Texas in developing reports related to DSME and diabetes prevention by August 2016, the Diabetes Prevention and Control Program scheduled a conference call with Omada Health to discuss results of the "Prevent" online Diabetes Prevention Program. Prevent is recognized by the Division of Diabetes Translation through the NDPP recognition program which recognizes programs achieving results similar to the NDPP clinical trials.

   b. CDC advisors for the State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health (more commonly known as the 1305 grant) were in Austin on January 20th and 21st to learn more about how the grant is structured in Texas, and partners who are assisting with the 1305 work plan.

   c. The CMS Medicaid Prevention Learning Network supports state Medicaid agencies in improving access to, utilization of, and quality of preventive services. As part of this initiative, CMS is creating Affinity Groups for state Medicaid agencies to learn from one another and receive technical assistance around CMS priority areas. A Tobacco Cessation group is already underway, and a Diabetes Prevention and Management group will start in February 2016. The Diabetes Prevention and Control Program and the Office of the Medical Director, HHSC, developed an expression of interest document in order to participate in the new Diabetes Prevention and Management Affinity Group.

   d. The American Diabetes Association (ADA), American Medical Association (AMA) and Centers for Disease Control and Prevention (CDC) have partnered with the Ad Council to launch the first national public service campaign to raise awareness about prediabetes.

8. **Health Care Professionals Advisory Committee/Medical Professionals Advisory Subcommittee**, Craig Spellman, DO, PhD, FACE

a. An action item was presented to approve the updated Lipid Algorithm for Type 1 and Type 2 Diabetes Mellitus in Adults. Updates include adding PCSK-9 (Proprotein convertase subtilisin/kexin-type) and what to do if LDL is not at goal. After discussion the Health Care Professionals Advisory Committee members voted unanimously to move the revisions forward for TDC approval.

   Dr. Gonzalez made a motion to approve the algorithm as presented. The motion passed.

b. An action item was presented to update the date to January 28, 2016, for the Hypertension Algorithm. The members of the Health Care Professionals Advisory Committee want to indicate that the TDC still approves the goal of less than 130/80.

   Dr. Gonzalez made a motion to approve re-evaluation of the Hypertension Algorithm and change the approved date to January 28, 2016. The motion passed.

c. After discussion about vaccines, it was decided to get more information from the Centers for Disease Control and Prevention (CDC) before proceeding with recommendations regarding immunization schedules for persons with diabetes.

9. Outcomes Advisory Subcommittee, Maria Duarte-Gardea, PhD

a. An action item was presented to recognize six HMOs in seven markets, based on HEDIS indicators. The HMOs to be recognized were read: Community First Health Plans (San Antonio), FirstCare (Abilene), FirstCare (Waco), Humana Health Plan of Texas (Corpus Christi), Humana Health Plan of Texas (Houston), Humana Health Plan of Texas (San Antonio), and Scott and White Health Plan (Central Texas).

   Dr. Gonzalez made a motion to approve the list of HMOs for recognition as presented. The motion passed.

b. TDC members discussed indicators and whether there is a need to change recognition program criteria. The decision was made to continue the same procedure for recognition because the HEDIS measures addressed by the recognition program are related to ABCs (A1c, Blood Pressure and Cholesterol). It was recommended that the online listing of HMOs receiving recognition also include a listing or link to those not recognized so that performance can be compared.

c. Outcomes Subcommittee members recommended the following bills for sponsorship by the TDC: Preventing Diabetes in Medicare Act, H.R. 1686, and Access to Quality Diabetes Education Act, H.R. 1726.

   TDC members voted to put together a document and contact the AADE to find out how the TDC can show support.

10. Advocacy and Outreach Committee, Jason Ryan

a. Advocacy and Outreach Committee members also discussed the Access to Quality Diabetes Education Act, H.R. 1726; they would like to draft a letter of support for the TDC Chair's signature.

Mr. Ryan made a motion to write a letter of support to be signed by the TDC Chair. The motion passed.

Advocacy and Outreach Committee members will get the Chair a draft of the letter before February 14, 2016.

b. Mr. Ryan made a motion to approve the Executive Summary. The motion passed.

c. Upcoming 2016 events were noted: Taking Control of Your Diabetes in San Antonio on June 18; the Kidney Symposium in San Antonio on April 21-22; and the AADE state conference, in Austin on March 31.

11. Program reports

a. **Public Information and Education**, Jimi Ripley-Black reported on the National Prediabetes Awareness Campaign.
b. **Community Diabetes Projects**, Carol Filer, MS, RD, LD reported on the Community Diabetes Education Projects.

12. Member Announcements

a. A Medicaid survey about DSME was highlighted as part of an upcoming handout that will guide DSME.

b. There was a discussion on whether to extend the April meetings by an additional day for a Strategic Planning Session. It was decided to keep the original schedule for April 27-28, 2016.

13. Public comment

a. No public comment received.

14. Adjournment

a. Motion to adjourn at 3:57 pm

Statewide Assessment of Existing Programs for the Prevention and Treatment of Diabetes

As Required By
Section 103.0131
Texas Health and Safety Code

TEXAS DIABETES
COUNCIL

Texas Diabetes Council
December 2014

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Executive Summary:
Diabetes in Texas - A Call to Action

Diabetes Continues to Challenge the Physical and Fiscal Health of Texas

The prevalence of diabetes in Texas has increased by 57 percent over the past decade[1] and the projected future increase is dramatic.

- Today, the data shows that more than 2.1 million (10.6 percent) adult Texans have diabetes, and another 1.2 million (6.2 percent) have prediabetes.[2]
- For pregnant women, the numbers are even higher, with the latest data showing that an estimated 11.5 percent of pregnant women in Texas develop gestational diabetes compared to 1.9 percent who had pre-existing diabetes before the pregnancy.[3]
- Many more Texans are likely to have prediabetes, but aren't diagnosed. Results of national studies indicate that as many as 35 percent of U.S. adults have prediabetes (diagnosed and undiagnosed), a condition that makes them more likely to develop type 2 diabetes within the next ten years, and more likely to have a heart attack or stroke.[4]
- The State Demographer projects a quadrupling of the number of adult Texans with diabetes to almost 8 million by 2040.[5]

In 2012, diabetes cost an estimated $18.5 billion in Texas, including $12.3 billion in direct medical costs and $6.2 billion in indirect costs. The cost to Texas will increase substantially as the number of Texans with diabetes quadruples over the next 25 years.[6]

[1] Texas Department of State Health Services. *The Burden of Diabetes in Texas. A Report Prepared by the Office of Surveillance, Evaluation, and Research; Health Promotion and Chronic Disease Prevention Section*. April 1, 2013. Updated November 6, 2013.

[2] 2012 Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, for persons eighteen years of age and older. Data include both type 1 and type 2 diabetes. Persons with diabetes include those who report that they have been told by a doctor or other healthcare professional that they have diabetes. Persons with prediabetes include those who have been told by a doctor or other healthcare professional that they have prediabetes or borderline diabetes. Women and girls who report diabetes or prediabetes only during pregnancy are not included in prevalence.

[3] Texas Department of State Health Services Diabetes Prevention and Control Branch. *Texas Pregnancy Risk Assessment Monitoring System (PRAMS) Estimate of Pre-existing and Gestational Diabetes, 2004-2009*. Texas Diabetes, the Newsletter of the Texas Diabetes Council, Spring 2011. Publication No. 45-11004. http://www.dshs.state.tx.us/diabetes/PDF/newsletter/spring11.pdf

[4] Centers for Disease Control and Prevention. National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.

[5] Texas, Office of the State Demographer, Texas State Data Center. *Summary Report on Diabetes Projections in Texas, 2007 to 2040*. http://txsdc.utsa.edu/reports/Summary_Report_Diabetes.pdf.

[6] Texas Health and Human Services Commission. *Report on Direct and Indirect Costs of Diabetes in Texas As Required By S.B. 796, 82nd Legislature, Regular Session, 2011*. December 2012

http://www.hhsc.state.tx.us/reports/2012/direct-indirect-costs-diabetes-texas.pdf.

- Based on assessments of state agency programs and services in 2011-12, almost 400,000 Texans with diabetes received diabetes-related services through state Health and Human Services Commission programs, with identified costs reaching almost $312 million.[7]
- Almost 27,000 health care providers treated diabetes patients under state agency programs.[8]
- According to analysis of United Healthcare plan members, the average total annual cost for an adult plan member with employer coverage and diagnosed diabetes who interacted with the health care system in 2009 was approximately $11,700, compared to $4,400 for an adult with employer coverage not known to have diabetes. The average yearly total costs for a person with diabetes who developed complications were $20,700 – almost three times the average cost of $7,800 for diabetes patients without complications.[9]
- People with diabetes who do not have health insurance have 79 percent fewer physician office visits and are prescribed 68 percent fewer medications than people with insurance coverage—but they also have 55 percent more emergency department visits than people who have insurance.[10]
- Total costs of hospitalization for all diabetes in pregnancy was over $1.4 billion, or 7.8 percent of all maternal hospitalization costs in 2010.[11]
- Complications of diabetes include heart disease and stroke, blindness, amputations, and kidney disease. The largest components of medical expenditures for diabetes are:

    - Hospital inpatient care (43 percent of the total medical cost),
    - Prescription medications to treat complications of diabetes (18 percent),
    - Anti-diabetic agents and diabetes supplies (12 percent),
    - Physician office visits (9 percent), and
    - Nursing/residential facility stays (8 percent).[12]

Texas Diabetes Council Accomplishments

Established to address the growing prevalence of diabetes in Texas, and accompanying cost, the Texas Diabetes Council (TDC) consists of Governor-appointed volunteers including health care provider and consumer members with expertise in diabetes issues. Accomplishments of the TDC include:

- Increasing patient education opportunities in Texas through funding for community-based diabetes education programs;

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[7] Texas Department of State Health Services Diabetes Prevention and Control Branch. *Statewide Assessment of Existing Programs for the Prevention and Treatment of Diabetes as Required by Section 103.0131, Health and Safety Code*, 2013.

[8] Ibid.

[9] Deneen Vojta, Jeanne De Sa, Ted Prospect and Simon Stevens, *Effective Interventions For Stemming The Growing Crisis Of Diabetes And Prediabetes: A National Payer's Perspective*, Health Affairs, 31, no. 1 (2012): 20-26.

[10] American Diabetes Association. *Economic Costs of Diabetes in the U.S. in 2012*. Diabetes Care. 2013 Apr; 36 (4):1033-46. Epub 2013 Mar 6. http://www.diabetes.org/advocacy/news-events/cost-of-diabetes.html

[11] Wier, L.M., Witt, E., Burgess, J., and Elixhauser, A. *Hospitalizations Related to Diabetes in Pregnancy, 2008*. HCUP Statistical Brief #102. December 2010. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb102.pdf

[12] American Diabetes Association. op. cit. p. 1033

- Collaborating with the Legislature on legislation that protects children with diabetes while at school;
- Development of a diabetes "Center of Excellence" for patient treatment and professional training in the state (Texas Diabetes Institute, San Antonio);
- Publication and promotion of treatment guidelines for health care professionals and health plans; and
- Development of state policy that ensures insurance coverage and services for Texans with or at risk for diabetes.

Action Plan for Texas

The TDC has identified four significant opportunities as a call to action that builds upon past accomplishments, and takes full advantage of national, state and local efforts already underway to improve diabetes education, management and care in Texas. Our work in the priority areas that follow is dependent on the Legislature's continued funding and support of the Diabetes Prevention and Control Program at the Texas Department of State Health Services.

1) The **Texas Medicaid Transformation Waiver** (1115 waiver) has resulted in 111 projects across the state focusing on diabetes-related outcomes. This unprecedented opportunity to evaluate our approaches to diabetes prevention and control in Texas should lead to identification and dissemination of lessons learned and best practices.

Priorities for Texas Diabetes Council

- Evaluate whether waiver projects show quantifiable improvements relating to quality of care, population health, and cost of care for patients with diabetes.
- Work with the HHSC Center for Strategic Decision Support to explore opportunity for 50 percent federal match funding for this effort.

2) The **National Diabetes Prevention Program** (NDPP) is a public-private partnership of community organizations, private insurers, health care organizations, employers, and government agencies brought together to establish local evidence-based lifestyle change programs for people at high risk for type 2 diabetes. The community program costs less than $325 per participant[13], as compared to an average of $7,900 per year for the treatment of diabetes for one individual.[14] The *Texas State Healthcare Innovation Plan* recommends reimbursement for this one-year lifestyle change program by Medicaid and state employee health plans in order to achieve a projected reduction in risk for type 2 diabetes of 58 percent among individuals with prediabetes served by these health plans.

[13] Ackerman, R.T., Marrero, D.G., Adapting the Diabetes Prevention Program Lifestyle Intervention for Delivery in the Community: The YMCA Model, The Diabetes Educator 2007; 33;69.

[14] American Diabetes Association. op. cit. p. 1033

Priorities for Texas

- Using cost effectiveness data from United Healthcare and others, demonstrate value of establishing the NDPP as a covered benefit under Texas Medicaid and the Employment Retirement System of Texas (ERS).
- Working with the Texas Medical Association and others, promote health care provider referral to NDPP in Texas and educate providers about the need to screen and diagnose patients with prediabetes.

3) **Diabetes Self-Management Education (DSME) in Community Diabetes Projects** DSME improves clinical outcome measures related to blood sugar (A1c), blood pressure, cholesterol, and smoking status. Managed care organizations (MCO) currently under contract with Texas Medicaid are required to provide disease management and education services; however, information needed to assess the reach and effectiveness of these services is not currently available. Initial surveys of Medicaid MCOs indicate that fewer than half of the contracted MCOs automatically enroll patients with diabetes in self-management education. There is also a need for more DSME accredited sites recognized by the American Diabetes Association (ADA) or American Association of Diabetes Educators (AADE) to ensure that standards for demonstrating outcomes are met. The same standards, information and reporting should be required of DSME Medicaid Managed Care contracts.

Priorities for Texas Diabetes Council

- Work with HHSC to ensure Medicaid patients with diabetes are automatically enrolled in a DSME program and that HHSC is analyzing outcomes data demonstrating health and economic impact.
- Work with state agencies to ensure state reporting systems beyond Medicaid are evaluating DSME outcomes to demonstrate effectiveness in improving health.
- Increase access, referral, and reimbursement for AADE-accredited or ADA-recognized DSME programs that help prevent diabetes complications.
- Increase engagement of community health workers to promote linkages between health systems and community resources for adults with type 2 diabetes.

4) **Gestational Diabetes** Women with gestational diabetes are at high risk for developing type 2 diabetes later in life, and the infant is at risk of becoming obese during childhood and developing type 2 diabetes as an adult. Women with gestational diabetes have a 35-60 percent chance of developing diabetes in the next 10-20 years.[15] In Texas, Medicaid pays for over 50 percent of all births statewide.[16] A recent study by the Health and Human Services Commission and Texas Diabetes Council concludes that 9 percent of pregnant women participating in any Texas Medicaid program developed Gestational Diabetes

[15] Centers for Disease Control and Prevention: National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.

[16] Texas Health and Human Services Commission. Gestational Diabetes in Medicaid: Prevalence, Outcomes, and Costs. As Required By Rider 75, Senate Bill 1 83rd Legislature Regular Session, 2013. http://www.hhsc.state.tx.us/reports/2014/SB1-Gestaional-Diabetes.pdf

Mellitus (GDM) prior to delivery in 2012.[17] The study also concludes that birth certificate and hospital discharge data available prior to the study may have underestimated the prevalence of gestational diabetes by as much as 50 percent.
Currently, only between 40 to 50 percent of Texas women participating in the Medicaid or CHIP Perinatal program are screened for gestational diabetes.[18] Some screening may occur before these women participate in state programs; however, this percentage indicates that improvement can be made in screening rates. All women should be screened for gestational diabetes at 24 weeks of pregnancy, even if they have no symptoms, according to the latest national guidelines set by the American Association of Clinical Endocrinologists, the American Diabetes Association (ADA), the American College of Obstetricians and Gynecologists (ACOG), and the United States Preventive Services Task Force.

Furthermore, women who were diagnosed with gestational diabetes should, upon delivery of their baby, be referred to lifestyle change programs following the guidelines developed by the National Diabetes Prevention Program.[19] These programs focus on weight loss that can reduce risk for developing type 2 diabetes and future high-risk pregnancies. As a woman's pre-pregnancy weight increases, Medicaid expenditures also increase. This trend is more pronounced among women entering into a pregnancy with diabetes and is exacerbated among overweight and obese women. Obese women, regardless of diabetes status, tend to have the costliest maternal care and post-natal expenses (5 to 10 percent higher among non-diabetic obese mothers than normal weight non-diabetic mothers.)

Priorities for Texas Diabetes Council

- In collaboration with HHSC work to ensure Medicaid managed care plans screen all pregnant women they serve for gestational diabetes, and if diagnosed, receive appropriate management (medical nutrition therapy, self-management education, and supplies) and care to prevent complications, hospitalizations and potential neonatal intensive care unit costs for the newborn
- Work with HHSC to identify solutions to decrease poor birth outcomes experienced by infants born to mothers with gestational diabetes due to lack of adequate diabetes management.
- Work with HHSC to ensure that, upon delivering the baby, women in Medicaid and CHIP Perinatal Program who were diagnosed with gestational diabetes are referred to a local evidence-based lifestyle change program, such as the National Diabetes Prevention Program, to help prevent or delay the onset of type 2 diabetes.

[17] Ibid

[18] Ibid.

[19] http://www.cdc.gov/diabetes/prevention/resources.htm

Conclusion

The Texas Diabetes Council is strongly committed to identifying ways to simultaneously reduce overall expenditures while improving the delivery of evidence-based, cost effective prevention and health services that improve population health.

Given the 57 percent increase in diabetes prevalence in Texas over the past decade, and the projected quadrupling by 2040, the TDC is concerned that escalating healthcare costs resulting from complications of poorly controlled diabetes will continue to inhibit our ability to afford and sustain the health care delivery system. This poses a simultaneous threat at multiple levels: fiscally for the Legislature and Texas taxpayers, but also a threat to the health and quality of life of all Texans.

Introduction: Issues Related to the Assessment of Existing Programs for the Prevention and Treatment of Diabetes

Access to Health Outcomes Information for Program Evaluation and Planning

The majority of the information about state agency programs and services contained in this assessment report relates to numbers of Texans served and overall costs for programs and services. A critical element that the TDC finds lacking across most state agency programs is accessible health outcomes information based on clinical performance measures.
Over the 2012-13 biennium, the TDC developed guidance for disease management and diabetes self-management education under Medicaid Managed Care in Texas. These recommendations were presented to medical directors of health plans currently under contract with the HHSC. However, in order to assess the efficacy of these recommendations and demonstrate quality of care, the TDC and policymakers need access to de-identified, aggregated data about the results of diabetes self-management education services, hemoglobin A1c tests, blood pressure screening, cholesterol screening, eye exams, foot exams, and nephropathy screening of patients receiving treatment under Medicaid. Outcomes of these important tests and services have a direct impact on quality of life for these patients and their ability to avoid serious complications such as blindness, amputations, cardiovascular disease, and kidney disease.

Texas Medicaid maintains a quality dashboard that addresses hospitalization of persons with diabetes and whether or not testing services are provided but contains little information about the effectiveness of the services in maintaining quality of life.[20] More data are needed to identify areas for quality improvement.

It is important to note that the information already exists in health-care systems across the state. Regional health information exchanges have started the work of presenting this information in a way that is useful for assessment, quality improvement, and policy development. While progress varies across the state, the TDC found one area of the state excels in its ability to use health system data to illustrate the burden of diabetes and areas for improvement. The Dallas Fort Worth Hospital Council Foundation (DFWHCF) conducted a Community Health Needs Assessment to provide an analysis of the health-care needs of the North Texas community (Regional Health Partnership 9) for the Medicaid 1115 waiver. The assessment showed that the most common health conditions by volume that result in hospital admission from an emergency department encounter are stroke, diabetes, congestive heart failure, weak/failing kidneys, chronic bronchitis, and heart attack. Because DFWHCF can rank these conditions by payer, we know that diabetes showed the highest volume for adult inpatient emergency department encounters among the uninsured and Medicaid patients.

[20] Texas Health and Human Services Commission Uniform Managed Care Manual. Chapter 10.1.7 Performance Indicator Dashboard for Quality Measures. Accessed online at http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/Chp10/10_1_7.pdf

DFWHC Foundation Data Warehouse: 2010Q3 -2011Q3: Highest Volume for Adult Inpatient Emergency Department Encounters[21]

Highest Volume	1	2	3	4	5
All	Stroke	Congestive Heart Failure	Weak/Failing Kidneys	Chronic Bronchitis	**Diabetes**
Insured	Stroke	Weak/Failing Kidneys	Congestive Heart Failure	Heart Attack	**Diabetes**
Medicaid	**Diabetes**	Congestive Heart Failure	Weak/Failing Kidneys	Stroke	Chronic Bronchitis
Medicare	Congestive Heart Failure	Stroke	Weak/Failing Kidneys	Chronic Bronchitis	Heart Attack
Uninsured	**Diabetes**	Stroke	Weak/Failing Kidneys	Congestive Heart Failure	Heart Attack

Furthermore, DFWHCF was able to assess the top diagnoses with the underlying condition of diabetes. In patients seen throughout the regional health-care system that are residents of Dallas County, the top five primary diagnoses of patients with an underlying condition of diabetes were acute kidney failure (45 percent), septicemia (39 percent), urinary tract infection (35 percent), rehabilitation (31 percent), and pneumonia (29 percent).

At the state level, the Texas Medicaid Transformation Waiver (1115 waiver) offers an immediate opportunity to assess the effectiveness of a range of interventions focusing on patient education, clinical systems change, and workforce enhancement. Approximately 111 waiver projects are currently addressing measures recommended by the TDC. By categorizing these projects and reviewing their health outcomes in terms of effectiveness and efficiency, we can identify innovations in diabetes care and promote diabetes best practices in Texas.

Prevention of Type 2 Diabetes

The NDPP encourages collaboration among state government, community-based organizations, employers, insurers, health-care professionals, academia, and other stakeholders to prevent or delay the onset of type 2 diabetes among people with prediabetes.

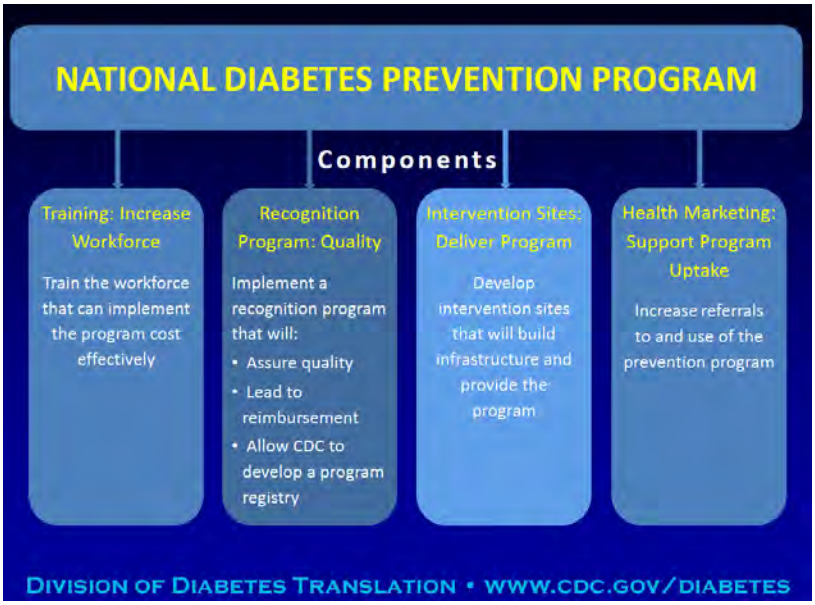
Led by the Centers for Disease Control and Prevention (CDC), the NDPP is an evidence-based lifestyle change program for preventing type 2 diabetes. It can help people at high risk of developing type 2 diabetes to cut their risk by more than half. Features of the NDPP lifestyle-change program include the following.

- The NDPP research study showed that making modest behavior changes helped participants lose five to seven percent of their body weight—that is 10 to 14 pounds for a 200-pound person.[22]

[21] Collins, S. Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Waiver, Regional Health Partnership 9: Community Needs Assessment Report Draft. Dallas Fort Worth Hospital Council. 2012. http://www.parklandhospital.com/whoweare/section-1115/pdf/Final_1115_Needs_Assessment_Report_5.22.12.pdf

[22] Knowler WC, Barrett-Connor E, Fowler SE, et al. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. *N Engl J Med* 2001;346(6):393-403.

- These lifestyle changes reduced the risk of developing type 2 diabetes by 58 percent in people with prediabetes.[23]
- Participants work with a lifestyle coach in a group setting to receive a one-year lifestyle change program that includes 16 core sessions (usually one per week) and six post-core sessions (one per month).



The inaugural partners of the NDPP were the YMCA and UnitedHealth Group. Using health-plan data to identify patients with prediabetes who could benefit from the program, UnitedHealth enrolled patients in low-cost ($275-$325 per person) community-based lifestyle-change programs, reimbursing the YMCA for each patient served. These patients were able to achieve a level of weight loss that reduced their risk for type 2 diabetes by 58 percent.[24]

Research indicates that by treating 100 high risk adults (age 50) for 3 years, the following benefits of the NDPP lifestyle-change program can be achieved:

- Prevents 15 new cases of type 2 diabetes[25]
- Prevents 162 missed work days[26]
- Avoids the need for blood pressure and cholesterol pills in 11 people[27]
- Adds the equivalent of 20 years of health[28]
- Avoids $91,400 in healthcare costs.[29]

The CDC maintains a recognition program for sites offering the NDPP. The goal is to ensure that prevention programs are delivered in a manner that achieves results demonstrated by initial studies and pilot projects. Currently YMCAs in Austin, Dallas/Fort Worth, and Houston are offering the NDPP through contracts with employers and insurers. However, the program must

[23] Ibid.

[24] Ackerman et al. op. cit.

[25] DPP Research Group, *N Engl J Med*. 2002 Feb 7;346(6):393-403.

[26] DPP Research Group. *Diabetes Care* 2003 Sep;26(9):2693-4.

[27] Ratner, et al. 2005 *Diabetes Care* 28 (4), pp. 888-894.

[28] Herman, et al. 2005 *Ann Inter Med* 142 (5), pp. 323-32.

[29] Ackerman, et. Al. 2008 *Am J Prev Med* 35 (4), pp. 357.363; estimates scaled to 2008 $US.

be implemented on a much larger scale to be available to more than a third of the adult population estimated to have prediabetes.

Texas was one of 16 states that received Model Design funding from the Centers for Medicare and Medicaid Services (CMS) to produce a State Health-Care Innovation Plan. States will use these plans to apply for an anticipated second round of award funding for Model Testing. Scaling of the NDPP in Texas is discussed under Model IV: Community-Based Public Health Innovations in the Texas State Healthcare Innovation Plan released in February 2014. The plan proposes to encourage multi-payer (commercial and Medicare) interest in the NDPP by demonstrating cost-effectiveness of lifestyle change programs to be offered by Medicaid and state employee health plans. An NDPP pilot program in STAR+PLUS is proposed to test the program's efficacy and cost-effectiveness in the Medicaid population. Development of a multi-payer NDPP database is proposed to track key statistics on participation and spending, by payer, over the course of the project. Efforts would include developing protocols for matching clinical data outcomes with NDPP participation data to support potential multi-payer alignment on NDPP as a covered benefit.

Diabetes Self-Management Education

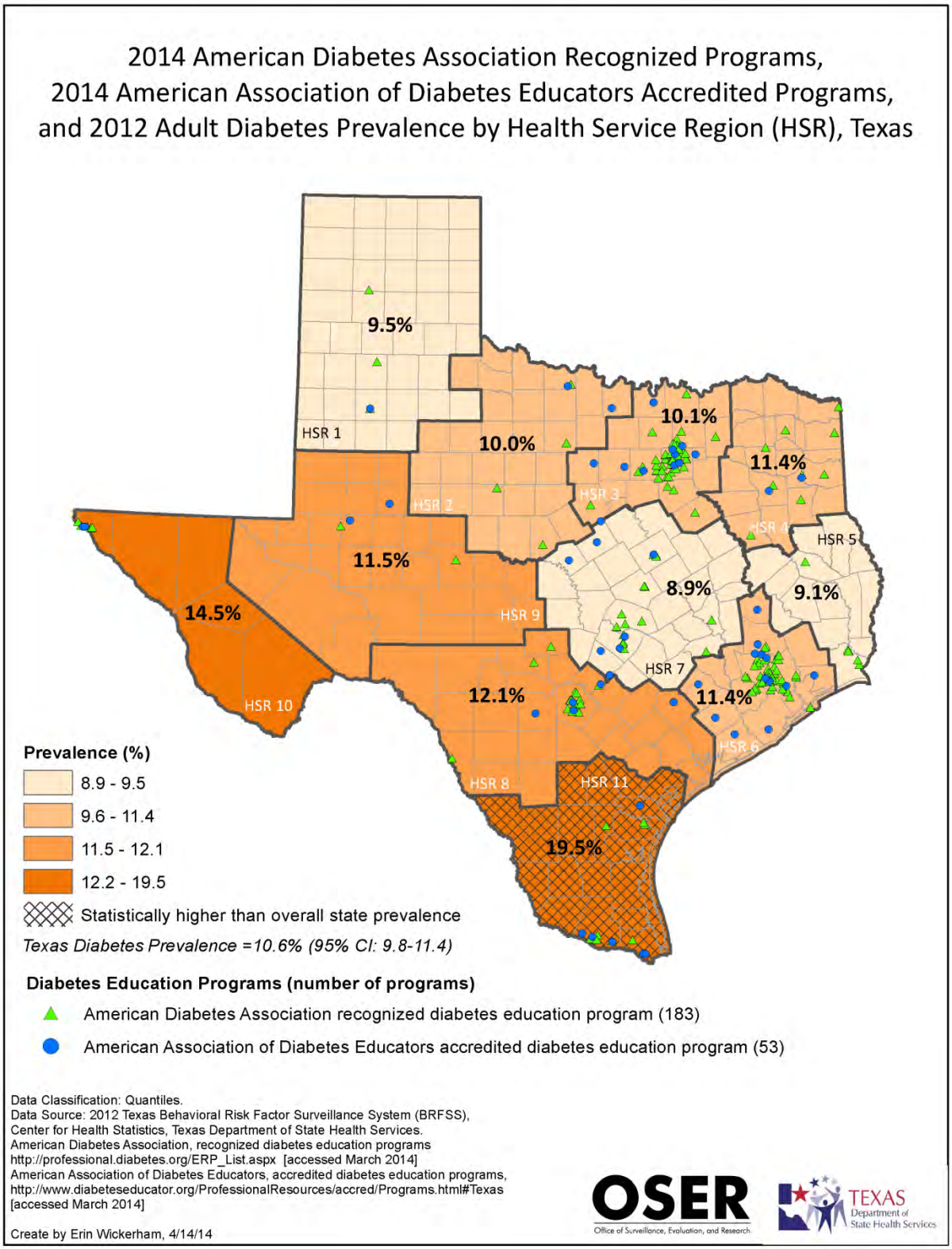
DSME is the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. This process incorporates the needs, goals, and life experiences of the person with diabetes and is guided by evidence-based standards. These standards are reviewed and revised approximately every five years by a task force of the ADA and published in *Diabetes Care* as "National Standards for Diabetes Self-Management Education."[30]

According to the national standards, DSME is effective for improving clinical outcomes and quality of life. Over time, DSME has evolved from didactic presentations to more interactive empowerment models, based on adult learning theory, that help patients overcome their personal obstacles to diabetes management, including economic, cultural, and literacy issues. There is no one "best" education program or approach, but programs incorporating behavioral and psycho-social strategies, culturally and age-appropriate content, and group education have proven effective. The standards emphasize ongoing support of patients and behavioral goal-setting.

The national standards address the need to initially document how a DSME program will operate within its organizational setting, develop an advisory group to maintain quality standards, and determine target audiences and educational needs. Education and experience of program staff are discussed, as well as elements needed for successful implementation and evaluation of the program based on patient outcomes.

The Balanced Budget Act of 1997 provides coverage of outpatient diabetes self-management training for Medicare beneficiaries with diabetes by entities deemed to meet quality standards. To uphold these standards, Medicare regulations stipulate that a DSME program must be accredited by a national accreditation organization in order to receive reimbursement. ADA and the AADE are currently recognized as national accreditation organizations.

[30] American Diabetes Association. National Standards for Diabetes Self-Management Education and Support. *Diabetes Care* January 2014 37:Supplement 1 S144-S153; doi:10.2337/dc14-S144 1935-5548.



In Texas, a Diabetes Self-Management Education Pilot Program required by the 81st Legislature attempted to demonstrate the effectiveness of DSME in the Texas Medicaid fee-for-service

population by requiring that a portion of this population be offered DSME that meets the same standards required by Medicare, including participation in an ADA-recognized or AADE-accredited program. A shortage of recognized and accredited sites in the Rio Grande Valley, where high rates of diabetes exist, was identified during the site recruitment phase. Sites that were formerly recognized or accredited noted they were unable to sustain the program due to low or no reimbursement for services. The Pilot Program was cut short by Texas Medicaid's shift from fee-for-service to Medicaid Managed Care. Managed care organizations (MCOs) currently under contract with Texas Medicaid are required to provide disease management and education services; however, outcomes data needed to assess the reach and effectiveness of these services is not currently available. Initial surveys of Medicaid MCOs indicate that fewer than half of the contracted MCOs automatically enroll patients with diabetes in self-management education. Rather, they inform patients of the availability of education and allow them to decide whether to participate or not.

In addition to ADA-recognized or AADE-accredited programs, community-based programs utilizing trained community health workers (CHWs) and *promotores* are a valuable resource for providing education and support of patients with or at risk for diabetes.

According to the AADE *Community Health Workers in Diabetes Management and Prevention Position Paper*, CHWs are uniquely positioned to collaborate with diabetes educators and other health-care providers to improve the quality of diabetes education and care, as well as prevention in local communities. CHWs that have completed specialized diabetes training are especially needed. CHWs are individuals who represent their ethnic, cultural, or geographic communities and provide a link between these communities and health-care providers. CHWs can assist in preventing diabetes and controlling the disease and its complications through education, lifestyle change, self-management, and social support. CHWs are well positioned to engage the people in their communities to prevent diabetes and its complications and are uniquely skilled to serve as bridges between community members and healthcare services because they:

- live in the communities in which they work,
- understand how to translate "medical talk" to community members,
- explain the community perspective to providers, and
- communicate in the language of the people in their communities.

Many community-based diabetes programs are not recognized or accredited by the ADA or AADE, and therefore not eligible for Medicare reimbursement.

Senate Bill 1051 (77th Legislature, Regular Session, 2001) required DSHS to establish and operate a training and certification program for persons who act as *promotores* or community health workers, instructors, and sponsoring institutions and training programs. Community health workers are currently used in DSHS-funded community diabetes projects focusing on lifestyle changes that prevent onset or improve management of diabetes in target populations. Federally qualified health centers, local health departments, and other non-profit organizations are contracted to provide series of classes on self-management, nutrition, or physical activity, or a combination of these series. DSME offered through existing DSHS-funded community diabetes projects (CDPs) reaches approximately 3,700 Texans with or at risk for diabetes. CDPs provide readily available models for expanding outreach to a much larger population in need of

education services when opportunities arise. Funding through the Centers for Medicare and Medicaid Services (CMS) for the TMF Health Quality Institute *Salud Por Vida* / Health for Life initiative expanded DSME interventions to reach an additional 11,607 persons with type 2 diabetes who previously had no access to DSME. Of these participants, 2,627 were Medicare beneficiaries, 5,338 were non-Medicare and 390 were dual-eligible, meaning their deductibles may be paid by Medicaid, but the majority of their care is covered by Medicare.

Professional Preparation and Continuing Education

Traditional health-care systems are designed to provide symptom-driven responses to acute illnesses, and are often poorly configured to meet the needs of the chronically ill.[31] Models that are focused on both outcomes and prevention have been developed and proposed as viable alternatives to the current care systems to address these problems. Successful chronic disease management has been challenging because of numerous factors, which include lack of information technology in outpatient settings; multiple sources of nonintegrated information; limited access to and use of diabetes specialists including education services; and time constraints. The Group Health Research Institute's Chronic Care Model was developed and organized around elements that have been shown to improve outcomes: decision support, clinical information systems, self-management education, and delivery system design.[32]

Most persons with diabetes receive care from a primary care physician, and much discussion has taken place regarding the need to strengthen primary care in light of changing systems of health-care delivery and rapidly emerging advances in diabetes treatment. The Patient-Centered Medical Home model has been proposed as a practical solution to access and quality issues surrounding primary care. The Patient-Centered Medical Home can be regarded as a vehicle to adopt the Chronic Care Model, as it combines elements of Chronic Care with a quality-based payment/reimbursement system and coordination of a health-care team that serves patient treatment and education needs.[33] Practice change is essential to provide the type of evidence-based care recommended by these models to effectively manage diabetes, prevent its serious complications, and delay or prevent type 2 diabetes.

The TDC has supported these models through development of minimum standards for diabetes care and a number of treatment algorithms and tools that guide evidence-based decisions regarding treatment of diabetes in Texas. These educational tools for health-care professionals are found online at www.tdctoolkit.org.

[31] Wagner EH, Austin BT, Von KorffM: Improving outcomes in chronic illness. *Manag Care Q* 4:12-25, 1996.

[32] Siminerio L, Zgibor J, Solano F: Implementing the Chronic Care Model for Improvements in Diabetes Practice and Outcomes in Primary Care: The University of Pittsburgh Medical Center Experience. *Clinical Diabetes*, Volume 22, Number 2, 2004.

[33] Bojadzievski T, Gabbay R. Patient Centered Medical Home and Diabetes. *Diabetes Care*. Apr 2011; 34(4): 1047–1053.

Background: Required Assessment and Method

Section 103.0131 of the Health and Safety Code states that, in conjunction with developing each state plan to prevent and control diabetes, the TDC shall conduct a statewide assessment of existing programs for the prevention of diabetes and treatment of individuals with diabetes that are administered by the Health and Human Services Commission (HHSC) or a health and human services agency, as defined by Section 531.001, Government Code. As part of the assessment, the council shall collect data regarding:

(1) the number of individuals served by the programs;

(2) the areas where services to prevent diabetes and treat individuals with diabetes are unavailable; and

(3) the number of health-care providers treating individuals with diabetes under the programs.

Not later than November 1 of each odd-numbered year, the TDC shall submit to the governor, the lieutenant governor, and the legislature a written report containing the findings of the assessment.

Method

In April 2012, the TDC updated its Plan to Prevent and Control of Diabetes in Texas for 2014-15. In conjunction with this planning process, the Diabetes Prevention and Control Program at DSHS initiated routine collection of data from state agencies regarding numbers of Texans served by each agency who can be identified as having diabetes, and the cost associated with providing those services. In addition to this ongoing, biennial assessment of state diabetes services, Senate Bill (SB) 796 (82R) established additional requirements for data collection, including information related to areas of the state where diabetes services are not available, and the number of providers involved in the delivery of services.

State agency services for persons with diabetes include direct medical care as well as education and skills development that allow persons who have or are at risk for diabetes to prevent or manage the disease, or adjust to living with diabetic complications such as blindness, amputations, and kidney disease. While direct medical care is provided through licensed medical practitioners, other services may be delivered by counselors, community health workers, educators, program specialists, and other professional groups. Some agency programs offer services statewide, while others are centered in areas of the state that are disproportionately affected by diabetes.

To facilitate data collection required by SB 796, a template was developed that allowed program administrators and data analysts of HHSC agencies to define "health-care provider" in the manner that applies to the services they offer, as well as describe the geographic location of service providers. This template was sent to the following HHSC agency programs identified as providing services for persons with diabetes in May 2012:

Texas Department of Aging and Disability Services (DADS)

- Texas Healthy Lifestyles Program

Texas Department of Assistive and Rehabilitative Services (DARS)

- Independent Living Services to Texans with Disabilities Impacted by Diabetes
- Vocational Rehabilitation Services to Texans with Disabilities Impacted by Diabetes

Texas Department of State Health Services (DSHS)

- Children with Special Health Care Needs (CSHCN) Services Program
- Kidney Health Care Program (KHC)
- Diabetes Prevention and Control Program (DPCP)
    - Community-based Diabetes Projects
    - Prevent Type 2 Diabetes Campaign
- Primary Health Care (PHC) Program

Texas Health and Human Services Commission (HHSC)

- Texas Medicaid
- Children's Health Insurance Program (CHIP)

TDC non-voting state agency members were asked to identify programs within their respective agencies that provide services for persons with diabetes and coordinate data collection with appropriate staff. In order to provide the most up-to-date description of services possible, most programs found it necessary to submit their data after August 31, 2012, when final data for state fiscal year (SFY) 2012 became available. Information required by SB 796 is summarized in Table 2.

Because this report was originally due November 1, 2013, data from SFY 2012 was requested because SFY 2013 data would not have been final in time for publication. The TDC received an extension on submission of the report; however, health and human services agencies were not asked to submit new data.

The following table summarizes specific requirements of Section 103.0131 of the Texas Health and Safety Code related to state agency diabetes services. Refer to individual program descriptions that follow for methods used to calculate numbers served and related expenditures.

Table 1. Texas State Agency Diabetes Programs

Agency and Program Name	Fiscal Year	Number of Individuals with Diabetes Served	Diabetes-Related Expenditures	Number of Health-Care Providers Treating Individuals with Diabetes	Areas Where Diabetes Services are Available/Unavailable
DADS Texas Healthy Lifestyles Program	FY 2010-11	903	Not available specifically for individuals with diabetes	102 lay leaders trained in 2010-11	Available through five of the 28 Area Agencies on Aging in Texas
DARS Independent Living Services	FY 2012	1,292	$1,552,163	Not available. Contracts as needed with medical providers. A Diabetes Field Specialist recruits and trains diabetes educators in blind services.	Division for Rehabilitation Services has 115 offices across Texas. Division for Blind Services has 24 state offices.
DARS Vocational Rehabilitation Services	FY 2012	4,913	$10,271,253	Not available. Contracts as needed with medical providers. A Diabetes Field Specialist recruits and trains diabetes educators in blind services.	Division for Rehabilitation Services has 115 offices across Texas. Division for Blind Services has 24 state offices.
DSHS Children with Special Health Care Needs Services	FY 2012	78	$409,132	15,419 providers that may potentially treat diabetes	Services available statewide.

Agency and Program Name	Fiscal Year	Number of Individuals with Diabetes Served	Diabetes-Related Expenditures	Number of Health-Care Providers Treating Individuals with Diabetes	Areas Where Diabetes Services are Available/Unavailable
DSHS Kidney Health Care Program	FY2012	9,769	$8,638,946	Not available	Services available statewide.
DSHS Community Diabetes Projects	FY2012	Nutrition Education 1,183 Physical Activity 1,282 Self-Mgmt. Classes 1,254	$1,247,029	36 Community Health Workers	Sixteen communities in Texas implement classes that assist residents in managing or preventing diabetes.
DSHS Prevent Type 2 Diabetes Campaign / Diabetes Tool Kit for Health Care Professionals	FY 2013	Not applicable	$164,469	Not applicable	Implemented in the following markets: Corpus Christi, El Paso, Houston, Laredo, San Antonio, Lower Rio Grande Valley, and Lubbock
DSHS Primary Health Care Program	FY 2012	Unknown	Unknown	59 contractors in 2012 (currently 54)	Contracted providers are available in each of the Health Service Regions.
HHSC Medicaid	SFY 2012	293,875	$262 million*	See maps in Appendix 1	Statewide
HHSC Children's Health Insurance Program	SFY 2012	14,752	$8.3 million**	See maps in Appendix 1	Statewide

Notes:

**designation of an individual with type 1, type 2, or gestational diabetes based on primary diagnoses. An additional $584 million was paid for services to individuals with diabetes listed as a non-primary diagnoses. These services are not necessarily directly related to diabetes.*

***designation of an individual with type 1, type 2, or gestational diabetes based on primary diagnoses. An additional $6.3 million was paid for services to individuals with diabetes listed as a non-primary diagnoses. These services are not necessarily directly related to diabetes.*

Programs for the Prevention and Treatment of Diabetes

Texas Department of Aging and Disability Services (DADS)

Program Name: *Texas Healthy Lifestyles Program*

Total Program Expenditures: $753,819 (FY 2011)
This amount includes both federal grant funds expended ($526,714) and the estimated amount of matching funds contributed by partner agencies in the fiscal year ($227,105). The matching fund amount includes in-kind services. The matching fund amount is estimated based on reports submitted by partner agencies.

Individuals Served:

Total	With Diabetes
2,136	903

Notes: *All data are for FY 10-11. Total includes individuals who participated in either the Chronic Disease Self-Management program or Diabetes Self-Management Program. Number with diabetes includes only those participating in the Diabetes Self-Management Program. The number includes individuals with prediabetes.*

Diabetes-Related Expenditures: Not applicable
This is a grant-funded program that supports both chronic disease and diabetes self-management. Costs cannot be broken out between these two activities.

Source of Funds:

Federal	*State*	*Other*
70 percent		*30 percent*

Notes: *State expenditures were not tracked. Partner agencies contributed matching funds, which are listed as "Other."*

Eligibility/Population Served:
Persons eligible for the Texas Healthy Lifestyle Program are age 60 and older. The target population includes minorities, persons living below the poverty level, and those who have one or more chronic health conditions. Several of the geographic areas target specific sub-populations:

- Alamo/Bexar County: Hispanic/Spanish Speakers
- East Texas: Alabama-Coushatta Reservation; State Prison Population
- Rio Grande: Hispanic/Spanish Speakers/Colonia residents and Ysleta Pueblo del Sur tribe

Services/Activities:
A Diabetes Self-Management workshop is held for two and a half hours, once a week, for six weeks, in community settings such as churches, community centers, libraries, and hospitals. People with type 2 diabetes attend the program in groups of 12-16. Workshops are facilitated

from a highly detailed manual by two trained leaders, one or both of whom are peer leaders with diabetes themselves. Classes are offered in English and Spanish.

Subjects covered include: 1) techniques to deal with the symptoms of diabetes: fatigue, pain, hyper/hypoglycemia, stress, and emotional problems such as depression, anger, fear, and frustration; 2) appropriate exercise for maintaining and improving strength and endurance; 3) healthy eating; 4) appropriate use of medication; and 5) working more effectively with health-care providers. Participants make weekly action plans, share experiences, and help each other solve problems they encounter in creating and carrying out their self-management program. Physicians and other health professionals, both at Stanford University and in the community, have reviewed all materials in the course.

Each participant in the workshop receives a copy of the companion book, *Living a Healthy Life with Chronic Conditions*, an audio relaxation tape, and an audio exercise tape.

Texas A&M School of Rural Public Health conducts the evaluation for this program. The primary evaluation tasks include developing a standardized data collection protocol for tracking program participants and conducting fidelity checks on key elements of program delivery.

Areas of the state where services to prevent diabetes and treat individuals with diabetes are available:

The Texas Healthy Lifestyle Program is offered through the following Area Agencies on Aging (AAAs).

1. **Alamo and Bexar Area Agencies on Aging**
   Atacosa, Bandera, Bexar, Comal, Frio, Gillespie, Guadalupe, Karnes, Kendall, Kerr, Medina, and Wilson Counties. Bexar County focuses on the 10 zip codes with the highest incidence of diabetes.

   - **Funds available:** $160,018 (two-year grant)
   - **Gaps in services**: The incidence of diabetes in Bexar County is 14 percent - twice the national average.

2. **Central Texas Area Agency on Aging – Aging & Disability Resource Center**
   Bell, Coryell, Hamilton, Lampasas, Milam, Mills, and San Saba Counties

   - **Funds available:** $149,867 (two-year grant)
   - **Gaps in services:** The 2009 epidemiological profile for Bell County (most populous county in the region) indicates it has a significantly higher rate of diabetes than the rest of the state (approximately 13 percent of adults in Bell County compared to 10 percent of adults in Texas).

3. **East Texas Area Agency on Aging**
   Anderson, Angelina, Bowie, Brazos, Burleson, Camp, Cass, Cherokee, Delta, Franklin, Gregg, Grimes, Hardin, Harrison, Henderson, Hopkins, Houston, Jasper, Jefferson, Lamar,

Leon, Madison, Marion, Morris, Nacogdoches, Newton, Orange, Panola, Polk, Rains, Red River, Robertson, Rusk, Sabine, San Augustine, San Jacinto, Shelby, Smith, Titus, Trinity, Tyler, Upshur, Van Zandt, Washington, and Wood Counties

- **Funds available:** $172,888 (two-year grant)
- **Gaps in services:** A survey conducted by the Brazos Valley Health Partnership found that 16 percent of older adults in the region were diagnosed with diabetes.

4. **Rio Grande Area Agency on Aging**
   El Paso County and Hudspeth County

   - **Funds available:** $159,818 (two-year grant)
   - **Gaps in services:** This region includes areas known as colonias, which are extremely low-income and lack basic infrastructure such as water, sewer, and electricity, making it difficult for residents to maintain basic hygiene and follow doctor's orders for disease management.

5. **Tarrant County Area Agency on Aging**
   Tarrant County

   - **Funds available:** $142,908 (two-year grant).
   - **Gaps in service:** According to the 2004 Behavioral Risk Factor Surveillance System report, 5.9 percent of Tarrant County residents are diagnosed with diabetes. Among persons age 65+, the rate is 18.9 percent.

Number of health-care providers treating individuals with diabetes under the program: The number of health-care providers participating in the program was not collected. This program utilizes lay leaders–persons from the local community–to lead classes. A total of 102 lay leaders were trained to administer the Diabetes Self-Management Program during fiscal years 2010-11.

Texas Department of Assistive and Rehabilitative Services (DARS)

Program Name: *Independent Living Services to Texans with Disabilities Impacted by Diabetes*

Total Program Expenditures*: FY 2011: **$10,119,054** and FY 2012: **$9,991,585**
Individuals Served:

	Total*	With Diabetes**
FY 2011	4,809	1,248
FY 2012	4,868	1,292

Diabetes-Related Expenditures:**

FY 2011	$1,430,279
FY 2012	$1,552,163

Notes:
**Total individuals served and payments from each fiscal year's funds for Independent Living Services*
- *Division for Rehabilitation Services cases in phase codes 10,14,22,26,28,30,32,34 in the state fiscal year*
- *Division for Blind Services cases in phase codes 06,10,12,14,22,26,28,30,32,34 in the state fiscal year*
- *FY 2011 figures are actual and FY 2012 are estimated expenses*

***Individuals served and payment from that fiscal year's funds for Independent Living Services for consumers with a cause code of Diabetes:*
- *Division for Rehabilitation Services cases with primary or secondary disability cause code 16*
- *Division for Blind Services cases with primary disability cause code 48 or secondary/tertiary cause code 16*

Source of Funds:

Federal	***State***	***Other***
90 percent	*10 percent*	

Notes: *Federal and state portions apply to the entire body of program expenditures over a year in roughly these ratios.*

Eligibility/Population Served:
DARS Independent Living Services are geared toward adults with significant disabilities with the goal of improving independence at home and in the community. DARS provides specialized services to help consumers avoid institutionalization. The consumer must have a significant disability that results in a substantial impediment to his or her ability to function independently in the family and/or in the community, and there must be a reasonable expectation that Independent Living Services assistance will result in the ability to function more independently.

Services/Activities:
DARS provides services for Texans impacted by the complications of diabetes including heart disease, stroke, amputations, blindness, and kidney disease. DARS Independent Living Services promote self-sufficiency despite significant disability−providing people with disabilities with improved mobility, communication, personal adjustment, and self-direction. Services include counseling and guidance, home modification, assistive devices and equipment, communication technology, mobility training, and other services. The DARS counselor also utilizes counseling

and referral to community resources to promote responsible diabetes self-management by consumers to slow the progression of complications and further disability.

Areas of the state where services to prevent diabetes and treat individuals with diabetes are available/unavailable:
DARS has two divisions that administer services across the state. The Division for Rehabilitation Services has 115 offices across Texas to serve Texans with heart disease, stroke, amputations, and kidney disease, as well as other disabilities. The Division for Blind Services has 24 offices across the state. Texans with disabilities can contact their local DARS office to initiate services. Experienced diabetes educators and programs are difficult to find in the rural areas of the state including Del Rio and surrounding counties, Odessa and surrounding counties, and the Panhandle outside of Amarillo and Lubbock.

Number of health-care providers treating individuals with diabetes under the program:
DARS does not have health-care providers or diabetes educators on staff, but contracts for medical services as needed from providers in the community. DARS also contracts with registered nurses, registered dieticians, or certified diabetes educators who specialize in diabetes education and have knowledge of adaptations for people with disabilities, especially blindness that present a unique challenge to the consumer's ability to self-manage his or her diabetes. These diabetes educators provide assessment, self-management education, and follow-up services to DARS consumers. DARS Division for Blind Services employs a Diabetes Field Specialist based in Austin who is responsible for recruiting and training diabetes educators in blind services and for addressing the concerns identified by DARS caseworkers for adaptive equipment and accommodations that may be needed by the consumer.

Texas Department of Assistive and Rehabilitative Services (DARS)

Program Name: *Vocational Rehabilitation Services to Texans with Disabilities Impacted by Diabetes*

Total Program Expenditures*: FY 2011: $264,663,482 and **FY 2012:** $273,536,962
Individuals Served:

	Total*	With Diabetes**
FY 2011	83,762	4,764
FY 2012	81,474	4,913

Diabetes-Related Expenditures:**

FY 2011	$10,502,861
FY 2012	$10,271,253

Notes:
**Total individuals served and payments from each fiscal year's funds for Vocational Rehabilitation Services*

- *Division for Rehabilitation Services cases in phase codes 10,14,22,26,28,30,32,34 in the state fiscal year*
- *Division for Blind Services cases in phase codes 06,10,12,14,22,26,28,30,32,34 in the state fiscal year*
- *FY 2011 figures are actual and FY 2012 are estimated expenses*

***Individuals served and payment from that fiscal year's funds for Vocational Rehabilitation Services for consumers with a cause code of Diabetes:*

- *Division for Rehabilitation Services cases with primary or secondary disability cause code 16*
- *Division for Blind Services cases with primary disability cause code 48 or secondary/tertiary cause code 16.*

Source of Funds:

Federal	***State***	***Other***
80 percent	*20 percent*	

Notes:
Federal and state portions apply to the entire body of program expenditures over a year in roughly these ratios.

Eligibility/Population Served:
The Vocational Rehabilitation (VR) program at DARS helps Texans with disabilities prepare for, find, and keep employment. The eligibility criteria for this program is: 1) the presence of a physical, mental, or cognitive impairment; 2) the impairment results in a substantial impediment to employment; 3) the individual (consumer) requires vocational rehabilitation services to be employable; and 4) the individual (consumer) is presumed to be capable of employment.

Services/Activities:
DARS provides vocational rehabilitation services for Texans impacted by the complications of diabetes including heart disease, stroke, amputations, blindness, and kidney disease. Through

the vocational rehabilitation program, DARS provides work-related services that are individualized and may include counseling and guidance, training, physical restoration, prostheses and orthoses, assistive devices and equipment, job placement assistance, and other services.

Employment enhances a person's sense of well-being and economic self-sufficiency, allowing a person to contribute to the growth and development of his or her community. Unemployment results in a lower standard of living, lack of financial control, and limited access to comprehensive quality health-care and healthy living resources.

This report identifies DARS consumers with a primary or secondary disability of diabetes mellitus. DARS not only provides services to remove the person's impediment to employment, but also attempts to promote responsible diabetes self-management through counseling and referral to community resources to slow the progression of complications and further disability. In addition, DARS works closely with employers who hire DARS consumers to address any questions they may have about the consumer's work productivity.

Areas of the state where services to prevent diabetes and treat individuals with diabetes are available/unavailable:
DARS has two divisions that administer employment services across the state. The Division for Rehabilitation Services has 115 offices across Texas to assist persons with disabilities with employment. Within this program, DARS does not specifically address Texans with heart disease, stroke, amputations, and kidney disease, as well as other disabilities unless it presents as an impediment to employment as determined by a qualified Vocational Rehabilitation Counselor. The Division for Blind Services has 24 offices across the state. Texans with disabilities can contact the local DARS office to initiate services.

Experienced diabetes educators and programs are difficult to find in the rural areas of the state including Del Rio, and surrounding counties, Odessa and surrounding counties, and the Panhandle outside of Amarillo and Lubbock.

Number of health-care providers treating individuals with diabetes under the program:
DARS does not have healthcare providers or diabetes educators on staff, but contracts for medical services as needed from providers in the community. DARS also contracts with registered nurses, registered dieticians, or certified diabetes educators who specialize in diabetes education and have knowledge of adaptations for people with disabilities, especially blindness that presents a unique challenge to the consumer's ability to self-manage his or her diabetes. These diabetes educators provide assessment, self-management education, and follow-up services to DARS consumers. DARS Division for Blind Services employs a Diabetes Field Specialist who is responsible for recruiting and training diabetes educators in blind services and for addressing the concerns identified by DARS counselors for adaptive equipment and accommodations that may be needed by the consumer.

Texas Department of State Health Services (DSHS)

Program Name: *Children with Special Health Care Needs (CSHCN) Services Program*

Total Program Expenditures: $25,032,734 (FY 2012)
Individuals Served:

	Total	With Diabetes
FY 2012	1,906	78

Diabetes-Related Expenditures:

FY 2012	$409,132

Notes:
The program can provide overall expenditure data for diabetes clients, but is not able to give specific expenditures pertaining to diabetes treatment. The program provides comprehensive coverage that includes services such as inpatient, drugs, dental, immunization, and well check-ups, and durable medical equipment (DME) that may not necessarily be related to diabetes treatment.

Source of Funds:

Federal	*State*	*Other*
46 percent	*54 percent*	

Notes:
Federal and state portions apply to the entire body of program expenditures over a year in roughly these ratios.

Eligibility/Population Served:
The CSHCN program is available to anyone who

1. lives in Texas
2. is under 21 years old (or any age with cystic fibrosis)
3. has a certain level of family income
4. has a medical problem that
   - is expected to last at least 12 months
   - will limit one or more major life activities
   - needs more health care than what children usually need
   - has physical symptoms (This means that the program does not cover clients with only a mental, behavioral, or emotional condition, or a delay in development.)

According to the 2009-2010 National Survey of Children with Special Health Care Needs (NS-CSHCN), 13.4 percent of children and youth in Texas under age 18 (919,876 children and youth) have special health-care needs.

When compared to the national average, Texas has a higher percentage of CSHCN under age 18 living in poverty. According to the 2009-2010 NS-CSHCN, almost 46.6 percent of Texas

CSHCN under age 18 live in households below 200 percent of the Federal Poverty Level (FPL), as compared to the national average of 44.3 percent.

Services/Activities:
The CSHCN Program helps children with special health-care needs and people of any age with cystic fibrosis. The program covers health-care benefits for children with extraordinary medical needs, disabilities, and chronic health conditions. Health-care benefits include a broad array of medical care and related services. The program helps clients with their medical, dental, and mental health-care, drugs, special therapies, case management, family support services (e.g., home modifications, van lifts), travel to health-care visits, insurance premiums, and transportation of deceased clients.

Areas of the state where services to prevent diabetes and treat individuals with diabetes are unavailable:
Services are available statewide.

Number of health-care providers treating individuals with diabetes under the program:
There are 15,419 providers who may potentially treat CSHCN clients with diabetes.

Texas Department of State Health Services (DSHS)

Program Name: *Kidney Health Care Program (KHC)*

Total Program Expenditures: $17,300,000 (FY 2012)
Individuals Served:

	Total	With Diabetes
FY 2012	19,563	9,769

Diabetes-Related Expenditures:
FY 2012 $8,638,946

Source of Funds:

Federal	*State*	*Other*
	100 percent	

Eligibility/Population Served:
The program is available to anyone who

1. lives in Texas
2. has an income of less than $60,000 per year
3. has a diagnosis of end-stage renal disease (ESRD) from a licensed physician
4. meets Medicare's definition of ESRD
5. gets regular dialysis treatments OR has received a kidney transplant
6. is not eligible for Medicaid medical, drug, or travel benefits

Demographics of the active client population of the KHC Program demonstrate an over-representation of certain characteristics in relation to the overall state population. (An active client is defined as anyone who was eligible for KHC benefits as of August 31, 2012.) Clients ages 45-74 years account for more than 73 percent of all active clients, but less than 30 percent of the total Texas population. More than 44 percent of all active clients are Hispanic. No racial/ethnic group, however, is more highly represented in the active client population than African-Americans. The proportion of active participants in this group is nearly triple the proportion of African-Americans in the Texas population (29.1 percent versus 11.4 percent, respectively). Males in the active client category comprise 58.8 percent of this group; females comprise 41.2 percent of this group. In relation to gross annual income, data show that 61.8 percent of active clients have a gross annual income below $20,000.[34]

Services/Activities:
The KHC Program helps people with end-stage renal disease (ESRD) get some of their health-care services. It helps clients receive dialysis treatments, access surgery, purchase drugs, travel to health-care visits, and pay Medicare premiums. ESRD is usually the result of years of chronic kidney disease caused by inherited conditions, medical conditions such as diabetes and/or hypertension, or an injury to the kidneys.

[34] DSHS *Kidney Health Care Program FY 2012 Annual Report*

Areas of the state where services to prevent diabetes and treat individuals with diabetes are unavailable:
Services are available statewide.

Number of health-care providers treating individuals with diabetes under the program:
Data not available.

Texas Department of State Health Services (DSHS)

Program Name: *Diabetes Prevention and Control Program (DPCP) Community Diabetes Projects (CDPs)*

Total Program Expenditures: **$**1,247,029 (FY 2012)
Individuals Served:

	Intervention Type	With Diabetes or Prediabetes
FY 2012	Nutrition Education	1,183
FY 2012	Physical Activity	1,282
FY 2012	Self-Management Class	1,254

The number of persons with diabetes or prediabetes represents unique/unduplicated individuals served by each intervention type. A total is not presented for all intervention types because individuals can participate in one or more of the interventions. For example, an individual can be enrolled in a cooking class, an exercise class, and a self-management class, and will be represented in each category/intervention type.

Diabetes-Related Expenditures:

FY 2012	$1,247,029

Source of Funds:

Federal	***State***	***Other***
29 percent	*71 percent*	

Eligibility/Population Served:
The DPCP contracts with local health departments, community health centers, and grassroots organizations to establish programs for promoting wellness, physical activity, weight and blood pressure control, and smoking cessation for people with or at risk for diabetes. Community Diabetes Projects (CDPs) target Texans who are disproportionately affected by diabetes, and have limited access to health services.
The goals of CDPs are to:

- Increase opportunities for implementing positive behavior and lifestyle changes in people with diabetes and those at risk of developing diabetes;
- Increase community, environmental, and systems changes in community sectors that will increase physical activity and healthy eating among the general population, especially those with diabetes and prediabetes;
- Institute project strategies or community policy and environmental changes conducive to risk reduction;

- Increase public and provider knowledge of the symptoms, risk factors and target goals for diabetes, prediabetes and gestational diabetes, and the importance of physical activity and healthy eating in preventing, delaying, or managing diabetes and its complications; and
- Increase health-care providers', payers', and patients' knowledge and use of the TDC's *Minimum Standards for Diabetes Care in Texas* and treatment algorithms.

Based on self-report data collected from 1,118 participants between October 3, 2010, and May 22, 2013, individuals served by CDPs are predominately middle-aged (average 54 years of age), female, Hispanic, obese, and have a self-reported history of diabetes. However, anyone with diabetes or at risk for diabetes in the communities where CDPs are located may participate in program activities.

Services/Activities:
In 2012, twelve CDPs in Texas collected data related to the outcome indicators below from participants attending the following interventions:

- DSME classes are conducted for persons with diabetes and their families. A minimum of two series of DSME classes are conducted annually and held at least once a week for four weeks.
- Nutrition series are conducted separately and include a minimum of three classes that meet for at least 30 minutes, once per week.
- Physical activity interventions are ongoing and no less than 30 minutes, once per week, for a minimum of eight weeks.

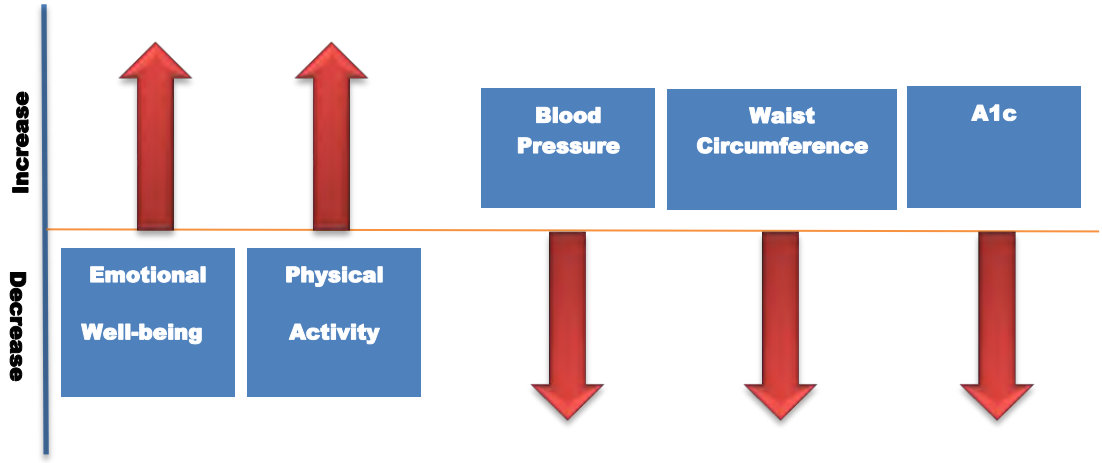
Outcome Indicators:

CDPs are required to collect data to show:	**CDPs are encouraged to show:**
• Decrease in average waist • Decrease in average body mass index • Decrease in average blood pressure • Number of participants identified as	• Decrease in average A1c • Decrease in average fasting blood glucose • Decrease in average cholesterol • Decrease in average triglycerides • Percent of participants receiving

CDP participants complete participant information forms at various points during their participation in CDP interventions (DSME, nutrition, physical activity). Preliminary findings based on about 1,600 records collected in 2012 indicate favorable changes among participants.

- Indicators of emotional well-being increased.
- Physical activity increased among all participants. Persons with diabetes experienced the greatest increase.
- Diastolic blood pressure decreased among persons with diagnosed diabetes. This represents the pressure in blood vessels when the heart rests between beats.
- Waist circumference decreased among both persons with diagnosed diabetes and those without diabetes. Persons with diabetes experienced the greatest decrease.
- A1c decreased slightly among persons diagnosed with diabetes. The A1c is a lab test that measures your average blood glucose level over the last two to three months. A person with an A1c value of 6.5 percent or greater has diabetes. The average A1c of CDP participants who were not diagnosed with diabetes was 6.7 percent, indicating that some participants who had diabetes had not yet been diagnosed.

Results:



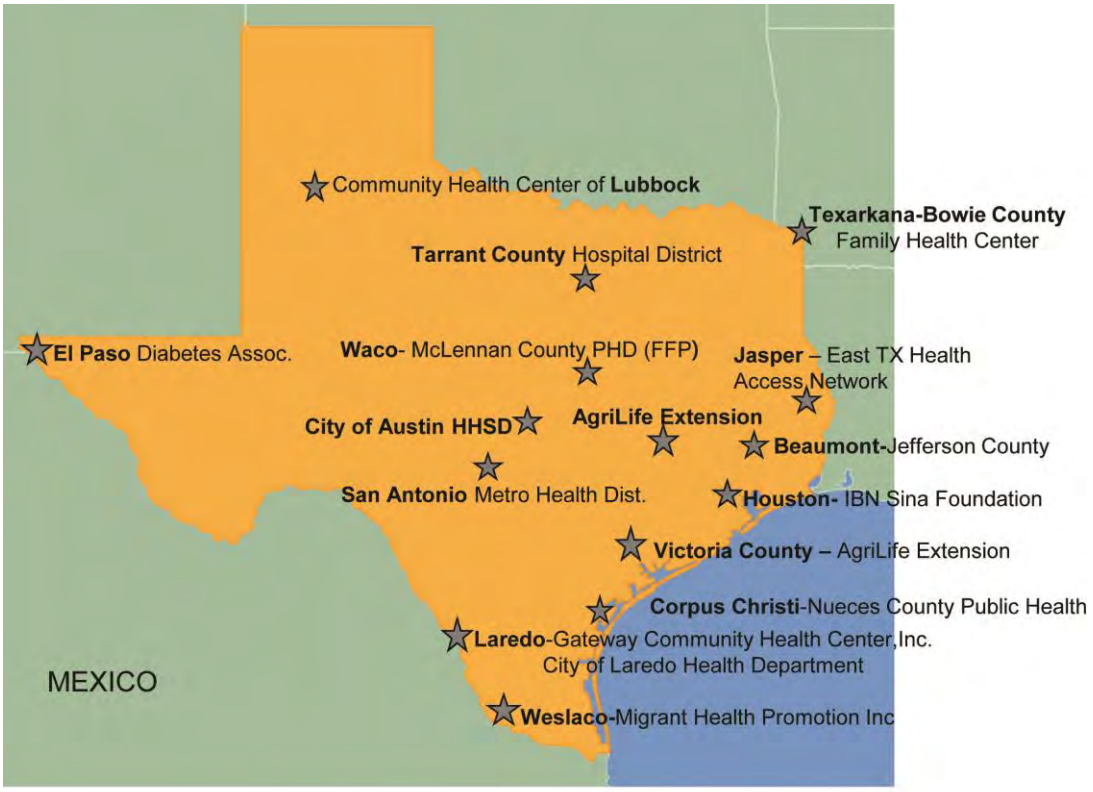
Areas of the state where services to prevent diabetes and treat individuals with diabetes are available/unavailable:

During 2012, DSHS contracted with the following organizations to offer community diabetes project interventions:

- City of Austin Health and Human Services Department
- Jefferson County Family Focused Diabetes Project
- Corpus Christi-Nueces County Public Health District
- El Paso Diabetes Association
- Tarrant County Hospital District
- Iba Sina Foundation – Houston

- Gateway Community Health Center, Inc. – Laredo
- City of Laredo Health Department
- Texarkana-Bowie County Family Health Center
- East Texas Health Access Network – Jasper
- Community Health Center of Lubbock
- Migrant Health Promotions, Inc. – Weslaco
- San Antonio Metropolitan Health District
- Waco-McLennan County Public Health District
- Texas AgriLife Extension Service*

**Serving Victoria County and other Texas counties through the Do Well, Be Well with Diabetes education program: http://fcs.tamu.edu/health/type_2_diabetes/diabetes_classes.php.*



Number of health-care providers treating individuals with diabetes under the program: Eight of the CDPs reported using certified CHWs to deliver diabetes self-management classes. There are a total of 36 (21.2 full time equivalents) CHWs employed by CDPs. The Texas DPCP continues to offer CHW training opportunities, and some CDPs are planning to expand the number of CHWs they employ through 1115 waiver projects described under services provided by HHSC/Texas Medicaid. CDPs who do not employ CHWs enlist area partners and health professionals to deliver diabetes self-management courses.

Texas Department of State Health Services (DSHS)

Program Name: *Prevent Type 2 Diabetes Campaign / Marketing support of the TDC's Diabetes Tool Kit*

Total Program Expenditures: $164,469 (FY 2013 purchase order for social marketing/advertising services)
Individuals Served:

FY 2013	Online Impressions	Website visits
Prevent Type 2 Campaign for March 2013	**44,072,286** (encountered online advertising)	**21,809*** preventtype2.org prevenirtipo2.org
Health-Care Professional Education (tdctoolkit.org)	NA	**6,397** tdctoolkit.org

Notes: *Only includes visits during March 2013 resulting from online advertising which directed visitors to the site.

Diabetes-Related Expenditures:

FY 2013	$164,469

Source of Funds:

Federal	***State***	***Other***
100 percent		

Population Served: Hispanics at risk for type 2 diabetes, ages 18-60. Health-care professionals statewide.

Services/Activities:
In addition to community-based diabetes programs, the DSHS DPCP used funding from the CDC Division of Diabetes Translation to promote National Diabetes Education Program (NDEP) messages and campaigns that focus on prevention of type 2 diabetes and diabetes management. Strategic goals include early identification (screening) of persons with diabetes or those at risk, and empowerment of the general public to reduce their risk for type 2 diabetes and control all types of diabetes.

The majority of persons with diagnosed diabetes are currently white, while diabetes rates are higher for African Americans and Hispanics. Those most likely to have diabetes, the older population and the Hispanic population, are the fastest growing populations in the state.

In 2010, the CDC Division of Diabetes Translation announced a National Diabetes Prevention Program (NDPP) to bring the results of the landmark Diabetes Prevention Program (DPP) study - a 58 percent reduction in type 2 diabetes among persons at risk - to the more than 79 million persons in the U.S. estimated to have prediabetes. A critical first component of this and other interventions is increased awareness among persons who have prediabetes of their risk for developing type 2 diabetes and ways to reduce their risk.

Market research was conducted during summer 2010 in Corpus Christi, McAllen, and Houston using focus groups that included Hispanics with prediabetes and separate groups consisting of those with multiple risk factors for diabetes. Marketing platforms for a type 2 diabetes prevention campaign were presented to each group, and based on discussion, strengths and weaknesses of each were identified. The public service announcement platform chosen for campaign implementation was titled "Prevent Diabetes before Serious Consequences," and included a graphic of a man who had experienced an amputation, presumably as a complication of diabetes. Strengths of this platform discussed by focus group members were summarized as follows:

- Shows the reality of the consequences. "The picture says it all."
- Emotionally compelling, shock-value. Jars them into internalizing the severity of consequences. They don't want this result.
- Strongly communicates proactive prevention—you need to take steps before this happens to you.
- Steps clearly communicated as solution to potential problem.
- Personalized experience: "I had an uncle, grandmother, aunt that lost a toe, leg, etc."

In 2010, DSHS and the TDC featured a diabetes-related complication—lower extremity amputation—in a television spot that urged Hispanics to get tested for prediabetes or diabetes. The television spot, supported by online advertising, was aired in the top four Hispanic markets (Houston, Corpus Christi, Rio Grande Valley, and Laredo) for two weeks leading up to Diabetes Alert Day in March, a national observance that encourages persons to determine their risk for type 2 diabetes and take action to prevent the disease and its complications.

The *Prevent Type 2 Diabetes* campaign promoted English and Spanish websites, www.preventtype2.org / www.prevenirtipo2.org, featuring the TV spot and educational video content developed by the National Diabetes Education Program and American Diabetes Association, among others. Visitors to these sites received referral to www.211texas.org for local diabetes screening resources, information about prediabetes and risk for diabetes, and state and national resources for preventing type 2 diabetes. A campaign goal is to increase awareness and screening for prediabetes and encourage persons at risk for diabetes to seek out programs that reduce their risk for diabetes through lifestyle changes.

Areas of the state where services to prevent diabetes and treat individuals with diabetes are available:

In 2013, DSHS continued the campaign through radio news/traffic sponsorship on Spanish-language and English crossover stations for three weeks targeting Hispanics ages 18-60 with a "Get Tested Today" message. The sponsorship broadcasted from March 11 through March 31, 2013, in Corpus Christi, El Paso, Houston, Laredo, San Antonio, and the Rio Grande Valley. Four animated banners in English, four animated banners in Spanish, four static banners in English, and four static banners in Spanish promoting type 2 diabetes prevention were placed on paid media interactive sites during the month of March 2013. Ads were placed on Google paid search from March 1 through March 31, 2013, generating 535 clicks and 127,032 impressions. Video pre-roll ads and additional companion banners were placed on Univision between March 4 and March 31, 2013. Pre-roll ads featured the existing 30-second TV spot in Spanish, generating 1,457 clicks and 334,858 impressions. Companion banners generated 1,040 clicks and 1,178,507 impressions. Ads placed on Millennial Mobile generated 23,981 clicks and 2,648,029 impressions, making this the most successful ad placement for the campaign run, and confirming research that a Hispanic audience is more likely to receive online messaging/advertising via mobile phones. Two new Facebook ads directed at Hispanics in Spanish and English were developed, promoting the "Diabetes Runs in Families" and "You Could Have Diabetes" messages. English ads placed on Facebook generated 5,991 clicks and 22,149,255 impressions. Spanish ads placed on Facebook generated 4,439 clicks and 17,634,605 impressions. During the month of March 2013, radio and online advertising was responsible for 17,155 visits to prevenirtipo2.org (11,087 unique visits) and 4,654 visits to preventtype2.org (4,275 unique visits)

Number of health-care providers treating individuals with diabetes under the program:
Since 1995, the TDC has developed and continuously reviewed minimum standards of care for patients with diabetes. These standards are used to define diabetes benefits required of health plans regulated by the Texas Department of Insurance. Appointed by the TDC chair, the TDC Medical Professionals Advisory Subcommittee brings together a multidisciplinary team of diabetes experts from across the state to review the latest research and treatment recommendations and update TDC standards of care, including 17 treatment algorithms, A1c target recommendations, and a Diabetes Tool Kit to assist in applying standards to practice. All professional materials developed by the subcommittee, as well as patient education materials and other resources, are available free of charge at the TDC's online address for health professionals, tdctoolkit.org. The TDC's Health Care Professional Advisory Committee works to increase awareness of TDC standards of care among managed care companies, health plans, physicians, and employer groups throughout Texas, and a subcommittee on outcomes examines data that can be used to evaluate the extent to which recommended care is delivered. In 2013, TDC advisory committee members developed recommendations for disease management and diabetes self-management education provided by Texas Medicaid managed care organizations. The recommendations are available to assist HHSC in assessing quality of care provided to persons with diabetes under managed care contracts. DSHS maintains the TDC website for professionals and recorded 6,397 unique visitors to the site in FY 2013.

Texas Department of State Health Services (DSHS)

Program Name: *Primary Health Care (PHC) Program*

Total Program Expenditures: $11,752,486 (FY 2012)
Individuals Served:

	Total	With Diabetes
FY 2012	70,902	Total unknown*

Notes:
** During the 83rd Legislative Session, the Legislature allocated $100,000,000 over the biennium for expanded primary health care (EPHC), with an emphasis on women's health. These providers will also provide chronic disease management for eligible clients, including diabetes care.*

With the launch of the EPHC, the PHC program will adopt more extensive reporting requirements. This will provide more details regarding the use of program services (both PHC and EPHC) by Texans with diabetes.

Diabetes-Related Expenditures:
FY 2012 unknown

Source of Funds:

Federal	***State***	***Other***
	100 percent	

Population Served:
Eligibility is limited to Texas residents whose gross family income is at or below 150 percent of the FPL and who do not qualify for any other program or benefit that provides the same services, such as Medicaid.
Beginning September 1, 2013, this program will serve residents at or below 200 percent FPL.

Services/Activities:
The PHC program, administered by the Division for Family and Community Health Services at the DSHS, began in 1987 in accordance with House Bill (HB) 1844, the Primary Health Care Services Act. PHC provides health care, including preventive health services and education, to Texas residents who could not otherwise receive such care. Services are provided through contracts with local health departments, community action programs, private nonprofit organizations, Federally Qualified Health Centers (FQHCs), hospitals, and hospital districts.
In FY 2012, 59 contracted providers expended $11,752,486 in state-allocated PHC funds. Of this total, contractors reported $9,680,244 expended for direct medical care services and $2,072,242 to provide non-medical services such as transportation, case management, and administration. Approximately 70,902 unduplicated patients in 166 counties received primary health-care services ranging from classes on improving health status to direct-care services for a one-time problem or a chronic condition.

At this time, contractors are not required to report clients by diagnosis. This prevents reporting the amount of funds dedicated to diabetes services.
The six priority services of the PHC program are:

- diagnosis and treatment
- family planning
- health education
- emergency services
- preventive services and immunizations
- laboratory services and x-ray

Additional optional services may also be provided. Optional services include:

- nutrition services
- home health care
- transportation
- environmental health
- social services
- health screening
- dental care
- prescription drugs, devices, and durable supplies
- podiatry services

Areas of the state where services to prevent diabetes and treat individuals with diabetes are available and number health-care providers treating individuals with diabetes under the program:
The Primary Health Care Services Program currently contracts with providers in each of the Health Service Regions. A map of providers is available online:
http://batchgeo.com/map/phctexascliniclocator

Number of health-care providers treating individuals with diabetes under the program:
There were 59 contractors providing primary care services under this program across the state in FY 2012.

Texas Health and Human Services Commission (HHSC)

Program Name: Medicaid

Total Program Expenditures: Approximately $52.5 billion (SFY 2012)
Individuals Served:

	Total	With Diabetes**
SFY 2012	4.2 million*	293,875

Notes:
** estimated unduplicated yearly served*
***designation of an individual with type 1, type 2, or gestational diabetes based on any diagnoses*

Diabetes-Related* Expenditures:

SFY 2012	$262 million

Notes:
**designation of an individual with type 1, type 2, or gestational diabetes based on primary diagnoses. An additional $584 million was paid for services to individuals with diabetes listed as a non-primary diagnosis. These services are not necessarily directly related to diabetes.*

Source of Funds:

Federal	***State***	***Other***
58.52 percent	*41.58 percent*	

Population Served:

- 4.2 million served out of 5.2 million enrolled acute care clients
- low-income families, children, related caretakers of dependent children, pregnant women, people age 65 and older, and adults and children with disabilities
- ~ 84 percent of all enrolled are provided Medicaid services

Individuals with incomes above predefined limits are ineligible for Medicaid. The Texas Medicaid program covers a limited number of optional groups, which are eligibility categories that states are allowed, but not required, to cover under their Medicaid programs. For example, Texas chooses to extend Medicaid eligibility to pregnant women and infants up to 185 percent of the FPL. The federal requirement for pregnant women and infants is 133 percent of the FPL. Another optional group Texas covers is known as the "medically needy" group. This group consists of children and pregnant women whose income exceeds Medicaid eligibility limits, but who do not have the resources required to meet their medical expenses. A "spend down" amount is calculated for these individuals by subtracting their incomes from the medically needy income limit for their household sizes. If their medical expenses exceed the "spend down" amount, they become Medicaid eligible. Medicaid then pays for those unpaid medical expenses and any Medicaid services provided after they are determined to be medically needy.

Children with family incomes above Medicaid thresholds may be eligible for the Texas CHIP program.

Services/Activities:
Medicaid is a jointly funded state-federal health-care program administered by HHSC. Texas covers certain population groups (mandatory eligibility groups) and has the flexibility to cover other population groups (optional eligibility groups). Medicaid is an entitlement program, which cannot limit the number of eligible people who can enroll, and Medicaid must pay for any services covered under the program. About one in seven Texans relies on Medicaid for health insurance or long-term services and supports.

Medicaid pays for acute health care (physician, inpatient, outpatient, pharmacy, lab, and x-ray services), and long-term services and supports (home- and community-based services, nursing facility services, and services provided in Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICFs/IID)) for people age 65 and older and those with disabilities.

Guidance regarding coverage of equipment and supplies (insulin pumps, syringes, testing strips, etc.) for persons with diabetes is found in the Texas Medicaid Provider Procedures Manual at http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx.

On March 1, 2012, most Medicaid clients and all Children's Health Insurance Program (CHIP) clients began obtaining their prescription drug benefits through a managed care plan. Outpatient prescription drugs will be a benefit of each Medicaid managed care program. CHIP is also a managed care program for which outpatient drugs are a benefit. Across the state, 19 MCOs have contracted with a total of seven different pharmacy benefits managers (PBM) – some PBMs are contracted with multiple MCOs. The Texas Medicaid/CHIP Vendor Drug Program website includes information on diabetes medications covered by Medicaid and PBMs serving Medicaid MCOs: http://www.txvendordrug.com/claims/managed-care.shtml.

Texas Medicaid Managed Care Quality Strategy: 2012 – 2016
The Texas Legislature, through the 2012-2013 General Appropriations Act and Senate Bill 7, instructed HHSC to expand its use of risk-based Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals. Under the Special Terms and Conditions of the Medicaid Transformation and Quality Improvement (1115) waiver, HHSC is required to develop a comprehensive quality strategy that reflects all managed care plans operating under the programs proposed through the waiver and submit to the Centers for Medicare & Medicaid Services (CMS) for approval. A draft of the Medicaid Managed Care Quality Strategy can be viewed at http://www.hhsc.state.tx.us/medicaid/quality-review/Health-Plan-Hospital-Performance.shtml.

Areas of the state where services to prevent diabetes and treat individuals with diabetes are available/unavailable:
Services are available statewide. Primary-care provider and specialist access maps are provided in Appendix 1, indicating the availability of key services to Medicaid eligible Texans with diabetes.

Number of health-care providers treating individuals with diabetes under the program: There are no data readily available to estimate this number. Providers from a variety of health-service and allied health fields provide services to the Medicaid eligible population. Primary-care provider and specialist access maps are provided in Appendix 1, including the number of providers available to treat HHSC-served individuals with diabetes.

Texas Health and Human Services Commission (HHSC)

Program Name: *Children's Health Insurance Program (CHIP)*

Total Program Expenditures: $618.9 million (SFY 2012)
Individuals Served:

	Total	With Diabetes**
SFY 2012	674,064*	14,752

Notes:
** estimated unduplicated yearly served*
***designation of an individual with type 1, type 2, or gestational diabetes based on any diagnoses*

Diabetes-Related* Expenditures:

SFY 2012	$8.3 million

Notes:
** Designation of an individual with type 1, type 2, or gestational diabetes based on primary diagnoses. An additional $6.3 million was paid for services to individuals with diabetes listed as a non-primary diagnoses. These services are not necessarily directly related to diabetes.*

Source of Funds:

Federal	***State***	***Other***
70.89 percent	*29.11 percent*	

Population Served:

674,064 individuals out of 999,629 CHIP−enrolled received acute-care services.
To qualify for CHIP, a child must be:

- A U.S. citizen or legal permanent resident,
- A Texas resident,
- Under age 19,
- Uninsured for at least 90 days,
- Living in a family whose income is at or below 200 percent of federal poverty level, and
- Living in a family that passes an asset test if family income is above 150 percent of the federal poverty level.

CHIP covers children in families who have too much income or too many assets to qualify for Medicaid, but cannot afford to buy private insurance. Most families in CHIP pay an annual enrollment fee to cover all children in the family. CHIP families also pay co-payments for doctor visits, prescription drugs, inpatient hospital care, and non-emergent care provided in an emergency room setting. CHIP annual enrollment fee amounts and co-payments vary based on family income. In addition, the total amount that a family is required to contribute out-of-pocket toward the cost of health-care services is capped based on family income.
Services/Activities:
The following services are covered under CHIP in Texas:

- Inpatient general acute and inpatient rehabilitation hospital services,
- Surgical services,
- Transplants,
- Skilled nursing facilities (including rehabilitation hospitals),
- Outpatient hospital, comprehensive outpatient rehabilitation hospital, clinic (including health center), and ambulatory health-care center services,
- Physician and physician extender professional services (including well-child exams and preventive health services such as immunizations),
- Laboratory and radiological services,
- Durable medical equipment, prosthetic devices, and disposable medical supplies,
- Home and community-based health services,
- Nursing care services,
- Inpatient mental health services,
- Outpatient mental health services,
- Inpatient and residential substance abuse treatment services,
- Outpatient substance abuse treatment services,
- Rehabilitation and Habilitation services (including physical, occupational, and speech therapy, and developmental assessments),
- Hospice care services,
- Emergency services (including emergency hospitals, physicians, and ambulance services),
- Emergency medical transportation (ground, air, or water),
- Care coordination,
- Case management,
- Prescription drugs,
- Dental services,
- Vision,
- Chiropractic services, and
- Tobacco cessation.

Areas of the state where services to prevent diabetes and treat individuals with diabetes are available/unavailable:
Services are available statewide. Primary-care provider and specialist access maps are provided in Appendix 1, indicating the availability of key services to CHIP eligible Texans with diabetes.

Number of health-care providers treating individuals with diabetes under the program:
There are no data readily available to estimate this number. Providers from a variety of health-service and allied health fields provide services to the CHIP eligible population. Primary-care provider and specialist access maps are provided in Appendix 1, including the number of providers available to treat HHSC-served individuals with diabetes.

Appendix 1− Texas Health Care Transformation and Quality Improvement Program (1115 Waiver) Projects Addressing Diabetes Care

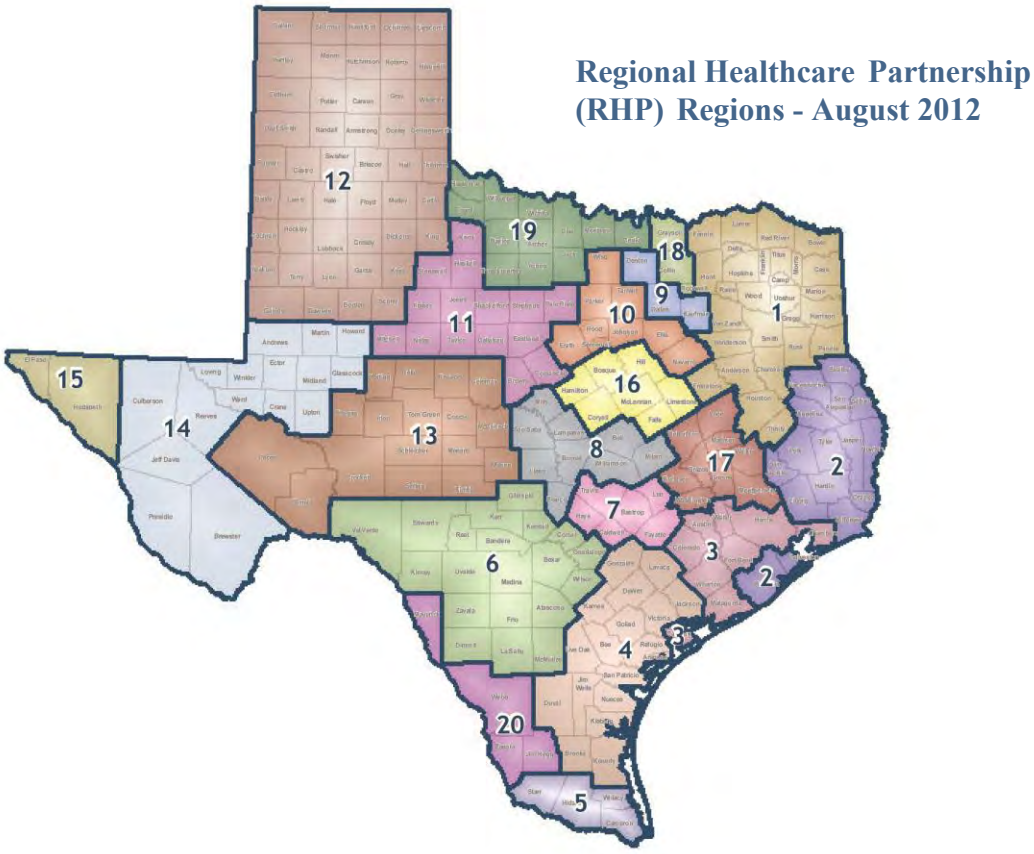
Overview

In 2011, HHSC established a waiver under section 1115 of the Social Security Act that allows the Centers for Medicare & Medicaid Services (CMS) and the states more flexibility in designing programs to ensure delivery of Medicaid services to eligible recipients. Section 1115 waiver authority will allow HHSC to expand managed care throughout the state while maintaining historic supplemental Medicaid funding to hospital providers.

The 1115 waiver provides HHSC the authority to make two types of payments to hospitals: payments for uncompensated care to Medicaid eligible patients and uninsured patients and incentive payments for health-care delivery system reforms. Both types of payments will require the hospital to be a Medicaid-enrolled provider and to have an intergovernmental transfer (IGT) of public funds submitted to the state, by the provider or on its behalf, to serve as the non-federal share of the payment.

Uncompensated care payments will be made to providers that submit a waiver application documenting unmet costs of providing hospital and non-hospital services to Medicaid patients and uninsured patients. The non-hospital service costs include physician costs, other non-physician professional costs, clinic costs, and outpatient drug costs. The addition of these non-hospital costs differentiates the uncompensated care payment under this waiver from a payment under the established Disproportionate Share Hospital (DSH) program.

Incentive payments will be made to providers that participate in health-care quality and delivery system reforms – this is referred to as the Delivery System Reform Incentive Payment (DSRIP) program. Providers participated in developing a plan for their region that is a result of collaboration through a Regional Healthcare Partnership (RHP – see map on next page). After the plan is approved and in place, the regional partnership will measure and report the outcomes of the region's reform initiatives as the basis for DSRIP payment to qualifying hospitals.



Regional Healthcare Partnership Plans

Plans developed by RHPs are organized to address four categories:

- Category 1: Infrastructure Development
- Category 2: Program Innovation and Redesign
- Category 3: Quality Improvements
- Category 4: Population-Focused Improvements (Hospitals Only)

A regional health-care planning protocol provided a menu of project options approved by HHSC and CMS that contribute to delivery transformation and quality improvement. The only projects eligible for payments from the DSRIP pool are those contained in this menu that are implemented as outlined in an RHP Plan approved by HHSC and CMS, with corresponding measures, milestones and performance improvement targets.

In order to achieve meaningful change by the end of the demonstration, every performing provider must link each of its Category 1 and 2 projects to a related Category 3 outcome. The outcomes shall assess the results of care experienced by patients, including patients' clinical events, patients' recovery and health status, patients' experiences in the health system, and efficiency/cost.

Diabetes-Related Outcomes

In 2012, the TDC formed a committee, with guidance by the Population Health Institute of Texas (PHIT), to identify and recommend appropriate outcome measures for diabetes for inclusion in the DSRIP menu of outcome measures (Category 3). The following National Quality Form (NQF) measures were recommended to HHSC:

1. Hemoglobin A1c (NQF 0059)
2. Blood Pressure (NQF 0061)
3. Low-Density Lipoprotein Cholesterol (NQF 0064)
4. Retinal or dilated eye exam (NQF 0055)
5. Foot exam (NQF 0056)
6. Nephropathy screening (NQF 0062)

The rationale for selection of these measures is that (1) they are established by CMS through the 2012 Physician Quality Reporting Measures Groups Specifications Manual and Release Notes and (2) they are already collected by physicians through electronic health records or other means, and reported to CMS on Medicare Part B claims and by most commercial health plans.

As of August 2013, the RHP Planning Protocol for Category 3 includes the following measures of diabetes care. The rationale or evidence supporting each measure is as follows:

> **Rationale/Evidence:** Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health-care dollars.

IT-1.10 Diabetes care: *HbA1c poor control (>9.0 percent)*[233] *- NQF 0059*

a. Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0 percent.
b. Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)
c. Data Source: EHR, Registry, Claims, Administrative clinical data

IT-1.11 Diabetes care: *BP control (<140/90 mm Hg)*[234] *– NQF* 0061

a. Numerator: Use automated data to identify the most recent blood pressure (BP) reading during the measurement year. The member is numerator compliant if the BP is less than 140/90 mm Hg.
b. Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)
c. Data Source: EHR, Registry, Claims, Administrative clinical data

IT-1.12 Diabetes care: *Retinal eye exam*[235]*—NQF 0055*

a. Numerator: An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:
    - A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year, or
    - A negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year
b. Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)
c. Data Source: EHR, Registry, Claims, Administrative clinical data

IT-1.13 Diabetes care *Foot exam- NQF 0056*

a. Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year.
b. Denominator: Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2).
c. Data Source: EHR, Registry, Claims, Administrative clinical data.

IT-1.14 Diabetes care: *Microalbumin/Nephropathy- NQF 0062*

a. Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.
b. Denominator: Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2).
c. Data Source: EHR, Registry, Claims, Administrative clinical data.

IT-2.7 Diabetes Short Term Complication Admission Rate- PQI 1[243]

a. Numerator: All non-maternal/non-neonatal discharges of age 18 years and older with a principal diagnosis code for short-term complications (ketoacidosis, hyperosmolarity, coma)
b. Denominator: Population in Metro Area or county, age 18 years and older.
c. Data Source: EHR, Claims

IT-2.8 Diabetes Long Term Complications Admission Rate- PQI 3[244]

a. Numerator: Discharges age 18 years and older with a principal diagnosis code for long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified).
b. Denominator: Population in Metro Area or county, age 18 years and older.
c. Data Source: EHR, Claims

IT-2.9 Uncontrolled Diabetes Admissions Rate- PQI 14245

a. Numerator: All non-maternal discharges of age 18 years and older with a principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication.
b. Denominator: Population in Metro Area or county, age 18 years and older.
c. Data Source: EHR, Claims

IT-3.3 Diabetes 30 day readmission rate

a. Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
b. Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission.

The Category 3 performance measure menu was updated in early 2014. Complete RHP Planning Protocols can be viewed at http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml

Identification of RHP Projects Utilizing Diabetes Measures

Using the RHP Plan data spreadsheets found on the HHSC website, (http://www.hhsc.state.tx.us/1115-RHP-Plans.shtml), proposed quality improvement projects were sorted based on Category 3 measures utilized. Projects including the diabetes measures listed above among their Category 3 outcome measures were extracted (Table 3, next page), totaling 156 projects. A full description of each project can be obtained by using the Project ID to search the corresponding RHP Plan document (also found at http://www.hhsc.state.tx.us/1115-RHP-Plans.shtml).

The project option column refers to Category 1 and Category 2 activities described in the RHP Planning Protocols to which Category 3 measures correspond. In determining a project valuation, regions determined the maximum amount of DSRIP funding that can be received for achieving project-related milestone(s), providing any rationale that was considered in assigning the value, i.e. relative effort, starting point, patient/community need, and potential avoided costs.

This analysis was completed using information published in December 2013, and reflects RHP projects that were in place or proposed at that time. Projects actually approved and implemented may be different from those listed below.

Table 3: Texas Health-Care Transformation and Quality Improvement Program (1115 Waiver) Projects Utilizing Diabetes Measures

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
1	02081260 1.1.1	1.9.2	East Texas Medical Center	Increase access to specialty healthcare by recruiting a full-time endocrinologist to establish a specialty clinic location and improve access to diabetes management.	Residents of service area in Northeast Texas that currently do not have sufficient access to diabetes or endocrinology care	$1,944,725.91
1	12727830 2.1.9	1.9.2	University Physician Associates (UPA)	Confirm gaps in specialty care related to diabetes (endocrinology, ophthalmology, podiatry, and nephrology) and develop/implement a plan to address those gaps.	Patients with diabetes in 3 counties where project clinics are located	$4,418,193.00
1	13792160 8.2.1	2.15.1	Community Healthcore	Collaborate with Good Shepherd Medical Center and the local FQHC in the Longview area to integrate primary and behavioral healthcare services to result in an integrated approach to health care that is "More Than Co-Location."	Adults with serious mental illness and diagnosed co-occurring primary care diseases of hypertension or diabetes that live in the Longview area	$260,605.00
1	13891320 9.1.2	1.9.2	Titus Regional Medical Center	Recruit an endocrinologist to increase the number of patients seen by the Diabetes Self-Management Education Program Team	Patients who are high risk for the complications of diabetes	$280,923.00
1	17787060 3.2.4	2.6.2	Red River Regional Hospital	Develop and implement an evidence-based diabetes management program and increase the percentage of diabetic clinic patients receiving the innovative intervention	Service area residents that currently do not have sufficient access to chronic disease management	$411,533.31

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
2	09409260 2.1.5	1.3.1	University of Texas Medical Branch Hospital	Implement and utilize chronic disease registries within the EMR, which will improve patient outcomes by tracking information within diabetes, CHF, asthma, hypertension, and COPD registries. UTMB's EHR dash boarding tool, RADAR, will also be utilized to improve chronic disease management by allowing providers to create patient specific interventions.	Patients diagnosed with chronic diseases, with a focus on diabetes, that primarily receive services in Galveston County.	$1,957,591.16
2	09409260 2.2.3	2.9.1	University of Texas Medical Branch Hospital	Provide care management and disease management services in Galveston and Brazoria counties to adult Medicaid, dual eligible (Medicare/Medicaid) and uninsured patients who have chronic disease (i.e. diabetes, hypertension, heart disease, COPD).	High risk patients need assistance navigating the healthcare system.	$1,295,205.94
2	11267160 2.2.1	2.2.2	Brazosport Regional Health System (BRHS): Lake Jackson Family Medicine Center (LJFMC)	Expand current diabetes self-management program, as well as the current Diabetes Outpatient Training Site (DOTS) program by increasing referrals for diabetes management and increasing course offerings through DOTS.	Current LJFMC diabetic patients and diabetic patients looking for a new primary care provider with a focus on diabetes management.	$1,810,000.00
2	13103020 3.1.3	1.3.1	Nacogdoches Memorial Hospital	Implement a functional chronic disease management registry to improve primary and preventative care to Medicaid and underserved populations of Nacogdoches County	Medicaid and uninsured patients in Nacogdoches and surrounding counties with diabetes, pre-diabetes or related risk factors.	$370,950.00
2	13638140 5.1.1	1.1.2	Tyler County Hospital District	Expand access to primary care by adding staff and expanding hours at Rural Health Clinic.	Patients served by the performing provider, especially those receiving services in urgent and emergency care settings, with a focus on medically underserved patients in need of diabetes care.	$484,914.00

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
2	138296208.2.1	2.2.2	CHRISTUS Hospital - St. Elizabeth	Establish team-based clinics to address complex chronic diseases such as congestive heart failure, diabetes, COPD and asthma. These clinics will offer intensive care management to optimize health and healthcare utilization, thus decreasing the cost and impact of these chronic diseases.	Residents of the CHRISTUS catchment area who suffer from congestive heart failure, diabetes, COPD or asthma.	$2,226,982.00
3	093774008.2.5	2.6.2	City of Houston Department of Health and Human Services	Establish self-management programs and wellness using evidence-based designs.	Individuals with diabetes or at risk for diabetes residing in an underserved area (Third Ward) of Houston	$4,735,666.07
3	111810101.1.5	1.6.2	The University of Texas Health Science Center - Houston	Expand access to medical advice and guidance to the appropriate level of care in order to reduce emergency dept use for non-emergent conditions by implementing a nurse-line medical triage call center that will be staffed 24/7/365.	Current and prospective clients of UT Health / UT Physicians especially chronic disease patients (ex. COPD, heart failure, diabetes). Expect to provide 400,000 visits/year by DY5.	$8,512,209.50
3	111810101.2.2	2.2.1	The University of Texas Health Science Center - Houston	The outpatient delivery system of UT Physicians will be redesigned to coordinate care for patients with chronic diseases (asthma, CHF, COPD, diabetes and hypertension), based on Wagner's chronic care model.	People in the service area with diabetes, hypertension, asthma, COPD, or CHF	$5,502,931.00
3	111810101.2.5	2.11.1	The University of Texas Health Science Center - Houston	Implement a technologically driven patient-centered medication therapy management program. Allscripts analytics tool will enable staff to identify patients at high risk for developing complications and co-morbidities, and patients that have not refilled their medications	Patients in the service area with diabetes, hypertension, asthma, COPD, or CHF	$3,464,808.00

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
3	111810101.2.6	2.12.2	The University of Texas Health Science Center - Houston	Implement a comprehensive transitions of care program which will ensure that patients have an appointment for follow-up with an appropriate physician prior to leaving the hospital, understand their discharge medications and other instructions and are followed up post discharge.	Cancer surgery patients, indigent patients with type 1 diabetes, and children/adolescents with type 1 diabetes who are graduating to adult diabetes management	$5,706,742.00
3	127303903.2.2	2.9.1	OakBend Medical Center	Patient Navigators will help and support these patients to navigate through the continuum of health-care services. Navigators will ensure that patients receive coordinated, timely and site-appropriate health-care services.	Patients with CHF, Diabetes, and COPD	$1,517,319.91
3	133355104.1.7 updated to 133355104.2.9	2.8.8	Harris County Hospital District Ben Taub General Hospital	Address the inefficiency of specialty clinics (focusing primarily on diabetes and rheumatology clinics) by making possible ordering best practices diagnostic algorithmic workups and eliminating the current practice of sequential ordering of individual tests.	All patients within the system may benefit from this project, with a focus on those referred to diabetes and rheumatologic clinics	$12,980,410.00
3	139135109.1.8	1.9.2	Texas Children's Hospital	Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with conditions affecting the endocrine system.	Patients seeking the full spectrum of services for metabolic syndrome, type I and type II diabetes. In particular, the focus is on patients who are at risk for diabetic retinopathy	$4,492,911.00
3	212060201.2.3	2.6.2	Rice Medical Center	Develop a Certified Diabetes Teaching Center to educate and assist patients with managing their chronic disease.	Patients Rice currently treats in its hospital and local clinics diagnosed with Type I or Type II diabetes. The secondary target population is patients in the community who are at risk or pre-diabetic	$77,610.00

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
4	020811801.1.1	1.3.1	CHRISTUS Spohn Hospital Beeville	Implement a chronic disease registry to assist Spohn in tracking and managing patient with chronic conditions, with an initial focus on CHF and diabetes.	Charity, Medicaid and self-pay patients with CHF and/or diabetes who are enrolled in the Care Transitions or Care Partners programs	$450,127.54
4	020811801.2.4	2.12.2	CHRISTUS Spohn Hospital Beeville	Expand Care Transitions program to focus on preventing readmissions for CHF and diabetes patients.	CHF and diabetes patients treated as inpatients at Beeville campus who are Medicaid/ self-pay/ charity	$482,279.50
4	094222902.1.2	1.3.1	CHRISTUS Spohn Hospital Alice	Implement a Chronic Disease registry to assist Spohn in tracking and managing patients with chronic conditions.	Charity, Medicaid and self-pay patients with CHF and/or diabetes who are not currently enrolled in Care Transitions or Care Partners programs	$543,711.95
4	094222902.2.4	2.19.1	CHRISTUS Spohn Hospital Alice	Implement a screening and treatment protocol to identify patients with medical (CHF and diabetes) and behavioral health dual diagnoses and assign a case manager to coordinate their care.	Patients at Spohn Alice hospital and Spohn's clinics with CHF or diabetes and a behavioral health diagnosis	$621,384.50
4	094222902.2.5	2.12.2	CHRISTUS Spohn Hospital Alice	Expand care transitions program to focus on preventing readmissions for CHF and diabetes.	CHF and diabetes patients treated as inpatients at Alice campus who are Medicaid/ self-pay/ charity	$582,548.52
4	121775403.1.2	1.3.1	CHRISTUS Spohn Hospital Corpus Christi	Implement a Chronic Disease registry to assist Spohn in tracking and managing patients with chronic conditions which will initially focus on patients with CHF and diabetes.	Charity, Medicaid and self-pay patients with CHF and/or diabetes who are enrolled in our Care Transitions or Care Partners programs. Patients are identified by case managers in the acute care setting and referrals submitted to the Community Outreach department for program enrollment	$3,255,212.80

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
4	12177540 3.2.1	2.6.1	CHRISTUS Spohn Hospital Corpus Christi	Adapt and disseminate AT&T's mobile application that offers instant feedback via text messaging, coaching, and patient/provider web portals as a patient self-management tool to reduce HbA1c in patients with Type 2 diabetes. Patients using the application will receive quarterly biometric screenings at the clinics (their medical home) as part of the program.	Patients with Type 1 or type 2 diabetics seen at Spohn's family health clinic sites and the Hector P Garcia Clinic (where Spohn physician residents provide care)	$3,720,243.20
4	12177540 3.2.10	2.12.2	CHRISTUS Spohn Hospital Corpus Christi	Expand care transitions program to focus on preventing readmissions for CHF and diabetes.	CHF and diabetes patients treated as inpatients at Spohn's Memorial, South, and Shoreline campuses who are Medicaid, self-pay, charity eligible	$3,487,728.00
4	12177540 3.2.5	2.19.1	CHRISTUS Spohn Hospital Corpus Christi	Implement a screening and treatment protocol in EDs and Family Health Centers to identify patients with dual diagnoses (medical and behavioral health) and assign a case manager to coordinate their care.	All patients presenting to Spohn's Corpus Christi hospital facilities with a CHF, diabetes, or a BH/SA diagnosis	$3,022,697.60
4	13643660 6.1.1	1.3.1	CHRISTUS Spohn Hospital Kleberg	Implement a Chronic Disease registry to assist in tracking and managing patients with CHF and diabetes	Charity, Medicaid and self-pay patients with CHF and/or diabetes who are enrolled in Care Transitions or Care Partners programs	$471,360.29
4	13643660 6.2.4	2.12.2	CHRISTUS Spohn Hospital Kleberg	Expand care transitions program to focus on preventing readmissions for CHF and diabetes.	CHF and diabetes patients treated as inpatients at Spohn's Kleberg campus who are Medicaid, self-pay, charity eligible	$505,028.88
4	13643660 6.2.5	2.19.1	CHRISTUS Spohn Hospital Kleberg	Implement a screening and treatment protocol in EDs and Family Health Centers to identify patients with dual diagnoses (medical and behavioral health)and assign a case manager to coordinate their care.	All patients presenting to Spohn's Kleberg hospital facilities with a CHF, diabetes, or a BH/SA diagnosis	$505,028.88

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
4	17460005857016.1.2 13095850 5.1.2	1.3.1	Corpus Christi-Nueces County Public Health District	With Diabetes Community Coalition of the Coastal Bend, implement a comprehensive system to include electronic medical records (EMR), an HIE and coordinated care record (CCR) in key community based health clinics and diabetes self-management education and support programs, creating a disease management registry for Nueces County.	Underinsured and uninsured patient population accessing services within the community and public health clinics and diabetes self-management programs in Nueces County	$1,998,139.00
4	17460005857016.2.1 13095850 5.2.1	2.6.3	Corpus Christi-Nueces County Public Health District	Create Diabetes Care Teams consisting of both Certified Diabetes Educators (CDEs) and Community Health Workers (CHWs) working through community Diabetes Self-Management Education/Support programs	Diabetes patients who are uninsured or underinsured and not covered by the Nueces County indigent health plan (Nueces Aid) who receive their health care from the Community Health Centers, Public Health Clinics, and hospital emergency departments	$1,209,042.00
5	12198910 2.2.1	2.15.1	Border Region Behavioral Health Center	Initiate integrated primary & behavioral health services for behavioral health clients diagnosed with co-morbid physical disorder of diabetes, hypertension, obesity or COPD offering Behavioral Health Services, Primary care services, Health behavior education and training programs, Case Management services, and Health screening.	Behavioral health clients diagnosed with co-morbid physical disorders of diabetes, hypertension, obesity or COPD may qualify for the patient panel in this program.	$545,680.18
5	13633270 5.1.1	1.1.2	Starr County Memorial Hospital	Obtain family practice physician with an OB background to provide services in the Rural Health Clinic as well as complete rounds at SCMH and integrate diabetes education in a group setting and optional one-on-one for diabetic, pregnant women, in an effort to promote a healthy pregnancy and decrease complications.	Indigent care & Medicaid population that seek services at rural health clinic or ER at SCMH with a focus on OB and diabetic populations	$698,160.00

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
6	085144601.1.2	1.3.1	University of Texas Health Science Center at San Antonio	Develop longitudinal clinical registries to improve quality of care at collaborating primary care practices that train medical students and residents in medicine and implement patient navigation to address health risks in patients who are not meeting their disease management goals	Low income patients with Medicaid, CareLink (county-funded financial assistance) who are not meeting health maintenance goals or are requiring narcotics for pain, targeting persons with uncontrolled diabetes or hypertension, persons who have chronic non-cancer pain and are treated with narcotics long-term, and HIV-infected persons who are overweight or obese and still gaining significant weight	$3,840,827.00
6	085144601.2.4	2.2.1	University of Texas Health Science Center at San Antonio	Implement specific Chronic Care Model activities within the practice, including a comprehensive care management plan, adopting evidence-based protocols, implementing patient self-management plans for chronic conditions, nurse-care management and medical group visits.	Vulnerable patient population with high burdens of chronic disease and socioeconomic disadvantage. More specifically, patients with clinical parameters for hypertension and diabetes that are above recommended therapeutic goals, as well as patients with poor follow-up histories	$2,987,310.00
6	085144601.2.5	2.9.2	University of Texas Health Science Center at San Antonio	Implement a patient navigator program linked to a primary care safety net clinic to improve diabetes outcomes. Community health workers will engage high-risk patients, identified by glycosylated hemoglobin values greater than 9%, through home and community-based interventions to address barriers to successful interaction with the health system and self-management	Diabetes prevalence in the patient panel is 30%, with 1 in 4 of those having glycosylated hemoglobin values greater than 9%	$853,517.00

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
6	09130890 2.2.3	2.6.2	San Antonio Metropolitan Health District	Implement the Community Diabetes Project, which will expand access to the Stanford Chronic Disease Self-Management and Diabetes Self-Management Programs for individuals living with diabetes and their family members/caregivers as well as those that are at risk for developing diabetes.	The Community Diabetes Project will be provided throughout the city of San Antonio, with an emphasis on neighborhoods within the central urban core which has a high burden of diabetes and prediabetes within geographic disparity areas. These areas correspond with those sectors of the city with higher percentages of minorities (Hispanic and African American), low educational attainment and household income, along with high rates of uninsured or underinsured.	$5,135,153.00
6	13325790 4.2.1	2.7.1	Texas Center for Infectious Disease	1) Increase targeted testing for latent tuberculosis infection (LTBI) in high-risk populations; 2) Provide routine testing for LTBI with interferon gamma release assays (IGRAs) instead of tuberculin skin testing to minimize false positive tests in BCG-vaccinated patients and avoid unnecessary LTBI therapy; 3) Provide routine treatment of LTBI through a 12-dose, 12-week regimen administered by DOT to improve patient adherence and completion of LTBI therapy; 4) Facilitate hospitalization for TB care for those few patients who cannot be successfully treated as outpatients.	Individuals with the highest risk of contracting TB and developing active TB, specifically individuals who live in congregate settings, such as homeless shelters and drug rehabilitation centers, as well as individuals with HIV and/or diabetes.	$5,977,008.00
6	13614120 5.2.10	2.2.1	University Hospital	Implement Chronic Care Model (CCM) activities at two primary care sites within the University Health System network for patients with diabetes.	Patients diagnosed with diabetes	$6,152,080.00
6	13649110 4.1.1	1.9.2	Southwest General Hospital	Develop and implement a Gestational Diabetes program to educate and monitor patients throughout their pregnancy, therefore improving fetal outcomes.	Pregnant teens and women at risk for or diagnosed with gestational diabetes	$887,030.00

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
6	138411709.1.1	1.1.2	Guadalupe Regional Medical Center	Move a long standing indigent clinic (that would potentially close soon due to unsafe conditions) to the hospital campus, improving access and security. Increase the volume and scope of services to improve continuity, access and effectiveness of chronic disease care in the community.	Indigent and uninsured patients with chronic a disease such as diabetes, hypertension, CHF and COPD	$2,295,949.00
7	133340307.2.1	2.15.1	Hill Country MHMR Center (dba Hill Country MHDD Centers)	Integrate primary care into the Hays County Mental Health Clinic so as to provide both primary and behavioral health care for individuals with Severe and Persistent Mental Illness	Individuals in Hays county who have a psychiatric diagnosis and receive mental health treatment at the clinic who have risk factors associated with diabetes and hypertension	$1,532,410.00
7	137265806.2.5	2.12.1	University Medical Center at Brackenridge (UMCB)	Create a multi-disciplinary team that monitors and coordinates the care of patients with chronic disease immediately following discharge from hospital to home, and from home to primary care.	Adult patients being discharged from UMCB with one or more illnesses such as Diabetes, Congestive Heart Failure, Asthma and COPD (target conditions) who also have a history of frequent hospital admissions and ED visits.	$7,648,122.00
7	137265806.2.9	2.8.4	University Medical Center at Brackenridge (UMCB)	Current Adult Inpatient Diabetes Team only provides inpatients with referrals to outpatient care, with no opportunity for communicating the discharge regimen or HbA1c test results to the follow-up care provider. This project prepares and communicates discharge plans to the follow-up healthcare provider for helping to manage the disease post-discharge and provides education to inpatients at a time when they are most likely to be receptive	Adult inpatients at UMCB and two other Seton-operated hospitals in Travis County who are either at risk for diabetes, or diagnosed with diabetes and who are at risk for readmission.	$5,604,023.00

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
7	17669250 1.1.1	1.9.2	St. Mark's Medical Center	Expand access to OB-GYN physician services by recruiting an additional OB-GYN physician. Additionally, this project will assess the viability of and develop/implement a plan to expand access to specialty care/wound care services related to cardiovascular disease and diabetes through the expansion of clinical facilities and recruitment of additional specialty physicians.	Patients that require specialty OB-GYN services or other specialty care/wound care services related to cardiovascular diseases and diabetes that reside in Fayette County and Lee County.	$147,420.00
7	20132030 2.2.2	2.6.2	City of Austin - Health & Human Services Department	Increase community health workers and/or community-based organizations in the Hispanic and African-American communities that provide culturally appropriate diabetes self-management education	African Americans and Hispanics with diabetes.	$730,000.00
7	30745930 1.1.1	1.3.1	Community Care Collaborative (CCC)	Implement and use chronic disease management registry (DMR) functionalities to alert and inform care teams when patients with two or more chronic diseases require intervention and follow up.	Patients at or below 200% of FPL with multiple chronic conditions, including heart failure, chronic kidney disease, behavioral health issues, COPD, hypertension, malignant neoplasms, and diabetes	$10,568,256.00
7	30745930 1.2.3	2.19.1	Community Care Collaborative (CCC)	Develop a care management approach specific to individuals dually diagnosed with diabetes and clinical depression	CCC patients dually diagnosed with clinical depression and diabetes.	$5,263,250.00
9	02090820 1.2.2	2.6.2	Texas Health Presbyterian Hospital Dallas	Partner with faith communities in the service area to design self-management wellness programs using evidence-based practices.	Individuals in the community who may not have access to primary care, are unlikely to seek primary care, and suffer from high blood pressure or diabetes that is unmanaged.	$1,232,911.56

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
9	02096780 1.2.2	2.2.1	Texas Health Presbyterian Hospital Denton	Provide chronic diabetes patients education and management to help them understand their daily regimen and need for monitoring their disease process.	Chronic diabetes patients in need of education and disease management services with A1C>9, history of DKA, and more than one admission in the last 12 months.	$269,044.81
9	09414030 2.2.2	2.2.1	Texas Health Presbyterian Hospital Kaufman	Provide chronic diabetes patients education and management to help them understand their daily regimen and need for monitoring their disease process. Need for the project: A model to coordinate and prescribe care. A Certified Diabetes Educator, pharmacist, physicians, nurses, nutritionist, and a case manager will help coach and navigate patients.	High risk diabetic patients with A1c > 9, history of DKA, and more than one admission in prior 12 months.	$77,702.77
9	09419400 2.2.2	2.12.1	Doctor's Hospital at White Rock Lake	Develop a standardized care transition process for case managers to utilize in discharging patients, increase partnership with community-based providers to ensure that patients receive appropriate post-acute care services in an appropriate setting. To accomplish this, Doctors Hospital at White Rock Lake will hire an additional ED case manager, engage with community organizations, perform follow-up calls to ensure proper adherence to care instructions, and determine whether the patient requires additional community placement for ongoing primary or preventative care	Patients discharged from Doctors Hospital at White Rock Lake with one of the following primary diagnoses: COPD (DRGs 190-192), Pneumonia (193-195), Acute MI (280-282), Heart failure (291-293), and Diabetes (637-639).	$290,800.00

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
9	121776204.2.1	2.2.2	Baylor Medical Center at Irving	Provide focused education and point of care testing for underserved patients who have diabetes, CVD and/or Respiratory disease that are in need of education, clinical management and training within a primary care setting. We will co-locate primary care and chronic disease management services to improve clinical outcomes. This project is new because it will provide CHF and Asthma education and point of care testing, all which have not been done before. We have had some Diabetes education in our Clinics but not a formal and focused program for the Medicaid/Uninsured population.	Patients with diabetes, cardiovascular diseases and respiratory diseases.	$647,937.00
9	121790303.2.1	2.2.2	Baylor Medical Center at Garland	Provide focused education and point of care testing for underserved patients who have diabetes, CVD and/or Respiratory disease that are in need of education, clinical management and training within a primary care setting. We will co-locate primary care and chronic disease management services to improve clinical outcomes.	Patients with chronic diseases in need of disease management education.	$832,715.00
9	126679303.2.1	2.2.2	Methodist Charlton Medical Center	Develop and implement a chronic disease management intervention. The target population is our patients that need education on managing diabetes and have high risk needs associated with diabetes.	ED patients who have either a principal or secondary diagnosis of diabetes and need education on managing diabetes and have high risk needs associated with diabetes based on clinical protocols of HbA1c >9.0%, at least one ED visit in the past 12 months and/or have not received diabetes education within the past five years.	$2,375,593.00

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
9	127295703.1.3	1.3.1	Parkland Memorial Hospital	Design/ develop/ implement a patient registry that will provide support to providers in managing health care of those enrolled in Parkland's medical homes as well as those patients with chronic care conditions.	Patients with specific conditions will be enrolled into the registry. Initially, patients with diabetes will be targeted. Patients with other conditions will be enrolled as appropriate.	$14,329,840.00
9	127295703.1.5	1.9.2	Parkland Memorial Hospital	Increase access to specialty care by: 1) recruiting mid-level providers in the following specialties: cardiology, diabetes, neurology, smoking cessation, ophthalmology, and general surgery; and 2) adding support staff as appropriate.	Parkland patients in need of services in the following specialties: cardiology, diabetes, neurology, smoking cessation, ophthalmology, and general surgery	$12,175,681.00
9	127295703.2.4	2.2.1	Parkland Memorial Hospital	Incorporate into its care delivery system a chronic care model based on the Wagner Chronic Care Model, modified, as appropriate, for Parkland's low income patient population.	Parkland's low-income population with an initial focus on patients with Diabetes and Congestive Heart Failure (CHF). In subsequent years, patients with other conditions – Chronic Kidney Disease (CKD), COPD, Hypertension, pediatric asthma, pediatric obesity – will be enrolled into the chronic disease management model.	$16,296,680.00
9	135032405.2.2	2.2.2	Methodist Dallas Medical Center	Develop and implement a chronic disease management intervention geared toward improving effective management of chronic conditions (the focus will be diabetes).	ED patients who have either a principal or secondary diagnosis of diabetes and need education on managing diabetes and have high risk needs associated with diabetes based on clinical protocols of HbA1c >9.0%, at least on ED visit in the past 12 months and/or have not received diabetes education within the past five years.	$3,744,024.38

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
9	136360803.2.1	2.2.1	Denton County Health and Human Services	Implement a chronic disease registry to track Medicaid and low income diabetic patients. This will facilitate a comprehensive listing of Medicaid and low income diabetes patients in Denton County. In addition, diabetes care will be provided incorporating the Chronic Care Model developed by Wagner.	Persons with diabetes who are low income or Medicaid recipients.	$2,099,469.00
9	138910807.2.2	2.6.1	Children's Medical Center of Dallas	Work with agencies and organizations in Dallas County to align and coordinate community-based prevention and wellness activities in the focused areas of asthma and diabetes to improve the health and self-management of children and their families. We will establish self-management programs and wellness programs using evidence-based designs. We will engage community health workers, both promoters and Grand Aides.	Children in Dallas County with an initial focus on those with asthma.	$6,828,278.00
9	139485012.2.1	2.2.2	Baylor University Medical Center	Provide focused education and point of care testing for underserved patients who have diabetes, CVD and/or Respiratory disease that are in need of education, clinical management and training within a primary care setting. We will co-locate primary care and chronic disease management services to improve clinical outcomes.	Patients with Diabetes, Cardiovascular Diseases (CVD) and Respiratory Diseases (Asthma/Chronic Obstructive Pulmonary Disease).	$3,916,572.00
9	195018001.2.1	2.2.2	TRINITY MEDICAL CENTER	Provide focused education and point of care testing for underserved patients who have diabetes, CVD and/or Respiratory disease that are in need of education, clinical management and training within a primary care setting. We will co-locate primary care and chronic disease management services to improve clinical outcomes	Patients in need of chronic disease education and management services.	$228,613.00

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
9	209345201.2.2	2.2.1	Methodist Richardson Medical Center	Develop and implement a chronic disease management intervention.	Patients who need education on managing diabetes and have high risk needs associated with diabetes based on clinical protocols of HbA1c >9.0%, history of DKA, more than one admission in the past 12 months and/or have not received diabetes education within the past five years.	$1,050,953.00
10	022817305.2.4	2.6.2	Tarrant County/dba Tarrant County Public Health	Reduce the number of preventable admissions pertaining to hypertension by implementing the evidence-based Stanford Chronic Disease Self-Management Program in the offices of Medicaid providers within the Texas Health Resources system. Uses CHWs to educate patients.	Tarrant County low income residents from 14 selected zip codes who have been diagnosed with diabetes and/or hypertension.	$1,252,625.00
10	112677302.2.1	2.2.1	Texas Health Harris Methodist Hospital Fort Worth	Provide seamless care for low income and uninsured residents of Tarrant County living with diabetes to improve health outcomes and self-management competency, prevent unnecessarily reduced quality of life, and decrease inappropriately high reliance on acute and emergent care community resources. Linking diabetes patients that present to the ED or as inpatients to a primary care physician could significantly enhance the number of patients who have access to diabetes education and support.	Low income / uninsured community members with diabetes who are not currently being managed and are seen frequently in the ED and have multiple admissions.	$501,209.32
10	121794503.2.1	2.2.1	Texas Health Harris Methodist Hospital Stephenville	Identify patients who do not have medical home and others appropriate for diabetes education. They will be referred to diabetes outpatient education classes	Patients with type 1 or type 2 diabetes, prediabetes, or gestational diabetes.	$43,029.43

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
10	126675104.2.1	2.2.2	John Peter Smith Hospital	Improve diabetes clinical outcomes and self-management skills in a patient-centered medical home. This is a new intervention based on Wagner's chronic care model interwoven into a new medical home setting.	Low income individuals with diabetes.	$14,327,813.98
10	126675104.2.16	2.2.1	John Peter Smith Hospital	The multidisciplinary Wagner Chronic Care Model will be utilized to effectively approach the care and management of childhood and adolescent asthma and obesity/diabetes in our community with the goal of improving outcomes, preventing complications and reducing potentially preventable ED visits and inpatient readmissions. The target population is children and young adults with a diagnosis of asthma and/or obesity/diabetes who are currently accessing primary care services within our school based health centers as well as our community health centers.	Children and young adults with a diagnosis of asthma and/or obesity/diabetes who are currently accessing primary care services within our school based health centers as well as our community health centers.	$407,845.00
10	130614405.2.1	2.2.1	Texas Health Arlington Memorial Hospital	This project will help individuals with diabetes who are traditionally underserved and give them access to diabetes education and regular clinical care so they can take ownership and better manage their diabetes. This project intervention is an expansion of the current diabetes education program at THAM to include a nurse practitioner-run outpatient clinic for patients with diabetes.	Underserved diabetes patients with A1C (>9.0%), DKA history and greater than one hospital admission in last 12 months.	$238,791.16
10	131036903.1.1	1.1.2	Texas Health Harris Methodist Hospital Cleburne	The project will provide supplemental primary care providers and to expand primary care access to patients in region Primary Care through APRNs with prescriptive authority	People with diagnoses to include COPD, heart failure or diabetes who are uninsured without access to additional resources and who have a high frequency of inpatient admissions and ER visits within the last 6 months.	$451,060.04

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
10	135036506.2.1	2.2.2	Baylor All Saints Medical Center at Fort Worth	This project will provide focused education and point of care testing for underserved patients with diabetes, CVD and Respiratory disease. Co-locate primary care and chronic disease management services	Patients with diabetes, CVD, and respiratory disease.	$1,282,945.66
10	136326908.2.1	2.2.1	Texas Health Harris Methodist Hospital Hurst-Euless-Bedford	This project provides seamless care for low income and uninsured with diabetes to improve health outcomes and self-management by linking them to a PCP.	Indigent or government-funded patients with a diagnosis of diabetes in the community who do not have access to receive care to manage their disease or those who need additional support in the management of their diabetes.	$119,573.56
10	186221101.2.2	2.2.2	Methodist Mansfield Medical Center	The project will develop and implement a chronic disease management intervention geared toward improving effective management of chronic conditions (primary or secondary diagnosis of diabetes).	ED patients with diabetes who need education on managing diabetes and have high risk needs associated with diabetes based on clinical protocols of HbA1c >9.0%, have at least one ED visit in the past 12 months.	$367,209.00
10	206106101.2.1	2.1.1	Wise Clinical Care Associates	Implement the patient-centered medical home model in 3 WCCA primary care clinics and hire 2 physicians.	All WCCA patients, with an emphasis on those with diabetes	$8,740,551.00
11	138644310.2.4	2.6.1	Hendrick Medical Center	Expand a diabetes education program by adding classes and distributing educational materials at additional locations/events.	Individuals in the Hendrick Medical Center catchment area with diabetes	$1,755,575.00
12	094121303.2.1	2.11.1	Memorial Hospital	Implement a process to track and reconcile patient medication and to educate patients regarding appropriate use, expected outcomes and interaction of medications.	Emergency room and acute care patients who are diagnosed with a chronic disease relating to high blood pressure, specifically including diabetes and chronic heart failure, who are taking multiple medications.	$101,007.15

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
12	137999206.1.1	1.3.1	University Medical Center	Select and implement a chronic disease registry. A patient population with specific chronic conditions (examples: diabetes, congestive heart failure,) will be selected and the trained staff will utilize the tools within the chronic disease registry for patient contacts and education, into which each patient's data will be entered.	Patients admitted to University Medical Center, diagnosed with a particular chronic disease.	$5,344,003.00
12	137999206.2.1	2.2.1	University Medical Center	Implement care teams at designated ambulatory clinics within University Medical Center Physician Network Services (PNS) or Texas Tech to care for patients with chronic conditions (focusing on patients with hypertension or diabetes).	Patients 18 through 75 years of age, seen/managed in designated ambulatory clinics within PNS or Texas Tech who have chronic conditions (with a focus on patients with hypertension or diabetes)	$5,076,803.00
13	091770005.2.2	2.6.2	Concho County Hospital	Implement a Health and Wellness Center to educate and understand patients with diabetes needs.	Patients 18-75 years of age with Type 1 or Type 2 diabetes	$409,360.00
13	130089906.2.2	2.2.2	Ballinger Memorial Hospital District	Implement diabetic management program care model in the rural health clinic.	At risk diabetes patients of Ballenger Memorial Hospital that need services from specialists.	$159,849.00
13	137226005.1.4	1.3.1	Shannon West Texas Memorial Hospital	Implement infrastructure that supports patient population health and coordination of care by expanding a chronic disease management registry to provide patient-center care for patients with diabetes.	All patients diagnosed with diabetes at Shannon Clinic.	$3,196,711.00
14	081939301.2.1	2.2.1	Texas Tech University Health Science Center-Permian Basin	Implement a Diabetes Medical Home based on Wagner's chronic care model in Odessa Family Medicine clinics.	Diabetic patients who don't have primary provider because they're uninsured or not able to find a Medicaid provider in the area.	$1,408,991.00

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14	08193930 1.2.2	2.3.1	Texas Tech University Health Science Center-Permian Basin	Establish clinics focused on management of diabetes, blood pressure, and lipids. Includes Tier 1 and 2 Stations clinics and Diabetes Registry.	Ethnic groups at high risk for diabetes, hypertension and stroke.	$1,011,583.00
14	08193930 1.2.3	2.12.2	Texas Tech University Health Science Center-Permian Basin	With Medical Center Hospital, develop a transition program to provide appropriate and timely clinic care after hospital discharge for diabetic patients.	Ethnic groups at high risk for diabetes, hypertension and stroke.	$686,432.00
14	09417260 2.2.1	2.12.2	McCamey Hospital	Implement consulting for newly diagnosed and uncontrolled diabetes patients.	Patients with newly diagnosed diabetes or with uncontrolled diabetes.	$22,000.00
14	11268490 4.2.1	2.2.2	Reeves County Hospital	Implement a Certified Diabetes Education Program geared toward helping those patients diagnosed with diabetes to better manage their chronic condition.	Patients who utilize the Pecos Valley Rural Health Clinic and have been diagnosed with type 1 or 2 diabetes.	$483,661.42
14	11271100 3.1.4	1.9.2	Odessa Regional Medical Center	Improve access to gestational diabetes care through Perinatal Center	Women with Gestational Diabetes Mellitus (GDM) or Pre Gestational Diabetes Mellitus with a focus on the Hispanic population.	$2,067,153.28
14	11271100 3.2.2	2.2.2	Odessa Regional Medical Center	Develop and implement an inpatient and outpatient diabetes ctr.	Patients with diabetes and a need for diabetes management.	$1,679,562.04
14	13523530 6.2.5	2.7.1	Medical Center Hospital	Hire diabetes outreach coordinators who will be responsible for coordinating screening events, making referrals, and health promotion activities. Addition of bi-weekly diabetes education sessions.	Persons who are screened for diabetes and follow-up education and treatment.	$2,369,711.00

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
14	136143806.2.2	2.7.1	Midland Memorial Hospital	Diabetes screening for diagnosis with referrals for treatment and education impacting hospital admissions for short-term diabetic complications	Adults with undiagnosed or untreated diabetes due to lack of education or cost barriers.	$3,290,340.00
14	136145310.2.1	2.2.1	Martin County Hospital District	Comprehensive self-management education program for diabetes using care teams	Any patient considered “high risk” and those treated in the ED or admitted with diabetic complications.	$705,787.00
15	084597603.1.1	1.9.3	TEXAS TECH HS CTR FAMILY MED	Recruit 4 additional providers (two therapeutic optometrists and two ophthalmologists) and the required staff and technicians, and facilitate access through the development of an electronic referral system from our primary care clinics to ophthalmology.	Region's ocular patients. Specifically, those with diabetes-related ocular conditions in the low-income, indigent, Hispanic and Medicaid population.	$3,587,790.00
15	084597603.1.2	1.3.1	TEXAS TECH HS CTR FAMILY MED	The project will establish an enterprise wide disease management capability with the ability to support multiple diseases and conditions, available to all clinical departments in our organization. Establish registries for patients with Diabetes in the Departments of Family Medicine and Internal Medicine, and for patients with breast cancer in the Department of Internal Medicine.	Chronically ill patients in the region, specifically those with diabetes and cancer	$1,678,494.00
15	084597603.2.1	2.1.3	TEXAS TECH HS CTR FAMILY MED	This project will complete the infrastructure development, provider recruitment, system redesign and training required to allow the Kenworthy Family Medicine Clinic to achieve level 1 NCQA designation as a medical home.	Patients of Family Medicine Kenworthy Clinic at risk of or diagnosed with diabetes.	$1,932,465.00
15	094109802.1.3	1.3.1	Las Palmas Medical Center	This project will establish a diabetes Clinical Information System (registry) to structure, organize, and trend patient data for registries, performance measurements, and prevention services. This registry will help identify patients for inclusion and assist patients through the registry to track and manage their disease.	Persons with diabetes and prediabetes.	$3,304,277.01

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
15	138951211.2.3	2.9.1	University Medical Center of El Paso	Create specific case management positions to discharge our Medicaid and Unfunded patients with chronic conditions to appropriate medical homes for follow-up healthcare treatment utilizing other UMC projects that will provide for clinic growth and expansion, as well as appropriate home health-care services, and finally coordinating homeless and transient patients to our partner homeless residential facilities. The target population is our patients with Congestive Heart Failure, Renal Failure, Hypertension, Obesity, and Diabetes.	High-risk (diabetes, CHF, hypertension, obesity and renal disease) patients in need to self-management education and coordination of care.	$6,387,501.56
15	138951211.2.5	2.2.1	University Medical Center of El Paso	Diabetes Chronic Care - This project will redesign the outpatient delivery system to coordinate care for patients with chronic diseases and improve patient outcomes, with a focus on diabetic patients. We will coordinate an appointment for Diabetic patients within 4 days from discharge at UMC to UMC-NHC for patients without a PCP or NHC patients. Utilizing the Chronic Care Model and a team approach we will create a comprehensive medical home for Diabetic patients.	Patients with chronic conditions, primarily diabetes.	$3,903,473.18
16	084859002.2.3	2.18.1	Heart of Texas Region MHMR Center	This project will provide supportive services for individuals and families living with chronic behavioral health issues by utilizing trained peer support specialists who have made substantial progress in managing their own illness and who have recovered to the point where they are living successful lives in the community. The peer specialist would work with consumers to set achievable goals to prevent or self-manage chronic diseases such as diabetes or COPD	Medicaid and uninsured individuals.	$309,842.00
16	121792903.2.7	2.2.1	Hamilton General Hospital	Introduce a chronic disease management program to address major chronic health issues such as diabetes, respiratory disease, and obesity	Patients of Hamilton General Hospital with chronic disease including pneumonia, COPD, and diabetes	$2,948,311.00

RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
16	14071400 1.2.1	2.2.1	Limestone Medical Center	This project will implement wound care which is a chronic disease process that causes hospitalization and ER utilization. The services will provide access to wound care intervention that currently requires traveling great distances for care.	Patients with potentially preventable hospitalizations, including diabetes, peripheral vascular disease, and other disease processes that cause skin breakdown ultimately resulting in chronic wounds with short and long term complications.	$884,466.90
17	18979100 1.2.1	2.2.2	Huntsville Memorial Hospital	Implement chronic disease management models to enable patients to better manage their health.	Patients with multiple admissions due to failure to appropriately manage their chronic diseases, with a focus on diabetes, as well as those who are admitted or are in observation at HMH for chronic conditions	$2,693,030.00
18	08443420 1.2.3	2.3.1	Texoma Community Center	Expand/enhance the integration of mental and primary health care by increasing efficiency and redesigning how the primary care clinic program is accessed. Includes quality improvement of patient-centered scheduling and other focused solutions to barriers to access and patient satisfaction, and expanding from a ½ day of blended service to a full 5-day, full access model for both primary and psychiatric care services.	Patients who have co-occurring psychiatric and physical health illnesses, especially chronic physical problems such as diabetes, heart problems, high blood pressure, etc. along with severe and persistent mental illness.	$1,785,938.00
18	16955380 1.1.1	1.1.2	Tenet Frisco, Ltd d/b/a Centennial Medical Center	With the Collin County Adult Clinic (CCAC), expand access to primary care through expanded primary care clinic hours/ staffing, enhanced diabetes and hypertension management and education, wellness check-ups and screening for women, and seamless referral for HIV/AIDS issues and testing.	Collin County Adult Clinic patients, who are primarily women and diabetic.	$278,388.00

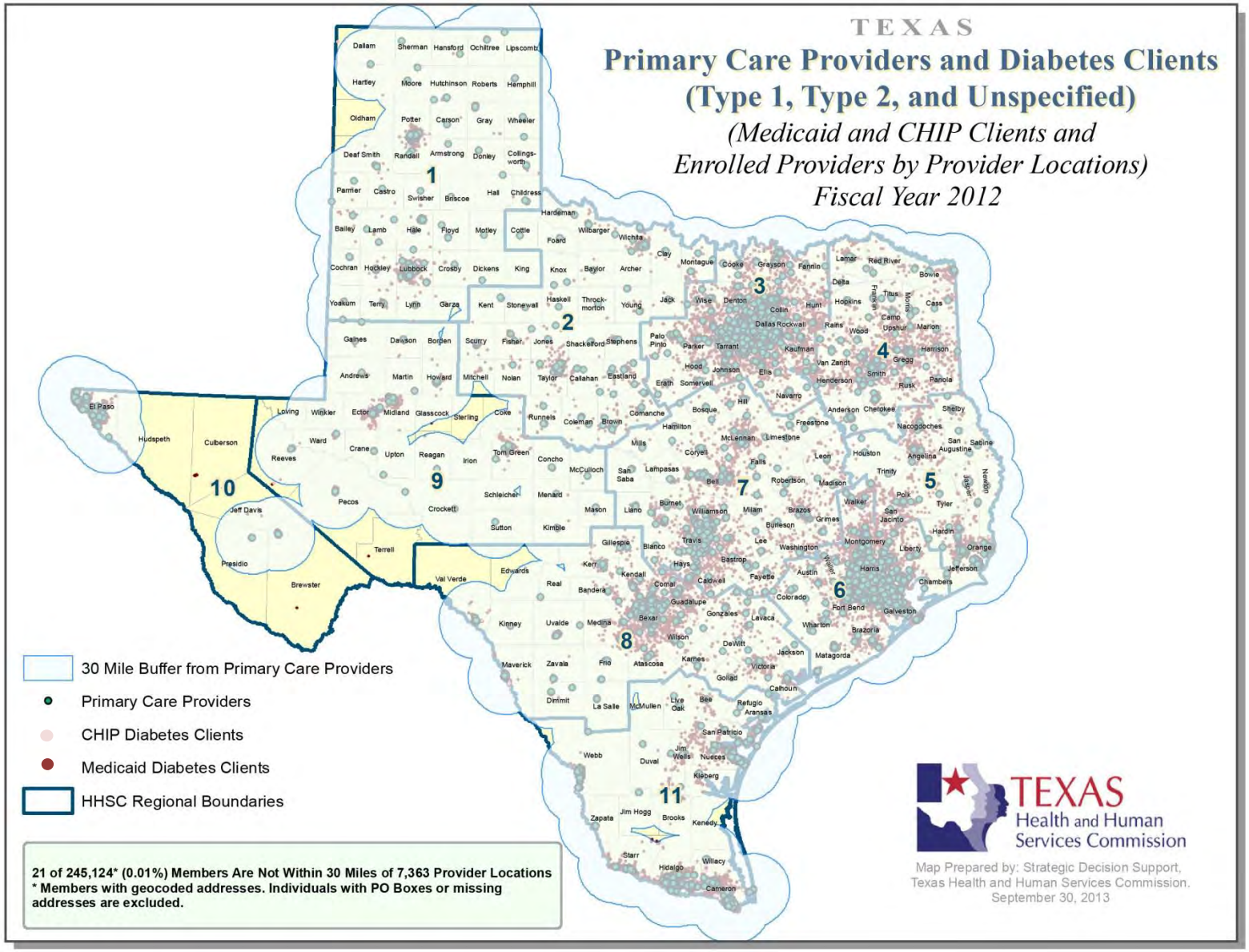
RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
19	127305405.2.2	2.2.1	Bowie Memorial Hospital	This project will provide resources to establish a chronic disease management program for patients with diabetes and coordinate transitions to continuing care when necessary for patient care. Approximately 53% of our patients are either Medicaid eligible, uninsured or county indigent, and we expect they will benefit from the availability of a chronic disease management program.	Patients with diabetes in need of chronic disease management in Montague County – RHP 19 .	$344,001.00
19	135034009.1.5	1.9.2	Electra Memorial Hospital	Recruit specialists including pediatricians, OB/Gyns, internists, a pulmonologist, and a urologist to Wichita Falls, with priority access being given to children and patients with diabetes, UTI, advanced pneumonia and COPD.	Residents of RHP 19 that need specialty care	$6,275,811.00
19	138353107.2.2	2.6.1	Seymour Hospital	Seymour Hospital plans to implement a Community Wellness Program. This program will be open to the general public with special emphasis on the underserved members of our community which include the elderly, indigent, and charity populations, as well as Medicare/Medicaid recipients, the uninsured/underinsured and those who face financial or geographical barriers to care.	Underserved members of community, including the elderly, indigent/charity populations, Medicaid/Medicare recipients, uninsured, and those with financial or geographic barriers to care who have diabetes, hypertension, are obese, smoke, and/or have a sedentary lifestyle.	$470,764.00

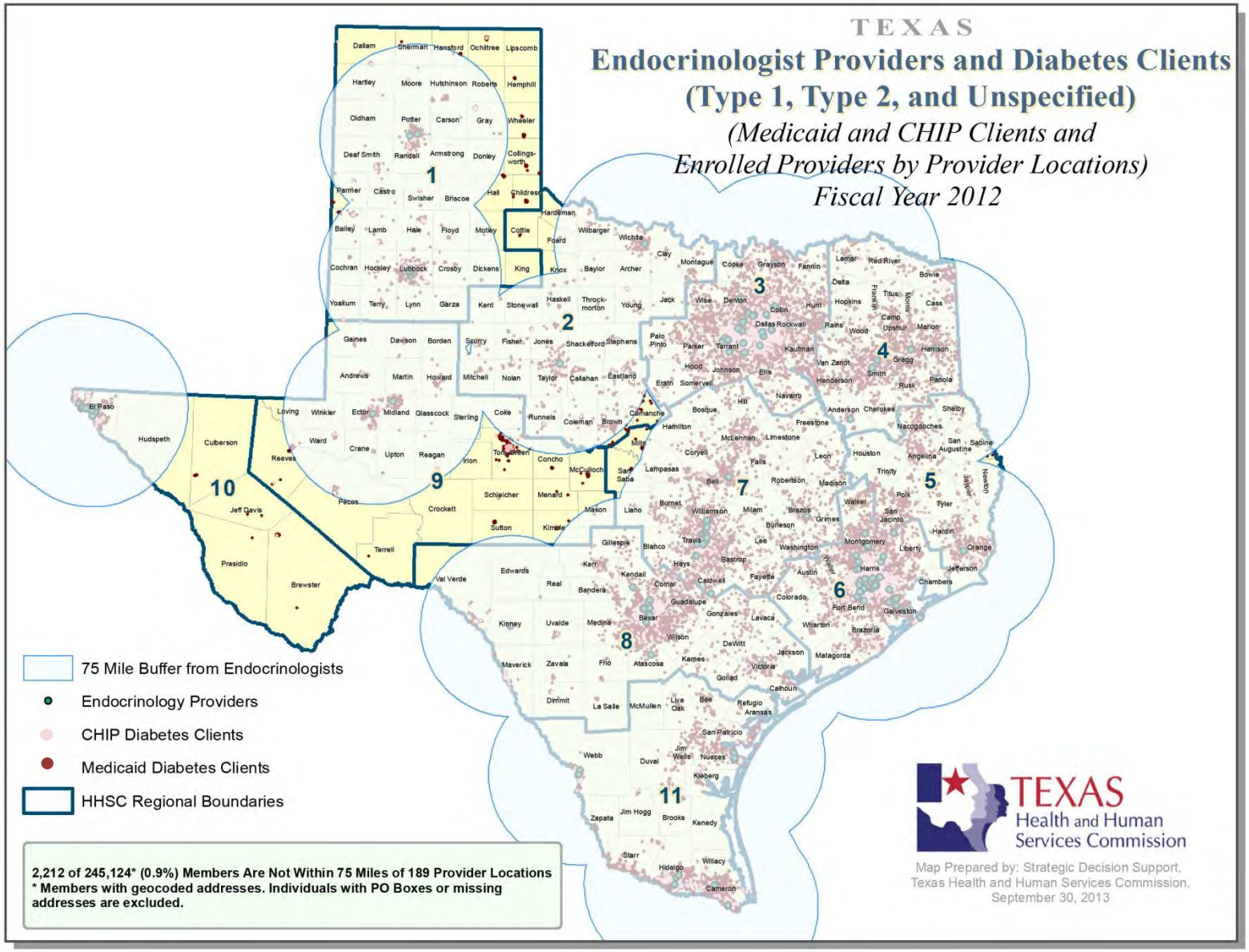
RHP #	Unique Project ID	Project Option	Provider Name	Project Description	Target Population	Approved Value for Years 2 3*
20	13791740 2.2.1	2.2.2	City of Laredo Health Department	Increase Disease Self- Management (DSM) interventions in primary care to address diabetes and obesity using the CLHD model HLVM (diabetes and hypertension self-management and education; hypertension and diabetes screening; physical activity, learning healthier food choices, cooking healthier; psychosocial case management, peer education in the clinical setting). As a new effort DSM HLVM will be integrated into primary care service	High risk individuals (and their families), Title V patients or uninsured indigent persons	$250,000.00
						$305,105,507.86
	Average Diabetes Project Amount:			**$2,748,698.27**		

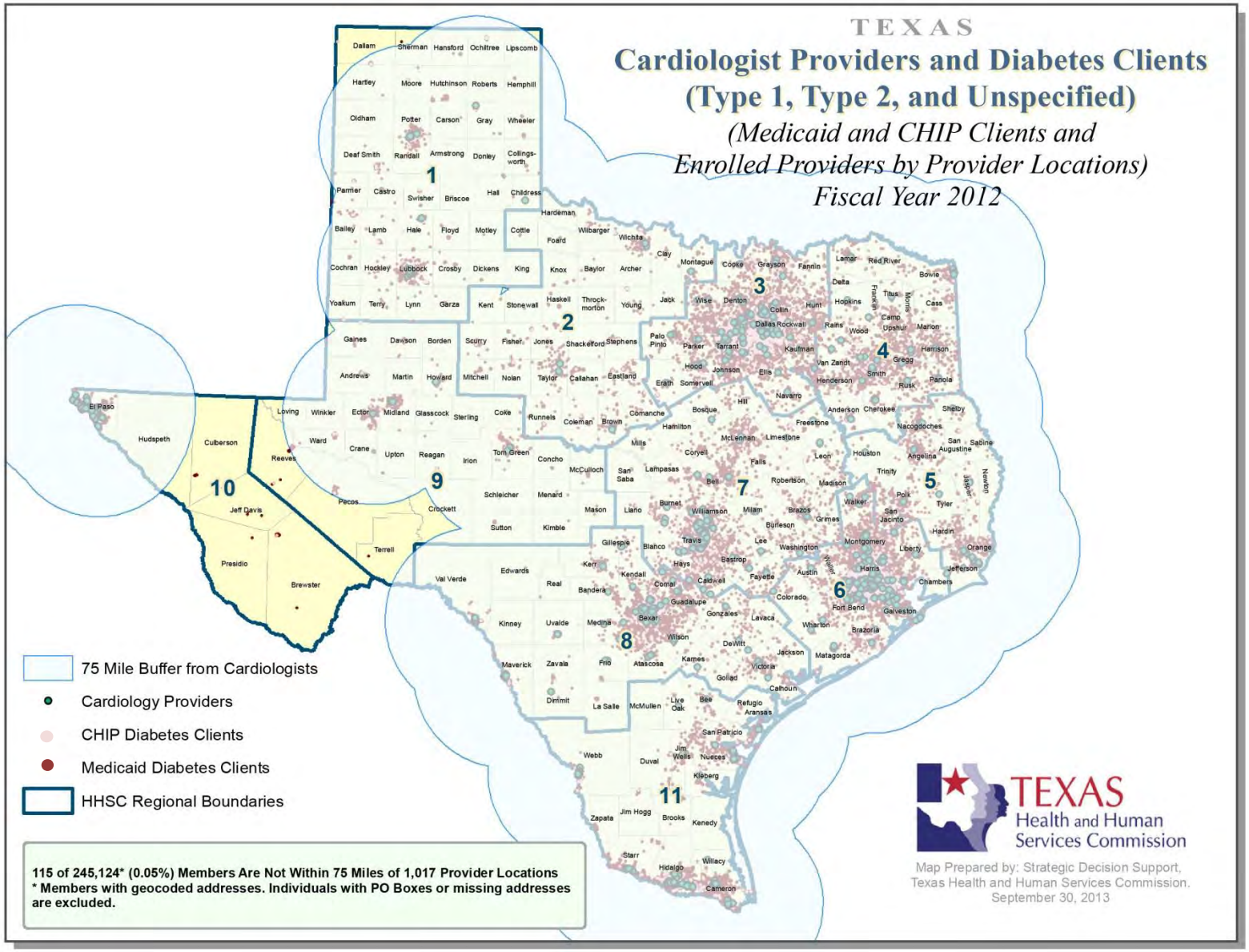
Appendix 2− Texas HHSC Maps of Diabetes Clients Access to Selected Provider Types

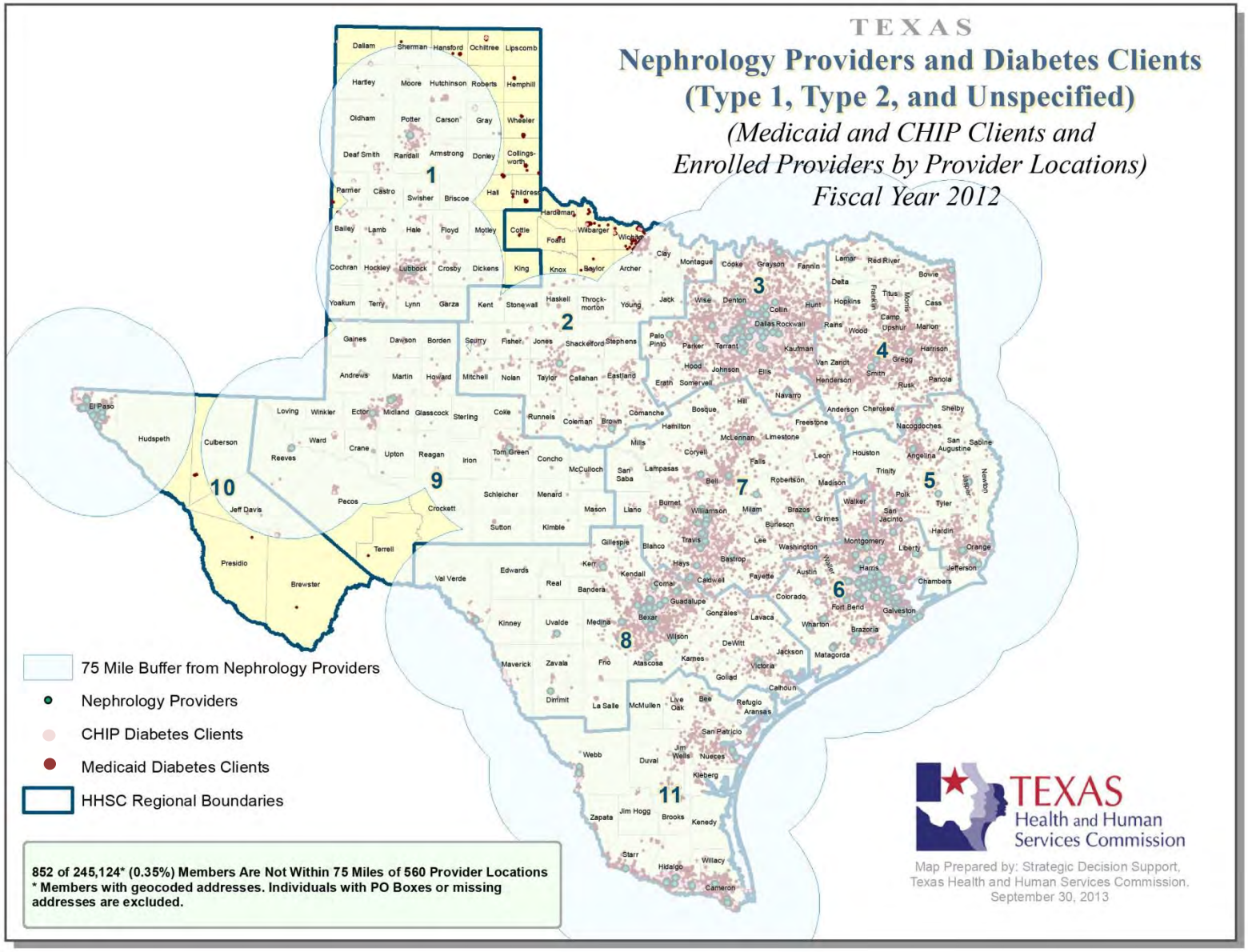
The following maps illustrate the location of HHSC clients in Texas who have diabetes in relation to the enrolled HHSC provider groups who typically treat patients with diabetes. In response to legislative requirements for this report, the number of providers is given, along with analysis of proximity of providers to patients with diabetes. These maps also indicate areas of the state where clients may have limited access to services. Maps include locations of the following medical providers:

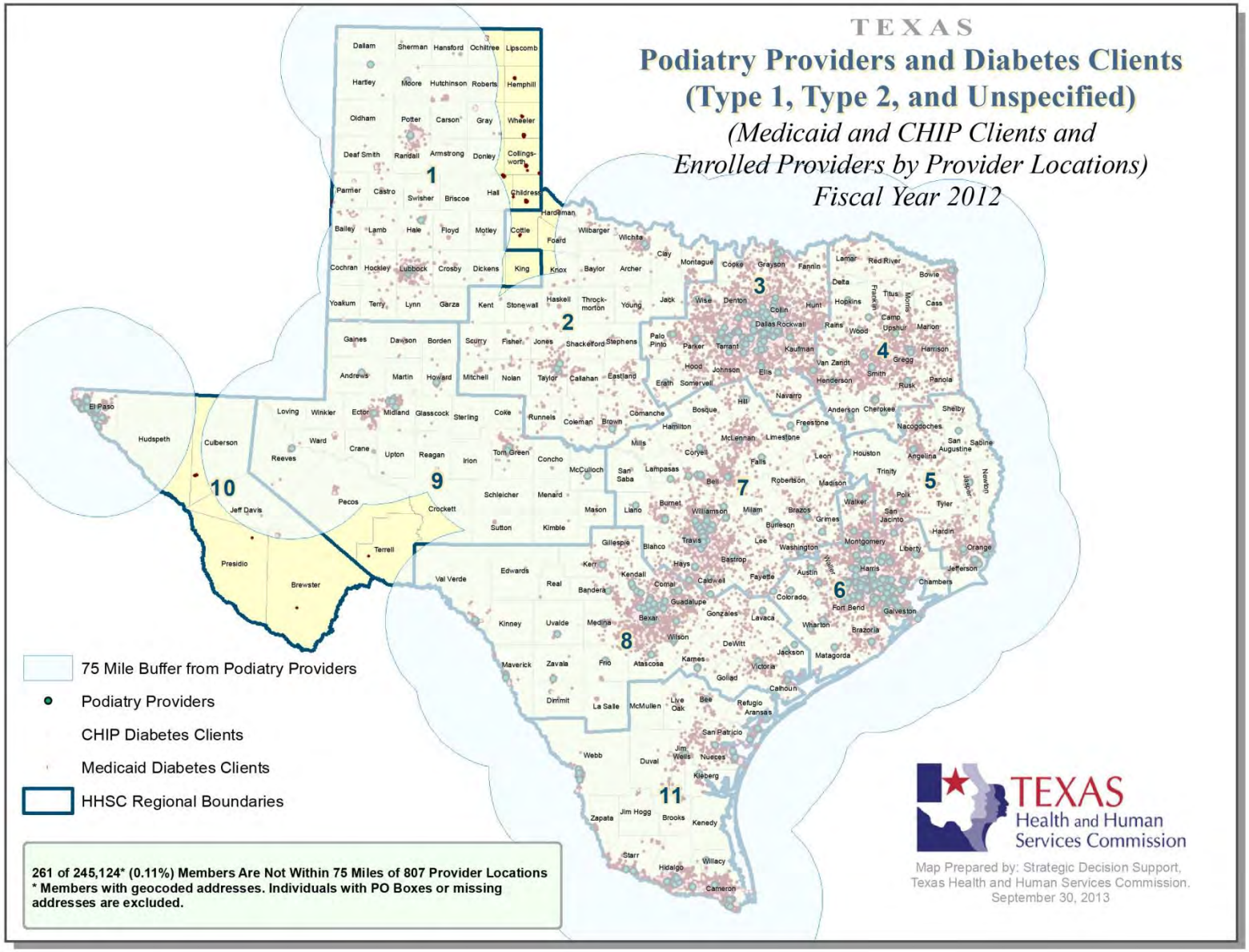
- Primary Care Providers
- Endocrinologists
- Cardiologists
- Nephrologists
- Podiatrists
- Obstetricians/Gynecologists (OB/GYN – in relation to clients who have gestational diabetes)

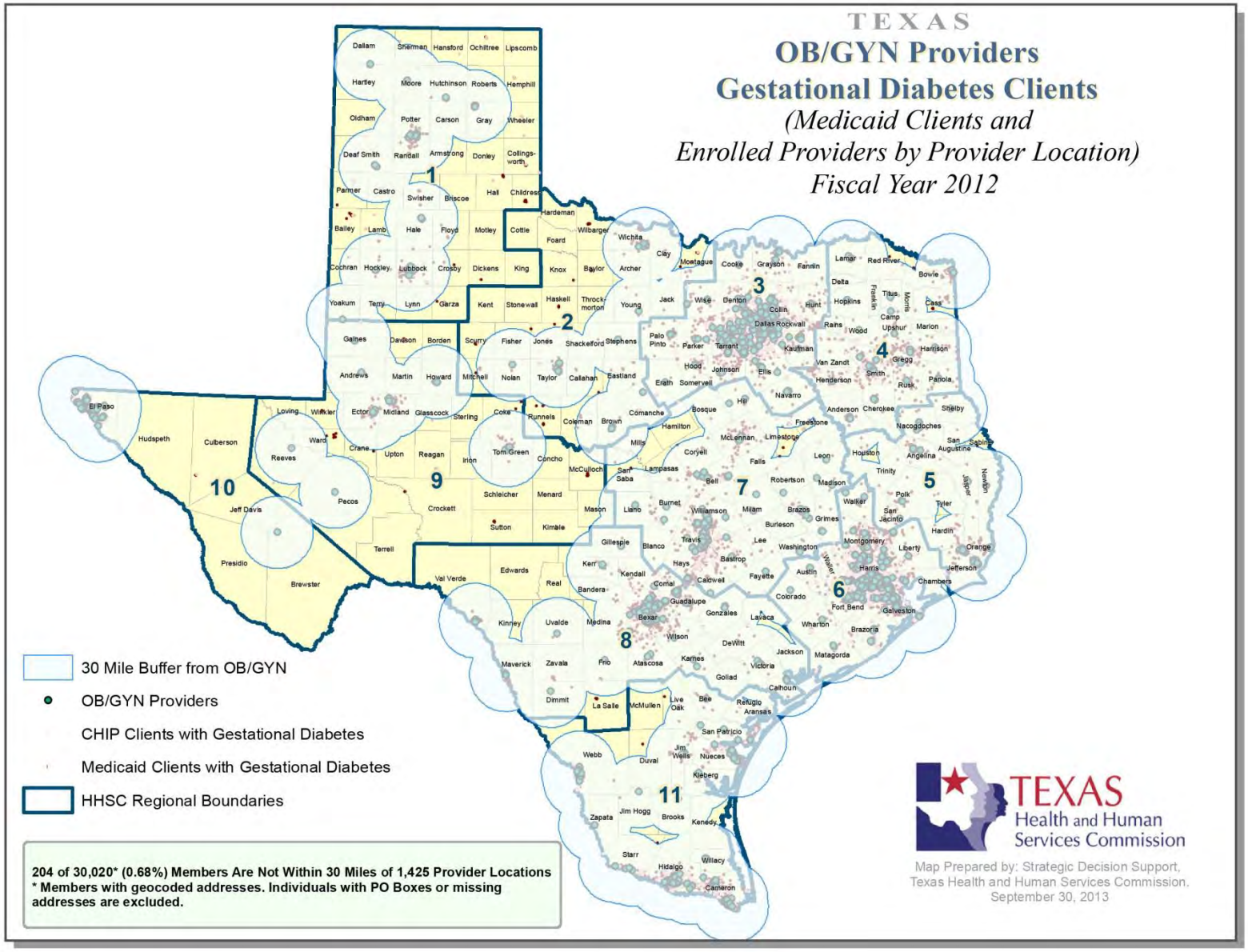

TEXAS
Primary Care Providers and Diabetes Clients
(Type 1, Type 2, and Unspecified)
(Medicaid and CHIP Clients and
Enrolled Providers by Provider Locations)
Fiscal Year 2012
30 Mile Buffer from Primary Care Providers
Primary Care Providers
CHIP Diabetes Clients
Medicaid Diabetes Clients
HHSC Regional Boundaries
21 of 245,124* (0.01%) Members Are Not Within 30 Miles of 7,363 Provider Locations
* Members with geocoded addresses. Individuals with PO Boxes or missing addresses are excluded.
TEXAS
Health and Human
Services Commission
Map Prepared by: Strategic Decision Support,
Texas Health and Human Services Commission.
September 30, 2013


TEXAS
Endocrinologist Providers and Diabetes Clients
(Type 1, Type 2, and Unspecified)
(Medicaid and CHIP Clients and
Enrolled Providers by Provider Locations)
Fiscal Year 2012
75 Mile Buffer from Endocrinologists
Endocrinology Providers
CHIP Diabetes Clients
Medicaid Diabetes Clients
HHSC Regional Boundaries
2,212 of 245,124* (0.9%) Members Are Not Within 75 Miles of 189 Provider Locations
* Members with geocoded addresses. Individuals with PO Boxes or missing addresses are excluded.
TEXAS
Health and Human
Services Commission
Map Prepared by: Strategic Decision Support,
Texas Health and Human Services Commission.
September 30, 2013


TEXAS
Cardiologist Providers and Diabetes Clients
(Type 1, Type 2, and Unspecified)
(Medicaid and CHIP Clients and
Enrolled Providers by Provider Locations)
Fiscal Year 2012
75 Mile Buffer from Cardiologists
Cardiology Providers
CHIP Diabetes Clients
Medicaid Diabetes Clients
HHSC Regional Boundaries
115 of 245,124* (0.05%) Members Are Not Within 75 Miles of 1,017 Provider Locations
* Members with geocoded addresses. Individuals with PO Boxes or missing addresses are excluded.
TEXAS
Health and Human
Services Commission
Map Prepared by: Strategic Decision Support,
Texas Health and Human Services Commission.
September 30, 2013


TEXAS
Nephrology Providers and Diabetes Clients
(Type 1, Type 2, and Unspecified)
(Medicaid and CHIP Clients and
Enrolled Providers by Provider Locations)
Fiscal Year 2012
75 Mile Buffer from Nephrology Providers
Nephrology Providers
CHIP Diabetes Clients
Medicaid Diabetes Clients
HHSC Regional Boundaries
852 of 245,124* (0.35%) Members Are Not Within 75 Miles of 560 Provider Locations
* Members with geocoded addresses. Individuals with PO Boxes or missing addresses are excluded.
TEXAS
Health and Human Services Commission
Map Prepared by: Strategic Decision Support,
Texas Health and Human Services Commission.
September 30, 2013


TEXAS
Podiatry Providers and Diabetes Clients
(Type 1, Type 2, and Unspecified)
(Medicaid and CHIP Clients and
Enrolled Providers by Provider Locations)
Fiscal Year 2012
75 Mile Buffer from Podiatry Providers
Podiatry Providers
CHIP Diabetes Clients
Medicaid Diabetes Clients
HHSC Regional Boundaries
261 of 245,124* (0.11%) Members Are Not Within 75 Miles of 807 Provider Locations
* Members with geocoded addresses. Individuals with PO Boxes or missing addresses are excluded.
TEXAS
Health and Human
Services Commission
Map Prepared by: Strategic Decision Support,
Texas Health and Human Services Commission.
September 30, 2013


TEXAS
OB/GYN Providers
Gestational Diabetes Clients
(Medicaid Clients and
Enrolled Providers by Provider Location)
Fiscal Year 2012
30 Mile Buffer from OB/GYN
OB/GYN Providers
CHIP Clients with Gestational Diabetes
Medicaid Clients with Gestational Diabetes
HHSC Regional Boundaries
204 of 30,020* (0.68%) Members Are Not Within 30 Miles of 1,425 Provider Locations
* Members with geocoded addresses. Individuals with PO Boxes or missing addresses are excluded.
TEXAS
Health and Human
Services Commission
Map Prepared by: Strategic Decision Support,
Texas Health and Human Services Commission.
September 30, 2013

Appendix 3 –Texas Diabetes Council Recommendations for Diabetes Disease Management and Diabetes Self-Management Education (DSME) Provided by Texas Medicaid

Background:
In August 2012, the Texas Diabetes Council (TDC) requested the opportunity to provide guidance regarding guidelines for disease management and diabetes self-management education (DSME) for Texas Medicaid managed care organizations (MCOs).

The Texas Health and Human Services Commission (HHSC) Office of the Medical Director has communicated that HHSC is open to reviewing guidelines for diabetes disease management and DSME for Medicaid MCOs to be drafted by the TDC. A document will be prepared containing the proposed guidelines. Once the guidelines have been reviewed and accepted by HHSC, a means of presenting them to the MCO will be discussed.

The following links to Texas Medicaid's Uniform Managed Care Manual were provided to the TDC for review:

Link to Chapter 9.1 "Disease Management"
http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/Chp9/9_1.pdf

Link to the entire manual: http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/

Link to the **Managed Care Contract** and what is currently required of a Medicaid MCO for Diabetes Disease Management:
http://www.hhsc.state.tx.us/medicaid/managed-care/UniformManagedCareContract.pdf

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7. Disease management requirements
The MCO must provide a comprehensive disease management program or coverage for Disease Management (DM) services for asthma, diabetes, and other chronic diseases identified by the MCO, based upon an evaluation of the prevalence of the diseases within the MCO's membership. Please refer to the **Uniform Managed Care Manual**, Chapter 9.1 "Disease Management," for additional DM requirements.

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8.1.14 Disease Management (DM)
The MCO must provide or arrange the provision of comprehensive disease management (DM) programs consistent with state and federal statutes and regulations. The program design of these DM programs must focus on the whole person, typically high-risk enrollees with complex chronic or co-morbid conditions rather than traditionally-designed programs with restricted diagnoses or disease silos. These programs must identify enrollees at highest risk of utilization of medical services, tailor interventions to better meet enrollees' needs, encourage provider input in care plan development, and apply clinical evidence-based practice protocols for individualized care.

Texas Diabetes Council Guidance Regarding Diabetes Self-Management Education (DSME):

Texas is one of 46 states that enacted statutes requiring state-regulated insurance and managed care plans to cover medication, supplies, equipment, and education related to diabetes management. In 1997, the Balanced Budget Act expanded coverage for diabetes supplies, equipment, and education within the Medicare program. However, consistent and reliable coverage for self-management training has not been provided to all Texans who are Medicaid and CHIP recipients across all Medicaid benefit plans (MCOs, Primary Care Case Management, Fee-for-Service).

Diagnosed Diabetes:

In recommending minimum requirements for DSME for persons who have diabetes, the TDC refers to Medicare benefits policy as the standard to which health plans should strive to adhere. Based on this policy, health plans should ensure that:

(1) an assessment of a recipient for the diabetes self-management training includes a review of the recipient's medical history, risk factors, health status, resource utilization, knowledge and skill level, and cultural barriers to effective diabetes self-management;

(2) a recipient receives a minimum of:

(A) 10 hours of initial self-management training with a diabetes educator; and

(B) three hours of initial nutrition education with a registered dietitian;

(3) after receipt of the initial self-management training, the recipient receives a minimum of two hours of training each year with a diabetes educator and two hours of training each year with a registered dietitian;

(4) if diabetes self-management training is provided in group sessions, the recipient has direct, face-to-face interaction with the educator and is offered a sufficient number of individual sessions to meet the recipient's cultural and educational needs; and

(5) the recipient may repeat all or part of the self-management training as necessary, regardless of whether the recipient is diagnosed with a new health condition or experiences a change in health status.

(6) the TDC supports the American Diabetes Association's National Standards for Diabetes Self-Management Education and the American Association of Diabetes Educator's National Standards for Diabetes Self-Management Education and Support as a guidance for development of DSME programs.

Prediabetes:

Prediabetes means a person has a blood glucose (blood sugar) level that is higher than normal but not high enough to be classified as diabetes. The CDC estimates that more than one third of adult Americans and half of all adults aged 65 years and older have prediabetes. People with prediabetes have an increased risk of developing type 2 diabetes that can lead to serious health problems such as vision loss, lower limb amputations, and kidney disease.

Studies have shown that people with prediabetes who lose a modest amount of weight (five to seven percent) and increase their physical activity to 150 minutes a week can prevent or delay the onset of type 2 diabetes. The National Diabetes Prevention Program is a 12-month program that has demonstrated effectiveness in improving the health of people with prediabetes. Participants meet in a group setting and learn about important changes that can help prevent type 2 diabetes, such as losing a modest amount of weight, being more physically active, and managing stress.

The TDC supports the following guidance regarding patients with prediabetes published in the American Diabetes Association Standards of Medical Care in Diabetes -2012:

- Patients with impaired glucose tolerance (IGT), impaired fasting glucose (IFG), or an A1C of 5.7–6.4 percent should be referred to an effective ongoing support program targeting weight loss of seven percent of body weight and increasing physical activity to at least 150 minutes per week of moderate activity such as walking.
- Follow-up counseling appears to be important for success.
- Based on the cost-effectiveness of diabetes prevention, such programs should be covered by third-party payers.
- Metformin therapy for prevention of type 2 diabetes may be considered in those with IGT, IFG, or an A1C of 5.7–6.4 percent, especially for those with BMI .35 kg/m2, age 60 years, and women with prior gestational diabetes.
- At least annual monitoring for the development of diabetes in those with prediabetes is suggested.

Disease Management:

Since 1995, the TDC has developed and continuously reviewed minimum standards of care for patients with diabetes. These standards are used to define diabetes benefits required of health plans regulated by the Texas Department of Insurance. Appointed by the TDC chair, the TDC Medical Professionals Advisory Subcommittee brings together a multidisciplinary team of diabetes experts from across the state to review the latest research and treatment recommendations and update TDC standards of care, including seventeen treatment algorithms, A1c target recommendations, and a Diabetes Tool Kit (www.tdctoolkit.org) to assist in applying standards to practice. The TDC's Health Care Professional Advisory Committee works to increase awareness of TDC standards of care among managed care organizations, health plans, physicians, and employer groups throughout Texas, and a subcommittee on outcomes examines data that can be used to evaluate the extent to which recommended care is delivered.

Disease management programs should strive for adherence to the following minimum standards of care, and develop performance indicators based on these standards. The TDC Medical Professionals Advisory Subcommittee is available to consult with managed care organizations regarding adoption of standards of care and efforts to evaluate disease management programs.

Diabetes Minimum Practice Recommendations for Children and Adults

TEXAS Department of State Health Services
Publication # 45-12085
TEXAS DIABETES COUNCIL
Revised 8/9/12

Name: _____ ID#: _____ D.O.B.: _____ Sex: M F

Exam/Test/Counseling Schedule

Suggested Result Codes: **O**=Ordered, **N**=Normal, **A**=Abnormal, **E**=Done Elsewhere, **R**=Referred

Complete History & Physical	Initial visit and at clinician's discretion (including risk factors, exercise & diet)	Date						
Family history	Annually	Date						
Education and Counseling								
Diabetes education[1]	Initial visit, annually and at clinician's discretion	Date						
Medical Nutrition Therapy	Initial visit, annually and at clinician's discretion	Date						
Exercise counseling	Initial visit and at clinician's discretion	Date						
Depression Screening[2]	Initial visit and at clinician's discretion	Date						
Sexual Function (male/female)	Initial visit and at clinician's discretion	Date						
Lifestyle/Behavior								
Smoking cessation	Initial visit and at clinician's discretion	Date						
Alcohol reduction	Initial visit and at clinician's discretion	Date						
Physical Examination								
Blood pressure Target: <130/80 mm Hg Target: <125/75 mm Hg if ≥1g proteinuria	Every visit	Date Result						
Weight/Height	Every visit (Height annually)	Date Result						
BMI Adult Overweight=BMI 25–29.9 Adult Obesity=BMI ≥ 30	Every visit	Date Result						
Foot Exam • Visual inspection for skin and nail lesions, calluses, infections, deformities • Monofilament / 128 Hz tuning fork • Pedal pulses	Every visit Annually or as needed Annually or as needed	Date Results						
Oral/Dental inspection Refer for dental care every 6 months	Every visit	Date Result						
Dilated Fundoscopic Eye Exam (ophthalmology or optometry)	Annually or as indicated by eye specialist	Date Result						
Laboratory Studies								
A1c[3]	Every 3-6 months	Date Result						
Kidney • BUN/Creatinine • eGFR • Urine MicroAlb:Cr ratio • iPTH[4]	 Annually or every 3-6 months if abnormal Annually or every 3-6 months if abnormal Initial visit, then annually As indicated (if CKD stage 3+)	Date Result						
Liver • AST (SGOT) / ALT (SGPT)	Annually or every 3-6 months if abnormal	Date Result						
Lipid Profile • Triglycerides • HDL • LDL	Annually if at goal, otherwise every 3–6 months (> age 18)	Date Result						
TSH	Annually or as needed	Date/Result						
Vitamin D (25-OH-Vit D)	As indicated	Date/Result						
Testosterone / PSA	At clinician's discretion	Date/Result						
Other		Date/Result						
Cancer Screening								
Pap-pelvic[5]	When sexually active and every 1-5 yrs to age 65	Date/Result						
Mammogram	Age 40 and every 1-3 yrs	Date/Result						
DRE	Annual age 40-50 to age 75	Date/Result						
Colonoscopy	Age 50, repeat 10-20 yrs if no risk factors	Date/Result						
Immunizations[6]								
Influenza vaccine	Annually	Date						
Pneumococcal vaccine	Age <65; Repeat ≥ 65 (at least 5 yrs apart)	Date						
Tdap	Every 10 yrs	Date						
Shingles vaccine	One time at age 60	Date						
Hepatitis A	2 doses	Date						
Hepatitis B	3 doses	Date						
Child & Adolescent								
Immunizations	Refer to CDC Guidelines	Date						
Growth & Development[7]	Every visit	Date						

[1] Diabetes education should address self-care behaviors including healthy eating, being active, monitoring, taking medication, problem solving, reducing risks and healthy coping. (From the American Association of Diabetes Educators 7 Self-Care Behaviors™ framework found at http://www.diabeteseducator.org/ProfessionalResources/AADE7/)

[2] Patient Health Questionaire-2 (PHQ2, depression screen) and Patient Health Questionaire-9 (PHQ9, depression diagnosis)

[3] **Intensify management if:** Absent/stable cardiovascular disease, mild-moderate microvascular complications, intact hypoglycemia awareness, infrequent hypoglycemic episodes, recently diagnosed diabetes. **Less intensive management if**: Evidence of advanced or poorly controlled cardiovascular and/or microvascular complications, hypoglycemia unawareness, vulnerable patient (ie, impaired cognition, dementia, fall history).

[4] Consider Nephrology or Endocrinology evaluation if CKD stage 3, proteinuria, elevated iPTH

[5] Screening for Cervical Cancer: U.S. Preventive Services Task Force Recommendation Statement. *Ann Intern Med.* 2012;156:

[6] Refer to CDC guidelines at http://www.cdc.gov/vaccines/schedules/easy-to-read/index.html for updates

[7] Use WHO charts for years 0-2 and CDC charts for 2+ years age

See disclaimer at www.tdctoolkit.org/algorithms_and_guidelines.asp

Texas Diabetes Council A1c Goals

TEXAS Department of State Health Services
TEXAS DIABETES COUNCIL
Approved 10/29/09

A1c Goals

Individualize goal based on patient risk factors

A1c < 6-7% **A1c < 7-8%**

Intensify management if:

- Absent/stable cardiovascular disease
- Mild-moderate microvascular complications
- Intact hypoglycemia awareness
- Infrequent hypoglycemic episodes
- Recently diagnosed diabetes

Less intensive management if:

- Evidence of advanced or poorly controlled cardiovascular and/or microvascular complications
- Hypoglycemia unawareness
- Vulnerable patient (ie, impaired cognition, dementia, fall history)

A1c is referenced to a non-diabetic range of 4-6% using a DCCT-based assay. ADA Clinical Practice Recommendations. *Diabetes Care* 2009;32(suppl 1):S19-20

References

1. The Action to Control Cardiovascular Risk in Diabetes Study Group. Effects of intensive glucose lowering in type 2 diabetes. N Engl J Med 2008;358:2545-2559.
2. The ADVANCE Collaborative Group. Intensive blood glucose control and vascular outcomes in patients with type 2 diabetes. N Engl J Med 2008;358:2560-2572.
3. The Diabetes Control and Complications Trial Research Group. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. N Engl J Med 1993;329:977-986.
4. The Diabetes Control and Complications Trial/Epidemiology of Diabetes Interventions and Complications (DCCT/EDIC) Study Research Group. Intensive diabetes treatment and cardiovascular disease in patients with type 1 diabetes. N Engl J Med 2005;353:2643-2653.
5. Gæde P, Vedel P, Larsen N, Jensen GVH, Parving H-H, Pedersen O. Multifactorial intervention and cardiovascular disease in patients with type 2 diabetes. N Engl J Med 2003;348:383-393.
6. Gæde P, Lund-Anderson H, Parving H-H, Pedersen O. Effect of a Multifactorial Intervention on Mortality in Type 2 Diabetes. N Engl J Med 2008;358:580-591.
7. Holman RR, Paul SK, Bethel MA, Matthews DR, Neil HAW. 10-Year follow-up of intensive glucose control in type 2 diabetes. N Engl J Med 2008;359:1577-1589.
8. Ohkubo Y, Kishikawa H, Araki E, et al. Intensive insulin therapy prevents the progression of diabetic microvascular complications in Japanese patients with non-insulin-dependent diabetes mellitus: a randomized prospective 6-year study. Diabetes Res Clin Pract 1995;28:103-117.
9. Reichard P, Bengt-Yngve N, Rosenqvist U. The effect of long-term intensified insulin treatment on the development of microvascular complications of diabetes mellitus. N Engl J Med 1993;329:304-309.
10. Shichiri M, Ohkubo Y, Kishikawa H, Wake N. Long term results of the Kumamoto Study on optimal diabetes control in type 2 diabetic patients. Diabetes Care 2000;23:Suppl 2:B21-B29.
11. UK Prospective Diabetes Study (UKPDS) Group. Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33). Lancet 1998;352:837-853.
12. UK Prospective Diabetes Study (UKPDS) Group. Effect of intensive blood-glucose control with metformin on complications in overweight patients with type 2 diabetes (UKPDS 34). Lancet 1998;352:854-865.
13. The Veterans Affairs Diabetes Trial Investigators. Glucose Control and Vascular Complications in Veterans with Type 2 Diabetes. N Engl J Med 2009;360:129-139.

See disclaimer at www.tdctoolkit.org/algorithms_and_guidelines.asp

Gestational Diabetes

Equipment, supplies, and self-management training, and preconception counseling are recommended for those with pre-existing diabetes and expectant mothers with gestational diabetes in order to prevent harm to the child from premature birth, birth defects, and increased risk for obesity and diabetes later in life. The TDC supports the following guidance published in the American Diabetes Association Standards of Medical Care in Diabetes-2012:

- Screen for undiagnosed type 2 diabetes at the first prenatal visit in those with risk factors, using standard diagnostic criteria.
- In pregnant women not previously known to have diabetes, screen for GDM at 24–28 weeks' gestation, using a 75-g 2-h OGTT and the diagnostic cut points below.
- Screen women with GDM for persistent diabetes at 6–12 weeks' postpartum, using a test other than A1C.
- Women with a history of GDM should have lifelong screening for the development of diabetes or prediabetes at least every 3 years.
- Women with a history of GDM found to have prediabetes should receive lifestyle interventions or metformin to prevent diabetes.

Screening for and diagnosis of GDM
Perform a 75-g OGTT, with plasma glucose measurement fasting and at 1 and 2 h, at 24–28 weeks' gestation in women not previously diagnosed with overt diabetes.

The OGTT should be performed in the morning after an overnight fast of at least 8 h.

The diagnosis of GDM is made when any of the following plasma glucose values are exceeded:

- Fasting $\geq$92 mg/dL (5.1 mmol/L)
- 1 h $\geq$180 mg/dL (10.0 mmol/L)
- 2 h $\geq$153 mg/dL (8.5 mmol/L)

Appendix 4 – Diabetes Facts and Figures

Defining Diabetes

Diabetes is a disease in which levels of blood glucose, also called blood sugar, are above normal. People with diabetes have problems converting food to energy. Normally, after a meal, the body breaks food down into glucose, which the blood carries to cells throughout the body. Cells use insulin, a hormone made in the pancreas, to help them convert blood glucose into energy.

People develop diabetes because the pancreas does not make enough insulin or because the cells in the muscles, liver, and fat do not use insulin properly, or both. As a result, the amount of glucose in the blood increases while the cells are starved of energy. Over the years, high blood glucose, also called hyperglycemia, damages nerves and blood vessels, which can lead to complications such as heart disease, stroke, kidney disease, blindness, nerve problems, gum infections, and amputation.

Main Types of Diabetes

The two main types of diabetes are called type 1 and type 2. A third form of diabetes is called gestational diabetes.

- Type 1 diabetes, formerly called juvenile diabetes, is usually first diagnosed in children, teenagers, and young adults. In this form of diabetes, the pancreas no longer makes insulin because the body's immune system has attacked and destroyed the pancreatic cells specialized to make insulin. These insulin-producing cells are called beta cells.
- Type 2 diabetes, formerly called adult-onset diabetes, is the most common form. People can develop type 2 diabetes at any age, even during childhood. This form of diabetes usually begins with insulin resistance, a condition in which muscle, liver, and fat cells do not use insulin properly. As a result, the body needs more insulin to help glucose enter cells to be used for energy. At first, the pancreas keeps up with the added demand by producing more insulin. In time, however, the pancreas loses its ability to secrete enough insulin in response to meals.
- Gestational diabetes is diabetes that first occurs during pregnancy. When women are pregnant, their need for insulin appears to increase, and many can develop gestational diabetes during the late stages of pregnancy. Gestational diabetes affects three to seven percent of all pregnancies in the United States.[35] Equipment, supplies, and self-management training, and preconception counseling are recommended for those with pre-existing diabetes and expectant mothers with gestational diabetes in order to prevent harm to the child from premature birth, birth defects, and increased risk for obesity and diabetes later in life.
- Other types of diabetes result from specific genetic defects, diseases of the pancreas, excessive amounts of certain hormones, medications, infections, and rare autoimmune disorders.

[35] Greene, MF, Solomon CG. Gestational Diabetes Mellitus — Time to Treat. *N Engl J Med*. 352:2544-2546. 2005.

What is Prediabetes?

In prediabetes, blood glucose levels are higher than normal, but not high enough for a diagnosis of diabetes. Without lifestyle changes to improve their health, 15 to 30 percent of people with prediabetes will develop type 2 diabetes within five years.[36] Individuals with prediabetes also have an increased risk of heart disease and stroke.

Several research studies, including the U.S. Diabetes Prevention Program (National Institutes of Health) have demonstrated that a structured lifestyle program that results in a modest weight loss of five to seven percent while encouraging healthy eating and increasing physical activity, can reduce risk for type 2 diabetes by 58 percent in those at high risk for diabetes or who have prediabetes.[37]

The National Diabetes Education Program's *2008 Survey of the Public's Knowledge Attitudes, and Practices Related to Diabetes* revealed significant gaps between perceived and actual risks of having prediabetes. Only 29 percent of the people at high risk for diabetes understood their risk for the disease, and only about two-thirds of people told they have prediabetes understood that they were at risk for diabetes. NHANES data from 2005 – 2006 show that 30 percent of U.S. adults 20 years or older had prediabetes. Only 7 percent of those determined by the medical exam portion of this survey to have prediabetes reported that they had been told that they had the condition, and only 48 percent of adults with prediabetes reported having a test for diabetes or high blood sugar in the past three years.[38]

Diagnosing Diabetes (Type 1 and Type 2)

Diagnosis of diabetes is based on plasma glucose (blood sugar) testing, through either a fasting plasma glucose (FPG) test, or an oral glucose tolerance test (OGTT). The OGTT is most commonly used to check for gestational diabetes. The American Diabetes Association affirmed the recommendation of an expert committee regarding use of the hemoglobin A1C (A1C) test to diagnose diabetes. The A1C test provides an average of blood glucose control over the previous two to three months, and is more commonly used by clinicians to evaluate how well their patients with diabetes are managing the disease. Patient A1C goals vary, but an A1C of six percent is generally associated with excellent diabetes management, whereas higher percentages are associated with increasing risk for complications.

Table 3 shows lab values used to diagnose prediabetes and diabetes using these three tests (FPG, OGTT, and A1C). Diabetes can be diagnosed with

- an FPG greater than or equal to 126 mg/dl

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[36] Division of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion. Prediabetes Facts. Accessed online at http://www.cdc.gov/diabetes/prevention/factsheet.htm, May 2014.

[37] Diabetes Prevention Program Research Group, Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin. *N Engl J Med* 346: 393-403. 2002.

[38] Testimony before the Subcommittee on Health, Committee on Energy and Commerce United States House of Representatives by Ann Albright, Ph.D., R.D, Director, Division of Diabetes Translation, Centers for Disease Control and Prevention, July 2010.

- a two-hour plasma glucose (PG) greater than or equal to 200 mg/dl (oral glucose tolerance test)
- an A1C greater than or equal to 6.5 percent*

Clinicians may repeat a test to confirm diagnosis.

Table 3. Diagnosis of Diabetes 2010[39]

NORMAL (non-diabetic)	PREDIABETES (IFG or IGT)**	DIABETES (type 1 and type 2)***
FPG < 100 mg/dL	FPG: 100-125 mg/dL	FPG ≥ 126 mg/dL
2-hour PG < 140 mg/dL	2-hour PG: 140 – 199 mg/dL	2-hour PG ≥ 200 mg/dL
A1C < 5.7 %	A1C 5.7 – 6.4 %	A1C ≥ 6.5%

Notes:
*The diagnostic test should be performed using a method certified by the National Glycohemoglobin Standardization Program (NGSP) and standardized or traceable to the Diabetes Control and Complications Trial (DCCT) reference assay.
****Impaired Fasting Glucose** (IFG) and **Impaired Glucose Tolerance** (IGT) are terms associated with prediabetes based on the type of test used to diagnose prediabetes. A person with IFG has prediabetes based on a fasting plasma glucose test, while a person with IGT has prediabetes based on an oral glucose tolerance test.
***Lab values for diagnosing gestational diabetes differ.

Adult Prediabetes Prevalence, 2012

In 2009, the Texas Behavioral Risk Factor Surveillance System (BRFSS) began collecting data on prediabetes prevalence in the state. Respondents to the annual BRFSS phone survey, which provides estimates of diabetes prevalence for the state and nation, are now asked the following question:
Have you ever been told by a doctor or other health professional that you have prediabetes or borderline diabetes?

According to the survey, about 1.2 million persons aged eighteen years and older in Texas (6.2 percent of this age group) have been diagnosed with prediabetes. These data are self-reported, requiring that respondents already be diagnosed by a physician to report that they have prediabetes.

The National Health and Nutrition Examination Survey (NHANES), combining interviews with clinical testing, reveals a much higher estimate of prediabetes prevalence in the U.S. Based on NHANES, in 2003 to 2006, 25.9 percent of U.S. adults aged 20 years or older had impaired fasting glucose (IFG)—35.4 percent of adults aged 60 years or older. Applying this percentage to the entire U.S. population in 2007 yields an estimated 57 million American adults aged 20 years or older with IFG, suggesting that at least 57 million American adults had prediabetes in 2007.

[39] American Diabetes Association. ADA Standards of Medical Care in Diabetes – 2010. *Diabetes Care*, Volume 33, Supplement 1, January 2010.

Diagnosed Prediabetes Prevalence by Sex, Texas Adults, BRFSS 2012

Male: 6.1%
Female: 6.2%

Diagnosed Prediabetes Prevalence by Race/Ethnicity, Texas Adults, BRFSS 2012

White, non-Hispanic: 6.4%
Black, non-Hispanic: 9.3%
Hispanic: 5.0%
Other: 5.2%

Diagnosed Prediabetes Prevalence by Age Group, Texas Adults, BRFSS 2012

18-29 Years: 1.3%
30-44 Years: 4.6%
45-64 Years: 9.1%
65+ Years: 9.4%

Diagnosed Prediabetes Prevalence by Educational Level in Persons 18 and Older, BRFSS 2012

No High School Diploma: 5.2%
High School Graduate: 5.6%
Some College: 7.1%
College +: 6.1%

Adult Diabetes Prevalence, 2012

According to 2012 BRFSS, an estimated 2.1 million persons aged eighteen years and older in Texas (10.6 percent of this age group) have been diagnosed with diabetes. Another estimated 440,468 persons aged eighteen years and older in Texas are believed to have undiagnosed diabetes (based on 2003-2006 NHANES age-adjusted prevalence estimate of 2.5 percent of persons twenty years of age and older).[40]

Diagnosed Diabetes Prevalence by Sex, Texas Adults, BRFSS 2012

Male: 11.0%
Female: 10.3%

Diagnosed Diabetes Prevalence by Race/Ethnicity, Texas Adults, BRFSS 2012

White, non-Hispanic: 9.4%
Black, non-Hispanic: 13.9%
Hispanic: 11.6%
Other: 8.0%

Diagnosed Diabetes Prevalence by Age Group, Texas Adults, BRFSS 2012

18-29 Years: 1.2%
30-44 Years: 5.4%

[40] Persons 20 years of age and older. Centers for Disease Control and Prevention. Prevalence of Diabetes and Impaired Fasting Glucose in Adults, Unites States, 1999-2000. MMWR. September 5, 2003; 52(35);833-837.

45-64 Years: 15.2%
65+: 24.9%

Diagnosed Diabetes Prevalence by Educational Level, Texas Adults, BRFSS 2012

No High School Diploma: 14.8%
High School Graduate: 11.0%
Some College: 9.8%
College +: 7.8%

Diabetes Prevalence Among Youth, (less than 18 years of age)

Diabetes among children and adolescents is mainly type 1. The SEARCH for Diabetes in Youth study funded by the Centers for Disease Control and Prevention and the National Institutes of Health indicated that 15,000 youth in the U.S. were newly diagnosed with type 1 diabetes annually, and about 3,200 youth were newly diagnosed with type 2 diabetes annually. The rate of new cases among youth was 19 per 100,000 each year for type 1 diabetes and 5.3 per 100,000 for type 2 diabetes.[41]

In 2007, the Texas BRFSS phone survey began including two questions regarding diabetes prevalence among youth. In households that include a child or adolescent, respondents are now asked if the child or adolescent has been diagnosed with diabetes, and if so, what type of diabetes they have (type 1 or type 2). While response to the question regarding type of diabetes has not been adequate to provide a reliable estimate of prevalence by type, the 2012 survey indicates that an estimated **21,352** Texas youth (**0.3 percent** of this age group) have been diagnosed with diabetes (type 1 and type 2).[1]

Diagnosed Diabetes Prevalence by Sex, Texas Youth, 2009, BRFSS 2012

Boy: 0.4%
Girl: 0.2%

Diagnosed Diabetes Prevalence by Race/Ethnicity, Texas Youth, 2009, BRFSS 2012

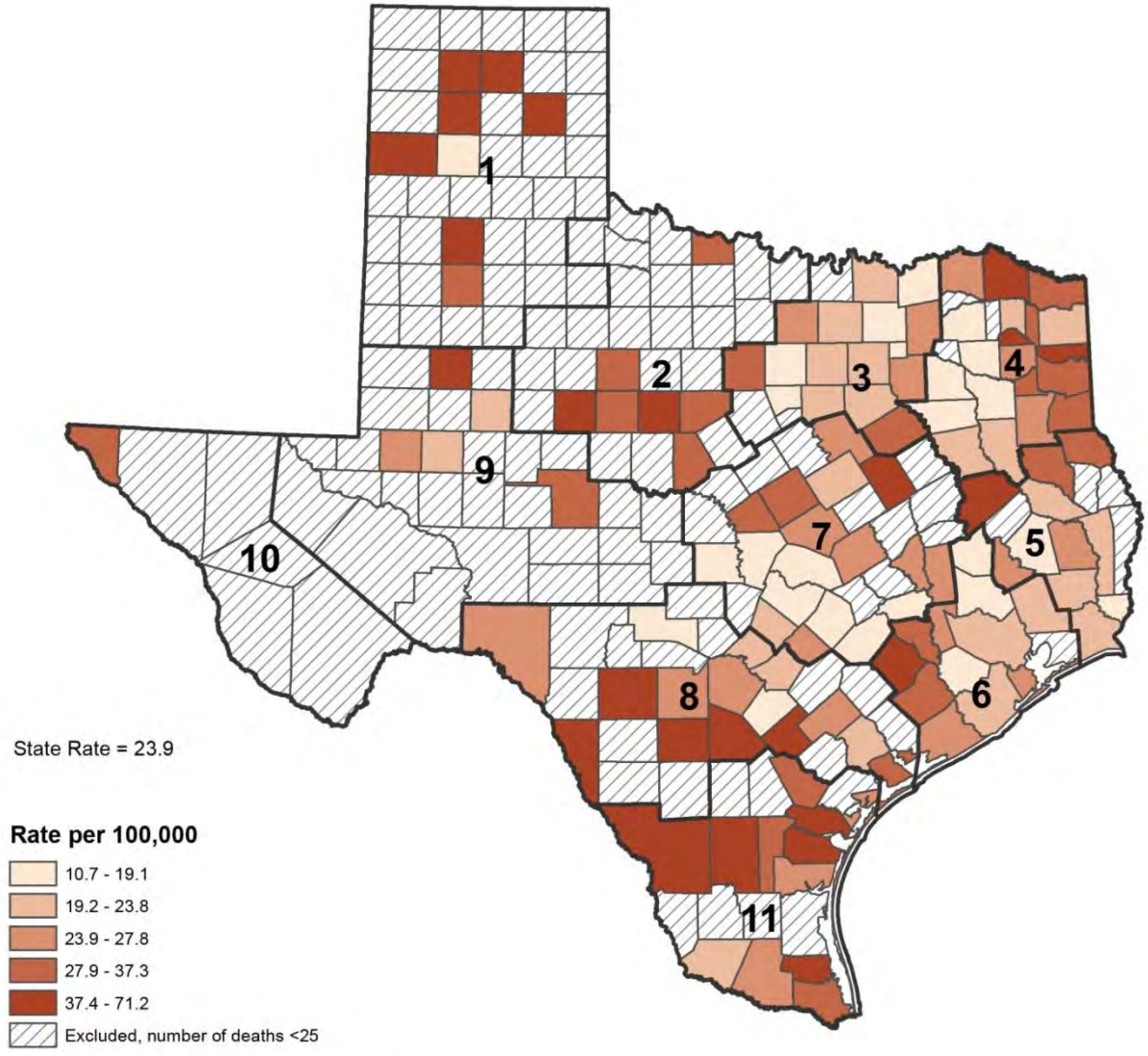
White, non-Hispanic: 0.3%
Black, non-Hispanic: No data available
Hispanic: 0.4%

[41] SEARCH Study Group. SEARCH for Diabetes in Youth: a multicenter study of the prevalence, incidence and classification of diabetes mellitus in youth. *Control Clin Trials* 25(5): 458-471, 2004.

Diabetes Mortality

Diabetes was the seventh leading cause of death in Texas in 2010.[42] In 2010, about **4,738** deaths were directly attributed to diabetes.

Diabetes Age-Adjusted Mortality Rate by County, Texas, 2007-2010.
Diabetes as underlying cause of death



Texas Department of State Health Services, Texas Vital Statistics. ICD-10 codes for E10-E14.

The map above shows the age-adjusted mortality rates per 100,000 persons for Texas by county for the years 2007 through 2010, with diabetes as the underlying cause of death. The state rate for the four years is **21.7 per 100,000.** A number of counties in Health Service Regions 8 and 11 had significantly higher diabetes mortality rates than the state rate. Many counties along the

[42] Texas Department of State Health Services, Texas Center for Health Statistics. All ages are included in mortality data.

eastern part of our state had higher diabetes mortality rates than the state, but these rates were not significantly different than the rate for the state as a whole. Since 2008, the age-adjusted mortality rate for diabetes in Texas declined significantly from **25.5 per 100,000** to **21.7 per 100,000** population in 2010.

Diabetes Mortality Rate (Per 100,000) by Race/Ethnicity, Texas, 2010[43]

The 2010 diabetes mortality rate for Texas was 21.7 deaths per 100,000 persons. Mortality rates by race/ethnicity in 2010 were:

- 16.5 per 100,000 non-Hispanic whites
- 34.4 per 100,000 Hispanics
- 36.8 per 100,000 non-Hispanic blacks
- 14.4 per 100,000 persons who fall in the "Other" category

The 2010 mortality rates (per 100,000) for non-Hispanic blacks and Hispanics were more than double that of non-Hispanic whites.

Treatment of Diabetes

Diabetes can lead to serious complications, such as blindness, kidney damage, cardiovascular disease, and lower-limb amputations, but people with diabetes can lower the occurrence of these and other complications by controlling blood glucose, blood pressure, and blood lipids. Many people with type 2 diabetes can control their blood glucose by following a healthy meal plan and exercise program, losing excess weight, and taking oral medication. Some people with type 2 diabetes may also need insulin to control their blood glucose. To survive, people with type 1 diabetes must have insulin delivered by injection or a pump. Among adults with diagnosed diabetes (type 1 or type 2), 14 percent take insulin only, 13 percent take both insulin and oral medication, 57 percent take oral medication only, and 16 percent do not take either insulin or oral medication.[44] Medications for each individual with diabetes will often change during the course of the disease. Many people with diabetes also need to take medications to control their cholesterol and blood pressure. Self-management education or training is a key step in improving health outcomes and quality of life. It focuses on self-care behaviors, such as healthy eating, being active, and monitoring blood sugar. It is a collaborative process in which diabetes educators help people with or at risk for diabetes gain the knowledge and problem-solving and coping skills needed to successfully self-manage the disease and its related conditions.

Treatment of type 1 diabetes. Lack of insulin production by the pancreas makes type 1 diabetes particularly difficult to control. Treatment requires a strict regimen that typically includes a carefully calculated meal plan, planned physical activity, self-blood-glucose testing several times a day, and multiple daily insulin injections.

Treatment of type 2 diabetes. Treatment typically includes a balanced meal plan, daily physical activity, self-blood-glucose monitoring, and in many cases, oral medication and/or insulin.

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[43] Ibid.

[44] Centers for Disease Control and Prevention. National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2007. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007.

Complications of Diabetes

Heart disease and stroke. Heart disease is the leading cause of death among persons with diabetes in the United States. Heart disease and stroke account for about 65 percent of deaths in people with diabetes.[45]

- In 2004, heart disease was noted on 68 percent of diabetes-related death certificates among people aged 65 years or older.
- In 2004, stroke was noted on 16 percent of diabetes-related death certificates among people aged 65 years or older.
- Adults with diabetes have heart disease death rates about 2 to 4 times higher than adults without diabetes.
- The risk for stroke is two to four times higher among people with diabetes.

High blood pressure. In 2005–2008, of adults aged 20 years or older with self-reported diabetes, 67 percent had blood pressure greater than or equal to 140/90 millimeters of mercury (mmHg) or used prescription medications for hypertension.[46]

Blindness. Diabetes is the leading cause of new cases of blindness in adults 20 to 74 years old. Diabetic retinopathy causes from 12,000 to 24,000 new cases of blindness each year.[47]

Kidney disease. Diabetes is the leading cause of kidney failure, accounting for 44 percent of new cases in 2008. In 2008, 48,374 people with diabetes began treatment for end-stage kidney disease in the United States. In 2008, a total of 202,290 people with end-stage kidney disease due to diabetes were living on chronic dialysis or with a kidney transplant in the United States.[48]

Nervous system disease. About 60 to 70 percent of people with diabetes have mild to severe forms of nervous system damage. The results of such damage include impaired sensation or pain in the feet or hands, slowed digestion of food in the stomach, carpal tunnel syndrome, and other nerve problems. Almost 30 percent of people with diabetes aged 40 years or older have impaired sensation in the feet (i.e., at least one area that lacks feeling). Severe forms of diabetic nerve disease are a major contributing cause of lower-extremity amputations.[49]

Amputations. In the United States, more than 60 percent of nontraumatic lower-limb amputations occur in people with diabetes. In 2010, about 73,000 nontraumatic lower-limb amputations were performed in adults 20 years or older with diagnosed diabetes.[50] The Texas

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[45] Centers for Disease Control and Prevention: National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.

[46] Ibid.

[47] Centers for Disease Control and Prevention: National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2007.

[48] Centers for Disease Control and Prevention: National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2011.

[49] Ibid.

[50] Centers for Disease Control and Prevention: National Diabetes Statistics Report, 2014

Health Care Information Collection reports that, in 2011, 3,608 hospitalizations for amputations occurred in persons with diabetes in Texas.[51]

Dental disease. Periodontal (gum) disease is more common in people with diabetes. Among young adults, those with diabetes have about twice the risk of those without diabetes. Persons with poorly controlled diabetes (A1c > 9 percent) were nearly three times more likely to have severe periodontitis than those without diabetes. Almost one-third of people with diabetes have severe periodontal disease with loss of attachment of the gums to the teeth measuring five millimeters or more.[52]

Other complications. Uncontrolled diabetes leads to biochemical imbalances that can cause acute life-threatening events, such as diabetic ketoacidosis and hyperosmolar (nonketotic) coma. People with diabetes are more susceptible to many other illnesses and, once they acquire these illnesses, often have worse prognoses. For example, they are more likely to die with pneumonia or influenza than people who do not have diabetes.[53]

Diabetes Costs

Diabetes contributes to a number of chronic complications and is associated with an increased utilization of health-care services. With an increasing prevalence of diabetes and an aging population, the burden of diabetes in the nation and Texas continues to grow. According to the American Diabetes Association and the Centers for Disease Control and Prevention, the direct and indirect costs of diabetes in the United States reached more than $245 billion in the United States in 2012. This estimate includes $176 billion in excess medical expenditures attributed to diabetes, as well as $69 billion in reduced national productivity. People with diagnosed diabetes, on average, have medical expenditures that are approximately 2.3 times higher than the expenditures would be in the absence of diabetes. Approximately one in five health-care dollars is attributed to diabetes.[54]

In 2012, diabetes cost an estimated $18.5 billion in Texas, including $12.3 billion in direct medical costs and $6.2 billion in indirect costs.[55]

[51] Source: Texas Health Care Information Collection. Texas Hospital Inpatient Discharge Public Use Data File, 2011.

[52] Centers for Disease Control and Prevention: National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2011.

[53] Ibid.

[54] American Diabetes Association. Economic Costs of Diabetes in the U.S. in 2012. *Diabetes Care*. 2013 Apr;36(4):1033-46. Epub 2013 Mar 6.

[55] Texas Health and Human Services Commission. Report on Direct and Indirect Costs of Diabetes in Texas As Required By S.B. 796 82nd Legislature, Regular Session, 2011. December 2012. http://www.hhsc.state.tx.us/reports/2012/direct-indirect-costs-diabetes-texas.pdf

Appendix 5 − Links to Additional Reports

In addition to this assessment of existing state programs for the prevention and treatment of diabetes, the following state agency reports also describe the burden of diabetes in Texas and state initiatives to improve diabetes treatment.

- Diabetes Self-Management Education Pilot Report
  http://www.hhsc.state.tx.us/reports/2012/diabetes-self-management-training-pilot.pdf

- Direct and Indirect Costs of Diabetes Report
  http://www.hhsc.state.tx.us/reports/2012/direct-indirect-costs-diabetes-texas.pdf

- Texas Medicaid Diabetes Prevention and Treatment Report (Medicaid Priorities for Diabetes)
  http://www.hhsc.state.tx.us/reports/2013/SB796-Diabetes-Priorities-Report.pdf

- The Burden of Diabetes in Texas (Updated April 2013)
  http://www.dshs.state.tx.us/diabetes/PDF/data/DiabetesBurdenReport2013.pdf

- Report on Telemonitoring in the Texas Medicaid Program
  http://www.hhsc.state.tx.us/reports/2013/Rider-55-Report-HB1.pdf

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Texas Radiation Advisory Board (TRAB)

Number of Members: 18

Committee Status (Ongoing or Inactive): Ongoing — Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 4/17/1961 **Date to Be Abolished:** N/A

Budget Strategy (Strategies) (e.g. 1-2-4): 4.1.3 **Strategy Title (e.g. Occupational Licensing):** Radiation Control

Budget Strategy (Strategies): **Strategy Title:**

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Health and Safety Code, Sec. 401.015
State Authority	Admin Code	25 TAC 289.130
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$9,045	$9,000	$9,000
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$9,045	$9,000	$9,000

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$13,957	$14,000	$14,000
Number of FTEs	0.19	0.19	0.19
Other Operating Costs	$180	$0	$0
Total, Committee Expenditures	$14,137	$14,000	$14,000

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	$23,182	$23,000	$23,000
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year

Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
4	4	4

Committee Description:

The Texas Radiation Advisory Board (TRAB) provides technical guidance and advice on radiation programs to DSHS, the Texas Commission on Environmental Quality, the Texas Railroad Commission, and other state entities such as the Texas Medical Board. All expenses for TRAB are paid through the DSHS; no funds are appropriated or provided by other agencies. The TRAB aids DSHS by providing valuable experience and technical expertise to assist in rule making and in formulating regulatory and consumer policies such as statements on food irradiation, emergency precautions for radiation accidents, and other medical issues. DSHS particularly needs the TRAB's expertise in the areas of radiology, nuclear medicine, and use of all evolving diagnostic and therapeutic uses of radiation.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

The committee meets in Austin, Texas. The statute and rules require the committee to meet quarterly and also contain provisions for special called meetings.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

The statute requires TRAB to (1) review and evaluate state radiation policies and programs (2) make recommendations and furnish technical advice to DSHS, HHSC, the Railroad Commission, and other state agencies on matters relating to development, use, and regulation of sources of radiation (3) review proposed rules and guidelines of any state agency relating to regulation of radiation sources and recommend changes in proposed or existing rules and guidelines. A state agency is required to consider TRAB recommendations and advice and provide TRAB with a written response. There are no reuquired documents.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

Recommendations and advice regarding Texas Regulations for Control of Radiation, which were adopted.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ? Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees? No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015? 396.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Working with chair to set agenda, preparing an filing agenda with Office of General Counsel, posting agendas to website, attending meetings, preparing minutes, preparing meeting packets for members, transmitting meeting packets to members, meeting follow-up, such as correspondence and fulfilling information requests. Tracking and monitoring of recommendations made by TRAB.

6. Have there been instances where the committee was unable to meet because a quorum was not present? No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

Meetings are posted in the Texas Register and include a public comment agenda item.

7b. Do members of the public attend at least 50 percent of all committee meetings? Yes

7c. Are there instances where no members of the public attended meetings? No

8. Please list any external stakeholders you recommend we contact regarding this committee.

Texas Railroad Commission, Texas Commission on Environmental Quality

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals? Yes

9b. Please describe the rationale for this opinion.

TRAB is an integral part of the regulation of radiation sources in this state.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute? Yes

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area? No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)? Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission? Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

TRAB provides expertise that is necessary to effectively regulate sources of radiation in the state.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

TEXAS RADIATION ADVISORY BOARD (TRAB)
MEETING MINUTES

Austin-Health and Human Services Commission, MHMR Center
Conference Room 164, 909 W. 45th Street, Austin, Texas 78751
Friday, September 18, 2015 at 10:30 AM

1. **Call to order**
John Hageman, M.S. C.H.P., Chair, called the meeting to order at 10:30 a.m. A quorum was present.

Members present at the meeting: Nora Janjan, M.D., M.B.A., M.P.S.A., Vice-Chair; Darlene Metter, M.D.; Ian Scott Hamilton, Ph.D.; Darshan Sachde; Bill Campbell; Kenneth Krieger, C.H.P.; Mitch Lucas, P.E.; Kevin Raabe; Judy Raab; and Mark Silberman, M.D.

Members not present: Robert Emery, DrPH; Amy Clark; Stephen Harris; John Johnson, D.V.M.; and Melanie Marshall, D.D.S.

Department of State Health Services (DSHS) staff present: Richard Ratliff, P.E.; Lisa Bruedigan; Jerry Cogburn; Ruben Cortez; Ray Fleming; Chuck Flynn; Robert Free; Joann Harthcock, Alyson Henry; Wendy Kaliszewski; Stacey McLarty, Shannon Quinn; Eric Skotak; Liz Speights; Jo Turkette; Karl Von Ahn; Helen Watkins and Peggy Westlund

2. **Introduction of guests**
Texas Commission on Environmental Quality (TCEQ): Charles Maguire, Bobby Janecka, and Dana Fine
Advocates for Responsible Disposal in Texas: Eddie Selig
Waste Control Specialist: Betsy Madru
Texas Low Level Radioactive Waste Disposal Compact Commission (TLLRWDCC): Leigh Ing
Railroad Commission of Texas (RRC): Grant Chambless

3. **Adoption of the minutes of the October 29, 2015 meeting**
Dr. Hamilton made a motion to approve the minutes. Mr. Krieger seconded the motion and the minutes were unanimously approved.

4. **Committee Reports and Recommendations**
   A. **Industrial, Nuclear Power, Uranium and Waste Committee**
      Mr. Krieger discussed the committee meeting.
   B. **Medical Committee**
      Dr. Metter discussed the committee meeting.
   C. **Topic Research Committee**
      Dr. Hamilton discussed the committee meeting.

5. **Program Reports**
   A. **Railroad Commission of Texas (RRC)**
      Mr. Chambless discussed the report
   B. **Texas Commission on Environmental Quality (TCEQ)**
      Mr. Maguire discussed the report.
   C. **Texas Department of State Health Services (DSHS)**
      Mr. Ratliff discussed the report.
   D. **Texas Low-Level Radioactive Waste Disposal Compact Commission (TLLRWDCC)**
      Ms. Ing had no update at this time.
   E. **U.S. Nuclear Regulatory Commission**
      Ms. Walker was not present at the meeting.

6. **Routine and Continuing Business**:
   A. **Resolution for Dr. Nichols for his service on the Board**
      Mr. Hageman read the resolution for Dr. Nichol's service to TRAB.
   B. **Update on activities of Radiological Response Volunteer Corps., sponsored by the Conference of Radiation Control Program Directors**
      https://www.crcpd.org/RRVC/rrvc/rfp/aspx
      El Paso, Texas received a grant from CRCPD to create a volunteer corps. Approximately 30 people are being trained to use monitoring equipment. Future updates will be included in the DSHS program report.

8. **New Business**
   A. **National Electron Beam Research Center at Texas A&M**
      Dr. Suresh Pillai presented a slideshow demonstrating the electron beam research at Texas A&M. The National Center for Electron Beam Research (NCEBR) is the leading academic and research organization in the world that is focused on the research, development, and commercialization of Electron Beam and X-ray technologies.

9. **Public Comments**
   None

10. **Identification of Agenda Items and/or topics for next or future TRAB or TRAB Committee Meetings**
    None

11. **Adjourn**
    Mr. Hageman adjourned the meeting at 12:00 p.m.

TEXAS RADIATION ADVISORY BOARD (TRAB)
MEETING MINUTES

Department of State Health Services
Conference Room N220, 8407 Wall St., Austin, Texas 78754
Friday, October 29, 2015 at 1:30 PM

1. **Call to order**
   John Hageman, M.S. C.H.P., Chair, called the meeting to order at 1:48 p.m. A quorum was present.

2. **Introduction of members and guests**
   Members present at the meeting: Nora Janjan, M.D., M.B.A., M.P.S.A., Vice-Chair; Darlene Metter, M.D.; Ian Scott Hamilton, Ph.D.; Bill Campbell; Robert Emery, DrPH; Kevin Raabe; Kenneth Krieger, C.H.P.; Amy Clark; Stephen Harris; John Johnson, D.V.M.; Mitch Lucas, P.E.; Mark Silberman, M.D.; and Judy Raab.

   Members not present: David Nichols, M.D.; and Melanie Marshall, D.D.S.; and Darshan Sachde.

   Department of State Health Services (DSHS) staff present: Richard Ratliff, P.E.; Lisa Bruedigan; Jerry Cogburn; Chuck Flynn, Liz Speights, Ray Fleming, Jo Turkette, Ruben Cortez, Peggy Westlund, Stacey McLarty, and Joann Harthcock.

3. **Adoption of the minutes of the September 18, 2015 meeting**
   Dr. Hamilton made a motion to approve the TRAB minutes with an amendment. Dr. Metter seconded the motion and the minutes were unanimously approved.

   Dr. Hamilton made a motion to approve the Medical Committee minutes. Dr. Metter seconded the motion and the minutes were unanimously approved.

   Mr. Krieger made a motion to approve the Industrial, Nuclear Power, Uranium and Waste Committee minutes. Dr. Hamilton seconded the motion and the minutes were unanimously approved.

Dr. Hamilton made a motion to approve the Topic Research Committee minutes with an amendment. Dr. Emery seconded the motion and the minutes were unanimously approved.

4. **Routine and Continuing Business**
   A. Review and, as needed, discuss and take possible action concerning a TRAB letter to be sent to Governor Abbott to re-implement the required fluoroscopy safety training required in 25 Tex. Administrative Code Sec.289.227(m)(9)€.
   Dr. Hamilton read the letter with one amended paragraph. The letter will be sent to the Department of State Health Services Commissioner, Kirk Cole. Mr. Campbell made a motion to approve the letter and forward to Commissioner Cole. Mr. Krieger seconded the motion and the letter was unanimously approved.

5. **Public Comments**
   None

6. **Adjourn**
   Mr. Hageman adjourned the meeting at 2:09 a.m.

TEXAS RADIATION ADVISORY BOARD (TRAB)
MEETING MINUTES

Austin-Health and Human Services Commission, MHMR Center
Conference Room 164, 909 W. 45th Street, Austin, Texas 78751
Friday, December 4, 2015 at 10:30 AM

1. **Call to order**
John Hageman, M.S. C.H.P., Chair, called the meeting to order at 10:30 a.m. A quorum was present.

Members present at the meeting: Nora Janjan, M.D., M.B.A., M.P.S.A., Vice-Chair; Darlene Metter, M.D.; Ian Scott Hamilton, Ph.D.; Darshan Sachde; Bill Campbell; Kenneth Krieger, C.H.P.; Mitch Lucas, P.E.; Kevin Raabe; Judy Raab; and Mark Silberman, M.D.

Members not present: Robert Emery, DrPH; Amy Clark; Stephen Harris; John Johnson, D.V.M.; and Melanie Marshall, D.D.S.

Department of State Health Services (DSHS) staff present: Richard Ratliff, P.E.; Lisa Bruedigan; Jerry Cogburn; Ruben Cortez; Ray Fleming; Chuck Flynn; Robert Free; Joann Harthcock, Alyson Henry; Wendy Kaliszewski; Stacey McLarty, Shannon Quinn; Eric Skotak; Liz Speights; Jo Turkette; Karl Von Ahn; Helen Watkins and Peggy Westlund

2. **Introduction of guests**
Texas Commission on Environmental Quality (TCEQ): Charles Maguire, Bobby Janecka, and Dana Fine
Advocates for Responsible Disposal in Texas: Eddie Selig
Waste Control Specialist: Betsy Madru
Texas Low Level Radioactive Waste Disposal Compact Commission (TLLRWDCC): Leigh Ing
Railroad Commission of Texas (RRC): Grant Chambless

3. **Adoption of the minutes of the October 29, 2015 meeting**
Dr. Hamilton made a motion to approve the minutes. Mr. Krieger seconded the motion and the minutes were unanimously approved.

4. **Committee Reports and Recommendations**
   A. **Industrial, Nuclear Power, Uranium and Waste Committee**
      Mr. Krieger discussed the committee meeting.
   B. **Medical Committee**
      Dr. Metter discussed the committee meeting.
   C. **Topic Research Committee**
      Dr. Hamilton discussed the committee meeting.

5. **Program Reports**
   A. **Railroad Commission of Texas (RRC)**
      Mr. Chambless discussed the report
   B. **Texas Commission on Environmental Quality (TCEQ)**
      Mr. Maguire discussed the report.
   C. **Texas Department of State Health Services (DSHS)**
      Mr. Ratliff discussed the report.
   D. **Texas Low-Level Radioactive Waste Disposal Compact Commission (TLLRWDCC)**
      Ms. Ing had no update at this time.
   E. **U.S. Nuclear Regulatory Commission**
      Ms. Walker was not present at the meeting.

6. **Routine and Continuing Business**:
   A. **Resolution for Dr. Nichols for his service on the Board**
      Mr. Hageman read the resolution for Dr. Nichol's service to TRAB.
   B. **Update on activities of Radiological Response Volunteer Corps., sponsored by the Conference of Radiation Control Program Directors**
      https://www.crcpd.org/RRVC/rrvc/rfp/aspx
      El Paso, Texas received a grant from CRCPD to create a volunteer corps. Approximately 30 people are being trained to use monitoring equipment. Future updates will be included in the DSHS program report.

8. **New Business**
   A. **National Electron Beam Research Center at Texas A&M**
      Dr. Suresh Pillai presented a slideshow demonstrating the electron beam research at Texas A&M. The National Center for Electron Beam Research (NCEBR) is the leading academic and research organization in the world that is focused on the research, development, and commercialization of Electron Beam and X-ray technologies.

9. **Public Comments**
   None

10. **Identification of Agenda Items and/or topics for next or future TRAB or TRAB Committee Meetings**
    None

11. **Adjourn**
    Mr. Hageman adjourned the meeting at 12:00 p.m.

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Texas School Health Advisory Committee (TSHAC)

Number of Members: 21

Committee Status (Ongoing or Inactive): Ongoing — Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 6/13/2005 **Date to Be Abolished:** N/A

Budget Strategy (Strategies) (e.g. 1-2-4): B.1.2. **Strategy Title (e.g. Occupational Licensing):** Women and Children's Health Services

Budget Strategy (Strategies): **Strategy Title:**

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Health and Safety Code, Sec. 1001.0711
State Authority	Admin Code	25 TAC, Sec. 37.350
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$3,370	$4,000	$4,000
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$3,370	$4,000	$4,000

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$20,053	$20,053	$20,053
Number of FTEs	0.4	0.4	0.4
Other Operating Costs	$600	$600	$600
Total, Committee Expenditures	$20,653	$20,653	$20,653

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
555 - Federal Funds	$24,023	$24,653	$24,653
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year

Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
5	5	5

Committee Description:

The purpose of the Texas School Health Advisory Committee (TSHAC) is to provide assistance to the agency in providing a leadership role in the support for and delivery of coordinated school health programs and services. The committee assists school districts in integrating health-promoting practices in the school setting, The TSHAC priorities reinforce the importance of coordinating chronic disease prevention and health promotion initiatives, beginning with the school-age population. The TSHAC helps support public health priorities by recommending, developing, and implementing initiatives based on school health legislation. The Legislature relies on the expertise of the TSHAC by charging it with specific duties (e.g., the Legislature required TSHAC to assist TEA in the development of rules that address physical activity requirements and CSH program recommendations.) Reason to retain: The TSHAC serves as a central coordinating resource in assisting state agencies, organizations, and local SHACs with the creation or revision of school health documents and tools impacting the health of students and staff at the school site. The TSHAC provides specific resources for local districts to facilitate and guide their work and to evaluate and report their progress to local school boards and the school community.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

The committee typically meets from 10:00 a.m. to 3:00 p.m. at the Texas Department of State Health Services, 1100 West 49th Street, Austin, Texas 78756. There is not a required frequency of meetings, but the committee typically meets 5 times per year.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

The committee shall file an annual written report to DSHS State Health Services Council and provide recommendations for the improvement of coordinated school health.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

The committee provided an annual report for 2015 to the DSHS State Health Services Council including recommendations. A decision to adopt or not adopt recommendations is not required.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ? Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees? No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015? 728.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Staff administer the appointment process for the School Health Advisory Committee (SHAC), which includes development of the application and criteria, soliciting reviewers, conducting the review of applications, and development of appointment correspondence. Staff develops agendas and schedules meetings, conduct or schedule needed presentations, and develop and maintain meeting minutes. Staff are responsible for conducting research and developing topics for SHAC consideration,

6. Have there been instances where the committee was unable to meet because a quorum was not present? No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

The committee is not a "governmental body" as defined in the Open Meetings Act, Government Code, Chapter 551. However, in order to promote public participation, each meeting of the committee shall be announced and conducted in accordance with the Open Meetings Act, Government Code, Chapter 551, with the exception that the provisions allowing executive sessions shall not apply. The agenda for each committee meeting shall include an item entitled public comment under which any person will be allowed to address the committee on matters relating to committee business. The presiding officer may establish procedures for public comment, including a time limit on each comment.

7b. Do members of the public attend at least 50 percent of all committee meetings? Yes

7c. Are there instances where no members of the public attended meetings? Yes

8. Please list any external stakeholders you recommend we contact regarding this committee.

Local school districts, Texans Care, Texas Education Agency, Texas Department of Agriculture, Texas Action for Healthy Kids, University of Texas Prevention Resource Center, Texas Pediatric Society

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals? Yes

9b. Please describe the rationale for this opinion.

The Texas School Health Advisory Committee is instrumental in identifying the needs of Texas school districts related to coordinated school health, and assembles the research and guidance needed to address those needs.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute? Yes

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area? No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)? Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission? Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

The committee provides necessary feedback from schools, parents, and state organizations impacting school health to determine the agency's role in addressign school health.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

Minutes

TEXAS SCHOOL HEALTH ADVISORY COMMITTEE

Regular Meeting

Tower Building, Room #T607
1100 W. 49th Street
January 11, 2016
10:00 a.m. to 3:00 p.m.

Members Present:		
Cynthia Cardenas Bob Conlon Jacklyn Cantu Barney Fudge Wrennah Gabbert	Jan Hungate Carmela James Debra Burnett Tamalyn Neuendorff Kelly Reed-Hirsch	Dora Rivas Reenie Smith Linda Seewald Anita Wheeler-Hill
Members Absent:		
Bill Coon Susan Donnenfield Gilbert Handal	Steve Kelder Joan Guerin Lavis	Becky Rendon Josette Saxton
Guests and Staff:		
Ellen Smith – TSHAC Staff Contact Laurie Anderson – DSHS Kelly Hickman – DSHS	Jennifer Haussler Garing – DSHS Emily Babcock – Texas Medical Assn.	

Agenda Item I. Welcome and Opening Remarks, Approval of Agenda and Minutes

A. The meeting was called to order at 10:00 a.m. by the Presiding Officer, Jan Hungate, Ed.D.

B. Dr. Hungate welcomed those attending the meeting and asked the guests to introduce themselves. The following guests were in attendance: Emily Babcock, Texas Medical Association and Jennifer Haussler Garing, DSHS, YRBS program

C. The agenda was reviewed. **ACTION:** Moved by Kelly Reed-Hirsch, seconded by Tamalyn Neuendorff, and approved by the members to accept the agenda as presented.

D. Minutes from the November 9, 2015, Texas School Health Advisory Committee (TSHAC) meeting were presented for approval. **ACTION:** Hearing no objections, it was moved by Bob Conlon, seconded by Anita Wheeler-Hill, and approved by the members to accept the November 9th, TSHAC meeting minutes as written.

Agenda Item II. Research and Recommendation on Promoting Positive School Climates to Improve Student Outcomes – Josette Saxton

Due to the absence of Ms. Saxton, this agenda item was tabled by consensus until the March 7, 2016 meeting.

Agenda Item III. Research and Recommendation on Physical Activity: Impact on Academic Achievement – Kelly Reed-Hirsch

Mrs. Reed-Hirsch presented the document which reflected the changes suggested by the members at the November 9th meeting. A question arose as to why the TAKS was referenced in #2.d. when that assessment is no longer used. It was determined that since the study was conducted using the TAKS, it was appropriate to leave the reference as is. It was also suggested that TEC§28.002 and 28.004 be linked and added to the footnotes **ACTION:** With no additional comments, it was moved by Reenie Smith, seconded by Tamalyn Neuendorff, and approved by the members to accept the document as presented.

Agenda Item IV. Research and Recommendation on Health Issues and Parent Involvement and Engagement– Dora Rivas, R.D.

Mrs. Rivas presented the document reflecting the suggestion of the members from the November 9th meeting. It was suggested that on section IV. Recommendations, the list under number 1 should be bulleted rather than numbered and that the #1 be dropped since there wasn't a #2. The information would then become be a single statement. It was also recommended to add examples of best practices to the document and add a third reference at the end of the document referring to the statute on parental involvement related to campus planning and site-based decision making. And finally, it was noted that School Health Advisory Committee in the first paragraph should be changed to School Health Advisory Council. This document will be brought forward for approval at the March 7th TSHAC meeting.

Agenda Item V. Agency Updates

A. Texas Education Agency – Barney Fudge

1. Work on Fitnessgram® is progressing and it is hoped to have information about next steps soon.
2. The 2014-15 School Health Survey has yet to be released as a result of technical difficulties.

B. Texas Department of Agriculture – Jaclyn Cantu

1. TDA will be collaborating with VISTA volunteers on school and community wellness improvements. They will be training and working with 20 VISTA team leaders for one year to address the most pressing needs and priorities within the target communities. The volunteers will:
   - Live and actively participate in the communities
   - Help support community needs by creating a healthier environment and expanding economic growth.
   - Assist school districts increase revenue
   - Find collaborative and cooperative, social and economic solutions for alleviating long-term hunger among the most vulnerable in the community.

   The volunteers will be working with the school's wellness policies.

   It was suggested by the members that a document be developed to evaluate the effectiveness of the wellness policies. Mrs. Wheeler-Hill will locate the WellSAT-i: Wellness School Assessment Tool for Implementation which measures policy implementation that it may serve as a foundation for the evaluation document. It was suggested that the TSHAC develop a Recommendation for Monitoring Wellness Policies.
2. TDA is collaborating with Texas Action for Healthy Kids (TAHK) to help train School Food Authorities on Wellness Policies. TAHK will conduct a train-the-trainer to the Education Service Center Child Nutrition Specialists in September.

C. Texas Department of State Health Services – Anita Wheeler-Hill, MSN, R.N.

1. The School Health Program has been conducting Nursing Jurisprudence trainings. The Board of Nursing requires R.N.s to take this course every 3rd cycle of their license renewal. Four trainings are scheduled: January 23 in Region 13, Feb. 9 and 11 in Lubbock and Amarillo, and Feb. 24 in Austin.
2. The Program is currently looking for an intern to support school health services.
3. A collaboration is ongoing with Texas Association for Health, Physical Education, Recreation and Dance (TAHPERD) on 1305 grant activities. Superintendents and other administrators were targeted for a TAHPERD presentation on physical activity and recess. Additionally, four webinars on physical activity and recess featuring Debbie Rhea are being conducted.
4. Year four of the 1305 grant is in progress. Wellness policies and how to engage parents will be part of the focus. A collaboration with ESC 2 focusing on parent involvement is being conducted.
5. DSHS is sponsoring keynote speaker; Margaret Wooten, for the Texas Action for Healthy Kids Summit.

Agenda Item VI. Research and Recommendation on School Bus and Automobile Idling – Revision – Anita Wheeler-Hill, MSN, R.N.

Mrs. Wheeler-Hill presented the document for member review. She stated that she repaired broken links but will still need to add additional current research and information. The following suggestions were offered:

- Funding sources for retrofitting buses
- Texas Clean School Bus.org
- EPA's clean school bus website
- 2010-2015 research articles
- Separate policy and research articles in the document
- Shorten Health Effects of Diesel Exhaust by bulleting items and omitting definitions
- Identify states that have school bus emissions legislation and link to them
- State there currently is no school bus emissions legislation in Texas

The changes and additions will be made and presented to the members at the March meeting for a second review.

Agenda Item VII. Research and Recommendation on Benefits to Students in School Districts that Prohibit Physical Education as Punishment – Revision – Carmela James, Ed.D.

Dr. James presented the document for first review. Several broken links were repaired or updated; however, newer and additional research still needs to be explored and added. The following additional information was suggested by members:

- Change AAHPERD to SHAPE
- Reference TEC Section 28.004 l and l-1 regarding the SHAC's role in making policy recommendations about daily recess and the importance of fitness planning. SHACs can recommend a policy about Prohibiting Physical Activity as Punishment relative to their role as stated in the code.
- Add alternatives as referenced in the italicized paragraph at the bottom of page 2

These changes and additional will be made and the document will be brought forward to the committee for a second review at the March meeting.

Agenda Item VIII. Resources for Students and Families Dealing with Economic Crisis – Revision – Wrennah Gabbert, R.N., Ph.D.

Dr. Gabbert presented the document to the committee for a second review. She informed the members that all of the broken links and old references were deleted or corrected noting AgriLife is the primary resource on this topic. Additionally, the research on this topic now focuses more on violence and trauma. No other changes were offered.
ACTION: With no additional comments, it was moved by Reenie Smith, seconded by Carmella James and approved by the members to accept the document as is.

Agenda Item IX. Youth Risk Behavior Survey – Jennifer Haussler Garing

Mrs. Haussler Garing shared information about the 2013 Youth Risk Behavior Survey. The YRBS is a biennial anonymous survey of self-reported information by public high school students funded by a state/federal partnership. The following behaviors are assessed:

- Leading causes of morbidity and mortality in adolescents
- Behaviors contributing to unintentional injuries and violence
- Sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection
- Alcohol and other drug use
- Tobacco use
- Unhealthy dietary behaviors
- Inadequate physical activity
- Prevalence of obesity and asthma

For 2015 the YRBS contained the following additional questions:

- More oral health questions
- Housing security questions
- Minority sexual orientation
- Synthetic marijuana
- E-cigarettes and vaping

The result of the 2015 survey will be available when the data is published.

An analysis of the data was shared. A further analysis was offered on the effects of Youth Assets on Risk Behaviors. It was concluded that connectedness matters – connection to the family, to school and the community. It was suggested by the membership to have a speaker from the Georgetown Project report on their activities and results over time relative to their work using Search Institute developmental assets.

Agenda Item X. Fitnessgram® - Barney Fudge

Mr. Fudge called the member's attention to the Texas Youth Fitness Project Executive Summary. He noted that data has been compiled from all over Texas but patterns have not been examined since the original results were summarized in 2007-08. The report summarizes result of analysis over the last four academic school years from 2011 to 2014. Direct comparisons with past data is not appropriate since the Fitnessgram® standards for aerobic capacity and body composition were updated in 2010 and 2013. However, the total number of schools submitting data were tracked along with the total number of student records. Key findings from the analysis of these data are provided in the report in three key areas: 1. patterns of fitness achievement; 2. changes in fitness achievement over time; and 3. associations between fitness achievement and academic achievement. Mr. Fudge highlighted the areas that were low. He also reviewed the Levels of Health Related Physical Fitness in Texas School Children and highlighted the areas that were low in this information as well.

Agenda Item XI. Brainstorming for New Objectives – Anita Wheeler- Hill, MSN, R.N.

Mrs. Wheeler-Hill informed the members that by statute, we are required to analyze Fitnessgram® data annually and make recommendations for coordinated school health based on the analysis. It was also noted that in addition to Fitnessgram® we would look at YRBS data and results of the School Health Profiles. The following issues were noted by members to consider when determining objectives:

- Best practices for fitness
- Fidelity
- Motivation of students
- Fitness for all

Consideration as to what the TSHAC can do to assist schools address some of the issues facing students will be explored. Developmental assets, e-cigarettes, and other new and emerging issues will also be discussed. Mrs. Wheeler-Hill asked the members to review the Fitnessgram® and YRBS data before the March meeting where objectives for the work plan will be determined. It was suggested that the members break into three groups at the March meeting to thoroughly discuss the issues and review any additional data the members may bring to the discussion. Additionally, any appropriate new data resource may be added to the CSH Data Sets document.

Agenda Item XII. Call for New CSH Data Websites and Agenda Topics for SHAC Meetings – Jan Hungate, Ed.D.

The following new topics were suggested:

- Drugs, tobacco and alcohol and their effects on the adolescent mind
- Alcohol, tobacco and other drugs
- Safe schools – healthy students
- Safe and drug-free schools
- Risky behaviors
- Substance abuse
- School connectedness
- Parent engagement
- Developmental assets
- Prescription drugs
- 5-2-1-0 Healthy Habits program

Agenda Item XIII. Next Meeting – Jan Hungate, Ed.D.

A. The next TSHAC meeting will be held on March 7, 2016 at the Tower Building, Room #T607 from 10:00 a.m. until 3:00 p.m.

B. Topics for the March meeting include:

- Research and Recommendation on Health Issues and Parent Involvement and Engagement – Document approval – Dora Rivas
- Research and Recommendation on Promoting Positive School Climates to Improve Student Outcomes – Document Review – Josette Saxton
- Research and Recommendation on School Bus and Automobile Idling – Revision for approval - Anita Wheeler-Hill
- Research and Recommendation on Benefits to Students in School Districts that Prohibit Physical Education as Punishment – Revision for second review – Carmela James, Ed.D.
- Resolution Supporting Inclusive Practices for Students with Exceptionalities in Texas Public Schools – Revision – First Draft – Josette Saxton
- Review of WellSAT-i: Wellness School Assessment Tool for Implementation and possible development of a tool for schools to assess the effectiveness of their wellness policies
- Viewing of *A Matter of Time* You-Tube trailer about the need for healthy school hours – Gilbert Handal
- Fitnessgram® History – Barney Fudge
- Development of Objectives for work plan – Anita Wheeler-Hill
- Agency Reports

Agenda Item XIV. Public Comment
There was no public comment given.

Agenda Item XV: Adjournment
ACTION: With no further business, it was moved by Bob Conlon, seconded by Dora Rivas and approved by the members to adjourn the meeting at 3:00 p.m.

Jan Hungate, Ed. D., Presiding Officer — **Date** **2/22/2016**

TSHAC MEMBERS
MEETING ATTENDANCE
January 11, 2016

#	NAME	CATEGORY	MEETING ATTENDANCE															
			9-8-14		11-10-14		1-12-15		3-3-15	5-11-15		9-14-15		11-9-15		1-11-16	
			YES	NO	YES	NO	YES	NO	YES | NO	YES	NO	YES	NO	YES	NO	YES	NO
1	Josette Saxton	Organization	X		X		X			X		X			X		X
2	Cynthia Cardenas	Parent	X		X		X				X	X			X	X	
3	Gilbert Handal	Physician	X		X		X			X		X		X			X
4	Bob Conlon	Counselor	X		X		X			X		X		X		X	
5	Bill Coon	Parent		X	X			X		X			X	X			X
6	Jaclyn Cantu	TDA	X		X		X			X		X		X		X	
7	Barney Fudge	TEA	X		X		X			X		X		X		X	
8	Wrennah Gabbert	Organization	X		X			X		X		X		X		X	
9	Jan Hungate	Administrator	X		X		X			X			X	X		X	
10	Carmela James	Administrator	X		X		X				X	X		X		X	
11	Steve Kelder	Organization		X		X	X				X		X		X		X
12	Joan Guerin Lavis	Parent	X		X			X		X		X			X		X
13	Debra Burnett	Nurse	X		X		X			X		X		X		X	
14	Tamalyn Neuendorff	Physical Ed.		X	X		X			X		X			X	X	
15	Kelly Reed-Hirsch	Organization	X		X			X		X		X		X		X	
16	Becky Rendon	Parent		X	X			X		X			X	X			X
17	Dora Rivas	Nutrition Srvs.	X			X	X			X			X	X		X	
18	Reenie Smith	GACPF	X		X		X			X			X	X		X	
19	Linda Seewald	Health Ed.		X	X		X			X			X	X		X	
20	Susan Donnenfield	Parent		X	X		X				X		X	X			X
21	Anita Wheeler-Hill	DSHS	Laurie Anderson		X		X			X		X		X		X	
	TOTALS		**15**	**6**	**19**	**2**	**16**	**5**	**Meeting Cancelled**	**17**	**4**	**13**	**8**	**16**	**5**	**14**	**7**

Guests:
Jennifer Haussler-Garing
Emily Babcock

Staff:
Ellen Smith
Laurie Anderson
Kelly Hickman

X **Missed more than 3 meetings in a row – send a letter**

Key:

X Missed a meeting

X Missed two meetings in a row

X Missed three meetings in a row – inform Chair

Total member attendance and absentees

X Attending and ordered lunch

X Attending but no lunch

X-T Teleconference

Recommendations for the Improvement of the Coordinated School Health Program

Approved - March 30, 2009

The following recommendations for modifications to coordinated health program requirements, developed by the Texas School Health Advisory Committee (TSHAC), are in accordance with Section 38.014 of the Texas Education Code:

1. Expand the current definition of Coordinated School Health (CSH), as defined in the Texas Education Code that lists four components, to include all eight components of CSH as defined by the Centers for Disease Control and Prevention (CDC). These eight components are: health education, physical education/activity, parent and community involvement, staff wellness promotion, counseling and mental health services, healthy and safe school environment, health services, and nutrition education/services.

2. In order to implement CSH programs, sufficient funding is necessary at the local, regional and state levels. It is recommended that the attached CSH model be used in order to develop, enrich and sustain CSH infrastructure at all levels.

3. Immediately revise the health and physical education Texas Essential Knowledge and Skills to align with national health and physical education standards and to reflect state mandates.

4. Build accountability for CSH at the local school district level through the use of an annual progress report to the local school board by the district school health advisory council.

5. Work with all districts, especially those with the greatest need, to evaluate and improve CSH utilizing the appropriate state agencies and Education Service Centers.

The Texas School Health Advisory Committee makes the following recommendations in addition to those in accordance with Section 38.014 of the Texas Education Code:

6. Establish the TSHAC as a statewide resource for evaluation of CSH recommendations to ensure that proposed school health initiatives have a greater potential for full integration.

7. Develop an annual evaluation of the implementation process for FITNESSGRAM® testing and data collection methods of school districts to identify best practices.

8. Utilize the results of the Texas Education Agency School Health Survey, Youth Risk Behavior Survey and the FITNESSGRAM® data to improve CSH programs and identify best practices and model programs at the state, regional, district and school campus level.

TSHAC
Texas School Health Advisory Committee

www.dshs.state.tx.us/schoolhealth/shadvise.shtm

March 4, 2013

Glenda R. Kane, Chair
State Health Services Council
Texas Department of State Health Services
P. O. Box 149347
Austin, Texas 78714-9347

Dear Ms. Kane:

Please consider this recommendation from the Texas School Health Advisory Committee (TSHAC) to expand the Texas definition of Coordinated School Health (CSH) to correspond with the eight component definition from the national Centers for Disease Control and Prevention (CDC); and, to formally add to the Texas school curriculum, a focus on the six types of health risk behaviors which contribute to the leading causes of disability and social problems in the United States and Texas.

Background information
CSH is an integrated, systematic set of planned, sequential, school-affiliated strategies, activities and services designed to advance student academic performance and promote optimal physical, emotional, social and educational development. CHS is coordinated by a multidisciplinary team accountable to the community for program quality and effectiveness. By addressing and integrating health-related issues, schools not only foster student academic achievement, but also help to establish healthy behaviors that last a lifetime. CSH must be directed toward the needs of students, responsive to the needs of families and reflective of the values of the local community.

The CDC supports an eight-component model for CSH consisting of eight health-related areas covering all aspects of the school environment that are linked together to function and coordinate as a unified, effective system to the benefit of the entire school community. The components are (1) health education; 2) physical education and physical activity; (3) nutrition services; 4) parental involvement; 5) health services; 6) counseling, psychological, and social services; 7) healthy and safe school environment; and 8) health promotion for staff. This model is based on significant research and has been adopted by individual school districts and by other states in the nation.

In Section 28.004 of the Texas Education Code, only four of the eight components are identified: (1) health education; 2) physical education and physical activity; (3) nutrition services; and 4) parental involvement. Members of the TSHAC unanimously agree that the Texas model is statutorily incomplete.

Six types of health risk behaviors have been identified to contribute to the leading causes of death, disability, and social problems in the United States: (1) tobacco use; (2) unhealthy eating; (3) inadequate physical activity; (4) alcohol and other drug use; (5) sexual behaviors that may result in HIV infection, other sexually transmitted diseases (STDs), and unintended pregnancy; and (6) behaviors that contribute to unintentional injury and violence. These behaviors are often established during childhood or adolescence, persist into adulthood, and are preventable.

Texas Dept. of State Health Services
School Health Program, MC 1923
P. O. Box 149347
Austin, Texas 78714-9347
Schoolhealth@dshs.state.tx.us

TEXAS Department of State Health Services

Members of the TSHAC unanimously agree that all six factors are vitally important to the required curriculum for Texas school children.

Recommendation
The TSHAC, in its official advisory capacity to the Department of State Health Services, formally recommends that the model for CSH for the State of Texas be expanded to follow the eight-component model used by the CDC. The TSHAC also recommends that the six health risk behaviors be included as part of the Texas CSH Model and curriculum requirements for the State's children. We request your support in moving this recommendation forward to the State Legislature.

Rationale
While many local School Health Advisory Councils, the Texas Education Agency, and DSHS recognize all eight components of school health and emphasize the six risk factors, these complete models are not in Texas law. If all eight components and six risk factors were in statute, the complete model would be required to be taught in all Texas schools.

The TSHAC supports including all eight components, especially numbers 6) counseling, psychological and social services and 7) a healthy and safe school environment, both especially high priorities at this time in our nation and in the current Texas legislative session.

Resources
Centers for Disease Control and Prevention, "Coordinated School Health", www.cdc.gov/healthyyouth/cshp/components.htm,

Centers for Disease Control and Prevention, "How States Can Support Coordinated School Health" www.cdc.gov/healthyyouth/cshp/states.htm

Texas Education Agency, "Coordinated School Health, A Systemic Approach to Addressing the Needs of Students" www.tea.state.tx.us/index3.aspx?id=2812

Texas Department of State Health Services, "Coordinated School Health" www.dshs.state.tx.us/schoolhealth/csh.shtm#2

Sincerely,

Jan Hungate, Ed.D., Presiding Officer
Texas School Health Advisory Committee

Encl: Suggested statutory changes to Sec. 28.004

Contact the Texas School Health Advisory Committee through Ellen Smith, TSHAC staff contact at ellen.smith@dshs.state.tx.us or 512/776-2140.

Texas Dept. of State Health Services
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P. O. Box 149347
Austin, Texas 78714-9347
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TEXAS Department of State Health Services

Fiscal Year 2015 Annual Report of the Texas School Health Advisory Committee

Name of advisory committee:
Texas School Health Advisory Committee

Staff contact at Texas Department of State Health Services:
Ellen Smith
512-776-2140
ellen.smith@dshs.state.tx.us

Reporting period: July 1, 2014 – June 30, 2015

This advisory committee was created by state law and is partially (with the exception of §2110.008) subject to Texas Government Code, Chapter 2110. A reporting requirement is contained in rules found in Texas Administrative Code Chapter 37.350. The rule states:

The committee shall file an annual written report to the council.

1. The report shall list the meeting dates of the committee and any subcommittees, the attendance records of its members, a brief description of actions taken by the committee, a description of how the committee has accomplished the tasks given to the committee by the council, the status of any rules which were recommended by the committee to the council and anticipated activities of the committee for the next year.
2. The report shall identify the costs related to the committee's existence, including the cost of agency staff time spent in support of the committee's activities.
3. The report shall cover the meetings and activities in the immediate preceding 12 months and shall be filed with the council each June. The presiding officer and appropriate department staff shall sign it.

Part 1 – Review

1. Description of the advisory committee, the committee's purpose, statutory authority, number and type of members, names of current members, and the number of meetings held over the past year.

A. Committee Background and Purpose:

The Texas School Health Advisory Committee (TSHAC) was created by Senate Bill 42, 79th Legislature, Regular Session, 2005. Now codified in the Health and Safety Code, Section 1001.0711, the purpose of the TSHAC is to provide assistance to the State Health Services Council (council) in establishing a leadership role for the Texas Department of State Health Services (DSHS) in the support for and delivery of coordinated school health (CSH) programs and school health services. The TSHAC rules have been promulgated and are published in the Texas Administrative Code, Title 25, Part 1, Section 37.350.

The state-level advisory committee's membership reflects the diversity of school health issues and adds another level of professional expertise to the systematic dissemination of CSH programming and school health services in Texas.

B. Membership:

By law, one representative from the Texas Education Agency (TEA) and one representative from the Texas Department of Agriculture (TDA) serve as members of the committee. By rule, the coordinator of the DSHS School Health Program and a representative of the Governor's Advisory Council on Physical Fitness (GACPF) serve as members along with 17 additional appointees. By rule, the criteria for membership specifically reflects the Centers for Disease Control and Prevention's CSH approach for integrating health-promoting practices in the school setting, including:

- Health Education
- Nutrition Environment and Services
- Employee Wellness
- Social and Emotional School Climate
- Physical Environment
- Health Services
- Counseling, Psychological, and Social Services
- Community Involvement
- Family Engagement
- Physical Education and Physical Activity

The criteria for membership can be reviewed at http://www.dshs.state.tx.us/schoolhealth/tshac/memberlist.shtm.

Fiscal Year 2015 Annual Report of the Texas School Health Advisory Committee

The following individuals are currently members of the TSHAC:

Members	Category
Debra Burnett, RN, School Nurse, Goodnight Middle School, San Marcos	Registered Nurse
Cynthia Cardenas Weslaco	Parent/Consumer
Robert Conlon, PhD, Whole Child Strategies PLLC, Sugarland	Counseling and Mental Health
William Coon, President/CEO, YMCA of El Paso, El Paso	Parent/Consumer
Susan Donnenfield, RN, School Nurse, Akiba Academy/Yavneh of Dallas, Dallas	Parent/Consumer
Melissa Dozier, Food and Nutrition Policy Liaison, Texas Department of Agriculture, Austin	Required by Law
Barney Fudge, Statewide Coordinator for Health Education, Texas Education Agency, Austin	Required by Law
Wrennah Gabbert, RN, PhD, CPNP, FNP-BC, Professor and Senior Associate Dean, Texas Tech University, Health Science Center, El Paso *TSHAC Assistant Presiding Officer*	Agency/Organization
Joan Guerin Lavis, MBA, Independent Facilitator, Love and Logic, Academic Tutor, El Paso	Parent/Consumer
Gilbert Handal, MD, Professor, Texas Tech University, Health Science Center, El Paso	Physician
Jan Hungate, EdD, Assistant Superintendent, West ISD, West *TSHAC Presiding Officer*	School Administrator
Carmela James, EdD, CSC, Counselor, Pasadena ISD, Pasadena	School Administrator
Steven Kelder, PhD, MPH, Associate Regional Dean, UT School of Public Health; Co-Director, Michael and Susan Dell Center for Healthy Living, Austin	Agency/Organization
Tamalyn Neuendorff, Social Studies Teacher, Columbus Jr. High, Columbus	Physical Educator
Kelly Reed-Hirsch, MPH, CHES, Public Health Program Manager, Harris County Public Health and Environmental Services, Houston	Agency/Organization
Becky Rendon, RN, School Nurse, Jackson Middle School, San Antonio	Parent/Consumer
Dora Rivas, RD, Executive Director, Food and Child Nutrition Services, Dallas ISD, Dallas	Nutrition Services
Josette Saxton, MSSW, Mental Health Policy Associate, Texans Care for Children, Austin	Agency/Organization
Linda Seewald, MSEd, Director of Health and Physical Education, Northside ISD, San Antonio	Health Educator
Reenie Smith, MSci, Senior Lecturer, Health and Human Performance Dept., Texas State University, San Marcos, Member, Governor's Advisory Council on Physical Fitness	Required by Rule
Anita Wheeler-Hill, MSN, RN, Coordinator, School Health Program, Texas Department of State Health Services, Austin	Required by Rule

The TSHAC committee met five times during fiscal year 2015: September 8, 2014; November 10, 2014; January 12, 2015; March 3, 2015; and May 11, 2015. Minutes of all meetings were forwarded to the council as required by rule, and are available online at www.dshs.state.tx.us/schoolhealth/shadvisecalendar.shtm. Attendance records for each meeting are included in minutes.

Meetings have been scheduled for fiscal year 2016 as follows: September 14, 2015; November 9, 2015; January 11, 2016; March 7, 2016; and May 9, 2016.

2. Overview of the activities of the advisory committee over the past year including major accomplishments, as well as future activities and plans.

The committee spent fiscal year 2015 assessing, studying, and framing the priority recommendation and resource documents to be developed during fiscal year 2016, derived from objectives identified in its new five-year plan.

Additionally, to comply with the TSHAC Document Revision Schedule, several documents were revised and approved by the committee.

A. Document Revisions
   1. Bullying Prevention Toolkit
   2. SHAC Self-Assessment
   3. Research and Recommendation of Student Consumption of Regular and Diet Sodas in High Schools
   4. Coordinated School Health Data Sets
   5. SHAC Annual Progress Report to the Board of Trustees

   The revised documents were posted on the TSHAC website and promoted through the DSHS *Friday Beat* e-newsletter to TSHAC stakeholder subscribers and through partner e-transmissions and websites. To view the revised documents, go to http://www.dshs.state.tx.us/schoolhealth/shadviserecommendations.shtm and http://www.dshs.state.tx.us/schoolhealth/shadviseresources.shtm.

B. Current and Future Projects
   The TSHAC is currently working on the following projects as determined by its new five-year plan, expected to be fully or mostly completed during Fiscal Year 2016:
   1. Mental Health and Suicide Prevention Resources Toolkit
   2. Research and Recommendation on Health Issues and Parent Involvement
   3. Research and Recommendation on Physical Activity and Academic Achievement
   4. Research and Recommendation on Safe School Climate

C. Document Revisions for fiscal year 2016
   The following documents will be revised in compliance with the committee's document revision schedule:
   1. Research and Recommendation on Recess and Physical Activity: Impact on Student Health and Academics

2. Research and Recommendation on Physical Activity
3. Research and Recommendation on Health Education for all Texas Students, Kindergarten through 12th Grade
4. Resolution Supporting Inclusive Practices for Students with Exceptionalities in Texas Public Schools
5. Childhood Obesity Prevention Resolution
6. Resources for Students and Families Dealing with Economic Crisis
7. School Bus and Automobile Idling
8. School Health Initiative Screening Tool
9. Benefits to Students in School Districts that Prohibit Physical Education as Punishment

D. Partner Collaboration
An exchange of ideas and information occurred among partners such as TEA, TDA, and GACPF during TSHAC meetings. Discussions and recommendations focused on statewide resources and initiatives as well as shared objectives.

E. Work Plan
The TSHAC continues to move toward its vision of "healthier Texans through coordinated school health" by following a well-designed plan. The first plan was initiated in fiscal year 2007, and the objectives and strategies of that plan have been completed or are ongoing at this time. The TSHAC is working on its second five-year plan. Objectives have been identified and prioritized, and assignments made. Priority objectives are currently undergoing development.

3. Challenges encountered by the advisory committee over the past year and how they were addressed.

A. Past funding cuts in education and health and changes in the school health laws have presented challenges for the TSHAC in regard to its ability to completely administer its charge.

B. In light of these barriers, the TSHAC has realized, now more than ever, the importance of continuing to develop tools and resources needed by schools to help navigate these overarching changes.

C. By statute, the majority of members cannot be reimbursed for travel expenses. Because of budget concerns, some of these members find it difficult to travel to all of the TSHAC meetings. Therefore, exploring alternative ways to conduct meetings is ongoing. One member has chosen to participate by teleconference which is now offered as a communication option.

4. Why is this advisory committee useful to the agency?

Issues and priorities identified by the TSHAC provide focus for the DSHS School Health Program. The TSHAC priorities reinforce the importance of coordinating chronic disease prevention and health promotion initiatives, beginning with the school-age population.

The TSHAC helps support public health priorities by recommending, developing, and implementing initiatives based on school health legislation. The Legislature relies on the expertise of the TSHAC

by charging it with specific duties (e.g., the Legislature required TSHAC to assist TEA in the development of rules that address physical activity requirements and CSH program recommendations.)

By focusing on its mission, described as its "charge" in the statute, the TSHAC furthers its goals by forging new partnerships, maintaining current ones, and strengthening others. The TSHAC serves as a central coordinating resource in assisting state agencies, organizations, and local SHACs with the creation or revision of school health documents and tools impacting the health of students and staff at the school site.

The TSHAC provides specific resources for local districts to facilitate and guide their work and provides a structure for the local SHACs to evaluate and report their progress to local school boards and the school community.

5. Additional information pertinent to the committee.

All recommendation and resource documents are exclusively created by TSHAC work groups to address relevant and priority school health topics important to school districts. These resources fill gaps in available resources and serve as valuable tools for school districts and local SHACs. The TSHAC will continue to focus on gaps in school health resources and new and emerging issues, determine its capacity to fill these gaps, respond to requests, and further its assistance to local SHACs. The Bullying Prevention Toolkit is an example of a product developed by the TSHAC to fulfill a need identified by local SHACs.

Part 2 – Evaluation

6. Costs related to the advisory committee.

A. Travel and related reimbursements for committee members:
$3,370.

B. Agency staff time and salary: The estimated annual staff time dedicated to the TSHAC is 719 hours. The annual related salary expense is $20,053. The primary staff supporting the TSHAC are:

1. Information Specialist III:
20 percent of time allocated = $10,398.
2. School Health Coordinator/Program Specialist V:
15 percent of time allocated = $9,655

C. Other expenses: Office supplies: $600

7. Summary of Activities and Recommendations.

A. Summary of Activities:

Just finishing its ninth year, the TSHAC has developed a new five-year work plan. Part of that plan involves the revision of TSHAC-created documents to stay in compliance with the TSHAC Document Revision Schedule. The TSHAC also focuses on support for local SHACs by providing tools to address new and emerging issues and challenges, such as addressing parent involvement in school health issues.

The state agency representatives (DSHS, TEA, TDA, and GACPF) frequently poll member opinions and seek recommendations in areas beyond legislated requirements. TSHAC members have also made recommendations in the areas of school health services, CSH, and local SHAC infrastructure.

The members' commitment to sharing best practices is evident during discussions and the careful screening of resources posted on the DSHS school health website from local districts and local SHACs. Dissemination of information and research is a critical component of the work plan, and every meeting includes some action related to communication with school health stakeholders.

B. Recommendations:

The following recommendations are presented for consideration by the council:

1. Encourage state agencies to utilize the expertise of the TSHAC when:
   a. promulgating or amending rules and regulations related to the health of students in schools and requirements for local SHACs;
   b. addressing CSH programs and services; and
   c. developing or revising school health education programs.

2. Explore collaboration between new traditional and non-traditional partners to further the TSHAC mission and goals.

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Tobacco Settlement Permanent Trust Account Administration Advisory Committee

Number of Members: 11

Committee Status (Ongoing or Inactive): Ongoing — Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 1999 **Date to Be Abolished:** N/A

Budget Strategy (Strategies) (e.g. 1-2-4): N/A **Strategy Title (e.g. Occupational Licensing):** N/A

Budget Strategy (Strategies): N/A **Strategy Title:** N/A

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Health & Safety Code, Sec. 12.137
State Authority		
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Method of Financing

Method of Finance	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
1 - General Revenue Fund	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year: 1 | 1 | 1

Committee Description: Review proposed rules, propose amendments, and grant final approval. Review annual audit results and provide feedback on disputed audits.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

Meetings are held annually in the Fall. There is no requirement as to the frequency of meetings.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

Recommendations of the administration of the distribution of the tobacco settlement proceeds to political subdivisions in Texas. The tobacco settlement permanent trust account administration advisory committee shall advise the board on the implementation of the department's duties under this subchapter. There are no required documents.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

Rule amendments to 25 TAC, Sec. 102.1-102.5; rules are pending publication for public comment and adoption.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ? Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees? No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015? 160.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Convene meetings, to include all administrative and logistical requirements, implement committee decisions, provide annual training as required, recruit and seek approval of nominated committee members, ensure state law is complied with in relation to the open meetings act, publishing in the Texas Register

6. Have there been instances where the committee was unable to meet because a quorum was not present? No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

Committee complies with the Open Meetings Act, Government Code 551 and posts meeting information and agenda with the Office of the Secretary of State in compliance with, Texas Administrative Code, Chapter 91. Notices posted in the Texas Register, notification provided to stakeholders, website: www.dshs.state.tx.us/tobaccosettlement

7b. Do members of the public attend at least 50 percent of all committee meetings? Yes

7c. Are there instances where no members of the public attended meetings? No

8. Please list any external stakeholders you recommend we contact regarding this committee.

None

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals? Yes

9b. Please describe the rationale for this opinion.

This is a fully functioning committee. It annually reviews results of any tobacco expenditure statement audits; reviews adopted rules and propose amendments as need dictates; and advises DSHS and Executive Commissioner regarding audit disputes and items impacting the distribution of Tobacco Settlement funds.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute? Yes

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area? No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)? Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission? Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

Committee provides advice on the distribution of the Tobacco Settlement funds. Required by state law, Health & Safety Code Chapter 12, Subchapter J. Tobacco Settlement Proceeds 12.131-12.139

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

TOBACCO SETTLEMENT PERMANENT TRUST ACCOUNT ADMINISTRATION ADVISORY COMMITTEE MEETING

Wednesday, October 24, 2012

Minutes

The Tobacco Settlement Permanent Trust Account Administration Advisory Committee (AAC) met on Wednesday, October 24, 2012 at 10:00 a.m.

AAC Members Present - in person or via conference call (cc):
King Hillier (Chairperson); Betsy Briscoe (cc), Jonny Hipp (cc), Carolyn Konecny, Judge Burt Mills (cc), Michael Nunez (cc); Darryl Primo (cc); David Salsberry(cc)

Department of State Health Services (DSHS) Staff Members Present:
Elaine McHard, Manager, Funds Coordination; Anne Glaspy, Program Specialist, Funds Coordination; Meghan Lyons, Program Specialist, Funds Coordination; Monty Waters, Assistant General Counsel

Additional Participants (in person or via conference call):
Jana Clift Williams, Allison, Bass & Associates; LLC, on behalf of Jim Allison; Keri Disney, on behalf of Committee Member Dr. Ron Anderson; Donald Lee, Texas Conference of Urban Counties (cc)

Opening of Meeting and Roll Call

Elaine McHard introduced herself as the Coordinator for the Tobacco Settlement Distribution Program on behalf of DSHS and identified other DSHS staff members present. Ms. McHard noted that the meeting was being held in accordance with the Open Meetings Act. Meeting minutes were being taken as well as digitally recorded, and a summary would be provided to all AAC members and other stakeholders. Chairmen Hillier then called the meeting to order.

Roll call was taken. Judge Mike Brown and Judge Raul Ramirez were not present for roll call. Don Hudson, Texas Council of Urban Counties, was also not present.

Adoption of October 26, 2011 Meeting Minutes

Mr. Hillier asked for motion to approve the October 26, 2011 meeting minutes. Motion was made by Mr. Primo and seconded by Ms. Konecny. Minutes unanimously approved as written.

Review of 2012 Audits

Ms. McHard outlined the timeline for the 2012 Tobacco Settlement Distribution as follows: expenditure statements were sent to 302 political subdivisions on December 31, 2011 with instructions to return completed statements by 5:00 p.m. March 31, 2012; DSHS certified to the Comptroller's office the percentage of the annual distribution to be paid to each eligible political subdivision on April 11, 2012; and the Comptroller's office distributed tobacco settlement proceeds on April 16, 2012. The 2012 audits were conducted and completed between May and August, 2012.

A total of 302 political subdivisions were eligible for Tobacco Settlement proceeds, which was comprised of: 139 Hospital Districts, 161Counties, and 2 Cities. Of these, 299 received tobacco settlement proceeds for 2012 as 3 chose not to apply; Grapeland Hospital District, Loving County, and Texhoma Memorial Hospital District. Total number of eligible counties decreased from 162 in 2011 to 161 in 2012 due to Dimmit County's consolidation with Dimmit Regional Hospital District.

The net 2012 annual distribution amount was $50,000,000, with the largest distribution going to Harris County Hospital District at $11,574,680.56, and the smallest of $108.14 to Gonzales County.

Twenty-six (26) political subdivisions were selected for audit based on the following criteria:

- Twenty-one (21) political subdivisions with 2011 expenditures exceeding their 2010 expenditures by $500,000 or more and not audited in the previous year;
- Five (5) political subdivisions who reported inter-governmental transfer payments for which no Indigent Care Affiliation Agreement was on file; and,
- "0" political subdivisions applying for tobacco settlement proceeds for the first time.

The audits resulted in 9 of 26 selected political subdivisions being informed of overpayment and those impacted are in agreement with the audit results. These funds will be recouped during the next distribution in 2013. Ms. McHard referred members to the *2012 Tobacco Settlement Distribution Audit Findings,* and *2012 Audit Recoupment Summary* handouts, located in their meeting packets for further detail regarding audits.

Mr. Jonny Hipp asked whether political subdivisions had been informed of specific ineligible expenditures identified on their audits. Ms. Glaspy advised that political subdivisions had been notified, by phone and in writing, along with instructions regarding the recoupment process. Ms. Disney asked for examples of ineligible expenditure items found at audit. Ms. Glaspy stated that two hospital districts reported taxes collected outside of the 2011 calendar year. For counties, ineligible expenditure items were non-direct healthcare related office and administrative expenses, and charitable contributions to free pharmacy and food programs.

Mr. Hillier advised that Commissioner Primo had requested a report outlining the total amount of tobacco program funds distributed to each political subdivision since the first distribution in 1999. He further advised that many Commissioners Courts would find this information helpful. Ms. McHard agreed to compile and distribute this report to members in the coming week.

Review of Program Rules

Ms. McHard updated the AAC on the status of proposed rule changes, which were discussed and voted upon during last year's meeting, and finalized on October 7, 2012. A copy of the final approved rules could be found in their meeting packets. Mr. Waters reminded the AAC that rule changes were minor in scope and in compliance with the four year rules review process. There were no further questions or comments from the group pertaining to the rule amendments.

Investment Advisory Committee Update

Ms. McHard advised that the Investment Advisory Committee (IAC) had held both scheduled meetings for 2012:

- During the March 23, 2012 meeting, the IAC agreed to a $50 million distribution, which was disbursed to all eligible political subdivisions on April 16, 2012. She explained what portion of the distribution came from the Distribution Stabilization Account (DSA) and under what conditions the DSA is used to supplement distributions. Ms. McHard also reviewed a memorandum from IAC Chairman Stuart Ford, dated April 13, 2012 that was addressed to all trust beneficiaries, advising that various economic conditions had negatively impacted portfolio performance. The IAC strongly encouraged all political subdivisions to budget accordingly, as the resulting 2013 distribution could possibly be lower than the 2012 distribution.

- During the October 19, 2012 IAC meeting, Mr. Paul Ballard, CEO/CIO of the Texas Treasury Safekeeping Trust Co., provided an update on global market conditions and various scenarios impacting the Tobacco Settlement Permanent Trust Account and the Distribution Stabilization Account. Discussion ensued between IAC members regarding portfolio performance in 2012 vs. 2011, preservation of capital, and how it could impact the 2013 distribution.

Administrative Advisory Committee Update

Ms. McHard thanked newest members for completing the required Open Records and Open Meeting Training. She advised that three committee member appointments were set to expire on August 31, 2012; one (1) from County Judges and Commissioners Association of Texas; one (1) from the political subdivision with the first largest annual distribution; and one (1) from the political subdivision with the second largest annual distribution. DSHS will be working with each of the appropriate authorities to seek appointments for these positions within the coming months.

Annual Meeting Schedule

Ms. McHard suggested a tentative date of Wednesday, October 23, 2013, at 10:00 a.m. for the next annual AAC meeting. There were no schedule conflicts cited by any of the members.

Adjourn

Motion was made and concurred to adjourn the meeting at 10:40 a.m.

TOBACCO SETTLEMENT PERMANENT TRUST ACCOUNT ADMINISTRATION ADVISORY COMMITTEE MEETING

Wednesday, October 23, 2013

Minutes

The Tobacco Settlement Permanent Trust Account Administration Advisory Committee (AAC) met on Wednesday, October 23, 2013 at 10:00 a.m.

AAC Members present via conference call:
Betsy Briscoe, Jonny Hipp, Carolyn Konecny, Michael Nunez; Darryl Primo; David Salsberry; Judge Mike Brown, Judge Jerry Bearden,

Department of State Health Services (DSHS) Staff Members Present:
Elaine McHard, Manager, Funds Coordination; Anne Glaspy, Program Specialist, Funds Coordination;

Additional Participants present, via conference call:
Jana Clift Williams, Allison, Bass & Associates; LLC, on behalf of Jim Allison; Keri Disney, Parkland Health System; Donald Lee, Texas Conference of Urban Counties; Windy Johnson, Texas Conference of Urban Counties; Julie Manning, University of Texas Doctoral Student - representing King Hillier, Harris Health System

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Opening of Meeting and Roll Call

Elaine McHard introduced herself as the Manager of Funds Coordination and Management Branch, responsible for overseeing the Tobacco Settlement Distribution Program on behalf of DSHS. Ms. McHard noted that the meeting was being held in accordance with the Open Meetings Act. Meeting minutes were being taken as well as digitally recorded, and a summary would be provided to all AAC members and other stakeholders. As Chairman King Hillier was unable to attend, Mr. Jonny Hipp volunteered to stand in and called the meeting to order.

Roll call was taken. It was noted that Mr. King Hillier, Judge Raul Ramirez, and Mr. Ted Shaw were not present for roll call. However, a quorum of eight members was present for voting purposes.

Mr. Greg Hudson, Texas Council of Urban Counties was also not present.

Administrative Advisory Committee Members

Ms. McHard advised that three committee memberships expired August 31, 2013; one (1) from County Judges and Commissioners Association of Texas; one (1) from the political subdivision with the first largest annual distribution; and one (1) from the political subdivision with the second largest annual distribution. She then announced new appointees: **Ted Shaw** – Interim Executive Vice President and CFO,

for Parkland Health and Hospital System, representing the political subdivision that (in the year preceding the appointment) received the second largest annual distribution; and **Honorable Jerry Bearden**, representing the County Judges and Commissioners Association of Texas.

Also, **Mr. King Hillier of Harris Health System** was reappointed to the committee. Mr. Hillier will represent the political subdivision that (in the year preceding the appointment) received the largest annual distribution. He will also continue to serve as chairman of this committee.

Ms. McHard thanked new members for completing the required Open Records and Open Meeting Training.

Adoption of October 24, 2012 Meeting Minutes

Mr. Hipp asked for motion to approve the October 24, 2012 meeting minutes. Motion was made by Mr. Salsberry and seconded by Mr. Nunez. Minutes were unanimously approved as written.

2013 Distribution

Ms. McHard outlined the timeline for the 2013 Tobacco Settlement Distribution as follows: expenditure statements were sent to 302 political subdivisions on December 31, 2012 with instructions to return completed statements by 5:00 p.m. March 31, 2013; DSHS certified to the Comptroller's office the percentage of the annual distribution to be paid to each eligible political subdivision on April 11, 2013; and the Comptroller's office distributed tobacco settlement proceeds on April 18, 2013. All 2013 audits were conducted and completed between May and August, 2013.

A total of 302 political subdivisions were eligible for Tobacco Settlement proceeds, comprised of: 139 Hospital Districts, 161Counties, and 2 Cities. Of these, 299 received tobacco settlement proceeds for 2013 as 3 chose not to apply; Grapeland Hospital District, Texhoma Memorial Hospital District, and Kenedy County.

The net 2013 annual distribution amount was $50,000,000, with the largest distribution going to Harris County Hospital District at $11,138,242.23, and the smallest of $1.00 to Briscoe County.

Ms. McHard also reviewed a letter from the Investment Advisory Committee which was delivered to political subdivisions with their 2013 distribution. This letter stated that, based on portfolio performance of the fund, political subdivisions should be prepared for no plan increase in next year's (2014) distribution.

At Jonny Hipp's request Mr. Don Lee, Council of Urban Counties, provided new committee members with an overview of the Tobacco lawsuit.

Review of 2013 Audits

Thirty-one (31) political subdivisions were selected for audit based on the following criteria:

- All Thirty-one (31) political subdivisions with 2012 expenditures exceeding their 2011 expenditures by $500,000 or more that had not been audited in the previous year;
- No ("0") political subdivisions were selected based on inter-governmental transfer payments for which no Indigent Care Affiliation Agreement was on file; and,
- No ("0") political subdivisions were selected due to applying for tobacco settlement proceeds for the first time

The audits resulted in 2 of 31 selected political subdivisions having been informed of overpayment. Those impacted are in agreement with the audit results. These funds will be recouped during the next distribution in 2014. Ms. McHard referred members to the *2014 Tobacco Settlement Distribution Audit Findings,* and *2014 Audit Recoupment Summary* handouts, located in their meeting packets for further detail regarding audits.

Mr. Hipp asked what type of feedback is provided to political subdivisions regarding their audit results. Ms. Glaspy advised that overpayment notification is in writing along with instructions for recoupment. Those underreporting are verbally informed. Also, any new noteworthy items are added to the Frequently Asked Questions document, which is available on the Tobacco website. No other questions or comments were posed by the committee regarding audits.

Annual Meeting Schedule

Ms. McHard suggested a tentative date of Wednesday, October 22, 2014, at 10:00 a.m. for the next annual AAC meeting. There were no schedule conflicts cited by any of the members.

Adjourn

Motion was made and concurred to adjourn the meeting at 10:35 a.m.

TOBACCO SETTLEMENT PERMANENT TRUST ACCOUNT ADMINISTRATION ADVISORY COMMITTEE MEETING

Wednesday, October 22, 2014

Minutes

The Tobacco Settlement Permanent Trust Account Administration Advisory Committee (AAC) met on Wednesday, October 22, 2014 at 10:00 a.m.

AAC Members present via conference call:
Betsy Briscoe, Jonny Hipp, Carolyn Konecny, Michael Nunez; Commissioner Darryl Primo; Judge Raul Ramirez; Keri Disney-Story; Judge Jerry Bearden

Department of State Health Services (DSHS) Staff Members Present:
Elaine McHard, Manager, Funds Coordination; Anne Stokey, Program Specialist, Funds Coordination

Additional Participants present via conference call:
Donald Lee, Executive Director, Texas Conference of Urban Counties (CUC); Windy Johnson for Michael Vasquez, Texas Conference of Urban Counties; Dina Welsh with Texas EMS Trauma and Acute Care Foundation (TETAF); David Pearson, President/CEO, Texas Organization of Rural & Community Hospitals (TORCH)

Opening of Meeting and Roll Call

Ms. McHard introduced herself as the Manager of Funds Coordination and Management Branch, responsible for overseeing the Tobacco Settlement Distribution Program on behalf of DSHS. Ms. McHard advised that Chairman King Hillier was unable to attend the meeting therefore Mr. Jonny Hipp would be standing in on his behalf. Ms. McHard noted that the meeting was being held in accordance with the Open Meetings Act. Meeting minutes would be taken as well as digitally recorded, and a summary provided to all AAC members and stakeholders.

Roll call was taken by Ms. McHard. It was noted that Mr. King Hillier, Judge Mike Brown, and Mr. David Salsberry were not present for roll call. A quorum of eight members was present for voting purposes. Mr. Greg Hudson, Hudson O'Leary, LLP, and Mr. Jim Allison, General Counsel for County Judges and Commissioners Association of Texas, were also not present. Jonny Hipp called the meeting to order on behalf of Chairman Hillier.

Administrative Advisory Committee Member Updates

Mr. Hipp asked Ms. McHard to introduce any new members. One new member was recognized - Ms. Keri-Disney Story from Parkland Health and Hospital System, representing the political subdivision that, in the

year preceding the appointment received the second largest annual distribution, replacing Mr. Ted Shaw. Mr. Hipp asked Ms. Disney-Story if she would like a briefing on the Tobacco Reimbursement Program. Ms. Disney declined citing her familiarity due to her participation in previous Administration Advisory Committee meetings.

Adoption of October 23, 2013 Meeting Minutes

Mr. Hipp requested a motion to approve the October 23, 2013 meeting minutes. Motion was made by Michael Nunez and motion seconded by Judge Jerry Bearden. Minutes were unanimously approved as written.

2014 Distribution

Ms. McHard outlined the timeline for the 2014 Tobacco Settlement Distribution as follows: expenditure statements were sent to all eligible political subdivisions on December 31, 2013 with instructions to return completed statements by 5:00 p.m. March 31, 2014; DSHS certified to the Comptroller's office the percentage of the annual distribution to be paid to each eligible political subdivision on April 9,2014, and the Comptroller's office distributed tobacco settlement proceeds on April 14, 2014. All 2014 audits were conducted and completed by DSHS between July and August, 2014.

A total of 303 political subdivisions were eligible for Tobacco Settlement proceeds, comprised of: 140 Hospital Districts, 161Counties, and 2 Cities. Of these, 297 actually received tobacco settlement proceed payments in 2014, as 3 chose not to apply; Grapeland Hospital District, Texhoma Memorial Hospital District, and Kenedy County. Three (3) political subdivisions, Borden County, Briscoe County, and Loving County, reported "0" expenditures.

The net 2014 annual distribution amount was $50,000,000, with the largest distribution going to Harris County Hospital District at $10,983,628.43, and the smallest of $17.75 to Roberts County.

Ms. McHard reviewed a letter from the *Tobacco Settlement Permanent Trust Account Investment Advisory Committee*, dated March 26, 2014 that was delivered to all political subdivisions along with their 2014 distribution. The Investment Committee advised that, in an effort to rebuild the Trust resulting from the damage caused by the 2008 financial crisis, political subdivisions should continue to plan for no increase in annual distributions for the time being.

Commissioner Darryl Primo asked if Administration Committee members were allowed to attend the Investment Committee meeting scheduled on Friday, October 24, 2014. Ms. McHard confirmed they were welcome to attend and offered to forward meeting information to those interested.

Review of 2014 Audits

Ms. McHard provided the committee with the results of the 2014 Tobacco Settlement statement audits, in accordance with the administrative rules requiring their annual review.

Thirty-two (32) political subdivisions were selected for audit based on the following criteria:

- Thirty (30) political subdivisions with 2013 expenditures exceeding their 2012 expenditures by $500,000 or more, and not audited in the previous year;
- One (1) political subdivision with Inter-Governmental Transfer payments with no Indigent Care Affiliation Agreement on file with DSHS; and,
- One (1) political subdivision applying for tobacco settlement proceeds for the first time

The audits resulted in four (4) of thirty-two (32) selected political subdivisions having been informed of

overpayment. Those impacted are in agreement with the audit results. These funds will be recouped during the next distribution in 2015. Ms. McHard referred members to the *2014 Tobacco Settlement Distribution Audit Findings,* and *2014 Audit Recoupment Summary* handouts, located in their meeting packets for further detail regarding audits.

Mr. Hipp asked Ms. McHard to describe the work we do to notify political subdivisions of their audit selection, and how their audit findings are communicated. Ms. Stokey provided a brief overview of the audit process, which is a collaborative effort allowing the political subdivision opportunity to explain any discrepancies. Overpayments are communicated to the political subdivision verbally and in writing, along with the instructions for recoupment. No other questions or comments were posed by the committee regarding 2014 audits.

Ms. McHard provided some background on the Upper Payment Limit (UPL) program as it relates to uncompensated care (UC), which is reported as an Inter-governmental Transfer (IGT) Payment on the tobacco expenditure statement. She advised that the UPL program was recently replaced as a component of the Medicaid 1115 Demonstration Waiver program, which has resulted in some confusion for reporting purposes. Ms. McHard requested the committee's input on providing better guidance so that the new UC/UPL program is accurately represented on the expenditure statement. Discussion ensued between the committee members regarding possible amendments to the expenditure statement, and it was agreed that further discussion would be tabled pending additional research for presentation to the committee at a later date.

Annual Meeting Schedule

Ms. McHard suggested options for the next annual Administration Advisory Committee (AAC) meeting; One suggestion was Wednesday, October 21, 2015, and the other to schedule during the same week as the Investment Advisory Committee (IAC) meeting. Based on prior scheduled IAC meetings, their next meeting could be Friday, October 23, 2015. Committee discussed and agreed that the next AAC meeting be tentatively scheduled for Thursday, October 22nd in the afternoon to coincide with the tentative IAC meeting. Ms. McHard further advised that we will liaise with our IAC contact at the Texas Comptroller's office to coordinate the next meeting date and time.

Adjourn

Mr. Hipp asked for motion to adjourn; motion made by Darryl Primo and committee members concurred to adjourn the meeting at 10:52 a.m.

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Toxic Substances Coordinating Committee

Number of Members: 6

Committee Status (Ongoing or Inactive): ongoing — Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 1987 **Date to Be Abolished:**

Budget Strategy (Strategies) (e.g. 1-2-4) NA **Strategy Title (e.g. Occupational Licensing)** NA

Budget Strategy (Strategies) NA **Strategy Title** NA

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	Health and Safety Code 503.002
State Authority	Admin Code	25 TAC, Chapter 1001
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Method of Financing

Method of Finance	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
1 - General Revenue Fund	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year 4 4 4

Committee Description: The Toxic Substance Coordinating Committee was established to coordinate communication among member agencies concerning each agency's efforts to regular toxic substances and harmful physical agents.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

The meetings take place at the Texas Department of State Health Services offices in Austin, Texas. Meetings are required to be held at least once each quarter on a meeting date set by the committee.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

There are no required deliverables.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

The committee does not make recommendations or provide advice. The committee was established to provide a means of communication and coordination between state agencies on environmental health issues. Through these interactions, member agencies can plan and coordinate activities related to toxic substances and harmful physical agents.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ?

Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

16 hours

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Staff of the Department of State Health Services provides administrative support for the committee. This includes compiling meeting minutes, distributing of meeting minutes to members, setting up meetings, posting the meeting announcement on the Texas Register, and planning the meeting.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

The meetings are open to the public. Meetings announcements are posted on the DSHS website and in Texas Register.

7b. Do members of the public attend at least 50 percent of all committee meetings?

No

7c. Are there instances where no members of the public attended meetings?

Yes

8. Please list any external stakeholders you recommend we contact regarding this committee.

Department of Agriculture, Texas Commission on Environmental Quality, Parks and Wildlife Department, Department of Public Safety of the State of Texas, and Railroad Commission of Texas - agencies represented on the committee.

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

Yes

9b. Please describe the rationale for this opinion.

The committee continues to serve as a means to coordinate communication among member agencies to regulate toxic substances and harmful physical agents and provides a plan for intergovernmental cooperation regarding toxic substances and harmful physical agents, and to collect information, conduct risk assessments, and provide public education.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

No

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

NA

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission? No

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

NA

TOXIC SUBSTANCES COORDINATING COMMITTEE (TSCC)

March 22, 2016
10:00 am – 11:30 am

Room M-653
Texas Department of State Health Services
1100 West 49th Street
Austin, Texas 78756

Attendance:

Attendees	**Agency**
Heidi Bojes	Texas Department of State Health Services (DSHS)
Josh Duty	DSHS
Emily Hall	DSHS
Jocelyn Hover-Jeansonne	DSHS
Laura Morse	DSHS
Diana Rangel	DSHS
Michael Tennant	DSHS
Beth Patterson	DSHS
Tina Walker	DSHS
Tina Williams	DSHS
Tracie Phillips	Texas Commission on Environmental Quality (TCEQ)
Alex Nuñez *(c)*	Texas Parks and Wildlife Department (TPWD)

(c) denotes that attendees participated by conference line.

Call to order and welcome visitors:
Laura Morse, DSHS

Approval of minutes dated December 15, 2015:
Minutes were approved as is.

Presenter:
Jocelyn Hover-Jeansonne (DSHS)
"Preparing for a Chemical Terrorist Event: Capabilities of the Texas Laboratory Response Network for Chemical Threats (LRN-C)."

Subcommittee reports:

- Harmful Algal Bloom (HAB) work group meeting update
  - The next TexHAB meeting will be held April 21, 2016.
    - Agenda items
      - ◊ HAB event updates
      - ◊ Research
      - ◊ Other activities
    - Specific response updates
      - ◊ Red Tide 2015 Summary
      - ◊ Golden Algae 2015 Update
      - ◊ Blue-Green Algae monitoring in reservoirs by TCEQ and U.S. Geological Survey (USGS)

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- Fish Sampling subcommittee meeting update
  - Subcommittee has not met in 2016.
  - Various fish advisories have been issued since the last subcommittee meeting.
    - Lake Livingston and Trinity River (U.S. Highway 287 to U.S. Highway 90)
      - ◊ Fish collection 2012–2013
      - ◊ Advisory-53 (ADV-53) issued December 18, 2015
      - ◊ Contaminants of Concern (COCs): Dioxins and PCBs
      - ◊ Presented advisory information to Polk County Hookers fishing club in Livingston, Texas, on January 21, 2016.
    - Arroyo Colorado
      - ◊ Fish collection January–February 2013
      - ◊ ADV-54 issued December 18, 2015, rescinding ADV-34
      - ◊ COCs: Mercury and PCBs
      - ◊ Pesticide concentrations in fish from the Arroyo Colorado have slowly decreased to acceptable levels overtime.
      - ◊ Smallmouth buffalo consumption recommendations for adults changed from DO NOT EAT to two meals/month.
    - Houston Ship Channel (HSC)
      - ◊ Fish collection September 2012
      - ◊ ADV-55 issued December 18, 2015, rescinding ADV-49 and ADV-50
      - ◊ COCs: Dioxins and PCBs
      - ◊ Pesticide concentrations in fish from the Galveston Bay Estuary (HSC) have slowly decreased to acceptable levels overtime.
    - Echo Lake (Fort Worth, Texas)
      - ◊ Fish collection April 2014
      - ◊ ADV-56 issued December 18, 2015, rescinded Aquatic Life Order-11 (AL-11)
      - ◊ COCs: Dieldrin, Dioxins, and PCBs
    - Lake Como (Fort Worth, Texas)
      - ◊ Fish collection April 2014
      - ◊ ADV-57 issued February 9, 2016
      - ◊ COCs: Dieldrin, Dioxins and PCBs
      - ◊ Presented advisory information to Lake Como Homeowners Association (HOA) on March 3, 2016.
    - Fosdic Lake (Fort Worth, Texas)
      - ◊ Fish collection April 2014
      - ◊ ADV-33 remains unchanged (issued December 20, 2007)
      - ◊ COCs: PCBs
    - More information about fish consumption advisories is available on the Seafood and Aquatic Life Group web page of the DSHS website: www.dshs.state.tx.us/seafood
  - Grant funds have been used for the purchase of advisory signs for some of the lakes.
    - Lake Como
    - Echo Lake
    - Fosdic Lake
  - An up-to-date fish consumption advisory booklet is being prepared.
  - The Total Maximum Daily Load (TMDL) Fish Project is ongoing.

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        - Risk assessment for Ellison Creek Reservoir in progress (fish collection May 2014)
        - Fish collection Mountain Creek Lake November 2015
        - Plan to sample Lake Worth November 2016
    - Potential San Jacinto River (SJR) Waste Pits project is being proposed.
        - EPA Superfund requested proposed budget to perform additional SJR monitoring.
- Environmental Health and Toxicology work group update
    - Work group has not met in several months.
    - If an issue or issues arise that the work group needs to address, contact Laura Morse to coordinate a meeting.

Agency updates on department policy and/or legislative issues:

- Texas Department of State Health Services (DSHS)
    - *Zika Virus*
        - DSHS is ramping up to respond to a potential Zika outbreak in Texas. The mosquito-borne virus has been spreading rapidly across South and Central America and the Caribbean over the past year. In February, the World Health Organization declared it to be a global health emergency. Zika is spread primarily by the *Aedes aegypti* mosquito. Illness is usually mild, but the virus has been associated with microcephaly, a birth defect that causes babies to be born with smaller heads than expected. At this time, local transmission is not occurring in Texas, but there have been several travel-related cases. As warm weather returns and mosquitoes become more active, the threat of local transmission will increase.
        - The **DSHS Laboratory** has built up its capacity to perform polymerase chain reaction (PCR) testing on human samples; the **Zoonosis Control Branch** is coordinating sentinel trapping of mosquitoes in select local areas of the state; and the **Birth Defects Epidemiology and Surveillance Branch** is preparing to implement "rapid ascertainment" for cases of microcephaly.
    - *Health Assessment and Consultation Program*
        - The Health Assessment and Consultation Program was reviewing data recently received for the Superfund site, North East 2nd Street Site, in Happy, Texas. Staff observed benzene, a contaminant not associated with the Superfund site, in some of the private wells. One of the wells had a level more than 100 times above the drinking water standard. DSHS notified Texas Commission on Environmental Quality (TCEQ), U.S. Environmental Protection Agency (EPA) and the Agency for Toxic Substances and Disease Registry (ATSDR) of the benzene contamination, and has been coordinating with them to address it. The contamination appears to be from a petroleum release. As a result, the TCEQ Petroleum Storage Tank/Dry Cleaner Remediation Program Section began sampling wells in the potential plume area. TCEQ's Toxicology Division has been talking with residents who have benzene contamination in their wells. DSHS will provide further assistance where needed.
        - On February 17, 2016, the U.S. EPA held a public meeting regarding a breach in the protective cap at the San Jacinto River Waste Pits Superfund site. In response to elevated community concerns and interest from U.S. Representative Gene Green, 29th District, EPA has requested assistance from

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DSHS in educating the community. DSHS staff are planning an educational campaign that will take place April 8th through April 13th. Staff will be going door-to-door in neighborhoods adjacent to the site to distribute educational materials and visit with residents to address their concerns. In addition, staff will be participating in the Baytown Nurture Nature Festival that will enable us to reach a broader audience regarding the DSHS fish consumption advisory that is in place for the San Jacinto River, Houston Ship Channel, and Upper Galveston Bay.

- Texas Commission on Environmental Quality (TCEQ)
  - *Development Support Documents*
    - Proposed – **Comments Due March 25, 2016**
      - Dibutylamine
      - Diisopropylamine
    - Finalized – Posted
      - Ethylene Glycol (Feb 2016)
      - Methoxysilanes (Jan 2016)
  - *Society of Toxicology Meeting (March 13-17, 2016)*
    - Several Toxicologists attended
    - Scientific Poster Presentations
      - Dose-Response Curves Derived from Clinical Ozone Exposures Can Inform Public Policy, by Sabine Lange, Michael Honeycutt, G. Tao, et al.
      - Common Misconception: Rats Receive a 4-5 Times Lower Ozone Tissue Dose than Humans at the Same Concentration, by Darrell McCant, Sabine Lange, Joseph Haney, Michael Honeycutt.
      - The Most Scientifically-Supported Approach for Assessing the Carcinogenicity of Oral Exposure to Hexavalent Chromium: Non-Linear, Non-Threshold versus Threshold Approaches (Top 10 risk assessment abstract), by J. Haney.
      - Chromium in Texas Groundwater - Is Allergic Contact Dermatitis a Risk?, by Shannon Ethridge and Allison Jenkins.
    - Top 10 Papers Demonstrating Application of Risk Assessment in 2015
      - Consideration of non-linear, non-threshold and threshold approaches for assessing the carcinogenicity of oral exposure to hexavalent chromium. Regul. Toxicol. Pharmacol. 73: 834-852, 2015.
      - Use of dose-dependent absorption into target tissues to more accurately predict cancer risk at low oral doses of hexavalent chromium. Regul. Toxicol. Pharmacol. 71: 93–100, 2015.
  - *Publications*
    - J. Haney. Development of an Inhalation Unit Risk Factor for Cadmium (proposed DSD out soon). Accepted in Regulatory Toxicology and Pharmacology.
    - J. Haney, T. Phillips, R. Sielken, et al. Development of an inhalation unit risk factor for isoprene. Regul. Toxicol. Pharmacol. 73: 712-725, 2015.
    - Special Issue of Chemico-Biological Interactions was finally released: Understanding the Health Risks of Lower Olefins. It's a compilation of what was presented at the Symposium on Understanding the Health Risks of Lower

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Olefins, which was hosted by the TCEQ November 5-6, 2014 (http://www.sciencedirect.com/science/journal/00092797/241)

- *Drinking Water*
  - Lead – TCEQ has experienced increased calls/PIRs about lead in drinking water as a result of Flint, Michigan issues. Question: Has DSHS experienced the same for blood lead levels, etc.?
  - Arsenic – Environmental Integrity project came out with a report recently, in which they recommend that the state warn residents not to drink water above the MCL. They looked at ~5 states that use supplemental language, but TCEQ currently uses EPA's recommended language (to change would require approval from EPA). This report could lead to more calls for DSHS on arsenic in water.

- Texas Department of Agriculture (TDA)
  - Staff was unable to attend and provide an update.
- Texas Department of Public Safety (DPS)
  - Staff was unable to attend and provide an update.
- Railroad Commission of Texas (RRC)
  - Staff was unable to attend, but provided an update via email prior to the meeting. DSHS read the update to meeting participants.
  - The RRC has a new executive director, Kim Corley, who previously worked for Shell Oil Company.
  - The Commission continues to operate on a decreased budget.
  - Only job vacancies that are critical are being filled, such as two District Office Director positions that are currently vacant (Kilgore District 5/6 and Midland District 8).
  - To continue to meet measurement criteria even with a decreased budget, the State Managed Plugging Program is plugging shallow abandoned oil and gas wells rather than deeper wells and the State Managed Cleanup Program- Site Remediation is remediating smaller tank battery sites.
- Texas Parks and Wildlife Department (TPWD)
  - Staff had no agency update for the meeting.

Public comment:

- No members of the public were in attendance.

Review of upcoming meetings in 2016:

- June 21, 2016 - DSHS, M-653, 10:00 am
- September 20, 2016 - DSHS, M-653, 10:00 am
- December 20, 2016 - DSHS, T-607, 10:00 am

Adjourn:

- Meeting adjourned before 11:30 am.

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Toxic Substance Coordinating Committee Quarterly Meeting

March 22, 2016 Tw Sign-in Sheet

Please initial to indicate attendance and make corrections as needed

INITIAL	NAME	AGENCY	PHONE	EMAIL ADDRESS
	Barker, David	TCEQ		
	Beauchamp, Richard	DSHS (EIET)	512-776-6434	richard.beauchamp@dshs.state.tx.us
	Bojes, Heidi	DSHS (EEDRS/EIET)	512-776-6704	heidi.bojes@dshs.state.tx.us
JD	Duty, Josh	DSHS (EIET)	512-776-6641	josh.duty@dshs.state.tx.us
	Dutta, Deba	DSHS (EIET)	512-776-2855	deba.dutta@dshs.state.tx.us
	Ellerbee, Tom	DSHS (EIET)	512-776-6039	tom.ellerbee@dshs.state.tx.us
	Hall, Emily	DSHS (EIET)	512-776-2652	emily.hall@dshs.state.tx.us
	Haney, Joseph	TCEQ	512-239-5691	jhaney@tceq.state.tx.us
	Hernendez, Sandra	DSHS	512-776-6175	sandra.hernandez@dshs.state.tx.us
	Holloway, Kitten	DSHS	512-776-3131	kitten.holloway@dshs.state.tx.us
JHJ	Hover-Jeansonne, Jocelyn	DSHS	512-776-3486	Jocelyn.hover-jeansonne@dshs.texas.gov
	Kindt, Amanda	RRC		amanda.kindt@rrc.state.us
	Mills, Brady	DPS		brady.mills@dps.texas.gov
LM	Morse, Laura	DSHS (EIET)	512-776-3004	laura.morse@dshs.state.tx.us
	Mudd, Anna	DPS		anna.mudd@dps.texas.gov
	Nunez, Alex	TPWD		
TP	Phillips, Tracie	TCEQ (toxicology)	512-239-2269	tracie.phillips@tceq.texas.gov
	Smith, LJ	DSHS (EIET)	512-776-6213	lj.smith@dshs.state.tx.us
MT	Tennant, Michael	DSHS (Seafood Safety)	512-834-6757 x2511	michael.tennant@dshs.state.tx.us
	Velez, Jose	DSHS (Pest)	512-776-6126	jose.velez@dshs.state.tx.us
	Villarreal, David	TDA		david.villarreal@texasagriculture.gov
TW	Walker, Tina	DSHS (EIET)	512-776-2932	tina.walker@dshs.state.tx.us
	Williams, Tina	DSHS (EIET)	512-776-6532	tina.williams@dshs.state.tx.us
	Ziqubu-Page, Thandi	DSHS (EIET)	512-776-6064	thandi.ziqubu-page@dshs.state.tx.us
	Erraguntla, Neeraja	TCEQ	512-239-2492	neeraja.erraguntla@tceq.texas.gov

NOTE: Please feel free to cross through names that need to be deleted so the list can be updated. Thank you!

Toxic Substance Coordinating Committee Quarterly Meeting

March 22, 2016 TSD Sign-in Sheet

Please initial to indicate attendance and make corrections as needed

INITIAL	NAME	AGENCY	PHONE	EMAIL ADDRESS
DR	Rangel, Diana	DSHS (EIET)	512-776-6572	diana.rangel@dshs.state.tx.us
BP	Beth Patterson	DSHS		Beth.patterson@
EH	Emily Hall	DSHS	ex. 2652	emily.hall
Visitors please sign in below				

NOTE: Please feel free to cross through names that need to be deleted so the list can be updated. Thank you!

Toxic Substance Coordinating Committee Quarterly Meeting
December 15, 2015 Sign-in Sheet
Please initial to indicate attendance and make corrections as needed

INITIAL	NAME	AGENCY	PHONE	EMAIL ADDRESS
	Archer, Natalie	DSHS (EIET)	512-776-3723	natalie.archer@dshs.state.tx.us
	Barker, David	TCEQ		
	Beauchamp, Richard	DSHS (EIET)	512-776-6434	richard.beauchamp@dshs.state.tx.us
HB	Bojes, Heidi	DSHS (EEDRS/EIET)	512-776-6704	heidi.bojes@dshs.state.tx.us
	Duty, Josh	DSHS (EIET)	512-776-6641	josh.duty@dshs.state.tx.us
DD	Dutta, Deba	DSHS (EIET)	512-776-2855	deba.dutta@dshs.state.tx.us
TE	Ellerbee, Tom	DSHS (EIET)	512-776-6039	tom.ellerbee@dshs.state.tx.us
EH	Hall, Emily	DSHS (EIET)	512-776-2652	emily.hall@dshs.state.tx.us
	Haney, Joseph	TCEQ	512-239-5691	jhaney@tceq.state.tx.us
	Holloway, Kitten	DSHS	512-776-3131	kitten.holloway@dshs.state.tx.us
AK	Kindt, Amanda	RRC		amanda.kindt@rrc.state.us
	Metzger, Kristi	DSHS (EIET)	512-776-7287	kristi.metzger@dshs.state.tx.us
	Mills, Brady	DPS		brady.mills@dps.texas.gov
LM	Morse, Laura	DSHS (EIET)	512-776-3004	laura.morse@dshs.state.tx.us
	Mudd, Anna	DPS		anna.mudd@dps.texas.gov
	Nunez, Alex	TPWD		
	Phillips, Tracie	TCEQ (toxicology)	512-239-2269	tracie.phillips@tceq.texas.gov
	Smith, LJ	DSHS (EIET)	512-776-6213	lj.smith@dshs.state.tx.us
	Tennant, Michael	DSHS (Seafood Safety)	512-834-6757 x2511	michael.tennant@dshs.state.tx.us
	Velez, Jose	DSHS (Pest)	512-776-6126	jose.velez@dshs.state.tx.us
DV	Villarreal, David	TDA		david.villarreal@texasagriculture.gov
	Walker, Tina	DSHS (EIET)	512-776-2932	tina.walker@dshs.state.tx.us
	Williams, Tina	DSHS (EIET)	512-776-6532	tina.williams@dshs.state.tx.us
	Ziqubu-Page, Thandi	DSHS (EIET)	512-776-6064	thandi.ziqubu-page@dshs.state.tx.us
	Erraguntla, Neeraja	TCEQ	512-239-2492	neeraja.erraguntla@tceq.texas.gov

NOTE: Please feel free to cross through names that need to be deleted so the list can be updated. Thank you!

Toxic Substance Coordinating Committee Quarterly Meeting
December 15, 2015 Sign-in Sheet
Please initial to indicate attendance and make corrections as needed

INITIAL	NAME	AGENCY	PHONE	EMAIL ADDRESS
JHJ	Jocelyn Hover-Jeansonne	DSHS	512-776-3486	jocelyn.hover-jeansonne@dshs.state.tx.us
AMA	Ama			
	Sandra Hernandez	DSHS		sandra.hernandez2@dshs.state.tx.us
Visitors please sign in below				
RP	Ben Patterson	DSHS		
	Cress Obamwonyi	DSHS		

NOTE: Please feel free to cross through names that need to be deleted so the list can be updated. Thank you!

Toxic Substance Coordinating Committee Quarterly Meeting
September 15, 2015 Sign-in Sheet
Please initial to indicate attendance and make corrections as needed

INITIAL	NAME	AGENCY	PHONE	EMAIL ADDRESS
	John Villanacci-Chair	DSHS (EIET)	512-776-6175	john.villanacci@dshs.state.tx.us
✓	Archer, Natalie	DSHS (EIET)	512-776-3723	natalie.archer@dshs.state.tx.us
	Barker, David	TCEQ		
✓	Beauchamp, Richard	DSHS (EIET)	512-776-6434	richard.beauchamp@dshs.state.tx.us
HB ✓	Bojes, Heidi	DSHS	512-776-6704	heidi.bojes@dshs.state.tx.us
JD ✓	Duty, Josh	DSHS (EIET)	512-776-6641	josh,duty@dshs.state.tx.us
✓	Dutta, Deba	DSHS (EIET)	512-776-2855	deba,dutta@dshs.state.tx.us
✓	Ellerbee, Tom	DSHS (EIET)	512-776-6039	tom.ellerbee@dshs.state.tx.us
	Haney, Joseph	TCEQ	512-239-5691	jhaney@tceq.state.tx.us
✓	Holloway, Kitten	DSHS	512-776-3131	kitten.holloway@dshs.state.tx.us
✓	Kindt, Amanda	RRC		amanda.kindt@rrc.state.us
✓	Langlois, Peter	DSHS (BD)	512-776-3131	peter.langlois@dshs.state.tx.us
	Metzger, Kristi	DSHS (EIET)	512-776-7287	kristi.metzger@dshs.state.tx.us
	Nunez, Alex	TPWD		
JDP ✓	Phillips, Tracie	TCEQ (toxicology)	512-239-2269	tracie.phillips@tceq.texas.gov
	Pitts, Don	TPWD		
	Rivera, David	DSHS (EIET)	512-776-6572	david.rivera@dshs.state.tx.us
✓	Smith, LJ	DSHS (EIET)	512-776-6213	lj.smith@dshs.state.tx.us
✓	Tennant, Michael	DSHS (Seafood Safety)	512-834-6757 x2511	michael.tennant@dshs.state.tx.us
✓	Velez, Jose	DSHS (Pest)	512-776-6126	jose.velez@dshs.state.tx.us
✓	Villarreal, David	TDA		david.villarreal@texasagriculture.gov
TW	Walker, Tina	DSHS (EIET)	512-776-2932	tina.walker@dshs.state.tx.us
	Williams, Tina	DSHS (EIET)	512-776-6532	tina.williams@dshs.state.tx.us
	Ziqubu-Page, Thandi	DSHS (EIET)	512-776-6064	thandi.ziqubu-page@dshs.state.tx.us
	~~Etraguntla, Neeraja~~	~~TCEQ~~	~~512-239-2492~~	~~neeraja.erraguntla@tceq.texas.gov~~

NOTE: Please feel free to cross through names that need to be deleted so the list can be updated. Thank you!

Toxic Substance Coordinating Committee Quarterly Meeting
September 15, 2015 Sign-in Sheet
Please initial to indicate attendance and make corrections as needed

INITIAL	NAME	AGENCY	PHONE	EMAIL ADDRESS
Visitors please sign in below				
LJ	Lindsey Jones	TCEQ	512-239-1784	lindsey.jones@tceq.texas.gov
DDM	Darrell D. McCant	TCEQ	512-239-4477	darrell.mccant@tceq.texas.gov
SL	Sabine Lange	TCEQ	512-239-3108	sabine.lange@tceq.texas.gov

NOTE: Please feel free to cross through names that need to be deleted so the list can be updated. Thank you!

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
537 - Department of State Health Services

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Youth Camp Advisory Committee (YCAC)

Number of Members: 9

Committee Status (Ongoing or Inactive): Ongoing — Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 9/1/1991 **Date to Be Abolished:** N/A

Budget Strategy (Strategies) (e.g. 1-2-4): 4.1.2 **Strategy Title (e.g. Occupational Licensing):** Environmental Health

Budget Strategy (Strategies): **Strategy Title:**

State / Federal Authority	Select Type	Identify Specific Citation
State Authority	Statute	HSC 141.010
State Authority	Admin Code	25 TAC 265.29
State Authority		
Federal Authority		
Federal Authority		
Federal Authority		

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	$0	$0	$0
Personnel	$0	$0	$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	$0	$0	$0
Total, Committee Expenditures	$0	$0	$0

Method of Financing

Method of Finance	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
1 - General Revenue Fund	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
Expenses / MOFs Difference:	$0	$0	$0

Meetings Per Fiscal Year

	1	1	1

Committee Description: The youth camp advisory committee is a statutory requirement by Health and Safety Code, 141.010 and consists of interested stakeholders to provide input, make recommendations, and to advise the Department of State Health Services on matters concerning youth camps and the implementation and administration of the Youth Camp Act.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. No bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

Committee meets anually in Austin. Yes, meeting frequency is in 25 TAC 265.29(a)(4).

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

Make recommendations to the executive commissioner regarding the content of the rules adopted to implement the Act. There are no required documents.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

Recommendations for changes in the Youth Campp Rules. All recommendations of the committee were initially adopted in the rule revision, however during the initial rule process there were concerns with one of the recommendations, and this was deleted from the rules revision at the behest of the State Health Services Council and the youth camp industry.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ? Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees? No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015? 80.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Set up meetings, submit Open Meeting notice, coordinate changes to the youth camp rules, request applications for committee vacancies and expired terms, process those applications and submit documentation for the appointment of new committee members.

6. Have there been instances where the committee was unable to meet because a quorum was not present? Yes

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

Yes, meeting notice posted on the youth camp web site, notice posted in the Texas Register, and direct email to interested youth camp representatives.

7b. Do members of the public attend at least 50 percent of all committee meetings? Yes

7c. Are there instances where no members of the public attended meetings? No

8. Please list any external stakeholders you recommend we contact regarding this committee.

Youth camp operators

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals? Yes

9b. Please describe the rationale for this opinion.

The committee fulfills its statutory charge to advise the Executive Commissioner on standards and procedures, and the content of rules implementing HSC Chapter 141.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute? No

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area? No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)? Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission? No

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

Texas Youth Camp Advisory Committee
Meeting Notes & Action Items

Purpose or Goal: Youth Camp Advisory Committee Meeting	**Location:** Department of State Health Services, Exchange Building, N 102, Austin, Texas
Meeting Date: 2/2/2012	**Time:** 9:30 A.M. – 12:00 P.M.

Attendees		
Beau Biron Committee Member	Danny Dawdy Committee Member	William Hinton Committee Member
Patricia Osborn Committee Member	Danielle Shaw Committee Member	Rod Moline DSHS
Laura Pfefferle DSHS	Heather Muehr DSHS	Michael Minoia DSHS
Larry Raper DSHS	Tim Huchton	Chuck Hart
Gail Zahara		

Minutes

The meeting was called to order at 9:36 by William Hinton. Everyone present introduced themselves.

There was a quorum present.

Review and approval of the meeting minutes from the last meeting of the Advisory Committee. The committee reviewed the minutes from the 10/6/2011 meeting. Meeting minutes were approved.

Department of State Health Services (DSHS) updates.

Mike Minoia gave an update on the Campus Program for Minors. The proposed draft rules are to be published in the Texas Register on Friday, February 3, 2012.

Rod Moline, Policy, Standards, and Quality Assurance (PSQA) Unit Manager, updated the Committee. Paula Anderson, PSQA manager for the youth camp program, is no longer with DSHS. Two other management positions in the PSQA unit are also vacant. Right now, DSHS is under a hiring freeze. All job descriptions are currently under review as a result of a budget reduction of 28%. In the current climate the Legislature is focusing on the economic impact of regulation. This also has resulted in a review of agency strategies on how to accomplish our mission. We are currently looking at DSHS's authority for various programs, and reviewing regulatory programs through Rider 59 of the Appropriations Act. We may reduce or eliminate those functions for which we have limited or no enforcement authority. The youth camp program is one of the programs in which DSHS has full authority, and we work in partnership with the Youth Camp Advisory Committee. In other programs DSHS may limit its role to an advisory one. DSHS needs to maximize current resources by spending time and attention on areas with high risk where we have clear authority. At this time a reduction in force is not anticipated but it may become necessary to reassign duties for some

personnel.

Danielle Shaw asked Rod at which point would DSHS stop regulating a program, even though it is mandated by statute. There would need to be a significant budget cut to affect the youth camp program. It is unknown if there may be an increase in the youth camp license fees at this time.

Bill Hinton stated that members of the youth camp industry are protective of the youth came name. He said the youth camp rules were created by their predecessors and that the rules are important to keeping camps in Texas successful. He is glad to hear that they are partners with the State. He recommended that if there was a reduction of resources for the youth camp program that inspections be prioritized based upon past compliance history. All agreed that the highest priority is camps operating without licenses. He also recommended DSHS attendance at educational conferences, such as the Southwest Camping Conference and CAMPference.

Elect chairperson, vice-chairperson, and secretary of the committee.

The committee voted to re-elect Bill Hinton as chairperson and Beau Biron as vice-chairperson. The committee decided that there was no need for a secretary at this time.

Process and timeline for replacement of committee members who have expired terms.

Currently three members of the Advisory Committee have expired terms. These are Charles Crews, Dan Dunagan, and Kathryn Ragsdale. Mike Minoia outlined the process for replacing members on the committee. It was decided that notice of the need to replace members be posted on the youth camp web site, emailed to interested people, and included in mailings of licenses from DSHS. The application process should remain open until May 1, 2012, at which time it may be necessary to extend the application process depending on the number of applicants.

Work on youth camp rule revisions to 25 Texas Administrative Code, Chapter 265.

The rulemaking process time line for the June 14, 2012 Council meeting was presented. The proposed rule revision will include the four-year review under Government Code Sec. 2001.039, so all rule sections will be open for comment and potential amendment.

The committee made the following additional recommended changes to the draft youth camp rules:

- §265.12(i)(5)(C) Delete “and” at the end of the sentence.
- §265.12(i)(5)(D) Delete “Training shall include the need to minimize one-on-one isolated encounters between an adult and a minor or between two minors.”
- New §265.12(i)(5)(E) “the need to minimize one-on-one isolated encounters between an adult and a minor; and”
- New §265.12(i)(5)(F) “the risk of sexual activity between campers, steps to prevent sexual activity between campers, and how to respond if sexual activity between campers occurs.”
- §265.15(m) add “at the minimum”, so this would read “Camp trip first aid kits. First aid kits containing at the minimum the items listed in subsection (f) of this section shall be taken on all out-of-camp trips.”

- §265.19(d) add "of campers", so this would read "Safety belts. In any vehicle used for transportation of campers that is equipped with safety belts or that is required by any law to be equipped with safety belts,"
- §265.19(d)(2) add "when the vehicle is in motion", so this would read "all campers shall wear the safety belts provided when the vehicle is in motion."
- Delete §265.23(a)(1)(B) if the general characteristics of a youth camp are changed.
- Delete §265.24(c)(1)(B) if the general characteristics of a youth camp are changed.

The committee voted approval for staff to make additional revisions to the draft rules if needed to reflect the proposed change in applicability in §265.11(25). It was also agreed that an additional meeting of the committee may be called to review the revisions.

Public comment.

No public comment was made.

The next committee meeting was set for September 20, 2012 at the Exchange building in Austin beginning at 9:30 A.M.

Meeting was adjourned at 11:52 A.M.

Minutes approved: _____

William Hinton, Chair, Presiding Officer

Texas Youth Camp Advisory Committee
Meeting Notes & Action Items

Purpose or Goal: Youth Camp Advisory Committee Meeting	**Location:** Department of State Health Services, Exchange Building, N 102, Austin, Texas
Meeting Date: 9/25/2013	**Time:** 9:30 A.M. – 12:00 P.M.

Attendees		
Beau Biron Committee Member	Danny Dawdy Committee Member	William Hinton Committee Member
Patricia Osborn Committee Member Via telephone	Britt Darwin-Looney Committee Member Via telephone	Laura Pfefferle DSHS
Michael Minoia DSHS	Heather Muehr DSHS	Michelle Mauldin
Courtney Hoffman	Tim Huchton	Rick Denison
Gail Zahara		

Minutes

The meeting was called to order at 9:46 by William Hinton.

There was a quorum present.

Department of State Health Services (DSHS) updates.

Mike Minoia gave an update on the replacement committee member. There were two applicants for the committee, one of which did not submit a complete application package (lacking the required two references). The documentation for appointing a new committee member had been sent up the chain of command.

Mike Minoia gave an update on the Campus Program for Minors (CPM). The program seems to be working well. Quite a few colleges and universities are sending in the required lists of CPM employees that have completed the training.

Mike Minoia then updated the committee on the 2013 youth camp season. There were 552 licensed youth camps, of which 505 were inspected. Only 47 licensed youth camps were not inspected, giving a 91.5% inspection rate. To date, there were 5 inspections referred for escalated enforcement. Two were camps operating without a license and the other three were for repeat violations. The most common deficiencies noted on inspections in 2013 were lack of proper documentation, including staff member character & integrity records, annual criminal background check lists kept on-site, and sexual abuse and child molestation training and examination program documentation kept on-site. Most of the camps cited for these deficiencies had the documentation at a central location, but not at the youth camp as required by rule.

DRAFT

Review and approval of the meeting minutes from the last meeting of the Advisory Committee. The committee reviewed the minutes from the 2/2/2012 meeting. Meeting minutes were approved. The meeting on 10/30/2012 did not have a quorum so there were no committee minutes.

The election of new committee officers was deferred to the next meeting.

Official comments on the proposed revisions to the youth camp rules, 25 Texas Administrative Code, Chapter 265.

- Section 265.17(f)(2)(C) – delete age and replace head gear with helmet, so this would read "(C) require all riders (campers and instructional staff) to wear appropriate protective helmets."
- Sections 265.12(g) and (h), and 265.23(c) - delete all references to "deferred adjudication.
- Section 265.24(b) – delete "by first-class mail" to allow for other methods of notification. Additionally it was proposed at all renewal correspondence be by email. However, upon discussion, this suggestion was withdrawn since email information is not currently required of the youth camp renewal application.
- Section 265.15(f) – add a sentence that first aid supplies should be in single use packaging.

Public comment. No public comment was made.

The next committee meeting was set for October 1, 2014 at the Exchange building in Austin beginning at 9:30 A.M.

Meeting was adjourned at 11:40 A.M.

Minutes approved: _____

William Hinton, Chair, Presiding Officer

DRAFT

Texas Youth Camp Advisory Committee
Meeting Notes & Action Items

Purpose or Goal: Youth Camp Advisory Committee Meeting	**Location:** Department of State Health Services, Exchange Building, N 102, Austin, Texas
Meeting Date: 10/21/2014	**Time:** 9:30 A.M. – 12:00 P.M.

Attendees		
Beau Biron Committee Member	Danny Dawdy Committee Member	William Hinton Committee Member
Timothy Huchton Committee Member	Michelle Mauldin Committee Member	Michael Minoia DSHS
Courtney Hoffman	Robert Sedillo	Robert A Miller
Bob Oatman		

Minutes

The meeting was called to order at 9:32 by William Hinton.

There was a quorum present.

The committee minutes from September 25, 2013 were approved.

Department of State Health Services (DSHS) updates.

Mike Minoia gave an update on the 2014 Youth Camp Season:

- There were 565 youth camps licensed in 2014.
- 523 of those camps were inspected in 2014. Giving a 92.6% inspection rate.
- Only 42 camps were not inspected. Explanations were given for why some of the youth camps were not inspected, including late license application submission, camps that did not operate, camps not being on-site without notice, and short duration camps.
- 13 cases were given to the Enforcement Group. 2 were for operating without a license, and 11 were for various deficiencies, but those camps had not submitted the required Corrective Action Plan.
- An update was given concerning results from the Sunset Advisory Commission. The youth Camp Advisory Committee was recommended for continuation, but the Youth Camp Training Advisory Committee was recommended for deletion.

The Committee recommended that DSHS focus on inspecting one week long camps, but were pleased with the inspection rate.

Mike Minoia also gave a report on the new committee member status, which was on hold from upper management.

DRAFT

The Committee elected new officers:

- Danny Dawdy was elected as Chairman.
- Michelle Mauldin was elected as Vice-Chairman.

The Committee discussed and recommended that DSHS consider adding overnight single sport camps to the General Charistics section of the rules.

Public comments:

- Courtney Hoffman discussed about during the legislative session 2 sessions ago, there was a bill that attempted to make weekend "camps" fall under the youth camp rules, but that bill never passed. She also discussed that operations falling into the grey area that did not currently fit into either youth camp licensing and child care licensing should at least be required to register with the State, and have some type of required training.

The next committee meeting was set for September 22, 2015 at the Exchange building in Austin beginning at 9:30 A.M.

Meeting was adjourned at 10:42 A.M.

Minutes approved: _____

- Danny Dawdy, Chair, Presiding Officer

DRAFT