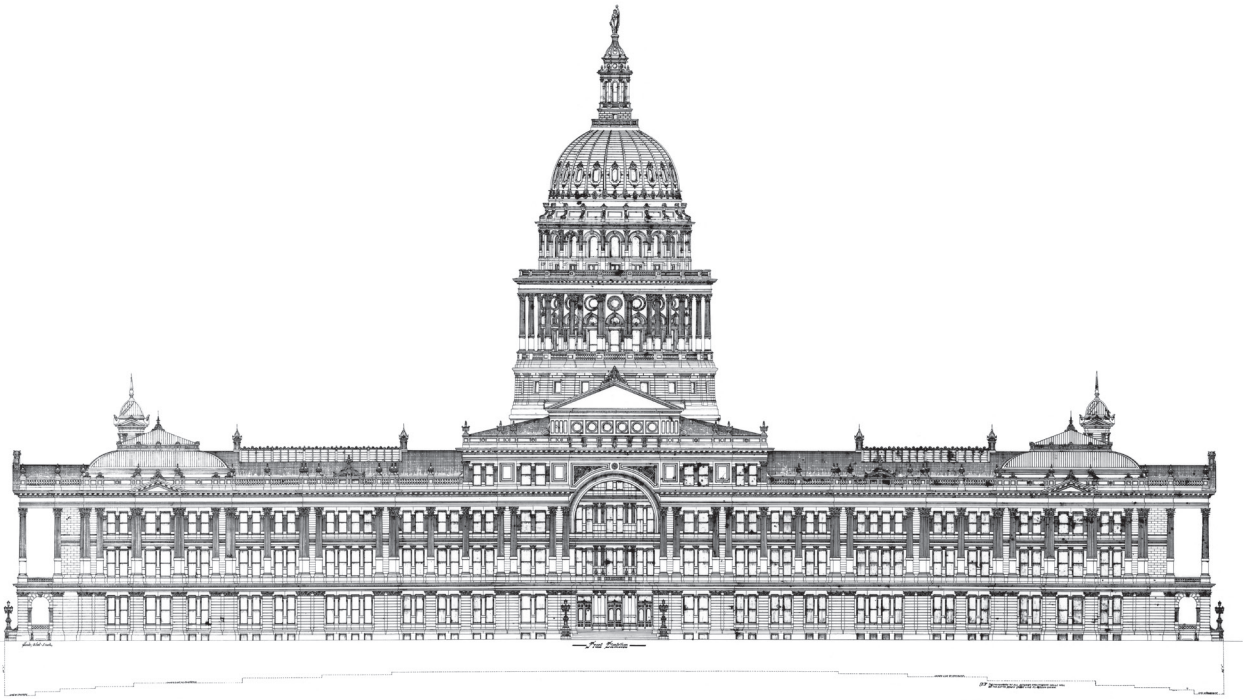
Interim Report

to the 82nd Texas Legislature

House Committee on

Public Health

December 2010



HOUSE COMMITTEE ON PUBLIC HEALTH
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2010

A REPORT TO THE
HOUSE OF REPRESENTATIVES
82ND TEXAS LEGISLATURE

LOIS W. KOLKHORST
CHAIRMAN

COMMITTEE CLERK
BRYAN LAW

Committee On
Public Health

December 6, 2010

Lois Kolkhorst
Chairman

P.O. Box 2910
Austin, Texas 78768-2910

The Honorable Joe Straus
Speaker, Texas House of Representatives
Members of the Texas House of Representatives
Texas State Capitol, Rm. 2W.13
Austin, Texas 78701

Dear Mr. Speaker and Fellow Members:

The Committee on Public Health of the Eighty-first Legislature hereby submits its interim report including the committee's findings and policy recommendations for consideration by the Eighty-second Legislature. The committee held six public hearings on the interim charges and gathered a broad requisite of knowledge from the leading experts and leaders in all the policy areas outlined by the interim charges. We hope this report will be a useful guide and point of reference for the Eighty-second Legislature.

We thank you for providing this committee the opportunity to serve the people of Texas by studying these important issues of public health for all Texans.

Respectfully submitted,

Lois Kolkhorst, Chair

Elliot Naishtat, Vice Chair

Garnet Coleman

John E. Davis

Veronica Gonzales

Chuck Hopson

Susan King

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ACKNOWLEDGMENTS

The House Committee on Public Health would like to thank all the legislative members and staffers who invested their time and energy into the development of this interim report.

The committee also extends gratitude to all the expert witnesses, state agency representatives, organizations and members of the public who provided invaluable testimony to the committee that helped to shape the following recommendations and content of this report.

INTERIM STUDY CHARGES

1. Monitor implementation of legislation intended to curb rising obesity rates in Texas. Study and make recommendations regarding better coordination of prevention efforts and evidence-based strategies to reduce the impact of obesity on health care costs. Include recommendations related to the use of federal stimulus funds targeted toward obesity prevention.

2. Study the state's ability to respond to the H1N1 virus. Examine issues related to vaccine and antiviral distribution and capacity, disease surveillance, communication with providers and the public, intergovernmental cooperation, and medical surge capability.

3. Determine how the state can best coordinate efforts to streamline health care delivery with health information technology (HIT). Identify areas in state law that affect the adoption and use of HIT. Recommend statutory changes as necessary.

4. Identify factors influencing health care cost trends in Texas, including practices or policies that may contribute to regional variations. Investigate medical imaging utilization and its impact on the cost and quality of health care. Recommend policy changes to promote best practices, reduce costs, and improve quality within the state Medicaid program, Employees Retirement System, and Teacher Retirement System. *Joint Interim Charge with House Committee on Appropriations*

5. Examine the need for and barriers to implementing routine HIV screenings as recommended in 2006 by the Centers for Disease Control and Prevention. Assess the impact of implementation on HIV transmission, health outcomes, clinical progression, and mortality.

6. Pursuant to HB 1672 (81R), Section 4, study the policies and procedures related to the disclosure required by Chapter 33, Health and Safety Code, to the parent, managing conservator, or guardian of a newborn child.

7. Identify any gaps in Texas laws that may prevent coordinated efforts, both statewide and on the border, to ensure a safe food supply. *Joint Interim Charge with House Committee on Border and Intergovernmental Affairs*

8. Monitor the agencies and programs under the committee's jurisdiction.

CHARGE # 1

Monitor implementation of legislation intended to curb rising obesity rates in Texas. Study and make recommendations regarding better coordination of prevention efforts and evidence-based strategies to reduce the impact of obesity on health care costs. Include recommendations related to the use of federal stimulus funds targeted toward obesity prevention.

INTRODUCTION

The committee held two hearings on this charge. The first and most substantial hearing was held on March 8, 2010 and the second additional hearing was conducted on August 26, 2010. The committee heard from a wide variety of witnesses on the topic and collected substantial new information based upon the testimony provided.

The March 8th hearing included numerous witnesses representing a variety of organizations, state entities and self. The committee received testimony in the following areas: Obesity trends in Texas, state employee wellness initiatives, state interagency initiatives, treatment and prevention and finally research.The second hearing on August 26th, provided an additional prospective on community initiatives to address obesity.

The recommendations and discussions provided in this section represent a compilation of a vast amount of data, testimony, and research on the issue of obesity. It is clear that stronger coordination of current state policy initiatives scattered across various state agencies is needed. However the committee would also like to stress that no government entity or program can create the type of personal responsibility that is needed from individuals, parents, and communities to effectively address the obesity crisis. Any government program must always seek community partners that will help promote personal responsibility for one's own life and wellbeing. Therefore with personal responsibility in mind, the following recommendations will not be general and vague, but specific to current state initiatives to curb rising obesity rates.

RECOMMENDATIONS

1. The Legislature could consider shifting all obesity prevention funding and efforts towards the prevention of early childhood obesity. For example, the Texas Fitness Now Grant could be used more strategically to target childhood obesity at an earlier age than the current age focus of the program.

2. All state agencies that receive funding for obesity prevention or healthy nutritional outreach programs should better coordinate efforts with other state agencies, academic institutions and community based groups to achieve better results.

3. The Health and Human Services Commission should continue to work with the federal government on better nutritional guidelines and standards for the Supplemental Nutritional Assistance Program (SNAP).

4. The Legislature should consider utilizing the established Renewing Our Communities Account (ROCA) to direct capacity building grants to faith and community based groups that seek to prevent early childhood obesity.

5. The state wellness program established by HB 1297, 80R should achieve higher state agency adoption rates and employee participation or be abolished.

6. The Legislature should support policies that provide better access to nutritious foods, farmer's markets and locally grown fruits and vegetables. For example, the Legislature could allow for Electronic Benefit Transfer (EBT) transactions at qualified farmers' markets.

7. The Health and Human Services Commission (HHSC) could study how the Nurse Family Partnership program could be enhanced to include early childhood obesity prevention education.

8. The Employees Retirement System of Texas (ERS) should report to the Legislature the health outcomes and cost savings of the bariatric surgery benefit adopted by ERS as required by SB 2577, 81R.

DISCUSSION

The Legislature could consider shifting all obesity prevention funding and efforts towards the prevention of early childhood obesity. For example, the Texas Fitness Now Grant should be used more strategically to target childhood obesity at an earlier age than the current age focus of the program.

The Legislature could consider investing all available obesity prevention funding and efforts into early childhood obesity prevention initiatives. Dr. Eduardo Sanchez, Vice President and Chief Medical Officer of Blue Cross Blue Shield of Texas, testified at the hearing before the committee that 16.3% of children and adolescents are obese in the United States. Obesity rates have tripled in the last 30 years. Dr. Sanchez testified that in 2007, 19% of 10 to 17 year olds were obese in Texas. Some of the consequences of childhood obesity are increase likelihood of developing hypertension, type-2 diabetes, and high cholesterol, decline in quality of life, and higher medical expenses. Culturally, more children are spending time watching television and playing computer or video games than playing outside. In response to the lack of physical activity of today's youth, the American Academy of Pediatrics recommends that pediatricians promote free, unstructured play and that children be physically active at least 60 minutes per day. Considering the information above, the committee found through testimony that preventing childhood obesity should be the focus of state policy.

Therefore, all state programs that implement obesity initiatives should target children at an earlier age. For example, the Texas Fitness Now grant is a program that supports in school physical education, nutrition and fitness programs for students in the sixth-eighth grades. Considering the findings of the committee, the Texas Fitness Now grant could be used more strategically to target children at an earlier age when obesity prevention programs can have the best impact.

A second program the committee program the committee reviewed was the Fresh Fruits and Vegetable Program. Todd Staples, Commissioner of Texas Department of Agriculture, testified that in 2009, 82 schools participated in the Fresh Fruits and Vegetable Programs (FFVP) which is a federally assisted program providing free fresh fruits and vegetables to students in participating elementary schools during the school day. Continued support for programs that promote healthy eating at a younger age can help children adopt healthier eating habits. Waiting until a child is an adolescent will not have the same effect as would instilling proper eating habits during early childhood.

All state agencies that receive funding for obesity prevention or healthy nutritional outreach programs should better coordinate efforts with other state agencies, academic institutions and community based groups to achieve better results.

All state agencies that receive funding for obesity related programs should collaborate with other state agencies, academic institutions and community based groups. Each group brings a different aspect that could be advantageous and could produce positive results for the reduction and prevention of obesity. For example, locally based organizations and

nonprofits are in the best position to assist state funded agencies in local communities by fostering local leaders and communities towards action. Academic institutions also play a key role. They provide ample research capabilities, federal funding, and data that could be disseminated to state agencies to help with community and governmental efforts against obesity. For instance, UT Southwestern Medical Center (UTSW), Center for Obesity, Diabetes and Metabolism Research, received $9 million of state funds to pull down $121 million in additional grant funding for obesity, diabetes and metabolism research. This amount of money has helped UTSW increase their obesity research efforts where it is now offering specialized training to students and faculty in the areas of interdisciplinary diagnosis, treatment and research of obesity and prevention of obesity related health complications.

Many other state agencies currently have programs seeking to curb and prevent obesity. Two of these agencies, Texas Department of State Health Services (DSHS) and Texas Department of Agriculture (TDA), currently receive both federal and state funding for obesity prevention or healthy nutrition outreach programs are. Through the American Recovery and Reinvestment Act, DSHS was awarded a onetime grant of approximately $3.89 million to better support current state policy initiatives that address obesity prevention. DSHS also has programs that range from increasing access to fresh fruits and vegetables to supporting the development of safe places for physical activities for children. DSHS also offers twenty local grant programs to Texas communities to implement policy and environmental changes to help prevent obesity, these include the El Paso and San Antonio's baby cafés, the Community Council of Greater Dallas and the Brazos Valley Community Action Agency to name a few.

The Texas Department of Agriculture (TDA) administers several federally funded child nutrition programs including the Summer Food Service Program (SFSP), which provides nutritious and free meals to children during the summer months. Although many states operate SFSP including Texas, many community sponsors of SFSP are only able to run the program for half of the summer break due to complex administrative rules and lack of volunteers. Commissioner Todd Staples in testimony to the committee expressed his desire to maximize federal dollars for the program by finding solutions that enable more community sponsors to participate and administer the program.

The Texas Interagency Obesity Council (IOC), created by SB 556, 80R, is charged with developing a strategic plan for the coordination of different obesity prevention and intervention programs in Texas. The Council is composed of the Commissioners representing the Texas Department of Agriculture, Texas Department of State Health Services and Texas Education Agency. The IOC is in the best position within state government to oversee the coordinating efforts of all state agencies, universities, and community based groups involved with obesity prevention. Through its coordinating efforts, the IOC can assist in bringing each group together to better coordinate the wide array of obesity related programs, especially with academic institutions. Governor Perry in his 2007 line item veto proclamation of HB 1, 80R stated the following:

- *Two appropriations are made for obesity research, and only one is needed. The other is for $18 million at The University of Texas Southwestern Medical Center at Dallas. One of my priorities is increasing collaboration among the agencies and institutions of higher education.*

Therefore based upon all the above efforts and investments, it is recommended that all state agencies that receive funding for obesity prevention or healthy nutritional outreach programs work with the IOC and academic institutions in order to better coordinate programs and use of funds. Further, the IOC should provide recommendations to the Legislature on gaps that might be filled or barriers that might require some policy development to overcome. The committee also finds that if better coordination is not achieved a review by the Legislature of all state funded obesity prevention programs should occur.

The Health and Human Services Commission should continue to work with the federal government on better nutritional guidelines and standards for the Supplemental Nutritional Assistance Program (SNAP).

The Supplemental Nutritional Assistance Program (SNAP) is a federally funded program that provides low-income households electronic benefits to purchase food for their households. Households can use SNAP benefits to purchase food for the household to eat and for seeds and plants that produce food for the household to eat. Some of the food that is eligible for purchase and are a cause concern are soft drinks, candy, cookies, and other similar types of "junk food." The Health and Human Services Commission (HHSC) in the past has requested a waiver to set nutritional guidelines for the state's SNAP program, however that request was denied by the federal government.

Despite this, the committee found that the state needs to continue to work with the federal government to address nutritional issues tied to obesity, especially if individuals are dually enrolled in taxpayer funded nutrition assistance programs and government medical coverage programs. Other states have already taken additional action to restrict the types of food items households can purchase with SNAP. In New York, Mayor Michael Bloomberg is seeking federal permission to bar recipients of food stamps from using them to buy soda or other sugared drinks. New York officials are seriously engaging the federal government on ways to coordinate the adoption of stricter rules on foods sold in schools and for SNAP recipients. Texas could also engage the federal government more seriously on finding a compromise to enhance the guidelines for nutritional standards that currently authorize the purchase of low nutritional quality foods and high calorie sugared drinks. Further, HHSC should evaluate what nutritional choices SNAP recipients make with their purchases and review options for promoting the purchase of healthy alternatives.

The Legislature should consider utilizing the established Renewing Our Communities Account (ROCA) to direct capacity building grants to faith and community based groups that seek to prevent early childhood obesity.

HB 492, 81R was enacted to strengthen faith- and community-based groups, expand social service options in Texas, and create a partnership between those groups and government in order to better help people in need. The Renewing Our Communities Account (ROCA) was created under HB 492, as a state general revenue account consisting of funds from appropriations, gifts, grants, donations, and other sources. The funds provide faith-and community-based groups the opportunity to strengthen their capacity and provide services to the community independent of government funding for services. In 2009, the OneStar Foundation: Texas Center for Social Impact, in partnership with the Texas Health and Human Services Commission, selected 40 small-and medium-sized faith- and community-based organizations to receive grants of up to $25,000. The Legislature should take advantage of ROCA and direct capacity building grants to faith-and community-based groups who seek in their mission to prevent early childhood obesity with their own funds and resources. Since faith-and community-based groups are already connected and involved in the community they have the power to reach children in after-school programs or through other community outreach venues. The ROCA funding mechanism creates a unique opportunity for government to use its resources to truly collaborate with local groups who work daily to address issues like obesity that challenge the health and wellbeing of their communities.

The state wellness program established by HB 1297, 80R should achieve higher state agency adoption rates and employee participation or be abolished.

HB 1297, 80R established a state employee wellness program that encourages state employees to participate in wellness activities. Dr. Adolfo Valadez, Assistant Commissioner at the Texas Department of State Health Services, testified before the committee that approximately 68% of state agencies and universities are currently engaged in the Building Healthy Texans Model Wellness Program which accounts for approximately 193,700 state employees (77%). However, it is unclear the actual number of state employees that participate in the program. Although 68% of state agencies and universities are engaged in the wellness program, the number of employees actually participating is unknown nor did the committee find any solid standards or outcome measures in place to evaluate the effectiveness of the program for employee health and taxpayer investments. Unless evidence can provided of increasing employee participation that correlates with better health outcomes, the Legislature should consider a review of the state wellness program and possible abolishment of the program to better ensure accountability for the use of taxpayer dollars.

The Legislature should support policies that provide increased access to nutritious foods, farmer's markets and locally grown fruits and vegetables. For example, the Legislature could allow for Electronic Benefit Transfer (EBT) transactions at qualified farmers' markets.

Access to nutritious foods, farmer's markets, fruits and vegetables are a key way to help curb childhood obesity. Policies that support such initiatives should be encouraged. For example, Texas schools participate in several children's nutrition programs. The Texas Department of Agriculture (TDA) oversees various federal programs in Texas, like the National School Lunch Program, School Breakfast Program, and Summer Food Service Program. Additionally, the TDA's Texas Public School Nutrition Policy established nutritional guidelines that schools participating in the federal child nutrition programs must follow. Many of the guidelines exceed federal regulations in order to promote a healthier environment in public schools. However, according to the Centers for Disease Control, in Texas there are only 28.3% of middle schools and high schools in 2009 that offer fruits and vegetables as healthy alternative options. More schools should be encouraged to offer substantially more options of fruits and vegetables instead of other "junk food" and low nutritional content foods.

Also, accessibility to farmer's markets is currently difficult for citizens who buy their food with the LoneStar card. According to the Centers for Disease Control (CDC), in 2009 there were no famer's markets in Texas that accepted EBT transactions like the LoneStar card. The Legislature could change this by allowing for EBT transactions at farmer's markets that would qualify for EBT use. Such a change, could substantially increase access to nutritious foods and locally grown fruits and vegetables, especially in urban areas.

Furthermore, programs and policies should be supported to better ensure that individuals in urban areas who do not have easy access to locally grown fruits and vegetables. For example the *Farm to Work* program is a DSHS employee initiative that provides employees the opportunity to receive a fresh basket of local produce delivered to their workplace every week. Also, the *Get Moving Houston Farmers Market Program* is another example of an initiative that brings fresh fruits and vegetables to Houston communities that are underserved by grocery stores and other fresh food outlets. Programs such as these have the possibility of drastically increasing access to nutritious foods, farmer's markets and locally grown fruits and vegetables.

The Health and Human Services Commission (HHSC) could study how the Nurse Family Partnership program could be enhanced to include early childhood obesity prevention education.

The Texas Nurse-Family Partnership (NFP) pairs registered nurses with low-income, first time mothers to improve prenatal care and provide one-on-one child development, education and counseling. The NFP has a proven track record of improving healthcare outcomes, job placement, home stability and lowering government provided medical costs for taxpayers. Nationally, the NFP according to the Health and Human Services Commission resulted in the following results for mothers and children:

56% reduction in emergency room visits
79% reduction in preterm deliveries
23% fewer subsequent pregnancies
20% reduction in welfare use
48% reduction in child abuse and neglect
83% increase in mother's labor force participation within four years
67% decrease in behavioral/intellectual problem within six years

Once enrolled in the program, the nurse visits with the mother from the second trimester of her pregnancy until her child is two years old. The nurse is there to provide support, education and counseling. The NFP could be enhanced to include efforts to help prevent and curb early childhood obesity. For example, some nurses paired with the new mother assist them with breastfeeding or inform the mother about the importance and benefits of breastfeeding. A 2007 US Department of Health and Human Services' Agency for Healthcare Research and Quality meta-analysis, of breastfeeding outcomes in developed countries, concluded that being breastfed as an infant is associated with a reduced risk of infectious and chronic conditions such as obesity.

Therefore, it would be advantageous for the nurse to also inform the mother about nutrition, necessary physical activity and other health measures that can help reduce childhood obesity. It is important that new mother's are properly informed about ways to help their new child lead a happy healthy life. Focusing preventive methods at the early age of a child's life has the highest probability of preventing and curbing early childhood obesity.

The Employees Retirement System of Texas (ERS) should report to the Legislature the health outcomes and cost savings of the bariatric surgery benefit adopted by ERS as required by SB 2577, 81R.

SB 2577, 81R required the Board of Trustees of the Employees Retirement System of Texas to implement a cost-neutral or cost-positive plan for providing bariatric surgery coverage for state employees eligible to participate in the state's employee health insurance, also known as the Group Benefit Plan (GBP). The new bariatric surgery benefit is expected to lower chronic disease rates, improve health outcomes and produce long term cost savings for the state and taxpayers. The committee heard testimony from Ann Fulberg, Executive Director of the Employee Retirement System, that the GBP expenses were exceeding revenue. In the 2009 fiscal year, the group benefit plan experienced a net loss of $102.4 million. Considering such shortfalls, ERS should closely monitor the new bariatric surgery coverage and provide an extensive report to the Legislature on the costs savings of providing this benefit. Most of all, the committee hopes that quality of life indicators and health outcomes will greatly improve for state employees who are currently receiving medical treatment for conditions related to morbid obesity. Early indicators from ERS seem to show that because of this new benefit more state employees are participating in the health plan's weight management program. Therefore, considering all the above, it is important that ERS provide the Legislature ongoing feedback on this important new benefit.

CHARGE #2

Study the state's ability to respond to the H1N1 virus. Examine issues related to vaccine and antiviral distribution and capacity, disease surveillance, communication with providers and the public, intergovernmental cooperation, and medical surge capability.

INTRODUCTION

The House Committee on Public Health held two public hearings on this charge. The first and most substantial hearing occurred on March 8, 2010 and a second follow up hearing on August 26, 2010. The committee heard testimony on the state's response to the 2009 H1N1 outbreak and on the state's vaccine distribution system. Testimony was also provided on the state's current efforts to prepare for a possible third wave of the H1N1 virus.

The first case of pandemic influenza A (H1N1) was reported in Texas in April of 2009. H1N1 quickly became a pandemic and had a significant impact in Texas and the United States. In fact, nationally there were, 57 million H1N1 related illnesses, 257,000 hospitalizations, and 11,690 deaths attributed to H1N1. In Texas, 2,316 hospitalizations, 585 ICU cases, and 240 deaths were linked to H1N1 according to the Department of State Health Services (DSHS). While the numbers seem alarming, the virus would have taken a much greater toll if the mortality rates were as a high as experts had projected. On August 10, 2010, the World Health Organization (WHO) declared that H1N1 was no longer a pandemic.

The Department of State Health Services (DSHS) was the lead Texas agency in coordination with the Centers for Disease Control (CDC) during the H1N1 outbreak. The committee received a wide array of testimony both positive and negative on the department's response to H1N1. In general, the committee found that improvements are still needed in the following areas: communication, timeliness in response, and coordination between all levels of government. Further, the committee found that the U.S.'s dependence on costly, foreign vaccines is a critical issue that must be addressed. The recommendations provided below seek to improve upon the past efforts of the state to prepare for and respond to any future disease outbreaks from diseases like H1N1.

RECOMMENDATIONS

1. The Legislature should continue to support the purchase and stockpile of antiviral medication.

2. The Legislature should support the development of in state manufacturing and distribution of the regular flu and H1N1 vaccines to ensure that shortages do not occur in this state, especially for highly vulnerable populations.

3. The Department of State Health Services (DSHS) should develop a more transparent and effective communication process with local authorities, healthcare providers and the public.

4. The Department of State Health Services (DSHS) should improve collaboration with the federal government, academic partners and local communities to improve the state's preparation and response, especially along the Texas border.

DISCUSSION

The Legislature should continue to support the purchase and stockpile of antiviral medication.

According to the The Department of State Health Services (DSHS) website DSHS partnered with numerous chain and independent pharmacies throughout the state to ensure antiviral medications (Tamiflu and Relenza) were available to uninsured and/or underinsured individuals during the H1N1 outbreak. The Legislature has maintained a policy of supporting the stockpiling of antiviral medication to help treat flu victims during an outbreak. Christopher Mediano, representing Genentech, in his testimony to the committee encouraged Texas to continue this policy or face an antiviral shortage similar to the H1N1 vaccine shortage if another outbreak occurs. Antiviral medications are very important in an outbreak to help the body fight of the infection and these medications also help keep the infection rates down by attacking the ability of the virus to replicate.

Also the testimony of Dr. Brett Giroir reiterated the need to be prepared if a similar outbreak event happens. He described the 2009 H1N1 outbreak in the following way, "We did not dodge a bullet: nature hit us square in the chest, but this time she was shooting a bb gun." A major reason H1N1 was not a public health and economic disaster, was that mortality rates of H1N1 were much lower than expected. Texas is better prepared for a possible third wave and currently has a sufficient stockpile of antiviral medication and flu vaccines in place.

The Legislature should support the development of in state manufacturing and distribution of the regular flu and H1N1 vaccines to ensure that shortages do not occur in this state, especially for highly vulnerable populations.

A key issue echoed by the testimonies received was the need for vaccine research and development in the United States. According to Dr. Brett Giroir, Vice Chancellor for Research for The Texas A&M University System, current methods for vaccine development are outdated and too slow to prepare for a pandemic. the current H1N1 vaccine relies on a traditional egg-based manufacturing method and can take up to eight months to reach peak vaccine output. While, egg-based vaccines are reliable, safe, and well-studied, they are also expensive and the U.S. relies heavily on foreign manufactures such as Glaxo-Kline Smith who produce them. These very problems were the reasons cited in testimony for the delayed response to the2009 H1N1 outbreak and the subsequent vaccine shortage. The federal government's FY 2010 budget included funding for the development of new cell-based and recombinant vaccine prevention methods. The federal budget also supported cell-based production in the U.S. in order to reduce foreign vaccine dependence.

In Texas, there are some promising state-wide strategic initiatives that also strive to research new vaccine development technologies. The first is the National Center for Therapeutics Manufacturing (NCTM) at Texas A&M. It was initiated two years ago from a $50 million award from the Texas Emerging Technology Fund and is partnered with M.D. Anderson Cancer Center. The NCTM when operational, would be the nation's first fully-flexible, modular vaccine research and manufacturing facility. This is promising for Texas since such a facility could have the capability to produce multiple products at once, and can surge to ten times regular baseline production within 24 hours. The NCTM facility will be functional by 2011 and the committee will continue to monitor the progress of this innovative facility.

Another important venture is Project GreenVax. This project is a partnership between G-CON Biotherapeutics and the Texas A&M University System. GreenVax project will be a fully-functional vaccine-manufacturing facility in Bryan, Texas at the Texas A&M Health Science Campus. This project was initiated by a $40 million federal grant and seeks to develop vaccines using *Nicotiana benthamian* plants, a relative of tobacco to make injectable vaccines against influenza and other infectious diseases. The facility should have the ability to produce 100 million doses of flu vaccine per month. It is important to note however that only egg-based vaccines are currently FDA approved for use. Dr. Giroir anticipates it will take at least four years before a plant-based influenza vaccine will be ready for standard FDA approval (unless granted emergency use authorization). If successfully developed and FDA approved, Dr. Giroir projected the long-term economic impact of GreenVax to the State of Texas could be in the billions of dollars.

The Department of State Health Services (DSHS) should develop a more transparent and effective communication process with local authorities, healthcare providers and the public.

Good leadership and a central point to disseminate information is critical during any disease outbreak or natural disaster. On April 24, 2009, Governor Rick Perry issued a state-wide disaster declaration to coordinate emergency response efforts and requested federal reimbursement for the state's response to H1N1. In response, local health departments, DSHS and the CDC notified the public through media press releases, Facebook, and Twitter about H1N1 prevention techniques and vaccine information. DSHS Commissioner, Dr. David Lakey, informed the committee that his department worked closely with the Centers for Disease Control (CDC) to discern best practices for the rapid and timely dissemination of information to the public during the past H1N1 outbreak. However the committee also heard testimony that local health departments, health providers and others who served as a key links to citizens in crisis, especially those in rural and border communities, were not effectively included in these lines of communication. Local authorities also testified to a lack of timely and updated information from DSHS in order to make important decisions. For instance, local school districts had difficulty determining the impact of school closings in order to prevent H1N1. This was critical because school closings have a significant impact on students, their caretakers, and employers.

After the H1N1 outbreak, DSHS spearheaded an After Action Response Planning for H1N1 which included: sending out surveys to stakeholders, holding critical feedback work group sessions with local health authorities and providers, review of flaws in past response plans and review of key findings from communicating with stakeholders. These actions should help DSHS improve the department's communication and operational plans in order to better respond and communicate information on future pandemics. The Legislature should continue to review the agencies updated response plan and provide legislative direction and feedback on the department's leadership and communication efforts.

The Department of State Health Services (DSHS) should improve collaboration with the federal government, academic partners and local communities to improve the state's preparation and response, especially along the Texas border.

The Department of State Health Services (DSHS) relies on reports from a surveillance network of doctors, hospitals and other stakeholders who have agreed to report flu cases to the department in order to timely track flu cases. DSHS then uses these reports to prepare a Weekly Flu Surveillance Report. A portion of that report classifies the flu activity level in Texas using classification criteria developed by the Centers for Disease Control (CDC). These classifications range from no activity to sporadic, local, regional and widespread. Such monitoring activities were reported to be successful by DSHS in 2008. DSHS should continue to improve upon emergency reporting and ongoing surveillance efforts in order to quickly secure federal resources and inform the public.

In addition, DSHS should improve communication and collaboration with the Border Health initiative. This initiative is part of the U.S. Department of Health and Human Services' Office of Rural Health Policy (ORHP). This last component is critical as testimony from the committee hearing on March 8, 2010 indicated a lack of coordination and leadership from the state on the border during the H1N1 outbreak and with federal and local governments and healthcare providers in the border region. Lastly, DSHS should reach out to all appropriate academic partners to obtain outside review and guidance on disease outbreak management and response.

CHARGE #3

Determine how the state can best coordinate efforts to streamline health care delivery with health information technology (HIT). Identify areas in state law that affect the adoption and use of HIT. Recommend statutory changes as necessary.

INTRODUCTION

The past decade has witnessed rapid advances in medical technology including the use of electronic means for recording and storing a patient's medical record. For the first time, a person's most private information, their medical history, could be shared instantly over an electronic exchange network. Health Information Technology (HIT) developed rapidly before policymakers could educate themselves on the public ramifications of this new technology. On the one hand, the technology offers the opportunity for a patient's medical record to be mobile and more easily accessed by patients and health care providers. HIT also provides health care providers a new tool to better record patient data, track a patient's medical history and reduce medical errors. However, the mobility that HIT provides also poses many dangers for patients. Unlike a paper record, HIT records are store electronically and thus are more prone to be shared, sold, illegally copied and hacked into by outside individuals and entities.

In 2007, The Legislature passed HB 1066, 80R to establish a statewide planning board called the Texas Health Services Authority (THSA) to develop a framework for the monitoring and development of HIT technology use in Texas. However for the most part, HIT technology use remains an unregulated and mostly regional activity in Texas. The only laws that are applicable are the federal HIPPA privacy laws, which fail to adequately address the numerous privacy and security issues presented by HIT technology. Texas law requires a business to inform their customers of a security breach in which their personal information was accessed. Texas law also requires informed consent in most circumstances for the sharing of certain medical information, like mental health history. Considering this patchwork of various state and federal laws, Texas needs to develop a clear and coherent regulatory framework for HIT use in Texas that preserves an individual's privacy rights in an electronic age.

The HIT landscape in Texas is changing from regional pockets of privately funded HIT networks to a statewide network, mainly due to the passage of the American Recovery and Reinvestment Act of 2009. The act appropriated billions of dollars for HIT. For Texas excluding the future receipt of Medicaid and Medicare enhanced reimbursements, a total of approximately $85 million has been or will be received. $29 million was awarded to the Health and Human Services Commission (HHSC) and The Texas Health Services Authority to administer the HIT grant funds. The other $35 million is expected to be distributed among four HIT Regional Extension Centers in Texas to assist in the adoption of HIT technology. Additional funds have also been distributed to the University of Texas, Texas State University and the University of Texas Health Science Center.

The Texas Health Services Authority (THSA) using $1 million in federal grant money drafted and submitted a strategic plan for the statewide adoption of HIT in Texas to the Office of the National Coordinator for Health Information Technology. The strategic plan was open for public comment but was not directly evaluated or approved by the Legislature before its submission to the federal government. Hence, this committee report represents the first legislative response and policy direction on HIT expansion in Texas since the passage of the American Recovery and Reinvestment Act.

The committee was charged with how to best coordinate efforts to encourage the adoption and use of HIT technology. However, the committee's recommendations in this section of the report seek to address very pressing issues of public policy as HIT is adopted and promoted by the federal government in Texas. The following key issues must be addressed by the 82nd Legislature: privacy rights and protections, individual consent, the regulation of the use of HIT technology and the enforcement of privacy protection laws. The Legislature will also need to evaluate the use of HIT in the state's Medicaid and foster care programs.

RECOMMENDATIONS

1. The Legislature should determine clearly in law who is the owner of medical records.

2. The Legislature should adopt privacy and security safeguards for the creation, storage and exchange of electronic medical records in Texas.

3. The Legislature should provide ongoing guidance to the Texas Health Service Authority (THSA) and periodic review of the implementation of the strategic plan for statewide adoption of HIT in Texas.

4. The State Auditor's Office (SAO) should audit the effectiveness of the federal HIT grants awarded to the Health and Human Services Commission (HHSC) and the Texas Health Service Authority (THSA).

5. The Electronic Health Information Exchange System Advisory Committee, created under HB 1218, 81R could be expanded to include consumer and privacy advocates and also computer security/risk assessment experts to advise all state entities involved in HIT technology.

DISCUSSION

The Legislature should determine clearly in law who is the owner of medical records.

State law is currently silent on the issue of ownership of medical records. Currently, this silence is interpreted to infer that the healthcare provider who produces the records owns the records. Therefore, state law provides patients a right to a copy of their medical record and a process for requesting the correction of any inaccuracies in a medical record. The American Medical Association's Code of Medical Ethics Current Opinion states, "Notes made in treating a patient are primarily for the physician's own use and constitute his/her property. The logic of this type of arrangement is that the medical record was produced by the healthcare provider for the benefit and use of the healthcare provider to serve a patient. Further, the cost to produce the record and maintain that record is bore by the healthcare provider. State law requires a physician to produce and keep an "adequate medical record" for each patient for a minimum of seven years.

However, the current policy of provider owned records with patient access to that record becomes more complicated with the use of electronic health records. For instance the answer to the question of who legally owns a patient's medical data after that medical data is transmitted, shared and stored elsewhere, is not known. A paper medical record has an original document and is copied in order to be shared with the patient's consent. An electronic health record is not copied but instead is transmitted instantly and a new electronic record is created and kept by the entities that receive the data transmitted.

Currently, a provider creates a new paper record for a patient when care is initially given. This paper medical record stays with that provider unless a patient consents to the release of the record in most cases that a request for that record is made. Electronic medical records however are different in that they can be exchanged on a health network and are always available to be retrieved by anyone searching for those records using a record locator tool within the health exchange. This new ability to "fetch and retrieve" a patient's data raises questions over how consent from the patient will be obtained and how many owners are there of a patient's medical record if the receiver of that medical record creates a new medical record and maintains that record every time the data is transmitted.

The Legislature should therefore review this question of the ownership of medical records considering the new reality of electronic health exchanges and the possible wide spread proliferation of personal health information. A recent article in the Journal of the American Medical Academy entitled "*Ownership of Medical Records"* by Mark Hall, J.D., described the need for a clear legal definition of medical record ownership this way:

> *Who owns medical information? The one who gives care, receives care, or pays for care? All of the above? None of the above? Does it really matter? In the emerging era of electronic health informatics, few other medicolegal questions are more critical, more contested, or more poorly understood. The American Recovery and Reinvestment Act of 2009 allocates up to an estimated $20 billion to implement clinical information systems, and it aims for the use of electronic health information "for each person in the United*

States by 2014." It fails, though, to resolve who owns this massive increase in electronic information. This legal uncertainty presents a major obstacle to integrating and using information about a single patient from various clinicians and hospitals.

Texas law does not clearly state who actually owns paper medical records, much less does the law address the new complexities of ownership of electronic health records. The law is silent on the issue of ownership, and only infers ownership to the producer of the health record. Therefore, the key policy question should be that when there are multiple electronic records created and transferred who is ultimately responsible for the ownership and safe keeping of those records. Does the current inference of ownership and the legal process for patient access to records provide the proper protections and accountability necessary when multiple owners of partial medical records and data exist within health information exchanges?

The Legislature should adopt privacy and security safeguards for the creation, storage and exchange of electronic medical records in Texas.

The greatest barrier to the adoption and use of HIT technology is the public's legitimate concern that their private health information is less secure in electronic form. The Health Insurance Portability and Accountability Act (HIPPA) authorized the development of the" Privacy Rule" which established consumer right provisions for medical records. However, the law is more symbolic than enforceable. The U.S. Health and Human Services, Office of Civil Rights has yet to enforce a single privacy violation despite over 23,000 complaints of HIPPA violations to the Office of Civil Rights.

The Health Information Technology for Economic and Clinical Health Act (HITECH Act) updated federal privacy laws but left most privacy enhancement protections and enforceability of laws to the states to decide. For instance, the states must decide whether or not all private health information will be protected equally or if various levels of privacy protections will continue to be the legal norm, for instance stronger protections for the disclosure of mental health information.

As stated previously, the main fear for the public with health information technology is the new potential possibilities for misuse of their health data, including the sale of the data. Some key policy questions for lawmakers are: How can the Legislature ensure the public's trust? What regulatory and legal framework can be established that best protects private health information from misuse? Further, the challenge to any enhancement of privacy law is the enforceability of that law. A privacy bill of rights for electronic health records for instance may sound good, but may not be enforceable as the lack of HIPPA enforcement actions have shown. Another challenge to consider is how to ensure that the use of health electronic exchanges is transparent to the public. In other words, how can patient's know where their personal health information is located or if it that information has been improperly disclosed. Any privacy rules and safeguards adopted by the Legislature must prove to be enforceable and must provide for transparency.

The Legislature should provide ongoing guidance to the Texas Health Service Authority (THSA) and periodic review of the implementation of the strategic plan for statewide adoption of HIT in Texas.

In 2007, the Legislature passed HB 1066, 80R by Representative Dianne White Delisi, that established the Texas Health Service Authority (THSA) as a public private corporation to promote, implement, and facilitate the voluntary and secure exchange of health information. The passage of the American Recovery and Reinvestment Act, made federal funds available for the Texas Health Service Authority to develop a statewide system of electronic exchange. However, in order to receive the federal funding, the THSA had to develop a strategic plan for the development of statewide electronic health exchange that met the federal criteria for meaningful use. The THSA established several workgroups to develop the plan and on August 26th, 2010 the THSA Board approved the strategic plan and submitted on September 10, 2010 to the Office of the National Coordinator for Health Information Technology (ONC). The Texas strategic plan was recently approved by the ONC and Texas will receive federal funds for HIT implementation.

In other states the legislature or a state agency have enacted plans related to health information exchanges including the model of exchange and the standards of the exchange. Considering the fact that the THSA and not the Legislature or a state agency developed the state's strategic plan, the Legislature should monitor the implementation of the plan and provide ongoing guidance to the THSA Board as HIT technology is more widely adopted and used in Texas.

The State Auditor's Office (SAO) should audit the effectiveness of the federal HIT grants awarded to the Health and Human Services Commission (HHSC) and the Texas Health Service Authority (THSA).

The State Auditor's Office (SAO) is authorized by Chapter 321 of the Texas Government Code to perform audits, reviews, and investigations of any entity receiving state funds. Typically, the State Auditor does not review federal funds used by state agencies or entities however considering the rapid injection of federal funds and quick implementation of HIT adoption in Texas, the SAO should monitor the uses of these funds and report on their effectiveness to the Legislature. Further, the Texas Health Service Authority (THSA), the corporation contracted with the Health and Human Services Commission (HHSC) to implement the state's health HIT plan will be under sunset review in 2013. An evaluation of the use of federal funds by HHSC and THSA by the state auditor would greatly enhance the Sunset Commission's ability to evaluate these agencies and their performance as related to health information technology adoption and use in Texas. The SAO could also audit the effectiveness of the federal Regional Extension Centers for HIT adoption and use.

The Electronic Health Information Exchange System Advisory Committee, created under HB 1218, 81R could be expanded to include consumer and privacy advocates and also computer security/risk assessment experts to advise all state entities involved in HIT technology.

The main reason for this recommendation is to make better use of the Electronic Health Information Exchange System Advisory Committee as established by HB 1218, 81R. The current advisory committee has a limited scope. The advisory committee's website states that the purpose of the advisory committee is to:

Advise the Health and Human Services Commission (HHSC) regarding the development and implementation of an electronic health information exchange system to improve the quality, safety and efficiency of health care services provided through Medicaid and the Children's Health Insurance Program (CHIP).

The scope of this committee is only for the Medicaid HIE Systems Operation and not for any other state entities involved with electronic health information exchange system in Texas. Therefore, the advisory committee does not advise or coordinate with the Department of State Health Services (DSHS) or the Texas Health Services Authority (THSA) on any of the other entities involved in electronic health exchanges in Texas.

The 81st Legislature sought to address the better integration and coordination of state agencies involved with HIT technology through SB 8, 81R. This legislation would have accomplished the better integration and coordination of the various agencies and entities implementing health information technology in Texas. However, SB 8 failed to pass. If the Legislature reconsiders and passes a bill similar to SB 8, 81R, the state would still lack a major advisory council to advise all state agencies involved in the coordination and regulation of health information technology. If the advisory council's scope was expanded then additional members should be added representing areas including consumer rights, privacy and computer security/risk assessment to better ensure all voices involved in health information exchange are considered as policies and regulations are developed over time.

CHARGE #4

Identify factors influencing health care cost trends in Texas, including practices or policies that may contribute to regional variations. Investigate medical imaging utilization and its impact on the cost and quality of health care. Recommend policy changes to promote best practices, reduce costs, and improve quality within the state Medicaid program, Employees Retirement System, and Teacher Retirement System. *Joint Interim Charge with House Committee on Appropriations*

INTRODUCTION

The committee held one joint hearing with the House Committee on Appropriations on May 10, 2010. The committee heard testimony from a wide array of healthcare leaders, policy implementers, state regulatory agencies, academic institutions and health industry trade associations on the factors influencing health care cost trends in Texas.

The recommendations and discussions provided in this section represents the compilation of a vast amount of data, testimony, and research on the issue of trends in health care costs. It is clear that healthcare cost trends are unsustainable for government, private insurance, employers, and individuals paying for healthcare. Numerous cost containment measures have been tried and implemented at both the federal and state levels over the past decade, however costs continue to rise. The Congressional Budget Office and the Government Accounting Office have warned that the Medicaid and Medicare programs are on an unsustainable path and the annual increases in health insurance premiums continue to threaten businesses' ability to provide health insurance for their employees. Further compounding the problem, is the U.S. national deficit of $13.7 trillion and a $18-$25 billion estimated budget deficit for Texas.

The State of Texas cannot solve this massive problem alone and there is no silver bullet, however a paradigm shift must occur in which individuals are empowered to take control of and have personal responsibility for their own healthcare. Government and local communities need to better collaborate to find local solutions to address the local and unique challenges different geographical areas of the state face, for instance like high obesity rates or HIV. State government in turn, must also be more responsive to local initiatives. State policies, programs and agencies must move away from top down approaches and find better ways to partner with community partners to share costs, prevent high cost chronic diseases, promote community based preventive care and provide education for individuals and communities on healthy living in order to see real results that improve health quality and lower healthcare costs. Therefore the recommendations provided below seek to achieve these goals for Texas.

RECOMMENDATIONS

1. The Legislature should review why a disconnect exists between a consumer's knowledge of the cost and value of a healthcare provider's services and the healthcare provider's knowledge of the cost and value of services provided to a consumer.

2. The Legislature should reconsider a consumer directed payment plan in the Medicaid program for certain populations.

3. The Legislature should consider adopting a results driven reimbursement system for the payment of medical care that is based upon health outcomes and standards of care.

4. The Legislature must address the dramatic rise in premature births in Texas and the associated long term costs.

5. The Legislature should require the registration and accreditation of certain imaging equipment in Texas.

6. The Health and Human Services Commission (HHSC) should review the rapid rise in home health and telemedicine services in the Medicaid program to determine if these services actually lower costs, increase quality of care and improve access to care.

7. The Department of State Health Services (DSHS) should improve and update the state's consumer guide website as required by SB 1731, 80R.

DISCUSSION

The Legislature should review why a disconnect exists between a consumer's knowledge of the cost and value of a healthcare provider's services and the healthcare provider's knowledge of the cost and value of services provided to a consumer.

The committee heard a wide array of expert testimony on the reasons for the factors contributing to healthcare costs in Texas and possible solutions. However, one of the most glaring and well documented reasons for the rapid rise in healthcare costs was not mentioned or discussed by the experts. The lack of consumer price transparency in healthcare hinders the ability of individuals to use their knowledge as a market force to drive down and stabilize medical prices.

Unfortunately most healthcare cost discussions leave out the most important person in the equation, the health consumer. Therefore, the health consumer is usually not taken into account as policy is created and ends up with little access and knowledge of the actual costs of their healthcare providers and the quality of care those providers give. This lack of transparency in the healthcare system is a huge barrier that prevents health consumers from comparing a healthcare providers costs and healthcare outcomes and results in unchecked medical inflation. The current third party payer system for healthcare has shifted the responsibility of finding and paying the best price for the best quality of service from the individual to either government or private insurers.

In summary, the fact remains that free markets and healthy competition among providers are the only time tested method for driving down costs and increasing quality in any system. Therefore, as long as the true costs of doing business in healthcare are kept hidden from consumers and left unchecked by third party payers, there remains little incentive for healthcare providers to compete for a patient's business through lower costs, better quality care and healthier outcomes. These positive incentives normally found in supply and demand economics are lost when supply and demand are kept separated by artificial barriers and lack of consumer knowledge.

The Legislature should reconsider a consumer directed payment plan in the Medicaid program for certain populations.

Texas Medicaid costs overall on average have increased between 6-8% per year. The state will face a huge budget deficit this next legislative session estimated at $18-$25 billion. The search for ways to lower costs while providing good medical care for the current Medicaid population is at a critical juncture. The persistent and unsustainable rising costs of the Medicaid program requires finding new ways to provide medical services to the Medicaid population. One option the Legislature should reconsider are consumer directed payment plans, also known as high deductible health plans (HDHP) for the Medicaid program.

A HDHP provides consumers with health insurance but allows the consumer to manage and control the type of services, treatment, and therapies they receive using their own health funding mechanism. In the private market, a HDHP has a high deductible amount that the patient would need to pay out-of-pocket and is usually an optimal plan for healthy individuals with no pre-existing conditions. A HDHP is especially favorable to consumers who seek more options over

how and where to spend their own healthcare dollars and savings.

The state's Medicaid population could also benefit from a HDHP plan. A HDHP plan with a Health Savings Account (HSA) tailored for the state's Medicaid program would seek to provide consumers more control over their healthcare spending while encouraging preventive care options before seeking unnecessary emergency room care. HSA's would also allow Medicaid populations to save their funds that are not used during the year for future medical expenses even after they leave the program. Such savings would award personal responsibility and could help a person transition out of Medicaid and into private coverage or pay for future out of pocket medical costs.

Another advantage of a HDHP is that such plans require the consumer to be more involved with the cost of their own medical care and can help prevent unnecessary care and over utilization of healthcare services because the patient is better informed. This will decrease utilization because unnecessary test or expenses will not be ordered unless the patient is informed and consents to spend the amount out of their own account. This will bring the patient and physician closer together as they discuss the costs and benefits of procedures, tests, and therapies. The State of Indiana and the State of North Carolina are currently piloting HSA projects in their Medicaid programs to test if Medicaid consumer ownership of funds can encourage a person on Medicaid to better partner with the state to lower costs and increase individual responsibility for one's health.

The Legislature authorized a feasibility study for a pilot HSA program in Medicaid under SB 10, 80R, however the feasibility study found that the administrative costs of the pilot would outweigh any potential savings from the pilot. Therefore the pilot was never implemented. However, The Legislature could consider a different approach towards an HSA pilot, similar to the Healthy Indiana HSA plan. Such an approach would allow the Legislature to test if the consumer directed model could actually work. If the HSA pilot proves successful in lowering costs, increasing individual responsibility and saving habits then expansion could be considered or vice versa if the pilot fails to show any of the above then it would be disbanded.

The Legislature should consider adopting a results driven reimbursement system for the payment of medical care that is based upon health outcomes and standards of care.

The committee heard testimony from Dr. Guy Clifton on the urgent need to reform the Medicaid system to one that pays and rewards providers for quality and patient outcomes verses the current fee for service payment system. Dr. Clifton testified that skyrocketing medical costs have the Medicaid program on an unsustainable course. He indicated that without substantial changes in the payment structure major price cutting and rationing of care would have to occur. Essentially, the current state Medicaid program and the healthcare system in general does not reward or incentivize high quality of care, efficiency or better health outcomes, especially in chronic disease management.

In the past, the Legislature has responded to increasing costs by moving away from a fee for service system to a managed care system for Medicaid. The state pays managed care companies a capitated amount to deliver and manage client services. This is advantageous to the state because costs can somewhat be set and the care of individuals is managed by a private entity. Managed care in Texas, does have a track record of reducing costs and increasing quality of care. However cost challenges remain, for instance, 10% of the children in Medicaid account for 70% of the costs, but yet the current payments for care do not reflect a strategy for improving and coordinating the high intensity medical needs of these children. Further, there is no clear model within managed care for basing payments upon health outcomes.

The Legislature introduced SB 7, 81R, last session which contained several provisions to begin pilot programs that paid based upon healthcare outcomes and quality of care. The Legislature did not pass SB 7 and will need to consider whether or not to reintroduce such similar legislation. Transitioning to a quality and result based payment system will require an upfront investment by the state to transition to a quality based payment system. The Health and Human Service Commission (HHSC) has established a Quality Payment Workgroup to prepare the agency and providers for this possible shift in the state's payment system.

The Legislature must address the dramatic rise in premature births in Texas and the associated long term health outcomes and costs.

According to the March of Dimes, in 2007 there were 55,490 preterm births in Texas, which represents 13.6% of all live births. Texas has experienced an increase in the number of infants born prematurely. In fact, the preterm birth rate in Texas increased 18% from 1994 to 2004. A preterm birth is considered to be a birth that is less than 37 weeks of the pregnancy. It is important to address such a disparity because there are varying risks and consequences that are associated with having a preterm birth. A preterm birth is linked to higher infant mortality rates, higher rates of chronic conditions and developmental delays. The more premature an infant is the greater the possibility of the infants need of life support, longer stays in the intensive care unit, and an overall increased stay at the hospital.

Many environmental, physical, and economical factors play a role in causing a women to go into premature labor. Those factors can increase due to the age of mother, race/ethnicity, or intervals between births. Some hospitals, such as Seton Health Care System, HCA Hospitals, and Parkland Health and Hospital System have been able to decrease their rates of preterm births by reducing voluntary inductions and improving outcomes while reducing costs. For example, the rate of premature births at Parkland Memorial Hospital have declined in the past two decades from 9.4 % of births in 1988 to 4.9% of births in 2006. Parkland credits its improvements to its prenatal care policies.

One strategy in reducing preterm births is to either reduce or completely eliminate early induction of labor for non-emergency purposes. Early induction of labor, done solely for scheduling purposes has become common. Most medical experts agree that C-sections for non-emergency situations should not be completed before 39 weeks. Early induction of labor could result in an increased rate of infants born with related complications. Further, early induction of labor can cause risks for the mother including preventable hospital infections. According to

research published in the January issue of the *American Journal of Obstetrics & Gynecology*, hospital readmissions for women in the postpartum period are often due to infections, and women have a higher risk of hospital readmission after cesarean than vaginal deliveries.

Dr. John Holcomb, with the Texas Medical Association, testified before the committee that preterm births are estimated to cost Texas Medicaid $1 billion annually in medical costs. Considering both the long term health effects of preterm births and the associated costs, the Legislature must address the rise of preterm births in Texas and determine the appropriate policies to address this rise.

The Legislature should require the registration and accreditation of certain imaging equipment in Texas.

Medical costs and health insurance premiums are continuing to rise in today's economy. Medical imaging utilization has also increased over the years because of its accuracy and helpfulness in diagnosing and treating illnesses. However, increased utilization of imaging equipment has played a major role in the increase amount of healthcare expenditures, especially when imaging equipment owners have been found to over utilize their own equipment.

Many times the offices or centers that administer the imaging equipment are not monitored, regulated or restricted in their use. By requiring that diagnostic imaging equipment is registered, the public will know who owns the equipment and exactly who will be receiving the reimbursements and payments for patient care. Also, it should be required that imaging equipment should be in compliance with national accreditation standards. Patients should be assured that the equipment the doctor or operator is using is in compliance with professional performance standards and procedures. Requiring the accreditation of imaging equipment would also help to ensure that the operator is trained to use and read information from the imaging machine.

It is essential that over utilization is reduced and tests are performed on patients when it is only appropriate and necessary to do so. Medical imaging has great benefits for consumers like reducing misdiagnosis and reducing inappropriate surgeries. However, The Legislature should require the registration and accreditation of imaging equipment in order ensure increased transparency and accountability for the operation and use of imaging equipment in Texas.

The Health and Human Services Commission (HHSC) should review the rapid rise in home health and telemedicine services in the Medicaid program to determine if these services actually lower costs, increase quality of care and improve access to care.

As more Medicaid patients have been choosing home health options instead of nursing homes concerns around the accountability and transparency around these new options have emerged. Home health can be advantageous because it allows the patient to stay in their community rather than relocating to a nursing home. Also, the home health option can help reduce long term care costs and improve the quality of care. Wayne Douglas, President of Community Care Division of Girling Health Care, Inc., testified before the committee that community care services are on average $1300 a month lower than nursing home services. Considering the current economic and

budgetary climate, it would be helpful to the public for HHSC to quantify and confirm the savings to taxpayers claimed by advocates of home healthcare.

Telemedicine services has also experienced an increase in usage in the Medicaid program. Telemedicine services uses mobile technology to deliver medical services to a patient when the doctor and patient are located in different areas. Telemedicine services are thought to improve access of care because it connects patients to their doctors when they have barriers, such as distance or mobility limitations, that prevent them from visiting their doctors. It also allows increased access to specialist and timely follow-up after procedures. HHSC should review each of these services to ensure that these services actually lower costs, increase quality of care and improve access to care. HHSC should closely monitor for potential abuse and report on the integrity of these services in order to better prevent the abuse and over utilization of these types of services.

The Department of State Health Services (DSHS) should improve and update the state's consumer guide website as required by SB 1731, 80R.

Under the direction of SB 1731, 80R, DSHS created a *Consumer Guide to Health Care* on its website offering healthcare information to the general public. This website provides a publicly available avenue for consumers to find information about healthcare costs, compare the cost of healthcare providers in their region, view types of procedures offered and other general healthcare costs and information.

Currently the *Consumer Guide to Health Care* is only available on the DSHS website and the Texas Medical Board is required to provide a link on their website. The committee found the DSHS website that hosts the guide was not very accessible to the public nor was the website either user friendly or contain information very useful to the public. It is also recommended that the website should be revised to make it more user friendly to the average consumer. DSHS should work with the Department of Information Resources (DIR) to increase the visibility and accessibility of the website by placing the guide on www.Texas.gov and work with DIR to ensure that the website meets best practices for accessibility, navigation and usefulness.

CHARGE #5

Examine the need for and barriers to implementing routine HIV screenings as recommended in 2006 by the Centers for Disease Control and Prevention. Assess the impact of implementation on HIV transmission, health outcomes, clinical progression, and mortality.

INTRODUCTION

The House Committee on Public Health held a public hearing on April 19, 2010 in Houston, Texas to discuss HIV and the potential impact of expanding routine HIV screenings. The committee heard testimony on the Centers for Disease Control's (CDC) recommendations to drastically expand HIV routine screening. Testimony was also provided on the potential health outcomes and current barriers that exist in implementing the CDC's recommendations.

HIV remains a public health risk in the United States and Texas today. The CDC estimates about 1.1 million individuals are infected in the United States and about 21% are unaware of their status. Approximately 54% of new HIV transmissions in the United States are due to people with unrecognized HIV infections. In 2008, approximately 63,000 people in Texas were known to be living with HIV/AIDS and certain areas of the state continue to experience high rates of HIV/AIDS infections. In fact, in 2008 over half of the people infected with HIV/AIDS in Texas were located in either the Houston (31.4%) or Dallas (21.3%) metro areas.

Further, HIV infection rates are increasing among elderly, women, minorities and rural populations. In 2006, the CDC released recommendations for HIV screening to address these trends in HIV. In particular, the CDC recommended that HIV testing and screening be a part of routine clinical care in all health care settings for patients ages 13-64 unless prevalence of undiagnosed HIV infection among patients in a given region has been documented to be less than 0.1%. Overall testing in the United States has increased since the CDC announced its guidelines, however state policies for expanding HIV testing have been diverse and vary. The committee also found and emphasizes the need for individuals to take personal responsibility for their own health by avoiding risky behaviors that greatly enhance the probability of contracting and transmitting HIV. Local communities also have a role in addressing HIV. Community outreach by local governments, faith and community based groups and others are vital and needed to help raise community wide awareness through education and encourage individuals to adopt behaviors that best prevent the spread of HIV at the local level.

The recommendations outlined below seek to move Texas towards better screening and testing for HIV through better state and local government collaboration, community partnerships and individual responsibility.

RECOMMENDATIONS

1. The Legislature should encourage areas of the state with high HIV/AIDS infection rates to apply directly to the Centers for Disease Control and Prevention (CDC) for local funding for screening and treatment programs.

2. The Legislature should encourage local health departments in areas with high HIV infection rates to work with healthcare facilities and providers to test more frequently for HIV.

3. The Legislature should review the collaborative HIV prevention efforts of the Department of State Health Services (DSHS) with all local health authorities on HIV/AIDS prevention, screening and testing.

4. The Department of State Health Services (DSHS) faith and community liaison should identify faith and community based groups that currently work on HIV/AIDS related issues and coordinate state and local government efforts with those groups.

5. The Legislature should review the regional variations in HIV/AIDS funding and determine if adjustments in state funds are necessary.

6. The State Auditor's Office (SAO) should monitor and report annually to the Legislature on all federal, state, local and private funds for HIV/AIDS prevention, testing and treatment in the State of Texas.

7. The Legislature should review the HIV/AIDS testing requirements as prescribed by HB 1795, 81R to determine if these provisions need to be amended to better align with best practices for testing pregnant mothers and newborns for HIV/AIDS in Texas.

DISCUSSION

The Legislature should encourage areas of the state with high HIV/AIDS infection rates to apply directly to the Centers for Disease Control and Prevention (CDC) for local funding for screening and treatment programs.

The first recommendation encourages areas of Texas with high HIV/AIDS infection rates to apply directly to the Centers for Disease Control and Prevention (CDC) for local funding for screening and treatment programs. Dr. Adolph Valadez, Assistant Commissioner for the Department of State Health Services Prevention and Preparedness Services, testified before the committee that in 2008, 63,000 people in Texas were known to be living with HIV/AIDS. Dr. Valadez also testified that 20-25% of persons who were unaware of their HIV infections were responsible for approximately 54% of new infections. Linking HIV-infected individuals to treatment significantly lessens transmission. Effective antiretroviral therapy reduces infectiousness as much as 92%.

The CDC provides grant based funding for HIV prevention to all states and localities that apply directly to CDC for funding. Currently six metropolitan areas in Texas, including Houston, are funded directly from CDC for HIV prevention activities. For example, Bernard Branson, Associate Director for Laboratory Diagnostic, Centers for Disease Control and Prevention, testified before the committee that Houston has received approximately $8 million for prevention and testing and the Texas Department of State Health Services has received $16.5 million from the CDC. Therefore direct CDC funding provides another avenue for areas around the state with high infection rates to obtain additional funding to help prevent the spread of HIV/AIDS. Local areas should take advantage of this additional resource for funding.

The Legislature should encourage local health departments in areas with high HIV infection rates to work with healthcare facilities and providers to test more frequently for HIV.

The second recommendation would encourage local health authorities and providers located in areas with high HIV/AIDS infection rates to expand HIV testing. Randall Ellis, Senior Director of Government Relations of Legacy Community Health Services, Inc., testified before the committee that between 54 to 70 percent of new HIV transmissions in the United States are due to people with unrecognized HIV infection. Also, Ellis testified that in Texas, 1 in 4 people discover HIV positive status after being sick with symptoms of AIDS. If people are diagnosed with HIV at an earlier stage they have a better chance of obtaining better treatment which can lead to slower clinical progression, reduce mortality and lower infection rates. For example, a report was released in September 2010 by the CDC regarding HIV rates among specific populations of men across the United States. The study found that 1 in 5 men in 21 U.S. cities had contracted HIV and that nearly half of those infected (44%) were unaware they had HIV.

Individuals with HIV/AIDS could also possibly be infected with other diseases or infections. An individual's lack of knowledge of their HIV status can cause other complications if they are already diagnosed with another disease. For example, it is possible for a person who has contracted HIV/AIDS to also have contracted Hepatitis C. In fact, Dr. Victor Machicau, with the University of Texas Medical School at Houston Texas Liver Center, testified at the committee hearing that 25% of patients who have HIV also have Hepatitis C. Furthermore, HIV can be detected in 8% of patients with Hepatitis C. Dr. Machicau also testified that approximately three to four million people are currently infected with Hepatitis C in the United States. HIV and Hepatitis C co-infections can cause difficulties for a patient's treatment if they are unaware of their HIV status. According to the CDC, a Hepatitis C infection in a person who has HIV can lead to liver damage more quickly and could also affect the treatment of an HIV infection.

Considering the public health risks cited above, the CDC in 2006 recommended that HIV testing and screening be a part of routine clinical care in all health care settings for patients age 13-64 unless prevalence of undiagnosed HIV infection among patients has been documented to be less than 0.1%. Healthcare providers should consider more actively testing for HIV in order to better detect the disease in its early stages. Early detection of HIV can save lives and taxpayer dollars and therefore ultimately avert expensive and complicated treatments for HIV and AIDS. One strategy the Legislature should encourage is to allow local health departments in areas of high infection rates to work with local healthcare providers to create comprehensive and coordinated testing.

Expanding HIV testing can help decrease the spread of HIV/AIDS since more people will be aware of their status. However, the decision to require more testing and screening should be made locally by communities and providers. Local health authorities are in the best position to work with healthcare providers to ensure that providers have the right resources and ability to test for HIV and that the local community is aware of the need to be tested and the locations that offer HIV testing.

The Legislature should review the collaborative HIV prevention efforts of the Department of State Health Services (DSHS) with all local health authorities on HIV/AIDS prevention, screening and testing.

Another key prevention step is to increase access to preventive health services including HIV testing. Barriers in HIV screening exist both on the provider side and on the patient side. Randall Ellis' testimony stressed that HIV-related stigma and discrimination still persists. Mr. Ellis stated that the following barriers currently exist for expanding HIV screening: self-realization of risk for HIV infection, patient requests for HIV testing and provider communication of HIV screening policies. These barriers can be overcome by better public collaboration between state and local healthcare officials on strategies to improve public awareness and communication between healthcare providers the public.

Ellis also testified that there is a need for uniform clinical testing strategies in Texas. There is also need for local buy-in and accountability for new screening guidelines. As discussed in the previous recommendation, clinics who determine that they have high rates of HIV will need to

been determined, a standard for collection of data to properly evaluate the program must be made. It was noted that many doctors may be reluctant to draw blood when otherwise not needed at a clinical visit, confirming the need for why an HIV screening and testing protocol at a clinic is needed.

Another barrier that hinders preventive screening and testing are that because of the numerous free HIV testing sites and low-cost treatment services, there is no specific policy for reimbursement of HIV testing for Medicaid in Texas. While it will be important to monitor how health care reform affect, HIV screening reimbursement rates. Medicaid and insurance plans need to have clear reimbursement and payment policies on HIV testing and treatment.

In essence, addressing all the above issues would require DSHS to drastically increase collaboration with several other state agencies, school districts and local health authorities to drastically improve efforts to slow and eventually halt rising rates of HIV in Texas.

The Department of State Health Services (DSHS) faith and community liaison should identify faith and community based groups that currently work on HIV/AIDS related issues and coordinate state and local government efforts with those groups.

Another important component of HIV prevention and awareness are the roles of community groups, faith organizations and local leaders. Therefore, the DSHS faith and community liaison should identify and partner with community and faith based groups that currently work on HIV/AIDS related issues and coordinate state and local government efforts with those groups. Community-based groups are already involved and active in the community and have the unique ability to reach out to members of their own community who are at high risk of HIV/AIDS infections. It is important to first identify which community organizations are working with HIV/AIDS related issues and collaborate.

During the 81st Legislature, HB 492 was passed to enhance the role of faith based and community based organizations in meeting the needs of Texans. Collaborating with such partners at a local level can help establish awareness and best practices and procedures in communities, provide additional outreach mechanisms to high risk populations and increase access to preventive healthcare services. All levels of government should work more closely with community and faith groups to better ensure that the best methods are being used to reach members of various communities. DSHS should follow the legislative intent of HB 492 and coordinate their HIV/AIDS policies with faith and community based groups working with populations effected by HIV/AIDS.

The Legislature should review the regional variations in HIV/AIDS funding and determine if adjustments in state funds are necessary.

The fifth recommendation recommends that the Legislature should review the regional variations in HIV/AIDS funding and determine if adjustments in the distribution of state funds are necessary. Certain areas of Texas have experienced higher rates of HIV/AIDS infections however a rise in HIV/AIDS does not necessary correspond to the funding that local areas receive for HIV/AIDS from federal, state, and private funds. According to the Legislative Budget

Board's Top 100 Federal Funding Source, in 2010, $95.4 million was allocated to Texas for HIV prevention and treatment. In 2009, according to the Centers for Disease Control (CDC), the top Texas cities that received funding from CDC were Houston, Dallas, San Antonio, Austin, Laredo, and El Paso. Currently, Houston receives the most funding for HIV. Bernard Branson, from the CDC, testified that Houston received approximately $8 million for HIV prevention in 2009. According to the CDC website, Dallas received approximately $2 million dollars in federal funding in 2009. Nearly over half of the people living with HIV/AIDS were located in Houston (31.4%) and Dallas (21.3%). Although Houston continues to have the highest percentage of people living with HIV/AIDS it is recommended that the state critically review the regional variations in all source funding to determine if the current funding arrangement is adequately distributed.

The State Auditor's Office (SAO) should monitor and report annually to the Legislature on all federal, state, local and private funds for HIV/AIDS prevention, testing and treatment in the State of Texas.

The State Auditor's Office **(**SAO) is authorized by Chapter 321 of the Texas Government Code to perform audits, reviews, and investigations of any entity receiving state funds. HIV/AIDS prevention is funded by a mix of state, federal, and private funds. According to Dr. Adolfo Valadez's testimony before the committee, Texas spent $131.9 million on medication, treatment, prevention and surveillance in 2007. 61% of these funds were federal funds and 39% were state. By monitoring and auditing the amount of all money spent on HIV/AIDS prevention, testing and treatment, the Legislature can make policy and funding determinations based upon an SAO audit. Further, private foundations and charities should also be included to see where additional resources are available in Texas.

The Legislature should review the HIV/AIDS testing requirements as prescribed by HB 1795, 81R to determine if these provisions need to be amended to better align with best practices for testing pregnant mothers and newborns for HIV/AIDS in Texas.

It is recommended that the newborn screening requirements as prescribed by HB 1795, 81R should be reviewed to assess whether the bill's provisions are the best practices for testing pregnant mothers and newborns. A woman can pass HIV to her child during pregnancy, during delivery, or during breastfeeding. Currently, HB 1795 requires HIV screening during the first health care visit and a second HIV test during the third trimester for all pregnant woman. Also, women without documented HIV testing in the 3rd trimester of pregnancy must be tested for HIV at the time of labor using an expedited test. Furthermore, if a woman's status is unknown at the time of delivery, she should be tested immediately postpartum with an expedited test. If the mother's status is unknown postpartum, it is recommended that the infant is tested less than two hours after birth. Identifying an HIV-infected mother as soon as possible is important as pre-exposure prophylaxis treatment to the child may be given to reduce the chance of transmission.

One of the requirements for newborn screening is that pregnant women are required to have an HIV screening during the first health care visit and a second HIV test during the 3rd trimester. Dr. Lisa M. Hollier, who practices high-risk obstetrics at LBJ General Hospital in Houston, expressed to the committee her concern about testing pregnant women during the 3rd trimester

instead of testing at the time of delivery. Dr. Hollier testified that testing during the 3rd trimester (approximately 28 weeks), instead of at the time of delivery, leaves 12-13 weeks in which a woman might acquire HIV infection prior to delivery. Further on this point, no uniform standard for when to test during the third trimester has been decided upon. There is also concern that based on the wording of HB 1795 many woman may not receive testing after their third trimester screening if their test was negative. There is still a 12-13 week window in which a woman could possibly acquire HIV. Additional testing during the time of labor and delivery is necessary to ensure that a mother is aware of her HIV status and the proper precautions can be taken. Also, testing during the third trimester will only help those who are receiving prenatal care. Dr. Hollier testified that approximately 46% of HIV infected woman receive no or inadequate prenatal care in Texas. This gap of women who are not receiving prenatal care leaves open a percentage of woman who will not receive preventative treatment during pregnancy.

HB 1795 also requires the testing of an infant for HIV less than two hours after birth if the mother's status is unknown. The tests are required by state law to be completed with a FDA-approved HIV test. However, Dr. Hollier testified that the FDA- approved HIV test might be inconclusive because current FDA approved tests do not have clinical data regarding use for newborn screening, cord blood specimens, or individuals less than 13 years of age. Due to the lack of data available it is recommended that an assessment is completed to determine the accuracy of FDA-approved tests on infants.

The new requirements also place a burden on the physician in attendance at delivery to instruct the laboratory to expedite the processing of the HIV test so that the results are received less than six hours after the time the sample is submitted. The current law requires the obstetrician to make sure that a rapid test is performed in an expedited manner by the laboratory. However, this burden of care should be placed on laboratory not the obstetrician. HB 1795 should be amended to place the responsibility of expediting testing on the hospital laboratory or the pathologist who directs the laboratory.

HB 1795 also places a burden on the physician or other person in attendance at delivery to order an HIV test on the newborn within two hours after the delivery if no prenatal or delivery HIV testing results are available. During the hearing Dr. Hollier testified that there are several incidences when obstetricians do not have pediatric privileges to order tests or provide newborn care outside of the neonatal resuscitation in the delivery room. As a result, an obstetrician's lack of hospital privileges creates a barrier in which the obstetrician is unable to order or perform a newborn HIV test. HB1795 should be amended to also require the hospital nursery personnel or the pediatrician to order or perform newborn HIV testing.

CHARGE #6

Pursuant to HB 1672 (81R), Section 4, study the policies and procedures related to the disclosure required by Chapter 33, Health and Safety Code, to the parent, managing conservator, or guardian of a newborn child.

INTRODUCTION

The Legislature passed HB 1672, 81R to amend Chapter 33 of the Health and Safety Code as it relates to the state's newborn screening program. The bill also added sickle cell testing to the newborn screening program and required the Department of State Health Services (DSHS) to develop a disclosure form to inform the parents, managing conservators, or guardians of a newborn of the potential uses of their child's genetic material. Once informed, parents and others retain the option to destroy blood spots by providing written consent to DSHS following the conclusion of the newborn screening test. In the event that the parent, managing conservator, or guardian allows for the retention of the genetic material, the bill provides the option to limit its use by means of written consent as well. Finally, the bill instructed the Speaker of the House to charge a committee of legislative members to study newborn screening. Specific emphasis was placed on disclosure and consent processes currently employed by the program.

The interim hearing on this subject resulted in a number of lingering concerns from lawmakers, panelists and members of the public. Further, the recent public outcry and concern over the disclosure and sale of blood spots by the state under a mandated program has created public distrust of government. The hearing revealed important policy questions regarding the ownership of genetic material once removed from the body and what rights parents, managing conservators, or guardians have over such material. The testimony provided also revealed that the disclosure aspects of the law should be improved to require and ensure informed consent of the relevant parties, especially regarding the potential residual use of blood spots. It cannot be emphasized enough how paramount these privacy concerns were in the committee's discussion and deliberation. Lastly, the committee heard testimony about the public health benefits of blood spot research and explored the need for increased efforts to inform the public of such benefits.

RECOMMENDATIONS

1. The Legislature should determine whether the state or the individual is the owner of blood spots and genetic material once such material is taken outside of the individual's body and also what rights parents, legal guardians and conservators have over such material.

2. The disclosure procedures as defined in HB 1672 (81R), are not adequate for ensuring informed consent to the parent, guardian or managing conservator of a new born child. The Legislature should amend the statute to at minimum require the informed consent of parents, guardians, or managing conservators for the residual uses of newborn screening blood spots.

3. The Department of State Health Services (DSHS) should immediately distribute the updated newborn blood spot screening disclosure form as required by law to ensure that parents, guardians, or managing conservators are informed about the storage and residual uses of blood spots.

4. The Department of State Health Services (DSHS) should add a privacy advocate and a member of the public onto the Institutional Review Board (IRB)**.**

DISCUSSION

The Legislature should determine whether the state or the individual is the owner of blood spots and genetic material once such material is taken outside of the individual's body and also what rights parents, legal guardians and conservators have over such material.

The committee discovered that state law is currently silent on the issue of blood spot ownership. Nationally, several states have already made ownership determinations. California, Michigan, Maine and Washington have all declared that residual newborn screening specimens are the property of the state. However, in Maine a parent may object to state ownership in writing, and in Michigan the state holds qualified ownership of specimens, meaning that it must still act on the best interest of the individual from whom the specimen was collected, protecting privacy and providing specimens for research that the community endorses. In contrast, several other states have defined genetic information explicitly as personal property, and Alaskan law further clarifies that an individual has a personal property right over his or her DNA. Determining ownership is critical to ultimately establish what rights parents, managing conservators, or guardians have over blood spot specimens and subsequently for the enforcement of privacy and informed consent laws.

The disclosure procedures as defined in HB 1672 (81R), are not adequate for ensuring informed consent to the parent, guardian or managing conservator of a new born child. The Legislature should amend the statute to at minimum require informed consent to parents, guardians, or managing conservators of the possible uses of newborn screening blood spots.

HB 1672 refers to disclosure as a process by which a parent, managing conservator, or guardian is provided with a written disclosure statement developed by DSHS. This form allows for the prohibition of the retention of the genetic material or limits the use of the material to the newborn screening test. The disclosure statement says that DSHS can use the residual newborn screening specimens for internal use and divulges how the material is managed and used. Committee members raised concerns that this disclosure process was insufficient and that informed consent should be required instead. Informed consent would involve a conversation between a parent, managing conservator, or guardian and an educated healthcare provider about the specifics of the program. This process would give individuals an opportunity to ask questions and have them answered to their satisfaction. Informed consent would also serve as an opportunity for individuals to learn about the potential public health benefits associated with residual blood spot use and research.

The Department of State Health Services (DSHS) should immediately distribute the updated newborn blood spot screening disclosure form as required by law to ensure that parents, guardians, or managing conservators are informed about the storage and residual uses of blood spots.

Committee members also expressed concern over the clarity of the initial newborn screening disclosure forms. DSHS representatives informed the committee that new improved forms had been developed and would be distributed. However, it was unclear from testimony when these new forms would be distributed to healthcare providers. The committee expressed concerns about the department's policy of continuing to use the old forms to fulfill the disclosure mandates as required by HB 1672. Several committee members requested that DSHS move quicker to remove the old forms from distribution and replace them with the new forms that better communicate and educate parents on the use of newborn blood spots and their parental rights under Texas law.

The Department of State Health Services should add a privacy advocate and a member of the public onto the Institutional Review Board (IRB) at the Department of State Health Services (DSHS) .

When it comes to the storage and residual use of newborn blood spot specimens, ensuring privacy must be a key goal. Once the screening is complete, DSHS stores the newborn blood spot card for on-going quality assurance tests and for other health disorders and research involving serious childhood diseases. Any proposed use of the blood spots outside of DSHS requires approval from the department's Institutional Review Board (IRB). The purpose of the IRB is to "ensure the safety, rights and welfare of human participants involved in the proposed research." However, the current board membership lacks anyone with expertise on privacy rights nor is there a member of the public on the board. Considering the sensitive nature involved in disclosing blood spots to third parties for research purposes, it is only responsible to include a privacy advocate and a member of the public in the approval granting process.

CHARGE #7

Identify any gaps in Texas laws that may prevent coordinated efforts, both statewide and on the border, to ensure a safe food supply. ***Joint Interim Charge with House Committee on Border and Intergovernmental Affairs***

INTRODUCTION

The United States has experienced numerous outbreaks of food borne illness over the past few years leading many policymakers both at the federal and state level to look at ways to improve the safety of food. Historically, the United States and Texas were agriculturally based societies and most food was grown locally. However, the rapid urbanization and industrialization of the 20th century led to the development of a massive food processing and distribution system that now serves as the primary mechanism for the delivery of food to most Americans. Further, free trade agreements and globalization have rapidly increased the amount of food imported into the United States and Texas, especially over the past decade.

The federal government currently has fifteen agencies that have some type of jurisdiction over food safety. Coordination at the federal level of all these various agencies has been difficult to achieve and food safety experts warn that too much food enters the United States without proper inspection. The Department of State Health Services (DSHS) serves as the lead agency in Texas for the regulation of food safety in Texas. The department's main regulatory mechanisms are the licensure and inspection of food facilities and investigations of complaints of food borne illness reports received by the department. DSHS informed the committee that the agency currently employs forty inspectors to enforce state law and conduct inspections of facilities.

The committee found one pressing issue to be that the current licensing structure is inadequate to ensure compliance and best practices across the food industry. The current approach of licensing a facility is archaic in nature and does not ensure the safety of the public. The committee therefore seeks to provide recommendations that would modernize the licensure process to incorporate the best academic and industry practices for food safety. The committee also reviewed DSHS, specifically their current food safety collaboration efforts with federal and local partners. The committee also received testimony on how border violence is hindering the ability of the federal government to conduct food safety inspections of imported food.

The following recommendations seek to create a smarter more efficient government that can better ensure the public's safety while better utilizing resources in order to increase collaboration and focus resources where they are needed most.

RECOMMENDATIONS

1. The Legislature should adopt the removal of the exemption to licensure for persons, firms, or corporations that ship raw fruits or vegetables as proposed by the House Committee substitute for SB 1329, 81R.

2. The Department of State Health Services (DSHS) should incorporate an educational component that promotes best practices in food safety into the licensure and re-licensure process for all food manufacturers and distributors. DSHS should add incentives to the licensure process to encourage the adoption of evidence based best practices in food safety.

3. The Legislature should pass a resolution to Congress urging the protection of Federal Drug Administration (FDA) and United States Department of Agriculture (USDA) food safety workers and inspectors on the Texas border.

4. The Department of State Health Services (DSHS) should continue to seek grant funding to study food safety inspection gaps along the Texas border**.**

5. The Department of State Health Services (DSHS) should better collaborate with all academic, federal and local partners to routinely review the safety of imported food into Texas.

DISCUSSION

The Legislature should adopt the removal of the exemption to licensure for persons, firms, or corporations that ship raw fruits or vegetables as proposed by the House Committee substitute for SB 1329, 81R.

State law currently provides an exemption to licensure for persons, firms, or corporations who ship raw fruits and vegetable. The exemption was initially granted by the Legislature due to historically low instances of food borne illness from raw fruits and vegetables. However, the 2008 tomato and pepper salmonella outbreak and the 2009 peanut outbreak, both of which caused serious illness in Texas, convinced state health officials to re-evaluate the state's public health policy of allowing unlicensed facilities that store and ship raw fruits and vegetables.

Further, as more food is imported from Mexico and other nations, warehouses storing fruit and vegetables are increasingly becoming a critical link in the food supply chain from the producers to the general public. Currently, Texas imports more fruits and vegetables from Mexico and other nations than at any other time in the state's history. According to the Texas Center for Border Economic and Enterprise Development, Texas imports from Mexico twice as much as Texas exports to Mexico. Considering this rapid rise in the importation of foreign grown fresh fruits and vegetables, the Legislature needs to act to better protect the public's health in this area. The storage and distribution of fruits and vegetables has become a critical but unregulated link in the state's food supply chain and thus warrants the removal of the licensure exemption.

The Department of State Health Services (DSHS) should incorporate an educational component that promotes best practices in food safety into the licensure and re-licensure process for all food manufacturers and distributors. DSHS should add incentives to the licensure process to encourage the adoption of evidence based best practices in food safety.

The committee heard compelling testimony from John Scott, Director of Quality Assurance at HEB, and Dr. Juan Anciso, PH.D representing Texas AgriLife Extension Service that safety cannot be tested or inspected into a food product, especially considering the vast amounts of food grown, shipped and sold every day in Texas. While government regulation through licensure of facilities and inspections provide a necessary set of safeguards for consumer protection, these safeguards only offer a minimum standard of protection. In fact, the public should not hold the illusion that government licensure and inspection programs will ensure the safety of the food they eat. A clear theme from the testimony heard by the committee on this issue was the need to incorporate best practices and education into the licensure process. Consumers also have a basic responsibility to protect themselves by knowing the basic safety precautions for buying, washing and cooking food.

In order to better study the theme of incorporating education into licensure as previously mentioned, Chair Lois Kolkhorst directed committee staff to hold an informal workgroup with representatives from the Department of State Health Services, the Food and Drug Administration, Texas AgriLife Extension and HEB to develop ideas for ways to incorporate food safety and best practices into the licensure process. The workgroup concluded that one way

to incorporate best practices into the licensure process would be to incentivize the food industry to enroll in educational training in best food safety practices and maintain ongoing continuing education requirements. DSHS would incentivize education incorporation by setting lower licensing fees and lower rates of inspection if education is incorporated by a licensee. However, a licensee that chooses not to incorporate education into licensure would face higher licensure fees and higher rates of inspection.

The Legislature should pass a resolution to Congress urging the protection of Federal Drug Administration (FDA) and United States Department of Agriculture (USDA) food safety workers and inspectors on the Texas border.

The committee heard disturbing testimony from Dr. Kevin Varner, with USDA about the disruption of USDA inspections of cattle on the Mexican side of the border due to drug cartel violence. While no USDA workers have been injured, Dr. Varner reported that USDA vehicles have been shot at by drug cartels and other individuals thus forcing USDA workers to avoid inspecting cattle in Mexico. USDA has established temporary holding cells on the Texas side of the border in order to continue necessary inspections along the Texas Mexico border. During an informal workgroup on the issue of food safety, a representative from the FDA also informed committee staff that violence along the Texas border is also a major concern for FDA inspection of imports into Texas from Mexico.

The U.S. Congress has traditionally not linked border security policies with food safety therefore these two now interconnected issues have no coordinated polices to speak of. For example, a 2009 report by the Congressional Research Office entitled *Mexico-U.S. Relations, Issues for Congress*, does not address the consequences of border violence for U.S. food safety workers and inspection efforts. The report does not link border violence and food safety at all. Further, the report only briefly touches on the topic of food safety by mentioning the FDA's confirmation that the source of the 2008 salmonella outbreak was Mexican grown jalapeño and serrano peppers. The Legislature should be concerned that a major report to Congress does not take into account the important role that a secure border plays in ensuring quality inspections of imported food.

However, the August 2010 joint hearing of the House Public Health and Border and Intergovernmental Affairs committees on food safety was an important first step for addressing the issue by making the public, the Legislature and the Congress aware of the link between and need for a border security policy that takes into account the logistics of inspecting imported food along the Texas-Mexico border.

The Department of State Health Services (DSHS) should continue to seek grant funding to study food safety inspection gaps along the Texas border.

The committee identified several gaps in food safety ranging from outdated licensing exemptions, lack of best food safety practices, increasing border violence and uncoordinated food safety efforts. However, a more in depth study of the issue involving government, industry and academia is needed to better identify and grasp the gaps in food safety, especially along the border region. The Department of State Health Services (DSHS) testified that the department has been actively seeking a grant from the Robert Woods Johnson Foundation to study gaps in the food safety system in Texas. DSHS has estimated that the study would need to be funded at $500,000 to successfully provide a comprehensive report on food safety gaps in Texas. Due to the large amount of food that is imported into Texas, the proposed study should be conducted. The study would greatly enhance the goal of identifying gaps in food safety and better position the Legislature to make future policy decisions on food safety and public health.

The Department of State Health Services (DSHS) should better collaborate with all academic, federal and local partners to routinely review the safety of imported food into Texas.

The Department of State Health Services (DSHS) did not provide the committee any evidence of a clear plan for improving food safety in Texas. Further, the department did not provide any testimony or comment on any current cooperation with or future plans for increased cooperation with federal, state, local or academic partners on food safety. The department's testimony before the committee only highlighted the current work of the department, the department's knowledge of the roles of various federal agencies and also the monitoring of federal legislation pertaining to food safety.

DSHS did inform committee staff that the department does work with the FDA on a daily basis however this seemed to be on a case by case basis and no overarching goals or strategic plan for cooperation with the FDA were identified by DSHS. The committee also did not find any clear evidence that the state's academic institutions were collaborating with DSHS on identifying food safety gaps or researching best practices. The Texas AgriLife Extension and HEB provided testimony and follow up comments that evidence based best practices and industry education needed to be incorporated into the DSHS licensure process. This type of collaboration would require a higher level of coordination and planning from DSHS than the department's current work with academic partners, industry representatives and the federal government.

CHARGE #8

Monitor the agencies and programs under the committee's jurisdiction.

INTRODUCTION

The committee requested the implementation status of legislation passed by the 81st Legislature from the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) in order to provide the Legislature better monitoring of state agency programs. HHSC and DSHS provided the following implementation reports per the committee's request. This section was included for purely informational purposes and does not make any recommendations or provide any discussion.

IMPLEMENTATION STATUS

Health and Human Services Commission
Status of Implementation, 81st Session

BILL: HB 233-Relating to the creation of an advisory committee to establish and recommend qualifications for certain healthcare translators and interpreters

STATUS: Implemented

The bill required the creation of an advisory committee to establish and recommend qualifications for certain healthcare translators and interpreters. The Advisory Committee on Qualifications for Health Care Translators and Interpreters was established and first met on January 20, 2010 and held several subsequent meetings. The committee approved submission of their findings to the executive commissioner of HHSC at a meeting on August, 27th 2010. The committee continues to meet. More information regarding the committee can be found online at: http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/HCT/default.shtml

BILL: HB 492-Relating to the expansion of faith and community based health and human services and social services initiatives.

STATUS: Implementation in Process

The bill required HHSC to establish and support the Task Force on Strengthening Non-Profit Capacity and to establish and support the Renewing Our Communities Account (ROCA) Advisory Committee. The bill also required HHSC to coordinate and facilitate the work of the Intergovernmental Coordinating Council (ICG) established by the bill. The Task Force held five hearings across the state, conducted a survey of non-profits and submitted a report to the Legislature on November 1st, 2010 with recommendations for legislative consideration. The ROCA Advisory Committee has met twice and will provide recommendations to the executive commissioner of HHSC on the use of the ROCA fund. The ICG has met three times and has identified barriers between state government and non-profits that hinder collaboration. The ICG will report the group's progress to the State Commission on National and Community Service and a report will be posted on the Governor's website and submitted to the Legislature.

BILL: HB 497-Relating to a study to determine the effect on the healthcare infrastructure in this state if the state Medicaid program is abolished or a severe reduction in federal matching money under the program occurs.

STATUS: Implemented

The report has been completed and was submitted to the Legislature.

BILL: HB 1240-Relating to information required to be provided to parents of an infant

STATUS: Implementation in Process

The bill requires hospitals and birthing centers to distribute parenting resource guides to Medicaid parents of newborns. Guides were developed and are now distributed. HHSC is currently evaluating the effectiveness of the guides and a report on the performance and impact of the resource guides is due by December 2010.

BILL: HB 1487-Relating to the alignment of certain Medicaid procedures regarding written orders for diabetic equipment and supplies with comparable Medicare written order procedures.

STATUS: Implemented

The bill required HHSC to review Medicaid forms and requirements for written orders for diabetic equipment and supplies to align similar to Medicare. HHSC has developed a simplified process in which the prescription is the only required documentation necessary for diabetic equipment which will align with Medicare's policy.

BILL: HB 1966-Relating to an e-prescribing implementation plan under the Medicaid and children's health programs.

STATUS: Implemented

The bill required HHSC to develop an implementation plan for e-prescribing. HHSC has completed the plan and released the e-prescribing plan on December 28, 2009.

BILL: HB 1990-Relating to a diabetes self-management training pilot program under the state Medicaid program.

STATUS: Implementation in Process

The bill required HHSC to develop a diabetic education program. HHSC is in the process of re-procuring the disease management contract for the program. HHSC estimates a start date of February 2011.

BILL: HB 2004-Relating to breach of computer security involving sensitive personal information and to the protection of sensitive personal information and certain protect health information

STATUS: Implementation in Process

The bill required HHSC to develop new protocols and response training for breaches of sensitive information. HHSC has finalized several trainings efforts related to the bill.

BILL: HB 2030-Relating to the Medicaid Drug Utilization Review Program and prescription drug use under the Medicaid program

STATUS: Implementation in Process

The bill required HHSC to ensure Medicaid prescriptions are valid for up to one year and requires HHSC to study the costs and benefits of the prior authorization process. HHSC received federal approval to implement the bill. HHSC must still evaluate the cost and benefits of the prior authorization process.

BILL: HB 2163-Realting to a study regarding the provision of certain medications through the Medicaid vendor drug program to children younger than 16 years of age.

STATUS: Implemented

The bill required HHSC to conduct a study to determine the appropriateness and safety of providing antipsychotic or neuroleptic drugs. HHSC submitted the report with findings to the Legislature on November 10th, 2010.

BILL: HB 2196-Relating to the establishment of a workgroup to study and make recommendations on the integration of health and behavioral health services.

STATUS: Implemented

The bill required HHSC to establish a workgroup to recommend best practices and policy training and service delivery to promote the integration of health and behavioral services. HHSC conducted the study and submitted a report to Legislature.

BILL: SB 203-Relating to healthcare associated infections and preventable adverse events in certain healthcare facilities

STATUS: Implemented

The bill required HHSC to adopt rules regarding the denial or reduction of reimbursement under Medicaid for preventable adverse events that occur in a hospital setting. HHSC adopted the required rules in July of 2010.

BILL: SB 705-Relating to long-term care consumer information and Medicaid waiver programs

STATUS: Implementation in Process

The bill required HHSC to make available long term care consumer information on the internet. HHSC and the Department of Aging and Disability Services (DADS) created a website on the DADS' webpage: www.dads.state.tx.us/ltss/. The bill also required the abolishment of the Consolidated Waiver Program (CWP). The abolishment of the CWP has been delayed until Jan. 2011 to avoid jeopardizing federal matching funds.

BILL: SB 1645-Relating to the distribution of a prescription drug and a study of the feasibility of establishing separate reimbursement rates under the Medicaid vendor drug program for certain pharmacy care management services.

STATUS: Implemented

The bill required HHSC to conduct a feasibility study on establishing separate reimbursement rates. The study was conducted and a report was posted online and submitted to the Legislature.

BILL: SB 1646-Relating to the creation of the Council on Children and Families

STATUS: Implementation in Progress

The bill required HHSC to establish the Council on Children and Families. Four council meetings have been held thus far. The council provided a report for HHSC's appropriations request in May of 2010 and a second report is expected in December 2010.

Department of State Health Services (DSHS)
Status of Implementation, 81st Session

BILL: HB 19- Relating to requirements for drugs dispensed by pharmacists.

STATUS: Implemented

Prescription labels and medication information sheets at state hospitals have been updated per the legislation. The broader implementation of the bill's requirements for pharmacists in general was not reported.

BILL: HB 448- Relating to requiring the Department of State Health Services to implement a provider choice system for certain vaccines.

STATUS: Implemented

DSHS informed Texas Vaccine for Children (TVFC) providers about the new vaccine choice requirement and the new inventory reporting requirement for the TVFC Electronic Vaccine Inventory (EVI). DSHS provided training for the new requirements in August 2010 and the new EVI system was implemented statewide in September 2010.

BILL: HB 449- Relating to the regulation of laser hair facilities

STATUS: Implemented

DSHS adopted rules for the regulating laser hair facilities and the department began accepting application in November 2010.

BILL: HB 492- Relating to the expansion of faith- and community-based health and human services and social services initiatives.

STATUS: Implementation in Progress

DSHS appointed a faith and community based liaison and is participating in the expansion of faith and community based services in Texas.

BILL: HB 594- Relating to the licensing and regulation of hearing instrument fitters and dispensers.

STATUS: Implemented

DSHS adopted new rules and the new rules became effective September 24, 2009.

BILL: HB 643- Relating to the qualifications of surgical technologists

STATUS: Implemented

DSHS is enforcing the new requirement that surgical technologists must be certified to be hired by a hospital or other healthcare facility.

BILL: HB 888- Relating to the detention and examination of certain persons accepted for a preliminary mental health examination.

STATUS: Implemented

DSHS is enforcing the new requirement and all state hospitals have been notified of the new requirements.

BILL: HB 888- Relating to the detention and examination of certain persons accepted for a preliminary mental health examination.

STATUS: Implemented

DSHS is enforcing the new requirement and all state hospitals have been notified of the new requirements.

BILL: HB 1232- Relating to establishing a local behavioral health intervention pilot project.

STATUS: Implemented

The bill required DSHS to enter into a Memorandum of Understanding with a local mental health authority to develop a complaint process for parents. DSHS complied with this requirement. The actual program implementation of the bill is a local initiative.

BILL: HB 1310- Relating to the use of a tanning facility by a minor

STATUS: Implemented

DSHS adopted new rules to comply with the bill and the new requirements took effect November 2010.

BILL: HB 1357- Relating to the regulation of freestanding emergency medical care facilities; providing an administrative penalty; creating an offense.

STATUS: Implemented

DSHS adopted new rules and licenses are being issued.

BILL: HB 1362-Relating to the pilot program for reporting of methicillin-resistant Staphylococcus aureus infections.

STATUS: Implementation in Process

The legislation required rules for a pilot study and report by September 1st, 2010. The rules were presented to the State Health Service Council for consideration. DSHS did not provide information on the status of the required report.

BILL: HB 1363- Relating to the diabetes mellitus registry pilot program

STATUS: Implemented

DSHS reports that the pilot program has been extended and that required provisions have been adopted.

BILL: HB 1510- Relating to including information on sudden infant death syndrome in a resource pamphlet for parents of newborn children.

STATUS: Implemented

The DSHS newborn children resource pamphlet for parents has been updated and posted on the departments website to meet the requirements of the bill.

BILL: HB 1671- Relating to mutual aid agreements for newborn screening laboratory services.

STATUS: Implementation Status Not Clear

DSHS is authorized to enter into mutual aid agreements with other states, however no action has been taken at this time.

BILL: HB 1672- Relating to newborn screening

STATUS: Implementation in Progress

DSHS developed the required NSB disclosure form and process. Blood spots are destroyed within 60 days of a request. Sickle cell trait has been included in the NBS screening program.

BILL: HB 1795- Relating to newborn screening and the creation of the Newborn Screening Advisory Committee.

STATUS: Implementation in Progress

DSHS established the Newborn Screening Advisory Committee and the committee has met. No funding was appropriated to screen for secondary panel disorders. DSHS updated the prenatal testing pamphlet to reflect changes in HIV testing of pregnant women.

BILL: HB 1850- Relating to changing the name of the South Texas Health Care System to the Rio Grande State Center.

STATUS: Implemented

DSHS changed the name of the facility to the Rio Grande State Center

BILL: HB 1884- Relating to the conveyance of state land in Hidalgo County

STATUS: Implemented

The state land in Hidalgo county has been conveyed

BILL: HB 2027- Relating to the adoption of the Revised Uniform Anatomical Gift Act

STATUS: Implemented

The application form and website have been updated to allow for electronic signatures and online education modules have been updated to comply with the new requirements.

BILL: HB 2055- Relating to the Chronic Kidney Disease Task Force

STATUS: Implementation in Progress

The legislation continued the work of the task force until September 2011 and a new report on the extended work of the task force will be due

BILL: HB 2154- Relating to the Physician Education Loan Repayment Program

STATUS: Implemented

DSHS signed an interagency contract with the Higher Education Coordinating Board and DSHS has fulfilled all agency obligations required by the bill.

BILL: HB 2917- Relating to authorizing the Department of State Health Services to obtain criminal history record information for certain applicants for employment.

STATUS: Implementation in Progress

DSHS has implemented the criminal history requirements at the Texas Center for Infectious Disease and the South Texas Health Care System. The Council on Sex Offender Treatment, an independent board administratively attached to DSHS, is establishing standards for the implementation of the required monitors for the sexually violent predator program.

BILL: HB 3961- Relating to the regulation of nursing.

STATUS: Implementation not successful

The bill required to the extent funding is available, the Texas Nursing Resource Center to conduct a study of alternate ways to assure clinical competency of graduates of nursing educational programs. The bill also required the Texas Nursing Resource Center to contract with an independent researcher to develop the research design and conduct the research. However, no contract was awarded because none of the applicants were either deemed qualified or capable of fulfilling the requirements of the bill.

BILL: HB 4029- Relating to the release of certain health care information.

STATUS: No Implementation required

The bill made changes that are consistent with current DSHS rules and policies

BILL: HB 4276- Relating to transportation for persons discharged from mental health facilities.

STATUS: Implemented

DSHS made changes to the transportation planning for discharged patients at DSHS state hospitals to comply with the bill.

BILL: HB 4560- Relating to certain diseases or illnesses suffered by certain emergency first responders.

STATUS: Implementation in Progress

DSHS has not yet adopted the necessary rule amendments in order to implement. The rules should be adopted before the 82nd Legislature.

BILL: HCR 88- Directing the Texas Department of State Health Services and the Texas Education Agency to educate parents of adolescent Texans regarding the importance of adolescents' receiving regular physical exams and updated immunizations.

STATUS: Implementation in Progress

DSHS and the Texas Education Agency (TEA) are working jointly to address adolescent health through several initiatives:

1.DSHS and TEA have agreed to address adolescent health issues using a positive youth development framework
2.DSHS and TEA have ongoing collaborative effort on STDs, AIDS and maternal health
3.DSHS is working on an initiative to promote the importance of adolescent preventive care
4.DSHS also promotes adolescent health through the Texas Healthy Adolescent Initiative that focuses on community-level support for adolescent development.

BILL: SB 203- Relating to infections and preventable adverse event in healthcare facilities

STATUS: Partial Implementation

No funding was provided to DSHS to fund the addition of preventable adverse events (PAE) to the healthcare-associated initiative. DSHS has submitted an exceptional item request for funding.

BILL: SB 291- Relating to hepatitis B vaccination for students enrolled in certain health-related courses of study at an institution of higher education.

STATUS: Implemented

DSHS adopted new rules which became effective May 2010

BILL: SB 292- Relating to the requirement that licensed physicians provide emergency contact information to the Texas Medical Board and to the creation of the Texas Physician Health Program.

STATUS: No Implementation Required

Allows DSHS to use information collected by the Texas Medical Board in the event of a disaster.

BILL: SB 343- Relating to the Health Foods Advisory Committee

STATUS: Implementation in Progress

DSHS in coordination with the Texas Department of Agriculture (TDA) appointed the Health Foods Advisory Committee. The committee met a report is expected before the 82nd Legislature.

BILL: SB 346- Relating to information submitted to and maintained in the immunization registry after an individual becomes an adult

STATUS: Not Implemented

DSHS discovered contradictions in statue during the rulemaking process and will seek clarification from the 82nd Legislature.

BILL: SB 347- Relating to the receipt and release of immunization information by the immunization registry in connection with a disaster; providing penalties.

STATUS: Not Implemented

DSHS discovered contradictions in statue during the rulemaking process and will seek clarification from the 82nd Legislature.

BILL: SB 476- Relating to staffing, overtime, and other employment protections for nurses.

STATUS: Implemented

DSHS adopted and published new rules in compliance with the bill

BILL: SB 526- Relating to grants for federal qualified health centers

STATUS: No Implementation Required

DSHS reauthorized the FQHC grant program and continued existing programs

BILL: SB 527- Relating to certain mammography systems that fail certification standards.

STATUS: Implementation in Progress

DSHS is implementing the current requirements of the bill however DSHS rules have not been updated to reflect the change in law.

BILL: SB 584- Relating to notification to a patient of a state-operated mental health facility or resident of a residential care facility of the exemption of certain trusts from liability to pay for support.

STATUS: Implemented

DSHS updated the state hospital admission process and the Patients' Rights Handbook was modified to include the required notification.

BILL: SB 703- Relating to the provision of a certified copy of a birth certificate for certain minors receiving services from the Department of Family and Protective Services and to the amendment of birth and death certificates

STATUS: Implemented

DSHS changed its administrative procedures to comply with the bill

BILL: SB 870- Relating to the Interagency Obesity Council (IOC)

STATUS: Implementation in Progress

The IOC has met and a report is expected to be completed and submitted before the 82nd Legislature.

BILL: SB 968- Relating to interactive water features and fountains

STATUS: Implemented

DSHS has adopted and published new rules in compliance with the bill

BILL: SB 1054- Relating to the Hill Country local mental health authority crisis stabilization unit.

STATUS: Implemented

The Hill Country MHMR's Crisis Stabilization Unit is operational

BILL: SB 1058- Relating to reporting requirements for health occupation regulatory agencies.

STATUS: Implemented

The Health Professions Council (HPC) is the lead agency on the bill. DSHS completed reporting requirements in February 2010 as directed by the HPC.

BILL: SB 1082- Relating to the storage, maintenance, and distribution of mammography medical records

STATUS: Implemented

The bill added permissive language to the Radiation Control Act to all DSHS to use the Radiation and Perpetual Care Account for specific purposes. No other implementation was required.

BILL: SB 1171- Relating to certain health-related reports, records, and information.

STATUS: Implemented

DSHS changed procedures to comply with the bill requirements regarding the confidentiality and release of certain health-related reports, records, and information regarding communicable diseases or health conditions.

BILL: SB 1271- Relating to the requirement that an orthotist or a prosthetist be licensed as a device manufacturer if fabricating or assembling without an order from certain health care professionals.

STATUS: Implemented

The bill clarified state law, no DSHS implementation required but agency practices and procedures were updated to comply.

BILL: SB 1326- Relating to the functions of the statewide health coordinating council

STATUS: Implemented

The SHCC is a council DSHS provides administrative support. DSHS adopted new procedures for the authorization to seek civil penalties against hospitals that do not supply information required by state law.

BILL: SB 1328- Relating to a study on the feasibility of providing vaccines to first responders deployed to a disaster area.

STATUS: Implementation in Progress

DSHS will contract out the feasibility study required by the bill. The contractor will be required to submit a completed report to DSHS by May 2011 and then DSHS will submit its findings to the Legislature by August 2010.

BILL: SB 1409- Relating to the definition of first responder for purposes of the immunization registry

STATUS: Implementation in Progress

DSHS is still in the process of adopting rules.

BILL: SB 1645- Relating to the distribution of a prescription drug and a study of the feasibility of establishing separate reimbursement under the Medicaid vendor drug program for certain pharmacy care management services.

STATUS: Implementation in Progress

DSHS is still in the process of adopting rules.

BILL: SB 1803- Relating to the Glenda Dawson Donate Life-Texas Registry.

STATUS: Implemented

SB 1803 requires the DSHS in consultation with the Texas Organ, Tissue, and Eye Donor Council, to implement a training program for all appropriate Department of Public Safety (DPS) and Texas Department of Transportation (TxDOT) employees on the benefits of organ, tissue, and eye donation and the procedures for individuals to be added to the statewide Internet-based registry of organ, tissue, and eye donors. DSHS has developed training and is conducting the required training requirements.

BILL: SB 1932- Relating to the licensing requirements of hospitals temporarily providing outpatient dialysis services to a person because of a disaster.

STATUS: Implemented

SB 1932 amends the Health and Safety Code to provide an exemption from end stage renal disease facility licensing requirements for a licensed hospital that provides dialysis only to individuals temporarily receiving outpatient services due to a disaster declared by the governor or a federal disaster declared by the president of the United States. DSHS has adopted rules to comply with the bill.

COMMITTEE MEMBER LETTERS

December 1, 2010

The Honorable Lois Kolkhorst
Chair
House Committee on Public Health
Capitol, E2.318
Austin, TX

Dear Chair Kolkhorst:

We sign this report with reservations about Recommendation 7 for Charge #4.

While there may be some benefits of a high deductible health plan (HDHP) for certain populations, it seems imprudent and unwise to assume that such benefits would apply to the Medicaid population in Texas.

An HDHP would certainly not be effective at providing coverage to the aged, blind and disabled, and pregnant women in Medicaid. The report notes that this plan would be optimal for an individual that is healthy and has no preexisting condition. Within the Texas Medicaid population, those qualifications could only apply to children or custodial parent in TANF who are at or below 17% of the Federal Poverty Level (FPL), who already make up the most affordable populations to cover.

As the report notes, HHSC conducted a study and found that the administrative costs of a pilot would outweigh the savings. Further, assuming that a population that lives below the FPL would have the resources to cover such high deductibles is flawed. A consumer directed payment plan does have some merits, but none would apply to the Medicaid population in Texas.

Finally, while we agree with the recommendations for obesity, it is concerning that we would focus our dollars so narrowly that some school age children over 12 would not receive some benefits. We should work to ensure that older children benefit from anti-obesity efforts in our state as well. With that recommendation, we further believe that physical education should be restored to high school age students in Texas.

Sincerely,

Representative Garnet F. Coleman

Representative Elliott Naishtat

SUPPLEMENTAL MATERIALS

Obesity Hearing
March 8, 2010, 9:00 a.m.

Charge 1: *Monitor implementation of legislation intended to curb rising obesity rates in Texas. Study and make recommendations regarding better coordination of prevention efforts and evidence-based strategies to reduce the impact of obesity on health care costs. Include recommendations related to the use of federal stimulus funds targeted toward obesity prevention.*

Panels:

A. (1.) Overview and Trends: Dr. Eduardo Sanchez, VP & Chief Medical Officer, BCBSTX

B. Implementation of Initiatives:

Wellness Initiatives - **Panel 1**

(2.) Ann Fuelberg, Executive Director of the Employee Retirement System

(3.) Raette Hearn, Director of Agency Administration at the Texas Comptroller's Office

Obesity Initiatives

Panel 2 - Interagency Council Initiatives: DSHS/TDA/TEA (SB 556, 80R)

(4.) Todd Staples, Commissioner of Texas Department of Agriculture

(5.) Dr. Adolfo Valadez, Assistant Commissioner at the Texas Department of State Health Services

Panel 3

(6.) Dr. Charles Bell, Deputy Executive Commissioner at Texas Health and Human Services Commission

(7.) Ms. Nancy Herron, Outdoor Learning Programs Manager at the Texas Parks and Wildlife Department

C. **Panel 4** - Practice:

(8.) Dr. Stephen Ponder, Pediatrician

(9.) Ms. Stacy Fisher, Dietician

D. Research:

(10.) Dr. Deanna Hoelscher, UTHSC: **Panel 5**

(12.) Dr. Peter Murano, AgriLIFE: **Panel 5**

Dr. Thomas Tenner , TTUHSC (invited): **Panel 5**

(11.) Dr. Mark Benden, TAMHSC: **Panel 6**

(13.) Dr. Jay Horton, UTSW: **Panel 6**

E. Public Comment

H1N1 Hearing
March 8, 2010
upon conclusion of Charge 1

Charge 2: *Study the state's ability to respond to the H1N1 virus. Examine issues related to vaccine and antiviral distribution and capacity, disease surveillance, communication with providers and the public, intergovernmental cooperation, and medical surge capability.*

Panels:

A. (15.) Overview and Trends and Pandemic Preparedness: Dr. James M. Galloway, Assistant U.S. Surgeon General

B. (16.) State Response: Dr. David Lakey, DSHS Commissioner

C. **Panel 1** - Local Response:

(17.) Dr. Susan, P. Fisher-Hoch, UTHSC Houston – Brownsville

(18.) Dr. Eric Higginbotham, Dell Children's Medical Center

C. **Panel 2** - Manufacturing Distribution and Capacity: H1N1 Antiviral and Vaccine

(19.) Mr. Christopher Mediano, U.S. Product Director Anti-Infectives/Virology & Specialty Care Genentech, A Roche Company

(20.) Mr. Peter Khoury, Vice President of Global Marketing for Baxter BioScience and Vaccine

D. Providers

(21.) Dr. Elena Marin, Su Clinica Familiar in Harlingen: **Panel 3**

(22.) Mr. Zachary Thompson, Director, Dallas Co. Health & Human Services: **Panel 3**

(23.) Dr. Wendy Chung, Pediatrician: **Panel 4**

(24.) Dr. Timothy Deahl, OB/GYN: **Panel 4**

E. Public Comment

HIT Hearing
May 11, 2010
8:30 a.m. - E2.012

Charge 3: *Determine how the state can best coordinate efforts to streamline health care delivery with health information technology (HIT). Identify areas in state law that affect the adoption and use of HIT. Recommend statutory changes as necessary.*

Panels:

A. Overview and Update: Forming Frameworks and Consensus

Mr. Stephen Palmer: *Director, Office of e-Health Coordination, Health and Human Services Commission (1.)*
Mr. Manfred Sternberg: *President, Texas Health Service Authority (2.)*

B. Providers and Stakeholders: Updates and Ideas

Mr. Kevin Storey: *CFO, Henderson Memorial Hospital (3.)*
Dr. Karen Van Wagner: *Executive Director, North Texas Specialty Physicians Board Member, Sandlot, LLC (4.)*
Mr. Ed Marx: *CIO of Texas Health Resources (5.)*
Dr. Robert W. Warren: *Pediatric Rheumatologist, Texas Medical Association and the Texas Pediatric Society. (6.)*

C. Privacy Concerns: The Issue of Consent

Dr. Dave Wanser: *Visiting Fellow at the LBJ School of Public Affairs at the University of Texas at Austin (7.)*
Dr. Deborah Peel: *Founder and Chair of Patient Privacy Rights (8.)*

D. Implementation Challenges and Workforce Planning: Future Needs

Mrs. Sue Biedermann MSHP, RHIA, FAHIMA: *Chair, HIM Program, Texas State University - San Marcos (9.)*
Dr. Jack Smith: *Dean of the School of Health Information Science, The University of Texas Health Science Center at Houston (10.)*

E. Public Comment

JIM PITTS
Chairman, House Appropriations Committee

TEXAS HOUSE OF REPRESENTATIVES

LOIS KOLKHORST
Chairman, House Public Health Committee

House Committees on Appropriations-S/C on Health and Human Services, S/C on General Government & Public Health Joint Hearing May 10, 2010 - Room E1.030

Public Health Charge 4: *Identify factors influencing health care cost trends in Texas, including practices or policies that may contribute to regional variations. Investigate medical imaging utilization and its impact on the cost and quality of health care. Recommend policy changes to promote best practices, reduce costs, and improve quality within the state Medicaid program, Employees Retirement System, and Teacher Retirement System.*

Panels:

A. Medical Inflation, Cost Curves, and Preventable Complications: Theories and Solutions

Guy Clifton, M.D., *Professor of Neurosurgery at the University of Texas Medical School at Houston; Author, Flatlined: Resuscitating American Medicine (a.)*

B. Long Term Care Costs: The Medicaid Population and Beyond

Wayne Douglas: *President, Community Care Division of Girling Health Care, Inc. (b.)*
Steve Wood: *President, TRISUN Healthcare (c.)*

C. Memorial Hermann Healthcare System Clinical Integration

Doug Ardoin, M.D.: *Memorial Hermann Healthcare System, Physician in Chief (d.)*
Michael Shabot, M.D.: *Memorial Hermann Healthcare System, Chief Medical Officer (d.)*
Jeff Brownawell: *Memorial Hermann Healthcare System, Chief Revenue Officer (d.)*
Chris Lloyd: *CEO, Healthnet Provider (d.)*

D. Texas Medical Professionals: Policies and Perspectives

John Holcomb, M.D.: *Texas Medical Association (e.)*

E. Exploring Cost Variations Among Public Pensions: Benefit Costs and Rates by Region

Ronnie Jung: *Executive Director, Teacher Retirement System of Texas (f.)*
Ann Fuelberg: *Executive Director, Employee Retirement System of Texas (g.)*
Ted Haynes: *VP of Health Care Delivery, Blue Cross Blue Shield of Texas (h.)*

F. Health Care Cost Trends and Quality Improvements: Medicaid Population and General Population

Tom Suehs: *Executive Commissioner, Health and Human Services Commission (HHSC) (i.)*
Charles Bell, M.D.: *Deputy Executive Commissioner for Health Services, HHSC (j.)*
Sylvia Cook: *Team Lead, Texas Health Care Information Collection, Texas Department of State Health Services (k.)*
Mike Gilliam Jr, M.S.W., M.P.H.: *Assessment and Benchmarking Specialist, Centers for Program Coordination, Policy & Innovation, Texas Department of State Health Services (l.)*

G. Medical Imaging: Costs, Ownership, and Utilization Policies

Jean Mitchell, Ph.D.: *Economist and Professor at the Georgetown Public Policy Institute (m.)*
James Webb: *President, Texas Independent Diagnostic Testing Facilities Association (n.)*
Bill Taylor, M.D.: *Radiation Oncologist, Texas Oncology (o.)*

HIV Hearing
April 19, 2010
10:00 a.m.

Charge 5: *Examine the need for and barriers to implementing routine HIV screenings as recommended in 2006 by the Centers for Disease Control and Prevention. Assess the impact of implementation on HIV transmission, health outcomes, clinical progression, and mortality.*

Panels:

A. Welcome: **Dr. Roberta B. Ness**, *Dean of the University of Texas School of Public Health*

B. Research

Dr. Susan Tortolero: *Director of the Center for Health Promotion and Prevention Research at the UT School of Public Health (1.)*
Dr. Steven Klemow: *Assistant Professor, Internal Medicine – Infectious Diseases - UT Southwestern (2.)*

C. Federal and State Initiatives

Dr. Bernard Branson: *Associate Director for Laboratory Diagnostics, Centers for Disease Control and Prevention - Division of HIV/AIDS Prevention (3.)*
Dr. Adolfo Valadez: *Assistant Commissioner, Prevention and Preparedness Services - DSHS (4.)*

D. Clinic and Community Experiences

Dr. Thomas Giordano: *Medical Director, Thomas Street Clinic - Houston, TX (5.)*
Mr. Randall Ellis: *Legacy Community Health Services, Inc. (6.)*

E. Associated Medical Matters

Dr. Victor Machicao*: University of Texas Medical School at Houston - Texas Liver Center (7.)*
Dr. Lisa Hollier, OB/GYN: *Program Director, LBJ Obstetrics and Gynecology Residency - University of Texas Medical School at Houston (8.)*

F. Insurance Involvement

Mr. Salil Deshopande: *Medical Director - United Healthcare (9.)*

G. Public Comment

Newborn Screening Hearing
May 17, 2010
10:00 a.m. - E2.012

Charge 6: *Pursuant to HB 1672 (81R), Section 4, study the policies and procedures related to the disclosure required by Chapter 33, Health and Safety Code, to the parent, managing conservator, or guardian of a newborn child.*

Panels:

A. Establishing Data Protocols and Defining Meaningful Use in a Digital Age

Mr. Kim Slocum: *Chair-elect of the Texas Health Institute (1.)*

B. Newborn Bloodspot Policy and Governance: Overview and Update

David L. Lakey, M.D.: *Commissioner, Texas Department of State Health Services (2.)*

C. Newborn Bloodspot Storage and Retrieval

Craig H. Blakely, Ph.D., M.P.H.: *Dean, Texas A&M Health Science Center School of Rural Public Health (3.)*

D. Public Disclosure and Parental Consent

Ms. Sharon Perry, RN: *Director of Maternity Services, Seton Medical Center (4.)*
Charleta Guillory, M.D.: *Neonatologist; March of Dimes, Texas Pediatric Society, Texas Medical Association and Texas Academy of Family Physicians (5.)*

E. Family Perspectives and Parental Rights

Ms. Cassie Medina *(6.)*
Mr. Wayne Krause: *Texas Civil Rights Project, Legal Director and Attorney (7.)*
Ms. Andrea Beleno *(7.)*
Mr. Keith A. Taylor *(7.)*
Ms. Maryann Overath *(7.)*

F. Public Comment

Food Safety Hearing
August 26, 2010
1:30 p.m. - E1.030

Charge 7: *Identify any gaps in Texas laws that may prevent coordinated efforts, both statewide and on the border, to ensure a safe food supply. Joint Interim Charge with House Committee on Border and Intergovernmental Affairs.*

Panels:

A. Current Governmental Issues and Trends

Ms. Susan Tennyson: *Director of the Environmental and Consumer Safety Section, Texas Department of State Health Services (D.)*
Mr. Kevin Varner, DVM: *Texas Area Veterinarian in Charge, USDA Animal and Plant Health Inspection Service (E.)*
Mr. Stuart Kuehn: *Texas State Plant Health Director, USDA Animal and Plant Health Inspection Service (E.)*

B. Public Threats: Solutions, Research and Education

Mr. Juan Anciso, Ph.D.: *Associate Professor and Extension Vegetable Specialist Texas AgriLife Extension Service (F.)*
Ms. Kerri Harris, Ph.D.: *Associate Professor, Meat Science & President and CEO of the International Hazard Analysis & Critical Control Points Alliance (G.)*
Mr. Charles J. Lerner, MD, FSHEA: *Chair, Committee on Infectious Disease; Texas Medical Association; Medical Director, Epidemiology/ Infection Control & Employee Health Methodist Healthcare System (H.)*

C. Retail Perspectives and Consumer Safety

Mr. Kevin Fisk: *Director of State Affairs at the Grocery Manufacturers Association (I.)*
Mr. John Scott: *Director of Quality Assurance, HEB (J.)*

D. Public Comment

Interim Wrap-Up Hearing
August 26, 2010
10:30 a.m. - E2.012

Charges:

Charge 1: Monitor implementation of legislation intended to curb rising obesity rates in Texas. Study and make recommendations regarding better coordination of prevention efforts and evidence-based strategies to reduce the impact of obesity on health care costs. Include recommendations related to the use of federal stimulus funds targeted toward obesity prevention.

Mr. Gordon Echtenkamp: *President/CEO Dallas YMCA (A.)*

Charge 2: Study the state's ability to respond to the H1N1 virus. Examine issues related to vaccine and antiviral distribution and capacity, disease surveillance, communication with providers and the public, inter-governmental cooperation, and medical surge capability.

Dr. Brett Giroir: *Vice Chancellor for Research at The Texas A&M University System (B.)*

Charge 3: Determine how the state can best coordinate efforts to streamline health care delivery with health information technology (HIT). Identify areas in state law that affect the adoption and use of HIT. Recommend statutory changes as necessary.

Dr. Billy Philips, PhD, MPH: *Vice President for Rural and Community Health at Texas Tech University Health Sciences Center, on behalf of the West Texas Health Information Technology REC (C.)*

Ms. Kathy Mechler, MS, RN, CPHQ: *Co-Director/COO Rural and Community Health Institute/CentrEast REC Texas A&M Health Science Center (C.)*