HOUSE COMMITTEE ON PUBLIC HEALTH
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2008

A REPORT TO THE
HOUSE OF REPRESENTATIVES
81ST TEXAS LEGISLATURE

JODIE LAUBENBERG
CHAIRMAN

RACHAEL HENDRICKSON
COMMITTEE CLERK

Committee On
Public Health

December 17, 2008

Jodie Laubenberg
Chairman

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

The Honorable Tom Craddick
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 Eightieth Legislature hereby submits its interim report including facts, findings and recommendations for consideration by the Eighty-first Legislature.

Respectfully submitted,

Jodie Laubenberg

Jim Jackson

Garnet Coleman

Vicki Truitt

Dora Olivo

Veronica Gonzales

Ellen Cohen

Susan King

Members: Jim Jackson, CBO, Garnet Coleman, Dora Olivo, Ellen Cohen, Veronica Gonzales, Susan King, Vicki Truitt

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INTRODUCTION

On January 26, 2007, the Honorable Tom Craddick, Speaker of the Texas House of Representatives, appointed nine members to serve on the House Committee on Public Health for the duration of the 80th Legislature. The following members were named to the committee: Chairman Dianne White Delisi, Vice-Chairman Jodie Laubenberg, CBO Jim Jackson, Garnet Coleman, Dora Olivo, Ellen Cohen, Veronica Gonzales, Susan King, and Vicki Truitt. Chairman Delisi resigned her seat on July 31, 2008. On August 5, 2008, Speaker Craddick appointed Vice-Chairman Laubenberg to the position of Chair.

Pursuant to House Rule 3, Section 34 (80th Legislature), the Committee has jurisdiction over all matters pertaining to:

> (1) the protection of public health, including supervision and control of the practice of medicine and dentistry and other allied health services;
>
> (2) mental health and the development of programs incident thereto;
>
> (3) the prevention and treatment of mental illness;
>
> (4) oversight of the Health and Human Services Commission as it relates to the subject matter jurisdiction of this committee; and
>
> (5) the following state agencies: the Department of State Health Services, the Anatomical Board of the State of Texas, the Texas Funeral Service Commission, the State Committee of Examiners in the Fitting and Dispensing of Hearing Instruments, the Texas Optometry Board, the Radiation Advisory Board, the Texas State Board of Pharmacy, the Board of Nurse Examiners, the Texas Board of Chiropractic Examiners, the Texas Board of Physical Therapy Examiners, the Texas State Board of Podiatric Medical Examiners, the Texas State Board of Examiners of Psychologists, the State Board of Dental Examiners, the Texas Medical Board, the Advisory Board of Athletic Trainers, the Dental Hygiene Advisory Committee, the Texas Cancer Council, the Texas State Board of Acupuncture Examiners, the Health Professions Council, the Office of Patient Protection, and the Texas Board of Occupational Therapy Examiners.

Speaker Craddick issued ten Interim Charges to the Committee on November 30, 2007 to study and report back with facts, findings, and recommendations.

This final report is the culmination of the Committee's hearings and investigations. The Committee wishes to express appreciation to the agencies, associations and members of the public who contributed their time and effort on behalf of the report. The Committee would also like to thank Phil Fountain and Kyle Dingman for their work on this report's first drafts.

Finally, the Committee would like to extend its sincere well wishes for Chairman Dianne White Delisi, who expended much effort towards the completion of this report, and who has dedicated so much time to the cause of Texas' health care.

HOUSE COMMITTEE ON PUBLIC HEALTH

INTERIM CHARGES

CHARGE: Monitor and evaluate the full array of wellness initiatives undertaken by the State of Texas to include the newly adopted state employee wellness and prevention legislation (HB 1297, 80th Legislature, Regular Session) and a pilot program to encourage healthy lifestyles, such as smoking cessation within the Medicaid program (SB 10, 80th Legislature, Regular Session) and for state employees. Develop strategies for maximizing potential health benefits and optimizing the return on the State of Texas' investments in wellness. Include a review of other state and private sector programs for employee wellness that result in prevention cost savings.

CHARGE: Research issues relating to the Indigent Health Care and Treatment Act (Chapter 61, Health and Safety Code) and related local health care initiatives (Chapter 534, Government Code), and make recommendations to address any imbalance between counties for the provision of health care.

CHARGE: Review issues relating to federal changes for tamper-resistant prescription pad requirements, and monitor the activity of the Texas Department of Public Safety Controlled Substances Advisory Committee in response to SB 1879, 80th Legislature, Regular Session.

CHARGE: Examine issues related to the Texas Anatomical Gift Act (Chapter 692, Health and Safety Code).

CHARGE: Examine the status of asthma in Texas, and make recommendations to prevent asthma and to assist children and adults with asthma to more effectively manage their disease. Develop strategies for decreasing the direct medical and indirect related costs associated with asthma.

CHARGE: Examine activities at the Texas Medical Board as they relate to the protection of public health and the practice of medicine, and the status of implementation requirements established by HB 1973, 80th Legislature, Regular Session. The committees should consider any findings by the Texas Sunset Commission. (Joint Interim Charge with the House Committee on Appropriations)

CHARGE: Examine the State of Texas' preparedness level to handle a public health emergency. (Joint Interim Charge with the House Committee on Defense Affairs and State-Federal Relations)

CHARGE: Review the effectiveness of the Driver Responsibility Program, and provide recommendations for increasing the collection rate of assessed penalties. Provide recommendations for amnesty and incentive programs established by the passage of SB 1723, 80th Legislature, Regular Session. Examine the status of Texas'

current statewide trauma system infrastructure and how the system may be optimized to meet future trauma care needs in a rapidly growing state with overburdened emergency rooms. (Joint Interim Charge with the House Committee on Transportation)

CHARGE: Study the state's current and long-range need for physicians, dentists, nurses, and other allied health and long-term care professionals. Make recommendations regarding strategies related to geographic distribution and barriers to recruitment of high-need professions, especially for primary care providers and long-term care professionals. (Joint Interim Charge with the House Committees on Border and International Affairs and Appropriations)

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

CHARGE # 1

WELLNESS AND HEALTHY LIFESTYLES

Monitor and evaluate the full array of wellness initiatives undertaken by the State of Texas to include the newly adopted state employee wellness and prevention legislation (HB 1297, 80th Legislature, Regular Session) and a pilot program to encourage healthy lifestyles, such as smoking cessation within the Medicaid program (SB 10, 80th Legislature, Regular Session) and for state employees. Develop strategies for maximizing potential health benefits and optimizing the return on the State of Texas' investments in wellness. Include a review of other state and private sector programs for employee wellness that result in prevention cost savings.

BACKGROUND

In January 2007, the Legislative Budget Board (LBB) submitted the report *Texas State Government Effectiveness and Efficiency; Selected Issues and Recommendations* to the 80th Legislature. In its recommendations, the LBB proposed the creation of a comprehensive state employee wellness program with the goal of reducing state costs and helping "individuals reduce health risk and prevent disease." The study calculated a rate of return on the state's investment at "$4.30 saved for $1.00 invested," and concluded that the State of Texas could expect to "save a cumulative $80 million in [the] three to five years" following the program's implementation.[1]

During the 80th Regular Session in 2007, the legislature passed HB 1297 by Delisi/Nelson and SB 10 by Nelson/Delisi. HB 1297 sought to establish a model worksite wellness program for agencies. SB 10 enabled the State of Texas to implement broad structural reforms in its Medicaid system. Section 531.094 of the bill also directed the Texas Health and Human Services Commission (HHSC) to establish a pilot program and other programs to promote healthy lifestyles within the Medicaid system.

According to the National Coalition on Health Care (NCHC), health insurance premiums in the United States for employers rose by 7.7 percent in 2006. This number is twice the rate of inflation, and is all the more concerning when considered in conjunction with national health care spending projections. NCHC also estimates that health care spending will escalate to $4 Trillion by 2015, a number that equates to 20 percent of the Gross Domestic Product (GDP).[2] Employers will continue to lose billions of dollars to rising health care costs and decreased productivity if new and innovative programs are not considered.

The business sector increasingly uses worksite wellness programs to improve workforce quality and reduce the long-term costs associated with increased health insurance premiums. In addition to direct costs, indirect costs include presenteeism, absenteeism, short-term disabilities, and long-term disabilities. Paul Hemp, the senior editor of the *Harvard Business Review*, describes presenteeism as "the problem of workers being on the job but, because of illness or other medical conditions, not fully functioning," and indicates that research shows presenteeism as cutting "individual productivity by one-third or more."[3]

Many Texas employers offer incentives to their employees for participation in programs promoting weight loss and chronic disease prevention. The Centers for Disease Control and Prevention (CDC) has reported that "chronic diseases are among the most common and costly health problems [and that] they are also among the most preventable."[4] The results of wellness-related programs have shown increased employee productivity and lowered healthcare-related costs. Employers cite rising health care costs as a hindrance to their providing health insurance coverage to employees. Wellness and prevention programs have the potential to level or reduce direct and indirect employer costs. Comptroller Susan Combs estimates that "companies that invest in wellness and disease management programs experience savings within 3-5 years."[5]

INTERIM STUDY

Speaker Tom Craddick issued the "Wellness and Healthy Lifestyles" interim charge to the House Committee on Public Health on November 30, 2007. The committee held a public hearing on January 17, 2008, and heard testimony from individuals representing state agencies, institutions of higher education, municipal government, private sector entities, and other stakeholders.

Panel 1 consisted of The Honorable Susan Combs, Texas Comptroller of Public Accounts; Albert Hawkins, Executive Commissioner of the Texas Health and Human Services Commission (HHSC); and Casey S. Blass, the Director of the Disease Prevention and Intervention Section of the Texas Department of State Health Services (DSHS).

Comptroller Combs described the wellness program she instituted within her agency, and the findings of her March 2007 Special Report, *Counting Costs and Calories; Measuring the Cost of Obesity to Texas Employers*. Her robust worksite wellness program at the Comptroller's office has set wellness goals, created a website for employees, and implemented a variety of programs. The voluntary initiative includes a recurring Fitness Rodeo and Wellness Fair with nearly sixty vendors, and has proven to be very helpful to her staff. Additionally, the Comptroller's office allows time for employees to attend wellness related appointments and physical activities. While she opposes mandating a worksite wellness program, the Comptroller suggested that the costs associated with an unhealthy workforce necessitates action by the government. Comptroller Combs detailed that unhealthy lifestyle issues in the workforce amount to a $15.3 Billion cost to Texas businesses. Additionally, the Comptroller reported that there is a $4.30 return on investment for every $1.00 invested into a worksite wellness program. Estimating the cost of an unhealthy workforce to the State of Texas at $15 Billion, Comptroller Combs recommended that the Committee consider tax incentives as a method to induce the private sector implementation of wellness programs.

Executive Commissioner Hawkins provided an update on the implementation of the SB 10 healthy lifestyles pilot program. The Commissioner reported that the pilot selection site will be made in February, and stressed that any potential incentives to participate in the program must be tangible and positive. He opposed the idea of a direct monetary payment, but preferred a voluntary credit-based system, with the state providing tax incentives to grocers for participation. Selected Medicaid recipients could be provided with credits for establishing healthy lifestyle habits such as increased exercise or participating in a smoking cessation program.

Speaking on behalf of Commissioner David Lakey, Director Blass detailed the steps that DSHS has taken to implement HB 1297 (80R) by Delisi/Nelson. Although the legislature did not appropriate direct funding, Mr. Blass reported that the agency is proactively moving forward with existing agency resources to comply with the legislative direction. The agency is currently in the process of rulemaking, hiring a wellness coordinator, and appointing the members of the worksite wellness advisory board. Mr. Blass said that a significant benefit of worksite wellness programs is the increased number of annual physical exams for each individual, and that this leads to early detection and quicker treatment of previously undiagnosed ailments.

Panel 2 was comprised of Paul B. Handel, MD, Medical Director of Blue Cross Blue Shield of Texas, and speaking on behalf of the Texas Coalition for Worksite Wellness; Ken S. Malcolmson, a Texas-based Market CEO for Human, Inc.; Gerald Cleveland, MA, Director of Health Promotion and Associate Faculty within Preventive Medicine and Community Health at The University of Texas Medical Branch - Galveston; William B. Baun, EPD, FAWHP, Director of the Wellness Program at The University of Texas M.D. Anderson Cancer Center, and serves as Chair of the Houston Mayor's Wellness Council; and Darrell Wells, Director of Risk Management for the City of Odessa, Texas.

Dr. Paul Handel reported to the committee that the United States is spending $700 Billion annually in the treatment of easily preventable diseases. In his presentation, Dr. Handel described obesity as a disability that "decreases quality of life, productivity and strongly predicts increased health care utilization and costs."[6] He further added that obesity is a steadily rising health risk factor, and that it will soon become the leading cause of cancer in the United States. Ken Malcolmson added to Dr. Handel's assessment, reporting that twenty-five percent of the Texas workforce is obese. He estimated that obesity results in $92 Billion in lost productivity and $75 Billion in direct costs. The National Center for Chronic Disease Prevention & Health Promotion has documented that Texas has exceeded a 10 percent increase in the prevalence of obesity between 1995 and 2006.[7]

Gerald Cleveland, William Baun, and Darrell Wells described specific worksite wellness initiatives that they manage on a daily basis. Their assessment was that a "one-size-fits-all" program would be less effective, and that program designs should be more flexible. Each mentioned implementing smoking cessation programs that are not arbitrarily limited. Mr. Baun reported that that it takes the average smoker at least eight attempts to quit smoking. Mr. Wells suggested that the state institute multiple worksite wellness pilot projects to see what works.

Panel 3 included Eduardo Sanchez, MD, MPH, Director of the Institute of Health Policy for The University of Texas Health Science Center at Houston's School of Public Health, and speaking on behalf of the Texas Medical Association (TMA) as a member of the TMA Council on Public Health; David Atkinson, Vice President and Executive Director for the fitness management and wellness consulting division of The Cooper Aerobics Center in Dallas, Texas, Cooper Ventures; Jerry Meece, RPh, FACA, CDE, owner and director of clinical services of Plaza Pharmacy and Wellness Center in Gainesville, Texas, and speaking on behalf of the Texas Pharmacy Association; Cleaves Bennett, MD, founder of No More Medicines, and a member of the Austin Mayor's Wellness Council; and Bill Hammond; President and CEO of the Texas Association of Business (TAB).

Dr. Eduardo Sanchez testified about the economics of prevention, and explained the enormous toll on American business poor employee health takes. He reported that the increased rates of obesity have caused dramatic growth in diabetes and cardiovascular disease over the past 20 years. Dr. Sanchez noted that potential preventive solutions include clinical services such as counseling on physical activity and worksite wellness programs that incentivize workers to increase physical activity. Speaking for the Dallas-based Cooper Aerobics Center, David Atkinson discussed health trends in Texas, and suggested connecting wellness with need. Atkinson concluded that wellness programs must look at risk factors, but also include broad

workforce screenings.

Jerry Meece described the Texas Pharmacy Association's Rx-perts program. The association operates diabetes care management programs in collaboration with local employers and their insurers, physicians and area pharmacists and has locations in San Antonio, Pittsburg and Mt. Pleasant, Texas. The program's goal is to improve health and well-being by helping patients better manage their diabetes. In this approach, the physician directs patient care, the patient takes personal responsibility for making healthy lifestyle choices, and the pharmacist supports the patient through education and counseling. Employers cover the patient's medication co-pays and other costs (depending on the funding structure) for this voluntary patient-centered program. After operating for six months in San Antonio, positive outcomes have already become evident. Participants have reported improved quality of life, better understanding of their disease and medications, and increased participation in recommended exams.

Dr. Cleaves Bennett, a retired Stanford physician, explained his view that the food industry negatively impacts the nation's health. He contended that access to wellness programs alone does not equate to good health, and that tax credits for heart-healthy foods would complement such programs. As president of the Texas Association of Business, Bill Hammond discussed how the business community is realizing the importance of worksite wellness, and that his own office has instituted a basic program for its employees. Mr. Hammond expounded that the average person is not aware of the true cost of health care. He opposed the idea of a health insurance mandate on private industry, but did suggest that a role for the state could include quantifying savings produced by wellness programs. Mr. Hammond argued that wellness programs can be beneficial to the bottom-line of small businesses. Furthermore, he advocated for additional tax incentives within the newly created margins tax system.

FEDERAL LEVEL ACTIVITY

Every decade, the United States Department of Health and Human Services (HHS) performs a research project, called *Healthy People* to provide science-based, 10-year national objectives for promoting health and preventing disease. Since 1979, *Healthy People* has set and monitored national health objectives to meet a broad range of health needs, encourage collaborations across sectors, guide individuals toward making informed health decisions, and measure the impact of prevention activity. Currently, *Healthy People 2010* is seeking to achieve increased quality and years of healthy life and to eliminate health disparities.

HHS is currently developing *Healthy People 2020*, which will assess the major risks to health and wellness, changing public health priorities, and emerging technologies related to the nation's health preparedness and prevention. The *Healthy People* process is inclusive and collaborative. The development process strives to maximize transparency, public input and stakeholder dialogue to ensure that *Healthy People 2020* is relevant to diverse public health needs and seizes opportunities to achieve its goals.[8]

STATE LEVEL ACTIVITY

On January 18, 2008, Joseph W. Thompson, MD, MPH, the Surgeon General for the State of

Arkansas, spoke before the 2008 Texas Public Health Policy Forum, in Austin, Texas. Dr. Thompson has served as a senior advisor to two Arkansas governors, and is the director of the Arkansas Center for Health Improvement. The center's mission is to improve "health through evidence-based health policy research, program development, and public issue advocacy."[9] Dr. Thompson has been involved in the development of health promotion and disease prevention programs undertaken in that state.

The state of Arkansas has put together a comprehensive plan to identify specific areas for behavior changes that result in healthier citizens. By targeting tobacco use, obesity, and physical inactivity, the *Healthy Arkansas* program attempts to counteract the burden of chronic diseases like diabetes, stroke, lung and heart diseases, and cancer. A user-friendly website provides strategies to reduce and/or eliminate the three primary behavior-related causes of these diseases with information on nutrition, physical activity and smoking cessation.[10]

The Arkansas Departments of Health and Human Services piloted a state-employee worksite wellness program, which was later replicated in all state agencies. The state employees self-initiate a health risk appraisal assessment, identify risk factors and targets, and track personal progress via the internet. When individuals achieve personal health goals, they receive a reward according to a tiered system. The highest achievable reward consists of three personal leave days (wellness days). Additionally, Arkansas has established a Child Health Advisory Committee and local parent advisory committees at each school in the state. The state also limited vending machine content and access on school campuses, increased physical activity and education requirements, added professional education as a requirement for cafeteria workers, and legally requires public disclosure of "pouring contracts" between school districts and soft drink vendors. Lastly, each school district is required to send a confidential child health report annually to parents that assesses their child's body mass index.

Dr. Thompson noted how wellness programs can increase the health of a state's workforce, and added that a healthy workforce could increase the economic competitiveness of a state in attracting new economic development.

LOCAL LEVEL ACTIVITY

In the written and oral testimony to the Public Health committee on January 17th, Darrell Wells described the Family Health Project, a worksite wellness initiative operated by the City of Odessa for city employees and their families. Created more than ten years ago, the Family Health Project has six components ranging from a family health clinic, which provides free primary care, to a fitness and wellness center. The project also networks with local health care providers through direct contracts, which allows the Family Health Project to be administered internally.

Since its inception, the Family Health Project has realized a number of savings for the City of Odessa, both in terms of the total costs of claims covered by the city and in costs per-member-per-year (PMPY). These savings are significant when compared to other "benchmark cities". Both measures of savings were described by Mr. Wells in his testimony:

Total Claims: Mr. Wells explained in oral testimony that the City of Odessa's healthcare claims for FY 2004 were $ 6 Million. He noted that these claims fell to $5 Million in FY 2005, $3.4 Million in FY 2006, and $3.8 Million in FY 2007. He observed that over a two-year period, the City of Odessa could boast a $2 Million savings. Mr. Wells' written testimony indicated that this constituted a $4 Million difference between Odessa and the average total cost of the benchmark cities.

Per-Member-Per-Year (PMPY): Mr. Wells explained that the PMPY cost for the City of Odessa in 2005 was $1795. He compared this in written testimony to benchmark cities whose PMPY costs ranged from $2947 to $2316.

Finally, according to testimony provided by Mr. Wells, the Family Health Project is well suited for duplication in other cities. Cities would uniquely benefit from replication of Odessa's results due to the need for "day-to-day," "close-in" management of each city's unique membership.

PRIVATE SECTOR ACTIVITY

The Texas Coalition for Worksite Wellness is a statewide organization that includes a cross-section of "Texas businesses, health care advocates and chambers of commerce,"[11] and was established in response to increasing public and private sector health care costs. The vision of the coalition is to promote "a healthier Texas workforce" that "produces a stronger, fiscally healthier Texas economy poised to compete in the global marketplace."[12] Additionally, a coalition goal is to increase "the number of Texas businesses that incorporate employee wellness into their corporate business and health care strategies."[13]

Ken Malcolmson testified before the committee about the worksite wellness program in place at Humana, Inc. Each employee is enrolled into a patient-centric wellness program, and is administered a health risk assessment. The employee has access to their program via the Internet and telephone. At Humana, when an individual participates in a physical activity, it is documented and rewarded. Rewards include $75 for telephone coaching, which has proven critical to the program's success.[14] The program has shown that 53 percent participants have not returned to smoking after 180 days in the Humana smoking cessation program, and 58 percent of participants have lost weight in the weight management and physical activity program. Additionally, 95 percent of enrollees indicate that they have made positive changes to their eating habits.[15] Mr. Malcolmson detailed the successes at Humana, but stressed the importance of individual privacy and information protection.

Sabre Holdings is the parent company of Travelocity. In 2004, Sabre began an employee wellness program that includes fitness, nutrition, stress relief and weight-loss challenges. Located in Southlake, Texas, the company's headquarters includes a gym and walking/running trails, as well as free Active Relief Technique sessions with a chiropractor. Employees earn credits toward health insurance premium discounts by participating in health activity programs, including aerobics classes, completing Internet-based wellness assessments, having an annual physical examination, and attending personal development activities (i.e., company-sponsored health fairs, flu shots, blood donations, and community charity efforts that include physical activity). Sabre's wellness program has economically benefited the company by keeping health

care costs down. In 2006, the company's health care costs rose far less than the national average increase of 9 percent. For their results, *Men's Fitness* named Sabre Holdings one of America's 15 fittest companies in January 2008.[16]

TEXAS LEGISLATIVE HISTORY

The State Employees Health Fitness and Education Act of 1983, Chapter 664, Government Code, allows a state agency, department, institution, or commission to use public funds for health fitness education and activities and available facilities for health fitness programs. These programs may be developed to diminish the risk factors associated with disease, develop greater work productivity and capacity, reduce absenteeism, and reduce health insurance costs.

HB 727, 78th Legislature, Regular Session, by Delisi/Janek, amended Subchapter B, Chapter 32, Human Resources Code, Section 32.059, and directed the Texas Health and Human Services Commission to launch a disease management pilot program for its Medicaid population with certain chronic diseases. These diseases include asthma, diabetes, heart failure, coronary artery disease and chronic obstructive pulmonary disease. The Texas Medicaid Enhanced Care Program provides patients with 24-hour access to a nursing hotline and personalized preventive care treatment plans.

HB 952, 79th Legislature, Regular Session, by Delisi/Barrientos amended Subtitle B, Title 6, Chapter 671, Government Code, and established an on-site nurse clinic within the Texas Commission on Environmental Quality (TCEQ). As a result, the agency now offers an advanced practice nurse clinic at its headquarters complex in Austin. The clinic, which opened in March 2006, is testing the merits of providing state employees access to an advanced practice nurse clinic at their work locations. This program was modeled after similar on-site clinic that has been operating successfully at the Texas Capitol Complex since 1992.

HB 1297, 80th Legislature, Regular Session, by Delisi/Nelson amended Chapter 664, Government Code, and has directed DSHS to designate a statewide wellness coordinator, and create a model statewide wellness program to improve the health and wellness or state employees. DSHS is required to report program findings and results to the legislature biennially. Additionally, the executive commissioner of HHSC is charged with appointing a 13-member worksite wellness advisory board.

SB 10, 80th Legislature, Regular Session, Section 531.094, by Nelson/Delisi, amended Chapter 531, Government Code, and has directed HHSC to prepare a report on the operation of the healthy lifestyles pilot program to the legislature not later than December 1, 2010. In addition to describing the operation of the program, the report is to include the effect of the incentives, and recommendations as to whether the pilot program should be continued or expanded.

COMMITTEE FINDINGS

Upon review of the DSHS February 2008 report, *Chronic Disease in Texas*, the House Committee on Public Health concludes that the primary cause of death and disability in Texas is chronic disease. The most prevalent chronic diseases include cardiovascular disease (stroke and

heart disease), cancer, chronic respiratory diseases and diabetes. 75 percent of all medical spending in the United States is dedicated to treating chronic disease. Beyond direct personal health and direct medical costs, the impact of chronic disease extends to reduced workforce productivity.

In the report, *Working Towards Wellness,* PricewaterhouseCoopers detailed the proactive role multinational companies have taken to promote behavioral health changes. The report identifies the workplace as "an important location for successful prevention strategies because of the growing amount of time" and the workplace's ability to leverage existing resources to provide a low-cost options in a supportive environment. PricewaterhouseCoopers promotes the concept of embedding a "culture of health" at the organizational level and contends that "[w]ellness must be inseparable from business objectives and long-term mission."[17]

The committee identified successful publicly-directed programs in place addressing issues related to workforce health and chronic disease management. Successful programs that promote long-term behavioral changes include:

- A Texas Comptroller of Public Accounts initiative instituted in 2007 that provides voluntary employee incentives to establish a culture of wellness. Comptroller Susan Combs provides participants with information, incentives, and tools to improve health outcomes. Approved offerings incorporate wellness fairs, a website, earned time off for healthy behavior changes, and on-site equipment and facilities.

- A City of Odessa project allowing eligible participants access to primary care, a fitness and wellness center, and educational offerings at no cost to the employee. The Odessa program has been credited with reducing healthcare claims costs by more than an average 35 percent, or $2 Million, every two years.

- A plan implemented by the State of Arkansas. As part of the *Healthy Arkansas* initiative, all state employees participate in a health risk appraisal, identification of risk factors and targets, and internet-based tracking of personal progress. Public schools limit vending machine content and access, increase student's physical activity, increase professional education for cafeteria workers, disclose contracts between districts and soft drink vendors, and send a confidential report to parents detailing their child's body mass index annually.

COMMITTEE RECOMMENDATIONS

The House Committee on Public Health recommends that the 81st Texas Legislature reduce the healthcare costs from chronic diseases by directing all state agencies to advance a culture of wellness and promote long-term behavioral changes among state employees. The legislative guidance should include a charge to the Texas Department of State Health Services with input from the Employees Retirement System of Texas to develop an evidence-based model wellness plan that incorporates best practices with the goal of incentivizing voluntary healthy behavior participation by state employees.

The House Committee on Public Health recommends that the 81st Texas Legislature combat obesity by directing the Texas Education Agency to establish minimum standards for physical education in all grades, kindergarten through 12th.

The House Committee on Public Health recommends that the 81st Texas Legislature strengthen the implementation and accountability of coordinated school health and nutrition programs.

CHARGE # 2

INDIGENT HEALTH CARE AND TREATMENT

Research issues relating to the Indigent Health Care and Treatment Act (Chapter 61, Health and Safety Code) and related local health care initiatives (Chapter 534, Government Code), and make recommendations to address any imbalance between counties for the provision of health care.

BACKGROUND

Texas County government is the primary provider of indigent health care for those not served by a hospital district. In 1985, The Texas Legislature created the Texas indigent health care program (IHCP) through the adoption of Chapter 61 of the Texas Health and Safety Code (Chapter 61). The IHCP mandates health service provision to those Texans who do not qualify for other assistance programs, and cannot afford health care by their own means.

Public hospitals and hospital districts are required to provide indigent health care. Counties must also develop indigent health care programs, unless the county is covered by a public hospital or hospital district.

The statute provides minimum eligibility standards at 21 percent Federal Poverty Level (FPL); however, the counties and hospitals may expand their requirements if they choose. It also sets out basic health care services that must be provided but counties and hospitals may choose to provide a number of optional services.

Counties choose their own methods to administer their indigent programs. If a county spends 8 percent or more of its general revenue tax levy (GRTL) on the state-mandated indigent services, then the State may provide assistance funds upon application. Department of State Health Services (DSHS) allocates these assistance funds, and determines the state's contribution based on a formula that considers the amount of indigent health care provided and the care recipients' average poverty level.

The matching funds are extracted from the State Assistance Fund. In fiscal year 2007, DSHS spent $2,604,110 in matching dollars.

INTERIM STUDY

On November 30, 2007, Speaker Tom Craddick issued an "Indigent Care and Treatment" charge to the House Committee on Public Health. In June, 2008, and in accordance with House Rule 4, Section 6, Subsection 2 (80th Legislature), Chairman Dianne White Delisi appointed Representative Jim Jackson to chair a subcommittee to monitor the "Indigent Health Care and Treatment" interim charge. In addition to Representative Jackson, the subcommittee members were Chair Jodie Laubenberg and Representatives Ellen Cohen, Susan King, and Dora Olivo. The subcommittee held a public hearing on October 13, 2008. The subcommittee heard testimony from agency officials and stakeholder groups.

Oral testimony during the hearing was presented by a series of five panels.

Panel One was composed of Jim Allison, Texas County Judges & Commissioners; Don Lee, Conference of Urban Counties; and Rick Thompson, Texas Association of Counties.

The panel members gave an overview of historical county involvement in indigent health care. The panel focused on three points:

- *Geographical Differences:* Texas is a geographically complex state. Panel members pointed out that attempting to uniformly define indigence in Texas, as opposed to setting a minimum standard, would be difficult. Any attempt to set a uniform definition would be arbitrary, because the definition of indigence is different across regions of the state.

- *Local Accountability:* Panel members also noted that the current system promotes local accountability and efficiency. The county-based model ensures that taxpayer dollars are spent close to where those dollars are collected. The system importantly encourages each indigent dollar to be spent in the most effective way.

- *Property Tax Funding:* Panelists also made clear that the method of funding indigent health dictates local direction and control. If the state were to expand its mandate on counties for indigent health care, this would increase the property tax burden on county residents. The panelists stressed that the dependence on property taxes for funding necessitates that counties be free to address indigent health care as they see fit.

Panel Two consisted of Connie Berry, Primary Care Office, Department of State Health Services; Karl Eschbach, PhD, State Demographer of Texas; and Jan Maberry, County Indigent Health Program, Department of State Health Services.

Dr. Eschbach related his findings pertaining to the indigent population in Texas. His office undertook to detail the number of truly needy in Texas. Dr. Eschbach explained his methodologies, which included extracting populations either incorrectly accounted for as poor by the U.S. Census, or eligible for other programs than the IHCP.

Once these populations were extracted, Dr. Eschbach found that the number of individuals at or below 25 percent FPL and eligible for the IHCP amounted to approaching 186,000. The number of individuals at or below 100 percent FPL equated to approximately 976,000 (see Table 1).

Table 1 U.S. Citizen Adults, Excluding Unmarried Mother with Children < 6 years old, enrolled college students, persons ages 65 or older receiving Social Security payments, persons with Supplemental Security Income, unmarried partners with non-poor spouses

ALL	Number	Percent
< 25 % of poverty	185,951	1.77%
<50% of poverty	367,196	3.50%
< 75% of poverty	637,398	6.07%
< 100% of Poverty	976,364	9.30%
Poverty Denominator	10,502,024	100.00%

In their testimonies, Ms. Berry and Ms. Maberry covered the variety of county and state providing health services available to the indigent and working poor.

In addition to Chapter 61, the Legislature also enacted Chapter 31 of the Health and Safety Code in the late Eighties. Chapter 31 established a Primary Health Care Program (PHCP),

administered through the Department of State Health Services. The PHCP serves Texas residents ineligible for other assistance programs and with an income of 150 percent FPL or less. DSHS currently contracts with 60 Federally Qualified Health Centers (FQHCs), local health departments and other entities in 144 counties to provide statute-driven basic primary care services for the purpose of reducing ER visits.

FQHCs are private non-profit or public clinics that receive competitive grant funding from the federal government and offer health services to all individuals at 200 percent FPL and below. FQHCs must work towards four key missions:

1. To improve the health status of underserved populations.
2. To assess the needs of underserved populations and design programs and services for the underserved.
3. To measure the effectiveness and quality of their services.
4. To operate as efficiently as possible and collaborate with other organizations.

FQHCs provide integrated health and social services, including help for substance abuse and mental health. FQHCs accept Medicaid and Medicare patients and charge others according to a sliding-scale schedule. The sliding scale can move down to $0 for those with no ability to pay, and FQHCs must be open to all regardless of their ability to pay.

FQHCs can receive up to $650,000 a year in grant funding. Additionally, they receive several benefits from FQHC status:

- Enhanced Medicare and Medicaid reimbursement
- Medical malpractice coverage through the Federal Tort Claims Act
- Eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost through the 340B Drug Pricing Program
- Access to National Health Service Corps
- Access to the Vaccine for Children program
- Eligibility for various other federal grants and programs

The federal government has also established the FQHC Look-Alike Program. FQHC Look-Alikes meet all the requirements for FQHC status, but have not been awarded grant funding. Often, Look-Alike certification acts as a stepping stone to FQHC designation. While FQHC Look-Alikes do not receive grant funding, they do receive several of the other FQHC benefits, including enhanced reimbursement, reduced-cost medications and automatic designation as a Health Professional Shortage Area.

To encourage the establishment of FQHCs in underserved areas, the Texas Legislature enacted the FQHC Incubator Grant Program in the 78th Legislative Session. Since 2006, the Incubator program has awarded millions of dollars in grants to nearly 100 health service entities, 50 of which have attained FQHC or FQHC Look-Alike status. Ms. Berry explained that the Incubator Program relieves some of the challenges of establishing FQHCs, and that FQHCs are particularly beneficial to underserved areas because of the emphasis on quality and on defining and meeting needs particular to the FQHC's community.

Panel Three consisted of Jose Camacho, Texas Association of Community Health Centers; Dr. John Guest, Teaching Hospitals of Texas; Dr. John Holcomb, Texas Medical Association; and Richard Schirmer, Texas Hospital Association.

Panelist testimony relating to indigent care centered on the importance of collaboration between counties, private clinics and hospitals. Hospital missions are increasingly moving towards prevention in the community, through the use of satellite clinics, community programs and mobile vaccination units.

Panelists pointed out that the 10 highest property-tax levying hospital districts are in Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Midland, Nueces, Tarrant and Travis counties. These 10 hospital districts, which include hospitals and medical schools, levy $1.4 Billion of the $2 Billion levied by all Texas hospital districts.

Testimony indicated that a significant challenge to access to health is that health care, rather than being cohesive, is subject to a silo effect. Agency programs do not always communicate well with each other, and aspects of the health care system can be isolated. The FQHC model is effective in remedying this and addresses all aspects of care.

Panel Four was composed of the Honorable Arlene Wohlgemuth, Texas Public Policy Foundation; the Honorable Ann Kitchen, Indigent Care Collaboration; and Rita Kelley, Texas Indigent Health Care Association.

Panelist testimony brought several points to light:

- *Focusing Resources*: Ms. Wohlgemuth discussed in depth the importance of focusing resources on helping the neediest. She relayed the work of the Bexar County Hospital District through the establishment of the Carelink program. Carelink is a prime example of efficiently focusing resources to assist the county's neediest citizens. While serving up to 200 percent FPL, the Carelink program operates budget-consciously and gears its program to provide help while insisting on individual responsibility and pride.

  Ms. Wohlgemuth also noted that expanding government assistance programs above the 100 percent FPL carries the dangers of wasting resources and pushing away private responsibility and charity. She remarked on a recent Congressional Budget Office (CBO) report, which concluded that between 25 and 50% of children enrolled in the State Children's Health Insurance Program (SCHIP) had been previously enrolled in private coverage. The CBO concluded that enrollment criteria should be redefined to ensure that SCHIP was insuring the target population. Ms. Wohlgemuth pointed to the SCHIP "crowd-out" situation as an example of how expanding government assistance beyond the neediest levels of citizens can unintentionally act as a disincentive for private solutions.

- *Creativity and Collaboration*: Panelist testimony stressed that counties are increasingly doing more with the resources at their disposal. The counties are able to do more through creativity and collaboration. Ms. Kitchen discussed the Integrated Care Collaboration

(ICC), a non-profit entity that assists counties and hospital districts in coming together to share relevant patient information to provide more efficient care and preventative treatment. Forty-four entities have joined the ICC to amplify their resources.

Ms. Kelley of the Texas Indigent Health Care Association (TIHCA) discussed her organization's developing role as a resource to the counties. TIHCA, although a relatively new organization, aims to bring creative solutions already in practice to the attention of all counties. Ms. Kelley noted that the counties' "story is not being told," and that counties are increasingly collaborating on a local and regional level to provide better and more extensive care to their indigent citizens.

Carelink uses creative solutions to keep individuals invested in the care system. Every individual is assigned a medical home, and this medical home works closely with Carelink patients to ensure that they are following through with treatment, and regularly keeping their primary care appointments. Carelink importantly uses a realistic sliding scale fee for all its patients. For some patients a clinic visit may be for as little as 50 cents, but the fee is an integral part of instilling individual pride and responsibility for their own care.

- *County Reporting*: Panelist testimony revisited the problems with current reporting to the state. The reports taken in by DSHS are used to determine a county's eligibility for state matching funds. However, the report does not reflect the full extent of county resources being used to care for the indigent. This is especially true for counties that extensively use volunteer doctors and nurses to provide care for its indigent.

Panel Five consisted of the Honorable Chad Adams, Ellis County Judge; the Honorable Keith Self, Collin County Judge; Diana Buckley, Ellis County Human Services; Eddie Olivariez, Hidalgo County; and Bride Roberts, Williamson County & Cities Health District.

- *Ellis County*: Judge Adams and Ms. Buckley provided testimony concerning Ellis County's innovative community-driven program. Since 2005, Ellis County has contracted with a local non-profit volunteer clinic, the Hope Clinic, for its indigent services. The County pays Hope Clinic an annual lump sum for pharmaceutical, physician, mental health and preventative services. This sum has been the seed money for the clinic's continual expansion since 2005.

  Ellis County's indigent program serves at 21 percent FPL; however, Hope Clinic serves to 200 percent FPL. Since 2005, the contract with the county has enabled Hope Clinic to hire a full-time doctor and full-time nurses, and to expand the number and types of services offered. The clinic additionally works closely with hospitals, doctors, and local specialists for volunteer time and donations. County participation and community volunteerism allows the clinic to offer a wide breadth of specialty and primary services to both the county indigent and working poor. While Ellis County technically provides indigent care up to 21 percent through the IHCP, the partnership with Hope Clinic means that the County is effectively subsidizing care for county residents up to 200 percent FPL.

Ellis County has remarkably benefited since the contract with Hope Clinic. Judge Adams reported an initial 81 percent drop in ER visits by indigent patients in the partnership's first year. This rate has been sustained, as has the significant drop in indigent care costs. The County is now expanding its contract with Hope Clinic to include dental care, and yet the County still spends less on indigent care than it did before its collaboration with Hope Clinic.

- *Collin County*: Judge Self recounted Collin County's approach to caring for its indigent population. Collin County's goal is to provide the indigent with health care, keep individuals out of ERs as much as possible, and to protect the county's taxpayers from unnecessary costs. Collin County has taken several measures to achieve these goals.

  In 2006, the Collin County Commissioners Court voted to expand its indigent eligibility from 25 to 100 percent FPL. The County conscientiously verifies applicants' information to ensure that taxpayers are protected from fraud and that the County is expending its resources to those who truly need help.

  Collin County also entered into contact with PrimaCare that same year. The PrimaCare contract works alongside the County's indigent health care program and gives patients five locations throughout the counties where they can receive family and urgent care 7 days a week during day and evening hours. Judge Self noted the importance of patients participating in their care with a $20 co-pay, and also remarked at willingness patients to contribute to their care. An important part of the PrimaCare partnership is that it helps the County identify individuals who qualify for the indigent program, and gives the working poor a medical home they can remain at if they move off the indigent program.

  Collin County also uses service agreements with local non-profit organizations on a fee-for-service basis. Judge Self emphasized that collaborating with these entities allowed the County to create a network of care within the county for patients. He also noted that the next step for Collin County is the incorporation of mental health care into the indigent care network. The County is currently exploring methods to improve the accessibility of mental health services and to increase awareness of options within the County for mental health help.

- *Williamson County*: Ms. Roberts spoke of the two programs that Williamson County and Cities Health District (WCCHD) uses to serve its indigent and working poor. All residents requesting assistance are prescreened so that they can be efficiently directed to the appropriate venue for help. Wilco Care is the program that WCCHD uses for its indigent, defined as those with incomes under 25 percent FPL. Wilco provides many elective services, including provision of diabetic supplies and education.

  To control indigent program costs and to increase efficiency, WCCHD contracted with a third party administrator and pharmacy benefits manager. These contracts have helped WCCHD expand its provider network and its primary and specialist care options. The County has since become timelier in its payments to providers, and further benefited from

a much more sophisticated reporting system. Since these contracts, WCCHD has reduced its total expenditures by 13 percent.

WCCHD also cares for those individuals at or below 200 percent FPL and are ineligible for other programs through the Community Clinics Services Program (CCS). Local clinics apply to the Commissioners Court for a fee-for-service contract, and the County uses interest from Tobacco Settlement Funds to finance these contracts. Each clinic is provided with an automatic screening software tool to more efficiently direct patients to available social services.

Ms. Roberts finally remarked on a newer tool that has been beneficial to both the county and the local private hospitals. When two participating private hospitals provide care to county program clients, WCCHD pays for those services into the hospital's Upper Payment Limit (UPL) fund to receive federal matching dollars. This partnership has drawn down additional federal dollars for health care in the area.

- *Hidalgo County*: In past years, Hidalgo County was one of the largest recipients of state matching funds. However, the County recently started partnering with private hospitals to draw down federal matching funds through UPL dollars. This has enabled Hidalgo to drastically improve its services and expand the area in which those services are provided.

  Mr. Olivariez related the complexities of making sufficient care available to needy individuals in a fast-growing county with low property tax revenues and little infrastructure in terms of philanthropy or hospital facilities. The public-private partnership has enabled Hidalgo County to make strides in developing such resources.

  Mr. Olivariez noted that his department focuses on integrating indigent care into all aspects of into health care. Within the county, officials have endeavored to break down any silos of care, and Mr. Olivariez suggested that such integration within DSHS would be helpful to the operation of state health care programs.

  Hidalgo has made several improvements to their health care system in recent years. The County has expanded the review of indigent care applicants to both target fraud and to make sure that individuals are taking advantage of all the programs available to them. The County has incorporated substance abuse and mental health treatment into its program, with the help of volunteer physicians and staff. The County also integrates prevention techniques into its network, using results-oriented approaches to determine the effectiveness of programs.

COMMITTEE FINDINGS

The Subcommittee's research and hearing brought the subject of indigent healthcare into three particular categories: who are the indigent, what care is being provided, and if counties are adequately responsible for their indigent. While the Subcommittee believes that other closely-related subjects are important to indigent care, it also found that its interim charge warranted a closely-defined scope of work related to Chapter 61 and the role of the counties in indigent

care.[18]

- *Who are the Indigent*: Perpetual confusion exists because informal discussion often uses the words "uninsured" and "indigent" interchangeably. While these measures are difficult to untangle, they are indeed different and require a degree of separate consideration by public health policymakers. The subcommittee heard repeated verification of the fact that those who do not have ready access to health care or are uninsured are not necessarily indigent by any other measure. By the same token, those who have access to health care and programs but opt out of that care are not medically indigent.

  The state demographer confirmed that the number of uninsured and *possibly* medically indigent Texas citizens hovers at about 1 million, when using a high estimate of 100 percent poverty level. Closer to the state-mandated floor, this number would be as low as 186,000 for 25 percent FPL.

- *What Care is being Provided*: The committee heard extensive testimony, and discovered through various research, a considerable number of community offerings for the indigent population, whether indigence be valued at 21 or 100 percent FPL. Community-based clinics such as FQHCs, local government programs such as county indigent programs, and local tax-supported hospitals all serve this population. Witness testimony and research evidenced that much thoughtful and creative service is being provided to the medically indigent population throughout Texas. Certainly some areas face greater challenges than others. However, even more certain is that the answer to these challenges lies at the local level, and the State's role should be to facilitate local development in a way that preserves local community independence and self-reliance.

  Community-based clinics of the FQHC model provide valuable tools for localities. These clinics can serve individuals in a personal fashion, and can give comprehensive care while providing other social services. When local communities coordinate clinics, volunteer programs and hospitals, the care for the indigent is truly functioning at the highest level.

- *To What Extent are Counties Meeting their Responsibility*: The structure of the state assistance fund has led many to assume that county indigent programs can be judged according to how close to 8 percent of General Revenue Tax Levy the county spends on its program. The assumption is that the nearer to 8 percent a county spends, the better job that county is doing. This measure is not meaningful in determining a county's commitment to its indigent, and does not accurately reflect the resources being expended by a community to help their indigent.

  The 8 percent measure is an arbitrary statutory ceiling to limit county liability, and prevent counties from getting into a situation where budgets are unable to sustain a community's needs because of the indigent program alone. The 8 percent also serves as an indicator for State assistance when a county's need for indigent care resources far outweighs the ability to raise sufficient property tax-generated revenue. While the 8

percent measure is useful for these purposes, it should not be used solely to determine county efforts.

Throughout its considerations, the Subcommittee maintained a distinction between the Uninsured and the Indigent. Witness testimony and Subcommittee research focused on determining if a third category, the Underserved Indigent, was a significant problem in the State. Counties are by and large being diligent in their efforts to serve not only their indigent but also their working poor. Most indigent, in fact, are being served by their counties. Counties have found ways to serve their indigent directly through their indigent programs, while also subsidizing care for the working poor indirectly. Counties have partnered with local hospitals and volunteer organizations to provide comprehensive care for their neediest residents. While these gauges are not as easy to measure as one number, they do provide a realistic view of county efforts and show the creativity counties are employing to the great benefit of their poorest residents.

While the Subcommittee's work identified areas of misconception, it also identified two distinct ways to continue on a path towards more efficient and effective indigent care. As heard in testimony, policy can take two directions: State and Federal government control or local and community action. The Subcommittee heard testimony that suggested the expansion of Medicaid. The Subcommittee also heard testimony about current community-driven efforts. The research and testimony considered by the Subcommittee has led the Subcommittee to firmly believe that communities are leading creative solutions to care for citizens in need of help. The Subcommittee believes that further expansion of State services would threaten to push out existing community programs, and discourage new and innovative local efforts. This unintended consequence would hurt community spirit and self-reliance, which is vital to the functioning of society.

The State's role in this issue should be to encourage and promote community-based programs. The State should not risk displacing the existence or the creation of locally-driven projects. Grassroots-level efforts can recognize the particular needs of communities, and more ably address those needs with less bureaucracy and more efficiently-allocated resources.

Public health policy should encourage two ideas for communities: collaboration and best practices.

- *Collaboration*: A repeated theme throughout witness testimony was "the silo effect." The silo effect is often pronounced at the state level. Programs and agencies simply do not coordinate with each other well. Counties and communities, however, can break down these silos through their combined efforts. Counties have much to learn from each other, and they should expand efforts to learn from each other how to best structure their programs.

- *Best Practices*: County collaboration and communication will help further identify best practices that communities can employ to better serve the indigent. During the hearing, the Subcommittee heard a breadth of best-practice techniques currently in use. Realistic sliding-scale fees for patients increase individual responsibility and pride. Verification

tools not only help protect taxpayers from potential fraud but also help ensure that needy citizens are receiving the services for which they qualify. Partnerships with local charities, volunteer clinics and providers encourage a wider gambit of services, while bringing county government and community members together. Case management and third party administrators allow county to better direct patient care while achieving cost savings and reducing redundancies.

COMMITTEE RECOMMENDATIONS

The House Committee on Public Health recommends that the 81st Texas Legislature direct the Department of State Health Services to use its County Indigent Health Program (CIHP) as a resource for county best practices. This should include expanded use of the CIHP website and facilitated sharing of county experiences.

The House Committee on Public Health recommends that the 81st Texas Legislature require state matching funds for indigent health be attached to best practice requirements, in addition to the 8 percent of General Revenue Tax Levy trigger.

The House Committee on Public Health recommends that the Department of State Health Services gather county stakeholders to create a reporting mechanism that is not overly-burdensome to reporting entities, but that also gathers information useful to both the State and counties. Changes to the reporting mechanism should be designed to more accurately portray the full extent of county efforts for its indigent healthcare programs.

The House Committee on Public Health recommends that each fiscal year, any unexpended money in the State Assistance Fund be transferred for use by the FQHC Incubator Grant Program. Incubator Grant Program models should focus on working with counties to serve both indigent and working poor populations.

CHARGE # 3

ACCESS TO CONTROLLED SUBSTANCES

Review issues relating to federal changes for tamper-resistant prescription pad requirements, and monitor the activity of the Texas Department of Public Safety Controlled Substances Advisory Committee in response to SB 1879, 80th Legislature, Regular Session.

BACKGROUND

Since 1981, Texas has been tracking Schedule II drug prescriptions. Schedule II drugs are the most potent drugs with medical uses, such as morphine or oxycodone. Because these drugs can cause severe psychological or physical dependence, the Legislature passed a law that required doctors to write all prescriptions for Schedule II drugs on a special three-part or *triplicate* form. Each prescription for Schedule II was required to have a Texas Department of Public Safety (DPS) identifying number, and these prescriptions were mandatorily reported to and monitored by DPS. In 1999, as a result of technological advances, DPS replaced the triplicate prescription with an *official* DPS prescription form.

Since the implementation of this program, Texas has seen a significant drop in Schedule II drug abuse. However, correspondingly, the national rate of prescription drug abuse has increased. The 2003 National Survey on Drug Use and Health recorded a more than five-fold increase in prescription pain killer abuse since 1990.[19] The National Institute on Drug Abuse estimates that 20 percent of the U.S. population 12 and over has abused prescription medications.[20] Prescription drug abuse has at least partially shifted from Schedule II drugs to "drug cocktails" of lower-risk scheduled drugs. Thus, many states have instituted electronic monitoring of Schedule II through Schedule IV/V drugs.

The federal government has taken several steps in the fight against prescription drug abuse. The United States Department of Health and Human Services (HHS) required all providers to include the National Provider Identification (NPI) number on their prescriptions as the standard unique identifier for health care providers. Beginning May 23, 2007, the NPI was required in lieu of legacy provider identifiers in the Health Insurance Portability and Accountability Act (HIPAA) standards transactions. The change to NPI was mandated for administrative simplification and better security.

More recently, the Centers for Medicare & Medicaid Services (CMS) implemented tamper-resistant prescription pad guidelines. Starting on October 1, 2008, Medicaid outpatient prescriptions must comply with these guidelines in order to be reimbursable. Congress also voted to incent doctors to use electronic prescriptions for Medicare prescriptions. Beginning Jan. 1, 2009, the federal government will boost Medicare's payments to doctors that send prescriptions electronically to a pharmacy rather than writing them out on paper and handing them to the patient.[21] Congress and CMS are ultimately encouraging providers and pharmacists to move all prescriptions, over time, to completely electronic systems.

RECENT LEGISLATION IMPACTING TEXAS

The federal U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 changed a part of the prescription drug reimbursement requirements within the Medicaid program. Congress mandated that all written prescriptions for Medicaid-covered outpatient drugs must be executed on tamper-resistant pads in order to be eligible for reimbursement. The Centers for Medicare and Medicaid Services (CMS) began to implement the new prescription pad rules on April 1, 2008.

As of April 1, 2008, to be considered tamper-resistant, the prescription pad were required to contain at least one of the following three characteristics:

1. One or more industry-recognized features designed to prevent unauthorized copying of the completed or blank prescription form;
2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription pad by the prescriber; or
3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

By October 1, 2008, a reimbursable written prescription must be ordered on a pad that contains all three of these characteristics to be considered tamper-resistant. This requirement does not apply to prescriptions that are transmitted to the pharmacy electronically, by telephone, through a facsimile, or as a refill of a written prescription that was initially dispensed at the same pharmacy prior to April 1, 2008.[22]

The Texas Health and Human Services Commission (HHSC) published a notice and updated their Internet website with the new prescription pad requirements for Texas Medicaid providers. HHSC sought an exemption to this new rule, but CMS determined that they did not have the authority to grant an exemption to federal law. Although the rule change was initially protested by the Texas Medical Association[23], the organization has since encouraged their members to use the new tamper-resistant prescription pads for all patients, not just those in the Medicaid program.[24]

The intent of SB 1879 (80R) by Williams/Hamilton is to combat the rise of prescription drug abuse, and its effects on law enforcement, health care, social services, and court costs to the state. This legislation expands DPS monitoring of prescription drugs from Schedule II drugs to include Schedule III through V pharmaceuticals, and established administrative penalties for noncompliance.

SB 1879 established a Controlled Substances Advisory Committee to advise the Texas Department of Public Safety on implementation. The bill statutorily defined membership of the committee to include the following:

1. The public safety director of the Department of Public Safety of the State of Texas or the director's designee;
2. A physician appointed by the governor;
3. A pharmacist appointed by the governor;
4. A physician appointed by the lieutenant governor;
5. A pharmacist appointed by the lieutenant governor;
6. A physician appointed by the governor from a list of names submitted by the speaker of the house of representatives;
7. A pharmacist appointed by the governor from a list of names submitted by the speaker of the house of representatives;
8. One member from each of the following boards:
    - Texas Medical Board

- Texas State Board of Pharmacy
- State Board of Dental Examiners; and
- Board of Nurse Examiners

Governor Rick Perry made the following appointments to the Controlled Substances Advisory Committee on February 13, 2008: Aaron Calodney, MD, of Flint; E. Alan Thornton of Lumberton; Catherine Scholl, MD, of Austin; and John Chaddick of Temple. Lieutenant Governor David Dewhurst has not appointed members to fill his physician and pharmacist slots. The Controlled Substances Advisory Committee has met twice, but has not indicated a timeline for the issuance of recommendations. Pursuant to SB 1879 (80R) by Williams/Hamilton, the Controlled Substances Advisory Committee will be statutorily disbanded on September 1, 2009.

INTERIM STUDY

On November 30, 2007, Speaker Tom Craddick issued the "Access to Controlled Substances" charge to the House Committee on Public Health. In June, 2008, and in accordance with House Rule 4, Section 6, Subsection 2 (80th Legislature), Chairman Dianne White Delisi appointed Representative Vicki Truitt to chair a subcommittee to monitor the "Access to Controlled Substances" interim charge, and to report as necessary. In addition to Representative Truitt, the subcommittee members are Representatives Ellen Cohen and Susan King. The subcommittee held a public hearing on September 19, 2008, and heard testimony from individuals in the law enforcement and medical sectors.

Panel 1 included two representatives from HHSC. Andrés Vasquez, Deputy Director of the Medicaid-CHIP Vendor Drug Program and Loretta Disney, Regional Manager, provided testimony regarding the implementation of the tamper-resistant prescription pad requirement.

Mr. Vasquez emphasized that HHSC's initial concern with the program had to do with decreased access for legitimate patients. HHSC did not want pharmacies to be forced to deny a valid patient prescription because of an incorrect prescription pad alone. Thus, in the process of implementation, HHSC stressed to doctors and pharmacies the importance of verification. If a pharmacist receives a non-compliant prescription, that pharmacist can merely call the doctor's office and verify the prescription. In this way, pharmacies can count that prescription as electronically submitted, and fill the prescription without undue burden to the patient.

Panel 2 consisted of Johnny Hatcher, Manager of DPS Narcotics Regulator Programs and Patrick Knue, Program Administrator. Mr. Hatcher commented on the progress of the Controlled Substances Advisory Committee, which has not yet made any recommendations as to the implementation of SB 1879 provisions. Mr. Hatcher also reported on the steps DPS has taken technologically in moving towards accessibility. He highlighted DPS' goals for the new database: real-time access to law enforcement to assist in the apprehension of deviant activity.

Considerable discussion in this panel's testimony centered on the numbers used for identifying individuals and entities that possess or prescribe controlled substances. Mr. Hatcher stressed his belief that the DPS registration number is the most secure way for law enforcement to apprehend doctor shoppers and doctors who are inappropriately prescribing.

Mari Robinson, Texas Medical Board (TMB) Director of Enforcement/Interim Executive Director, also provided testimony as to the status of SB 1879 implementation. In her testimony, Ms. Robinson applauded the opportunity presented by the passage of SB 1879. The information collected via this process could result in a real-time, web-interactive queriable system accessible to physicians, researchers, law enforcement and regulatory boards. If achieved, such a system would result in a higher standard of care for all patients and decreased incidents of drug misuse.

Ms. Robinson's testimony suggested that efforts be directed towards a pharmacy-based system. She pointed to Nevada, where pharmacies download a state-distributed software program that dispatches prescription information every night to the state pharmacy board's database. Nevada's methods allow the database to be updated every day. In Texas, pharmacies are required to provide information to DPS by the 15th of the month for prescriptions written in the previous month, meaning that associated parties do not have access to as up-to-date information and there can be as much as a 45 day lag in information.

Public Testimony was also heard from pharmacists, doctors and emergency room (ER) staff. The testimony fell into several broad themes: a need for interactive real-time accessibility for doctors, pharmacists, hospitals and law enforcement; and a focus on reducing redundancies and interruptions in patient care.

A major concern was that doctors already deposit their various identification numbers at local pharmacies, but they are still required to inscribe every identifier on any given prescription. The concern regarding this was two-fold. First, the number of prescriptions carrying valuable federal and state identifying numbers constitutes a security problem by increasing the ease of fraud. Second, witnesses stated that the act of physically writing these numbers on each prescription pad invariably undermines their ability to dedicate their time to patient care. One witness described the impact of these logistics as turning doctors into "clerks." Witnesses found these problems especially troublesome considering pharmacies can easily populate these fields from their databases as doctors send in prescriptions.

Witnesses repeatedly cited their belief that an appropriately-administered prescription monitoring problem would be a source of positive change in medicine. However, they believed that real-time accessibility was key for doctors to identify "doctor shoppers" before giving out prescriptions.

COMMITTEE FINDINGS

Senate Bill 1879's passage provided a great opportunity for Texas to identify doctor shoppers and reduce the likelihood of doctors unwittingly facilitating addicts' drug abuse. The advisory committee brought all stakeholders together in order that appropriated funds could be spent effectively for the benefit of all concerned parties. Unfortunately, DPS had already begun an upgrade in their technology infrastructure and is in the process of migrating the Narcotics Regulatory Program (which includes the Texas Prescription Program) from an older mainframe to a new "client-server" system. It appears that DPS has not used the advisory committee as a resource, nor has it incorporated any suggestions into the development of the client server

system, and in fact seems to have spent the majority of funds without any consultation with the advisory committee.

It also seems that DPS has not sufficiently tapped into available existing infrastructure to improve the reporting system. Many pharmacies in the state use standardized electronic systems to store patient and physician prescription data. These systems transmit data electronically to verify insurance coverage and provide claims data to insurance companies for payment. This technology infrastructure often contains all of the information that DPS collects as part of their prescription monitoring program. Integrating technology that is currently being used by pharmacies to collect and transmit data with the DPS prescription monitoring program has the potential for preventing pharmacies from becoming burdened with administrative tasks and providing more frequent data updates to DPS. DPS does not seem to have taken advantage of proven system options, but rather spent time and resources to recreate an entirely new system.

If DPS continues to act with little outside advice, make use of existing electronic systems or refuses to incorporate any outside suggestion, Texas risks missing an opportunity to take full advantage of the information offered by the expanded prescription monitoring. This information should be useful not only to DPS, but also doctors, regulatory boards and pharmacists. These groups all have an equal stake in creating an accessible and up-to-date system.

In addition to health care stakeholders, the expanded prescription-monitoring program should be able to share information with other states and with the relevant federal agencies. Given Texas' proximity with Mexico, and with other states, the system should not be insular but should be compatible with other authorities' systems. A special consideration in regards to interstate and federal collaboration is the identifying numbers used in reporting and monitoring.

Current practices do not ensure seamless delivery of care, and place undue burdens on pharmacies and doctors. Ensuring the validity of prescriptions and preventing doctor shopping should not be to the detriment of most legitimate patients who have real and immediate needs for their prescriptions. While common practice allows pharmacists to fill in missing identifying information onto prescriptions, this does not meet the current letter of the law. However, the intent of the law is to ensure that a prescription is valid before it is filled, not to nitpick whether the pharmacist or doctor is the one who fills in basic, non-prescriptive information.

COMMITTEE RECOMMENDATIONS

The House Committee on Public Health recommends DPS immediately cease the expenditure of funds for technology until input from all interested parties has been considered and incorporated into a sound plan for an IT system that will allow the greatest benefit possible to all who need to participate in curbing drug diversion. Serious consideration should be given to building the reporting system around pharmacy-based electronic systems already in use around the state.

The House Committee on Public Health recommends that the Controlled Substances Advisory Committee remain in place as the transition to expanded reporting continues and until a new monitoring program is in place. The DPS prescription-monitoring program should be guided by the recommendations of this committee, and the committee should be used as a resource to create

a truly seamless and functional system of reporting and monitoring.

The House Committee on Public Health recommends that the Advisory Committee study ways to reduce redundancies in the reporting system. This effort should particularly look at whether the continued use of a separate DPS registration number is necessary as the key identifier in the prescription monitoring program.

The House Committee on Public Health recommends that DPS adopt rules to make clear that pharmacists may fill in non-prescriptive information on prescriptions. This rule should clarify the intent of the law: ensuring that only valid prescriptions are filled.

CHARGE # 4

ANATOMICAL GIFT ACT

Examine issues related to the Texas Anatomical Gift Act (Chapter 692, Health and Safety Code).

BACKGROUND

The lifesaving potential of organ and tissue donation is limited by a demand for transplantable organs that massively outweigh the supply. Each day, 19 (of more than 94,000) Americans that are waiting for an organ will die, and the number is direr for the youngest patients.[25] For potential recipients under two years of age, approximately 30-50 percent will die while waiting for an organ for transplant.[26] Research indicates that more than 40 percent of potentially transferable organs are unavailable due to burial or cremation.[27] Additionally, estimates suggest that only 15 percent of the population has assigned up for an organ and tissue donor card.[28]

The State of Texas has take steps since the 1960s to increase of its transferable organ supply. Following national trends, the Texas Legislature adopted major provisions of the 1968, and later 1989, Uniform Anatomical Gift Act. During the 80th Regular Session, HB 3814 by Zerwas was introduced to model the Texas Anatomical Gift Act after 2006 revisions to the Uniform Anatomical Gift Act. On April 11, 2007, the House Committee on Public Health considered HB 3814 in a public hearing. After negotiations between stakeholder groups, the Senate amended and passed the companion to HB 3814 (SB 1597 by Janek/Zerwas) on May 14, 2007. SB 1597 was reported favorably by the House Committee on Public Health on May 16, 2007, and was placed on the House Major State Calendar on May 22, 2007. Along with numerous bills, SB 1597 did not receive final consideration by the full House before the body convened *Sine Die* on May 28, 2007.

In 2005, the 79th Texas Legislature passed HB 120 by Dawson/Zaffirini, which created the Donor Education, Awareness, and Registry (DEAR) program where individuals can indicate their desire to provide an anatomical gift when they die. In 2007, the 80th Texas Legislature passed SB 1500 by Zaffirini/Laubenberg to rename the DEAR program the "Glenda Dawson Donate Life – Texas Registry" in memory of Representative Dawson and to honor her contributions to promote organ, tissue and eye donation in Texas. The registry can be access via the Internet at: www.DonateLifeTexas.org.

INTERIM STUDY

On November 30th, 2007, Speaker Tom Craddick issued the "Anatomical Gift Act" charge to the House Committee on Public Health. The committee held a public hearing at The University of Texas M.D. Anderson Cancer Center in Houston, Texas, on March 12, 2008. The committee heard presentations by government officials, organ procurement organizations (OPOs) representatives, medical examiners, and various hospitals. Over the course of the hearing, the committee considered written and oral testimony that revealed the shortage of transplantable organs is a product of increasing demand and barriers to donation.

Oral testimony during the hearing was presented by three panels:

- **Panel One** was composed of O.H. Frazier, MD, of the Texas Heart Institute, Sam Holtzman, of LifeGift, and John Goss, MD, on behalf of the Baylor College of Medicine.

- **Panel Two** was composed of Donald Less, from the Texas Conference of Urban Counties, Sharon Derrick, PhD, from the Harris County Medical Examiners Office, and Stephen Pustilnik, MD, on behalf of the Texas Medical Examiners Association.

- **Panel Three** was composed of George Mallory, MD, of the Houston-based Texas Children's Hospital, Nancy Cychol, speaking for Cook Children's Medical Center in Fort Worth, and John Cutler, representing the Texas Transplantation Society.

Panelists testified on the problems in achieving an adequate supply of transferable organs and suggested potential solutions. Over the course of the hearing, panelists highlighted four major areas of concern:

Increasing Need for Organs:

Sam Holtzman, the President and Chief Executive Officer of LifeGift, a Texas-based organ procurement organization, discussed the increased need for donated organs and tissues. He explained how medical advances and innovations have improved over the past forty years. Mr. Holtzman highlighted the fact that many patients now survive when they otherwise would not have, and added that "some of the most impressive innovations in transplantation have come about in pediatrics."

Limited Potential Donor Pool for Pediatrics:

Explaining the need for donors, Dr. George Mallory noted that "[b]ecause there are not enough donors for the number of recipients, every donor counts a great deal, especially pediatric donors." Dr. Mallory stressed the severity of the problem for the pediatric transplant list and relayed that the infant list has the longest wait time. Nancy Cychol explained that maximizing a donation is important because "the pediatric donor pool is very small." Panelists also explained during testimony that the already-limited donor pool is further exacerbated by lack of cooperation among organ procurement organizations.

Denial of Organs or Tissue by Medical Examiners:

Testimony detailed how transferable organs can be lost when Medical Examiners withhold a donor's body for forensic investigation. Written testimony noted 561 reported cases of Medical Examiner denials between 1990 and 1992.[29] Because each donor can give multiple organs (usually three or more), these denials potentially represent thousands of lost opportunities for transplantation.[30]

Additional testimony indicated that today's Medical Examiner has become more willing to release organs for transplantation than their predecessors. In written testimony, Dr. Stephen Pustilnik, the Chief Medical Examiner for Galveston County and president of the Texas Medical Examiners Association, explained that Medical Examiners in the past were very careful not to disrupt the bodies within their jurisdiction to avoid the loss of potential evidence. Dr. Pustilnik explained that this conception "has been replaced by the

realization that Medical Examiners and Justices of the Peace play a significant role in the organ donation process to the potential benefit of multiple individuals."

Problems in the 1989 Texas Anatomical Gift Act:

Testimony described a myriad of problems in the 1989 Texas Anatomical Gift Act, many of which act as barriers to donation. Among these are:

- The 1989 TAGA prevents some people who may be close to the decedent from making a gift on the decedent's behalf (e.g., adult grandchildren).

- The 1989 TAGA makes no effort to prioritize uses of gifts among education, research transplantation, or therapy, despite anecdotal evidence suggesting that donors only contemplate their gifts being used for transplantation.

- The 1989 TAGA includes provisions that thwart a family's wish to donate by allowing a single family member to veto an anatomical gift. In a case where the decedent had no spouse and five children, a single "no" vote by one child trumps the "yes" votes of the remaining four.

Panelists also took time to discuss the appropriateness of potential solutions to the shortage of transplantable organs. Among these were:

Restrictions on Medical Examiner Denials:

Panelists explained during testimony that "since 1995, Texas law has required the medical examiner to come to the operating room of the donor before they can choose to not release any or all organs." They also explained that "the original rationale for this law was that numerous donors and organs were lost due to blanket denials by medical examiners without examining the organs and potential donation case as a whole."

Moreover, there was widespread agreement among panelists that:

1. "Medical examiners are charged with the responsibility of determining and certifying the cause and manner of deaths."[31]

and that this responsibility requires that:

2. "During this period of the time the medical examiner must ensure that the integrity of the body is maintained such that the cause and manner of death may be determined, that appropriate evidence may be collected, and that any injuries or natural disease may be documented."[32]

However, panelists explicitly disagreed about whether maintaining the integrity of the body could, at times, entail the need to refuse procurement of otherwise transferable tissue and organs.

While panelists agreed that some form of legislative guidance could be useful in balancing the benefits of organ donation against the medicolegal responsibilities of medical examiners, their views about the proper content of that guidance were determined by the steps they deemed necessary in the execution of a medical examiner's responsibility. Those panelists who suggested that no organ should ever need to be denied (including Dr. Mallory, Nancy Cychol, and Jim Cutler) were likely to favor statutory requirements designed to compel medical examiners to release organs. At the same time, those panelists who thought that some organs could be withheld were likely to favor modified legislative guidance worded to leave medical examiners with more discretion.

In explaining why a medical examiner's responsibility could, at times, entail the need to refuse procurement of otherwise transferable tissue and organs, panelists offered the following arguments:

1) The organ procurement procedure itself creates multiple injuries to the body of the deceased that, in instances of surreptitious violence toward a child, can mimic or obscure true inflicted injuries. Moreover, the extensive use of blood thinners has been used by criminal defense attorneys to explain the presence of bleeding in the brain of children who are beaten to death. The skin of the battered victim may also have valuable evidence such as bite marks, patterned injuries, and other trauma that would be irrevocably distorted and displaced by the organ harvest or tissue donation procedure.[33]

2) The public health obligations of the medical examiner can conflict with the procurement of organs and/or tissue in those cases where the investigation indicates that the heart may hold the answer about the cause of collapse and death, and any potential risk that may entail for the remaining living family. In those cases, the medical examiner in all good practice as a physician must be able to make the correct diagnosis and avert additional deaths and illness.

Against these arguments other panelists contended that:

1) "Searches of medical and legal literature have failed to find a single documented instance of organ procurement interfering with a criminal investigation, a prosecution, a defense, or the determination of cause and manner of death at autopsy. While this could be interpreted to mean that the proper subset of cases had been appropriately denied for procurement, there are many medical examiners' offices with zero denials and without future problems with legal proceedings."[34]

In testimony, panelists indicated that much of the dispute surrounding medical examiner denials could be restricted to cardiac tissue. In explaining why a medical examiner denial of a liver or kidney is likely to be unwarranted, Dr. Pustilnik explained that "there is nothing in the liver that will kill a person suddenly or drop them suddenly that the

transplant surgeon is not going to see, and [and which would] therefore not invalidate the organ for him to harvest; the same thing [is true] in the kidney, the same thing in the pancreas, etc. It's really hearts we're most interested in because those are the [organs] where we can find the most benefit to the family and have the most issue with finding things that are surreptitious."

Adoption of the 2006 UAGA:

Panelists generally supported the view that "the Revised Uniform Anatomical Gift Act as a necessary piece of legislation" and those panelists who objected to some provisions of the bill (including those panelists representing organizations of medical examiners) did support the bill "with certain revisions." In endorsing the bill, Sam Holtzman noted that the 2006 UAGA "retains all of the strengths of current Texas statutes but updates the statutes to reflect current practice in the 21st century."

Panelists explained that a compromise concerning medical examiner denials had been reached during the 80th Regular Session, and that a modified version of the UAGA reflecting that compromise would be acceptable to all stakeholders. Expounding on his comments regarding the importance of heart tissue,

COMMITTEE FINDINGS

The current version of the Anatomical Gift Act in Texas Statute supports unnecessary barriers to organ donation. During the Regular Session of the 80th Texas Legislature, HB 3814 and SB 1597 were filed to address these obstacles. However, SB 1597 was delayed and ultimately stymied because of stakeholder disagreements. Medical Examiners brought forth concerns about the absence of certain denial provisions contained in Chapter 693 of Texas Health and Safety Code. After stakeholder negotiation, denial provisions were incorporated into a Senate Committee Substitute for SB 1597 (80R).

During the interim committee hearing at The University of Texas M.D. Anderson Cancer Center, representatives of organ procurement organizations and pediatric hospitals raised concerns about the potential consequences of the denial of cardiac tissue in certain circumstances, such as contained in the substituted version of SB 1597.

COMMITTEE RECOMMENDATIONS

The House Committee on Public Health recommends that the 81st Texas Legislature adopt the language changes proposed to the Texas Health and Safety Code Chapter 692 through House Bill 3814 (80R) by Zerwas. This will update the Texas Anatomical Gift Act to not only encourage organ donation, but also to remove current impediments to the organ donation process.

The House Committee on Public Health recommends that ongoing consideration be given to the Medical Examiner community as Chapter 693 of the Texas Health Safety Code is reviewed.

The House Committee on Public Health recommends that the Texas Department of State Health

Services convene an ongoing advisory group to improve collaboration and cooperation among organ procurement organizations in order to better meet the needs of Texans. The advisory committee should consist of one representative from each OPO, one transplant surgeon from each OPO service area, two medical examiners and one organ donation recipient.

CHARGE # 5

ASTHMA MANAGEMENT AND PREVENTION

Examine the status of asthma in Texas, and make recommendations to prevent asthma and to assist children and adults with asthma to more effectively manage their disease. Develop strategies for decreasing the direct medical and indirect related costs associated with asthma.

BACKGROUND

Asthma is a chronic disease occurring in both adults and children and is characterized by inflammation of the inner lining of the airway. During an asthma attack, the main air passages of the lungs become inflamed and breathing becomes difficult. Asthma attacks range in severity and can include coughing, wheezing and gasping for air.

The Texas Legislature has taken multiple actions to curb the impact of asthma on Texans. In 1995, the 74th Texas Legislature passed HB 2850 by Naishtat/Moncrief that addressed asthma by establishing indoor air quality standards in public schools. In 2001, the 77th Texas Legislature approved HB 1688 by McClendon/Moncrief to authorize students to have their asthma medications (i.e., inhalers) available in public schools for physician-approved self administration. The 79th Texas Legislature expanded HB 1688's language to include anaphylaxis medication, as a part of 79R (3) HB 1 by Chisum/Shapiro. In 2007, the 80th Texas Legislature passed SB 82 by Van de Putte/Eissler, which amended the education code to include requirements for asthma training for coaches and extracurricular staff.

TEXAS MEDICAID COSTS FROM ASTHMA RELATED EMERGENCY ROOM VISITS

YEAR	TOTAL BILLED	TOTAL PAID
2004	$11,546,034	$3,071,382
2005	$23,570,852	$5,729,031
2006	$26,083,244	$6,173,907
2007	$26,086,720	$5,995,882
2008*	$11,042,639	$2,536,772
TOTAL	**$98,329,488**	**$23,506,974**

*Data as of July, 2008

Source: Texas Health and Human Services Commission, Medicaid/CHIP Division (July 2008)

Speaker Tom Craddick directed the House Committee on Public Health on November 30, 2007 to examine the following interim charge: "Examine the status of asthma in Texas, and make recommendations to prevent asthma and to assist children and adults with asthma to more effectively manage their disease. Develop strategies for decreasing the direct medical and indirect related costs associated with asthma."

INTERIM STUDY

On November 30, 2007, Speaker Tom Craddick issued the "Asthma Management and Prevention" charge to the House Committee on Public Health. The committee held a public hearing on January 17, 2007, and heard invited testimony regarding asthma prevention and management from two panels of experts from state government agencies, institutions of public education, and the private sector.

Panel One was comprised of Karissa Luckett, President of the Asthma Coalition of Texas (ACT); Laura Chapman, Regional Senior Program Director for the American Lung Association of Central States; and Diane Rhodes, Asthma Educator for North East ISD in San Antonio.

Panel Two consisted of Steven Conti, the Director of Disease Management at Seton Family of Hospitals; Denise Rebel, Asthma Management Program Coordinator at Presbyterian Hospital of Dallas; and Dr. Jeffrey Levin, Professor and Chair of the Department of Occupational and Environmental Medicine and the Department of Occupational Health Sciences at The University of Texas Health Science Center at Tyler.

Panelists testified to the current state of asthma in Texas and to the potential and ongoing policies designed to control the disease. Supplemented by written testimony, panelist testimony described the current status of asthma in Texas.

Prevalence: Across the state, in 2005, 1.5 million (6.7 percent) adults suffered from asthma and 2.5 million (11.5 percent) reported having had asthma at some point in their lives. Moreover, in 2005, asthma affected 7.3 percent of children and had affected 11.6 percent of children at some point in their lives.

Prevalence of asthma is unevenly distributed across race and gender lines. From the year 2000 to 2005, 5 percent of adult males and 8.4 percent of adult females were affected by asthma. Further, data from the same period suggests that "the prevalence of current asthma is significantly higher for African-Americans (9.2 percent) compared to Whites (7.3 percent) and Hispanics (4.3 percent)."[35]

Costs: Asthma imposes substantial and diverse burdens on Texas, including direct costs to asthmatics and their families and indirect costs to Texas businesses and school districts. Panelists discussed these costs and highlighted several in particular:

- **Direct Medical Costs:** Early in her testimony, Ms. Luckett noted the "great deal of money spent on asthma care in Texas." This expenditure of money is partially the product of the fact that, from the years 2000-2005, one out of every four adults currently suffering from asthma had made a trip to the emergency room within the last 12 months.[36] Nearly a third of these Texans had seen a physician for urgent treatment. Ms. Luckett also demonstrated that one dollar is spent every second on in-patient asthma hospitalizations.

- **Quality of Life Costs:** Panelists also described significant the quality-of-life costs of asthma. In addition to the quality-of-life costs engendered by the medical costs above, testimony revealed that nearly one-third of adults with "current asthma experience at least one day a year where they are unable to work or carry out their usual activities due to their asthma."[37] Moreover, according to the same source more than one-third of Texas adults with current asthma had trouble sleeping due to asthma within the last 30 days.

- **Indirect Economic Costs:** In testimony, Steven Conti included among the economic costs of asthma increased school absenteeism and lost work and productivity. He noted that, in addition to $9.4 billion dollars worth of direct costs, asthma creates more than $4.6 Billion dollars worth of indirect costs in missed school and work days. He also explained that asthma has the potential to cause an economic loss of up to $2.7 Million to a school district the size of the Austin Independent School District.

- **Mortality:** The mortality rate for asthma from 1999 to 2005 was 13.9 deaths per 1,000,000 individuals in the population. At 16.7 deaths per 1,000,000, the mortality rate for females was significantly higher than the rate for males (10.3

per 1,000,000). Moreover, "the mortality rate for African-Americans ... is almost three times the rate for Whites and four times the rate for Hispanics."[38]

Noting that asthma has no cure for, the Texas Asthma Plan explains that "the goal of asthma therapy is to successfully manage the disease."[39] "With proper management and care", the plan continues, "a person with asthma can live a long, healthy life with few symptoms."[40] Good asthma control can eliminate many of the costs identified above.[41]

In her testimony, Diane Rhodes noted that the National Asthma Education and Prevention Program's Guidelines for the Diagnosis and Management of Asthma (National Guidelines) "address four major components which must happen in order for asthma control to happen. It's awareness, it's education, it's medication, and it's environment. And [someone has] to have all four of those, and an understanding of all four of those ... to have control of [their] asthma."

Awareness: The area of awareness includes diagnosis of the patient's asthma, assessment of the severity of that asthma, and monitoring of the patient's responsiveness to treatment. Patient assessments describe the severity of the asthma, level of control which that patient has over their asthma, and responsiveness to treatment.[42] The severity and control of a patient's asthma are in turn described in terms of current levels of impairment and risk of future asthma exacerbations.

The national guidelines stress that:

> "Diagnosing a patient as having asthma is only the first step in reducing the symptoms, functional limitations, impairment in quality of life, and risk of adverse events that are associated with the disease. ... Responsiveness to asthma treatment is variable; therefore, to achieve the goals of therapy, follow up assessment must be made and treatment should be adjusted accordingly."[43]

In testimony, the panels described the area of awareness as an important gateway to progress in the other three areas of control. Ms. Rhodes noted that "if [someone doesn't] know [they] have asthma, [they're]not going to look for those triggers; [they] can get medication and be prescribed Albuterol, but if [they] don't know [they] have asthma, because the doctor has never told [them they] have asthma, then [they] don't have the awareness components, [they] don't know to watch for environmental issues, and [they are] not getting the education [they] need in order to control [their] disease."

Education: Throughout the hearing, panelists consistently stressed the importance of asthma education in allowing patients to effectively control their asthma. Panelists stressed that, when effectively provided, asthma education resulted in "reduction[s] in urgent care visits and hospitalizations, reduction[s] of asthma-related health care costs, and improvement[s] in health status."[44] Additional "benefits of value from self-management education are reduction in symptoms, less limitation of activity, improvement in quality of life and perceived control of asthma, and improved medication adherence."[45]

Evidence reviewed by the committee also demonstrated the importance of proper asthma education. The national guidelines stress that "asthma self-management education should be integrated into all aspects of asthma care, and it requires repetition and reinforcement."[46] Beginning at the time of diagnosis, asthma education should involve the entire healthcare team and be provided at all points of care.[47] Moreover, education should provide self-management skills training, not simply information.

Several panelists highlighted opportunities for Texas to improve asthma education. Describing her school district, Ms. Rhodes observed that "preliminary findings suggest education of asthma is lacking in all areas. ... There is a breakdown in the process dealing with education, reinforcement, and medication understanding from the medical community to the home." Explaining why asthma education provided by doctors is often inadequate, Denise Rebel stressed that "doctors don't have the time, and their staff don't have the time, to sit with [patients]." She went on to explain that patients can be intimidated by doctors and may hesitate to ask important questions.

In her testimony, Laura Chapman added that education programs in schools may be especially important given the difficulty doctors face in finding time to provide education. Ms. Rhodes gave several examples of steps that schools can take to provide asthma education. She noted that her school district incorporates asthma education into general health education provided to students. She also described parents' nights, during which professional health care providers present parents with information on asthma.

Medication: The national guidelines explain:

> "Asthma medications are categorized into two general classes: long-term control medications taken daily on a long term basis to achieve and maintain control of persistent asthma (these medications are also known as long-term preventive, controller, or maintenance medications) and quick-relief medications taken to provide prompt reversal of acute airflow obstruction and relief of accompanying bronchoconstriction (these medications are also known as reliever or rescue medications). Patients who have persistent asthma require both classes of medication."[48]

Testimony highlighted the importance of ensuring the availability of medication. Ms. Rhodes testified that many children in her school district could not afford controller medications or a second rescue inhaler to keep at school. She went on to explain that, because they lacked medication, numerous children were forced to leave school by ambulance to go to a hospital.

Environment: The national guidelines explain:

> "For successful long-term management of asthma, it is essential to identify and reduce exposures to relevant allergens and irritants and to control other factors that have been shown to increase asthma symptoms and/or precipitate asthma exacerbations. These factors are in five categories: inhalant allergens, occupational exposures, irritants, comorbid conditions, and other factors."[49]

During testimony, panelists stressed the importance of environment control to reduce exposure to

potential asthma "triggers." Panelists also explained that steps to reduce exposure should be taken not only in the asthmatic's home, but also in workplaces and in schools. Laura Chapman also noted that cigarette smoke can act as an irritant to asthmatics and stressed the role that smoking-cessation programs can play in improving an asthmatic's environment.

SCHOOL-DISTRICT LEVEL ACTIVITY

In addition to oral testimony, Ms. Rhodes also provided thorough written testimony describing the steps taken by North East ISD to help students control their asthma. She recounted how NEISD created its Asthma Program in the fall of 2006. The program consists of one full-time employee who works with all divisions of the school district to provide teachers, staff, parents, and students with asthma education.

Ms. Rhodes explained that the program is structured around the four components of asthma control and that the school district uses these four areas to improve outcomes for asthmatic students.

Steps taken to improve awareness: In her testimony, Ms. Rhodes described steps taken both to reduce the numbers of students with undiagnosed asthma and steps taken by the school district to monitor levels of asthma control. A letter identifying the symptoms of asthma is sent to all parents at the beginning of the school year. Moreover, information from asthma control tests, which are filled out during visits to the school nurse's office, is also sent home to parents. Both of these measures are intended to prompt a dialogue between parents and a physician.

Ms. Rhodes also described steps taken by the NEISD Asthma Program to monitor levels of asthma control. The program sends a twenty-five question asthma survey to parents and collects data on a variety of indicators: rates of absences due to asthma, EMS visits to schools, at-school rescue-inhalers usage, and asthma-related trips to the nurse's office.

Steps taken regarding medication: Testimony by Ms. Rhodes also included information on steps taken by the asthma program to address students with no medication on campus and to improve the management of medication. Ms. Rhodes explained that because of the importance of providing medication quickly after the first sign of symptoms, NEISD provides both a nebulizer and doses of quick-relief medication on every campus. Ms. Rhodes also explained that nursing staff at schools are educated on the importance of controller medications, asthma classification, and inhaler technique.

Steps taken to improve the school environment: Ms. Rhodes described the efforts of NEISD to improve the school environment for asthmatics:

- Facilities maintenance: To reduce exposure to potential triggers NEISD takes steps to ensure that facilities are well maintained, well ventilated, and that moisture within the building is controlled.

- Custodial Services: NEISD takes steps to ensure that custodial services for the district are well staffed. Moreover, to assist custodians, teachers are instructed to maintain a "clean-able" classroom and to remove non-curriculum cluttering.

- Teacher Instruction: The NEISD asthma program provides teachers and staff with information on asthma, including information on sources of irritants commonly found in classrooms. Teachers then use this information when furnishing their classroom.

Steps taken to provide asthma education: Testimony from Ms. Rhodes detailed district-wide initiatives to provide asthma education. She noted that asthma education had been integrated into the district's preexisting CATCH program, which provides health education to all students. This insures that multiple parties have access to asthma education resources, because teachers receive education when presenting CATCH materials and parents receive information from materials brought home by students.

Ms. Rhodes also described "Asthma Blow Out" events hosted by the school district. The events include presentations from volunteering allergists and pulmonologists from the area and are designed to provide information to the families of asthmatic students and to faculty and staff.

COMMITTEE FINDINGS

According to the Texas Health and Human Services Commission, since 2004, asthma-related emergency room visits have directly cost the state's Medicaid program in excess of $23.5 Million. Furthermore, ER providers have incurred nearly $75 Million in additional billed costs furnishing Medicaid services during that same period.

COMMITTEE RECOMMENDATIONS

The House Committee on Public Health recommends that the 81st Texas Legislature direct the Texas Education Agency (TEA) and the Texas Department of State Health Services (DSHS) to examine best practices in asthma management and prevention. The identified practices should be made available to education professionals via the TEA Internet website.

The House Committee on Public Health recommends that the Texas Health and Human Services Commission identify best practices in asthma management and prevention, and initiate a program targeting the Texas Medicaid population to educate individuals on this chronic disease, identify at-risk individuals for prevention, and manage diagnosed cases before they are treated at recurring emergency room visits.

CHARGE # 6

TEXAS MEDICAL BOARD

Examine activities at the Texas Medical Board as they relate to the protection of public health and the practice of medicine, and the status of implementation requirements established by HB 1973, 80th Legislature, Regular Session. The committees should consider any findings by the Texas Sunset Commission. (Joint Interim Charge with the House Committee on Appropriations)

BACKGROUND

The Texas Medical Board (TMB) is charged with the oversight and processing of physician licensing in Texas. Following the enactment of House Bill 4 by Nixon/Ratliff (78th Legislature, Regular Session), and Proposition 12 in 2005, which resulted in medical liability tort reform in Texas, the number of physician license applications increased from about 2,500 in 2003 to more than 4,000 in 2006. The rapid application growth as a result of the tort reforms measures significantly increased the approval time required for a physician to receive their license.

Traditionally, once a physician completes a residency program, they will establish a practice within 30 miles of that program. The increased wait period for licensure approval created an opportunity for other states with less cumbersome licensing procedures to aggressively recruit new physicians from Texas, further straining a stretched professional health workforce and reducing access to care in the state. In response to this situation, the 80th Texas Legislature passed HB 1973 by Delisi/Nelson to direct the TMB to streamline and improve the processes that will decrease the average number of days necessary to complete the licensure process, with a deadline of August 1, 2008. Additionally, HB 1973 directed the TMB to expedite licensure for individuals who indicate their desire to practice medicine in medically underserved areas (MUA), health professional shortage areas (HPSA), or in rural communities within the state.

INTERIM STUDY

On November 30, 2007, Speaker Tom Craddick issued the "Texas Medical Board" charge to the House Committee on Public Health.

COMMITTEE FINDINGS

In 2008, the TMB implemented the Internet-based Licensure Inquiry System of Texas (LIST). The LIST web-portal empowers physician licensure applicants to track the status of their application, and discover in a timely manner if any additional information or documents are needed to move the process forward. LIST may also be used to facilitate two-way electronic communication between an applicant and TMB staff. This measure has increased the efficiency of the physician licensure process.

In order to accelerate the approval of applications for individuals who intend to serve in MUA's, HPSA's, and/or rural areas, the TMB put in place rules that give priority to these applications. Under the targeted expedition rule, a priority status places these applicant's files ahead of those applicants without priority status for screening, assignment to a licensure analyst after successful screening, and for processing by a licensure analyst.

Prioritization begins with applicants who agree to treat Medicare and Medicaid patients for five years following licensure. The applicant must sign an agreement that will be posted on the TMB website indicating that they will accept patients enrolled in the Medicare and Medicaid programs. Due to overlapping and varying factors involved, the order of priority of applications assigned priority status is ranked below from highest to lowest:

1. Medicare/Medicaid and MUA and HPSA and rural
2. Medicare/Medicaid and two other factors (MUA, HPSA, or rural)
3. Medicare/Medicaid and one other factor (MUA, HPSA, or rural)
4. Medicare/Medicaid only
5. Three other factors (MUA, HPSA, and rural)
6. Two other factors (MUA, HPSA, or rural)
7. One factor (MUA, HPSA, or rural)[50]

COMMITTEE RECOMMENDATIONS

At the time of this report's completion, the Sunset Commission had not completed its evaluation of the Texas Medical Board. Any recommendations the Committee on Public Health might make are contingent on Sunset Commission's findings and recommendations.

CHARGE # 7

PUBLIC HEALTH EMERGENCY PREPAREDNESS

Examine the State of Texas' preparedness level to handle a public health emergency. (Joint Interim Charge with the House Committee on Defense Affairs and State-Federal Relations)

BACKGROUND

During the 80th Regular Session, the Texas Legislature passed the following legislation to bolster the State of Texas' preparedness to respond to a public health emergency:

- **SB 11 (80R)** by Carona/Corte codified the state's emergency management structure by dividing the state into disaster districts for homeland security preparedness, and established the Texas Statewide Mutual Aid System to facilitate mutual aid responses between local governments.

- **HB 15 (80R)** by Chisum/Ogden authorized $11 million to the Texas Department of State Health Services (DSHS) for the purchase of antiviral drugs.

- **HB 1493 (80R)** by Bonnen/Janek creates a severe storm research and planning center to develop storm surge tracking ability, flood warning systems, and public education for evacuation programs.

INTERIM STUDY

On November 30, 2007, Speaker Tom Craddick charged the House Committee on Public Health and the House Committee on Defense Affairs and State-Federal Relations with examining the preparedness level of the State of Texas to handle a public health emergency. On February 5th, 2008, the Public Health and Defense Affairs and State-Federal Relations committees held a joint subcommittee hearing. In accordance with House Rule 4, Section 6, Subsection 2 (80th Legislature), Representative Dianne White Delisi served as the Public Health subcommittee chair, and was joined by Representatives Veronica Gonzales and Vicki Truitt. At the hearing, public testimony was given by representatives of the State of Texas and other individuals with experience with emergency preparedness issues.

Panel 1 provided an overview of Texas' preparedness and was comprised of DSHS Commissioner, David Lakey, MD, Steve McCraw, Director of Homeland Security for the Office of the Governor, and Jack Colley, Chief of the Governor's Division of Emergency Management. The following six topics were highlighted during the panel discussion:

1) **Integration at All Levels:** Commissioner Lakey described the Health and Medical Disaster Response Structure, and discussed how it folds into the general emergency response plan for the State of Texas. An organizing principle of the Disaster Response Structure, the Commissioner noted, is that "things are coordinated state-wide to try to meet needs at the local level." If, during an emergency, the local level is unable to provide the resources needed a request for assistance is made to the Disaster District Committee (DDC) and Regional Liaison Officers (RLOs). A request may be made directly to the State Operations Center (SOC) if the DDC is unable to provide necessary materials to address the disaster.

2) **All-Hazards Planning:** All three panelists stressed the importance of the all-hazards approach to disaster planning. The *State of Texas Emergency Management Plan* states:

> "State and local emergency planning in Texas uses an all-hazard approach... All-hazard planning is based on the fact that most of the functions performed during emergency situations are not hazard specific. For example, evacuation may be required because of flooding, a chemical spill, or a terrorist threat. Hence, the most efficient approach to planning is to plan in some detail for the tasks required to carry out basic emergency functions, such as warning or evacuation that may have to be executed whether an incident is caused by a natural, technological, or man-made hazard. All-hazards plans are supplemented by some hazard specific plans for unique threats."[51]

3) **Training and Exercises:** Commissioner Lakey and Mr. McCraw articulated the importance of practice and training. Additionally, Mr. McCraw stressed the need for training in the use of equipment and cross-agency coordination for emergencies. Each panelist pointed to recent events, including Hurricane Dean and wildfire responses, which have provided practice to public health workers.

4) **Community and Family Preparedness:** Commissioner Lakey described the importance of helping families prepare for scenarios that include diminished or interrupted governmental services. The Commissioner described the "Ready or Not" media campaign, which encourages families to prepare for potential public health emergencies. The "Ready or Not" program targets the population through a number of mediums in three waves. Each wave stresses readiness for a different type of disaster.

5) **Equipment and Infrastructure:** All three panelists portrayed infrastructure as a critical part of preparedness. Mr. McCraw emphasized that "there's no substitute for equipment." Commissioner Lakey described steps taken by DSHS to increase emergency medical services (EMS) capacity, including partnerships with neighboring states and national contracts for ambulances. The Commissioner detailed attempts to acquire shelters, "jump bags," and "push packs" for medical special needs evacuees in the event of a disaster.

6) **Human Resources:** Commissioner Lakey spoke about the lessons learned about volunteer help since Hurricane Katrina in 2005. In particular, the Commissioner spoke of the need to "have the right person with the right skill-set at the right place," and about the web-based system introduced to coordinate volunteers and meet these needs. Commissioner Lakey went on to describe the Medical Reserve Corps (MRC) which, as a national network of doctors and nurses, will allow people to "train together, practice together and to be able to respond to a disaster."

Panel 2 was comprised of Dan Stultz, MD, President and CEO of the Texas Hospital Association, and John T. Carlo, MD, representing the Texas Medical Association. In addition to the topic discussed by the first panel, Drs. Stutz and Carlo elaborated on two additional issues:

1) **Trauma Infrastructure Capacity:** Dr. Stultz described the shortage in treatment capacity in Texas hospitals. Dr. Stultz reported that designated trauma hospitals are often on diversion status, that emergency room treatment capacity is strained, and he detailed hospital's struggle to maintain adequate intensive care capability.

2) **Liability:** Dr. Carlo discussed concerns within the medical community regarding exposure to personal liability in volunteering to respond to a disaster. Dr. Carlo stated that the Texas Medical Association has researched potential problems with liability and found that statutes protect health professionals in disaster situations. However, Dr. Carlo added, many healthcare professionals are unaware of these protections.

   In response to a question from Representative Dianne White Delisi about "good Samaritan" provisions included in HB 4 (78R) by Nixon/Ratliff, Commissioner Lakey testified earlier in the hearing that "certain things would fall under good Samaritan," but added that "in some physician's minds... they wouldn't [be protected]." Commissioner Lakey went on to conclude that "our opinion is that they would [be protected], but convincing the practitioners...has sometimes been difficult." Commissioner Lakey noted that protections are scattered across multiple statutes in a way which impairs their ability to reassure doctors. The Commissioner suggested that combining these protections under one statute could improve the confidence of medical volunteers.

Panel 3 was comprised of John Herbold, PhD, Director of The University of Texas Health Science Center and Scott Lillibridge, MD, of the Texas A&M University Health Science Center.

Dr. Herbold's testimony emphasized the importance of laboratory testing infrastructure. Herbold noted that many potential bio-terrorism agents, including anthrax and plague, are naturally occurring in Texas. Dr. Herbold recommended surveillance for microbes to distinguish between natural and un-natural, intentional and unintentional, human and animal exposure to diseases. To make this determination, Dr. Herbold explained that an "etiologic" diagnosis is required. Such a diagnosis can only be obtained in a laboratory, and there is not currently enough capacity to quickly conduct large numbers of these tests.

Dr. Herbold identified the Texas Veterinary Medical Diagnostic Laboratory and the DSHS laboratory services as areas needing legislative attention. Dr. Herbold recommended that the legislature encourage specimen submissions by healthcare providers, citizens, and ranchers. Lastly, Dr. Herbold advised continued support for regional human and veterinary diagnostic laboratories.

Following Dr. Herbold, Dr. Scott Lillibridge testified to emerging challenges impacting preparedness in Texas. Additionally, Dr. Lillibridge stated his belief in the importance of two initiatives:

1) The implementation of a statewide exercise and evaluation program. Dr. Lillibridge recommended such a statewide program to include the testing of patient surge capacities be led by the health community, and that federal preparedness grants be redirected to support these efforts.

2) Health preparedness in areas of high risk, such as the Texas-Mexico border and populated coastal regions of the state. Dr. Lillibridge testified that strict adherence to per-capita expenditures should be discouraged in support of a risk assessment model.

COMMITTEE FINDINGS

The House Committee on Public Health has found the State of Texas to be taking a comprehensive and coordinated approach to statewide preparedness for a public health emergency. State officials continue to improve their processes and have made improvements as a result of previous successful operations, including the aftermath of the Katrina and Rita hurricanes.

The medical community has identified concerns to the committee about medical liability in offering professional services, and about licensure reciprocity issues, during a public health emergency. During a joint hearing with the House Committee on Defense Affairs and State-Federal Relations, the Texas Department of State Health Services and the Texas Medical Association testified that medical liability protections, chiefly codified in the Texas Civil Practice and Remedies Code as the result of HB 4 (78R) by Nixon/Ratliff, and other statutory language, are in place. However, DSHS and TMA reported that providers are not convinced that there is satisfactory protection from liability.

COMMITTEE RECOMMENDATIONS

The House Committee on Public Health recommends that the 81st Texas Legislature direct the Texas Department of State Health Services to improve information distribution to medical providers of the protections in place when providing *pro bono* professional medical services during a public health emergency.

The House Committee on Public Health recommends that the 81st Texas Legislature direct state healthcare-associated regulatory agencies to establish a process for expedited approval of a temporary license to practice during a state of emergency involving a risk to the public health. The temporary license should not be contingent upon sponsorship of a Texas licensed practitioner, and should be available to licensed medical professionals from other states, as well as retired Texas practitioners. A provision should be in place for an applicant licensed in another state to have their licensure file electronically transferred and maintained with the Texas temporary license file.

CHARGE # 8

TRAUMA SYSTEM INFRASTRUCTURE/DRIVER RESPONSIBILITY PROGRAM

Review the effectiveness of the Driver Responsibility Program, and provide recommendations for increasing the collection rate of assessed penalties. Provide recommendations for amnesty and incentive programs established by the passage of SB 1723, 80th Legislature, Regular Session. Examine the status of Texas' current statewide trauma system infrastructure and how the system may be optimized to meet future trauma care needs in a rapidly growing state with overburdened emergency rooms. (Joint Interim Charge with the House Committee on Transportation)

BACKGROUND

As reported by the Texas Department of State Health Services, the leading cause of death for all persons under 44, injuries resulting in serious trauma cost the lives of 30 Texans every day and cost billions of dollars every year. Preventing these outcomes requires the coordinated and rapid provision of medical resources, and the state trauma system is tasked with ensuring that these resources are in place and immediately available at all times.

Authorized by House Bill 3588 (78R) by Krusee/Ogden, the Driver Responsibility Program (DRP) added funding to the state trauma system by requiring surcharge payments from drivers who habitually make moving violations. The DRP assigns points to moving violations classified as Class C misdemeanors. Habitual offenders who receive a substantial number of points or offenders who commit certain offenses have surcharges applied to them.

This surcharge is assessed by the Texas Department of Public Safety (DPS) to drivers who accumulate a total of six or more points during a three year period. The surcharge for the first six points is $100 and $25 for each additional point. If six or more points continue to accumulate on the driver's record, the driver may be required to pay for more than one year.

A driver may also be assessed surcharges regardless of their point totals for certain convictions, such as Driving While Intoxicated, Failure to Maintain Financial Responsibility, Driving Without a License, or Driving While License Suspended. The size of the surcharge assessed for these convictions depends on the type of violation.

HB 3588 allowed surcharge payments to be made in installments if the person assessed the surcharge was unable to pay in full. To help DPS improve their collection capabilities for DRP, the 80th Texas Legislature passed SB 1723 by Ogden/Krusee. SB 1723 authorized DPS to enter into and modify contracts to collect uncollected surcharges, but limits compensation to the collector to 30 percent of the surcharge and related costs. It also establishes a periodic amnesty program for driver's license holders who have been assessed a surcharge. Additionally, SB 1723 allows DPS to establish an indigency program for surcharged drivers and to reduce surcharges for some drivers.

INTERIM STUDY

On November 30, 2007, Speaker Tom Craddick issued the "Trauma System Infrastructure/Driver Responsibility Program" charge to the House Committees on Public Health and Transportation. On March 27th, 2008 a joint subcommittee hearing was held between the Public Health and Transportation Committees. In accordance with House Rule 4, Section 6, Subsection 2 (80th Legislature), Representative Dianne White Delisi served as the Public Health subcommittee chair, and was joined by Representatives Garnet Coleman, Jim Jackson, and Vicki Truitt. At the hearing, public testimony was given by representatives of various Texas state agencies and other individuals with knowledge of the DRP and the trauma system.

Panel One provided a financial overview of the DRP and related trauma funds. The panel consisted of Hayden Childs, from the Legislative Budget Board's Agency performance review

team and Jennifer Fox, from the Legislative Budget Board's Health and Human Services Team.

Panel Two provided testimony related to the use of trauma funds. The panel included Tom Suehs, of the Texas Health and Human Services Commission, Kathryn Perkins, R.N., of the Texas Department of State Health Services, Ronald Stewart, MD, of The University of Texas Health Science Center, Dinah Welsh, of the Texas Hospital Association, and Mike Click, R.N., of the Texas Organization of Rural and Community Hospitals.

Through two hours of testimony, the six panelists described an often Byzantine collection of six revenue streams, three state agencies, four trauma accounts, and an interwoven and heavily overlapping cluster of allocations used to fund trauma care. Although focused on the Driver Responsibility Program and its associated Comptroller Fund, testimony from the two panels also highlighted five Comptroller accounts related to trauma care:

The Driver Responsibility Program and Comptroller Fund #5111

Mr. Childs, an LBB agency performance review analyst, began testimony for the hearing with a description of the driver responsibility program. He described the four categories of violations which fall under DRP, the penalties for each type of violation, and the penalties for non-payment. He also remarked that the current DRP compliance rate was 37.7 percent and that the overall collection rate was 32.5 percent. He went on to explain that compliance with the DRP varies depending on the offence committed and that compliance rates range from 70.6 percent for points violations to 27.6 percent for no license violations.

Mr. Childs briefly outlined the allowances made by SB 1723 to improve compliance and collections. He explained that SB 1723 allowed for more extensive collection techniques, allowed installment plans to be reinstated after default by the offender, allowed amnesty programs, and allowed a reduction in penalties for offenders who show an improvement in behavior.

Ms. Jennifer Fox, a health and human services analyst at the LBB, explained the way in which funds related to the DRP are allocated. She explained that 1 percent of the funds from the DRP are allocated to the DPS to cover the costs of administering the program, that 49.5 percent of the funds are placed in the Trauma Facility and EMS Account No. 5111, and that 49.5 percent are placed into the general revenue fund.

Expanding on Account 5111, Ms. Fox explained that the account also receives revenues from the $30 State Traffic fine. She stated that local governments retain 5 percent of this money and that the remaining money is then divided so that 33 percent goes into Account 5111 and 67 percent goes into General Revenue. Finally, Ms. Fox noted that after contributions to General Revenue from the DRP and $30 State Traffic Fine reach $250 Million, additional funds are placed into Texas Mobility Fund 365.

Ms. Fox described the DRP collections, and explained that $98.4 million were collected in 2006, $158.5 million were collected in 2007, and that $79.2 million have been

collected up to that point in 2008. She noted that while $51,762,132 would be paid from account 5111 to the Department of State Health Services for the years 2008 and 2009, the Biennial Revenue Estimate (BRE) for those years indicated that Account 5111 would take in nearly twice that amount. Ms. Fox further explained that, if the present trend continues, Account 5111 is expected to end 2009 with a balance of $199,077,266.

Ms. Fox went on to describe the statutorily required distribution of funds from account 5111. Noting that $500,000 is set aside for extraordinary emergencies, she went on to explain that 96 percent of the remaining monies are allocated to fund a portion of uncompensated trauma care provided by hospitals designated as trauma facilities or by hospitals pursuing trauma designation. She explained that another 2 percent of the remainder is allocated to emergency medical service (EMS) providers, and that 1 percent is allocated Regional Advisory Councils (RACs) in the statewide system, and that 1 percent is allocated to administrative costs at the Department of State Health Services (DSHS).

Comptroller Fund # 5108

According to Kathryn Perkins, the Assistant Commissioner with the Texas Department of State Health Services that oversees EMS and Texas Trauma System coordination, Comptroller Fund 5108 is used to fund emergency medical services, trauma facilities, and trauma care systems. She explained that the revenue source for this fund is a $100 court cost on alcohol related convictions and noted that, from this money, $250,000 is set aside for extraordinary emergencies involving hospitals, licensed EMS, and first responders. From the remaining money, 27 percent is distributed to trauma-designated hospitals for uncompensated trauma care, 50 percent is distributed to EMS providers, 20 percent is distributed to RACs, and 3 percent goes to DSHS to administer the program.

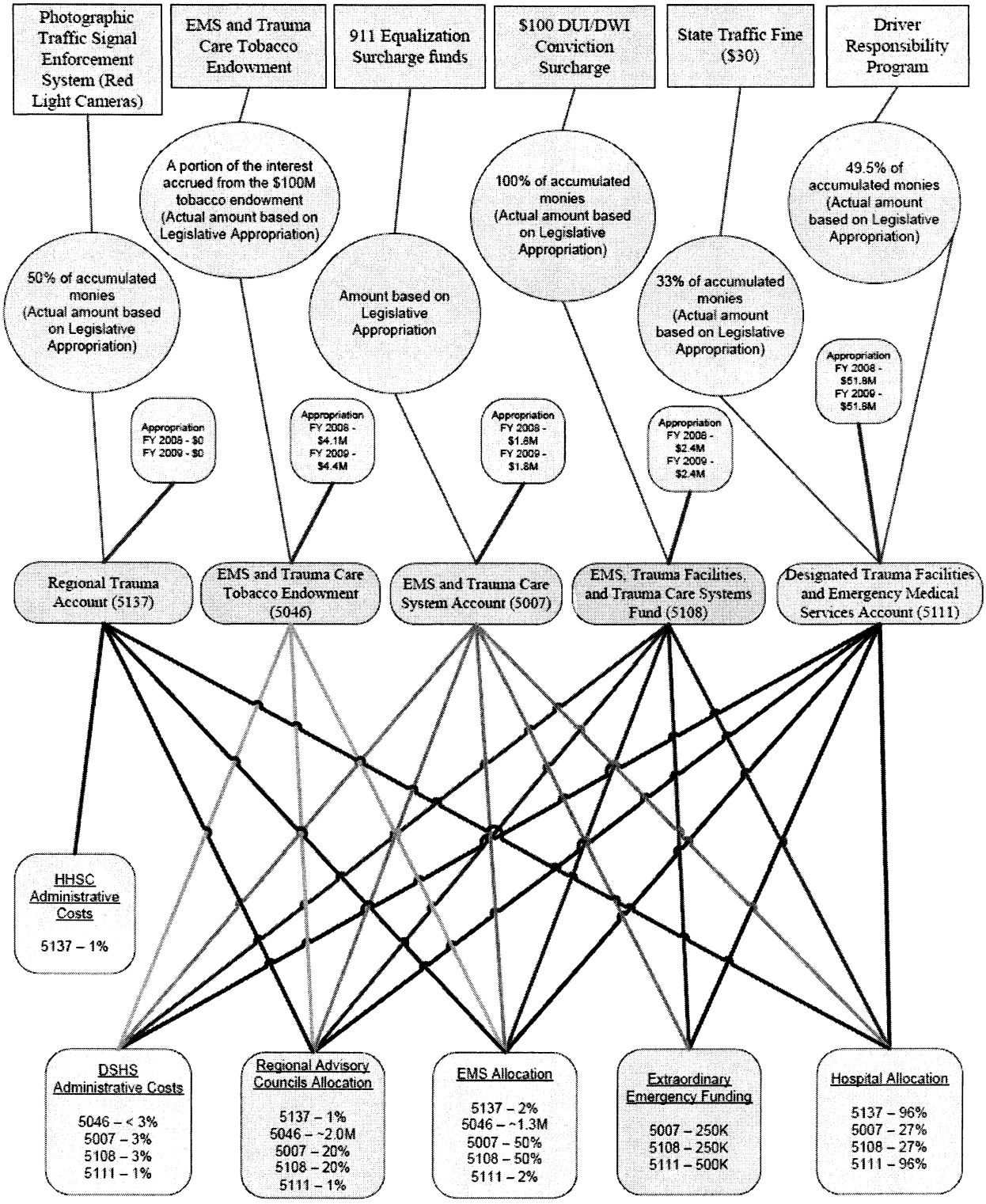
Comptroller Fund #5007

Commissioner Perkins described the EMS and Trauma Care Systems Account, #5007. She stated that the revenue source for this account was a portion of the 9-1-1 surcharge. The Commissioner explained that 27 percent of this money is distributed to hospitals for uncompensated trauma care, that 50 percent is distributed to EMS providers, that 20 percent is distributed to RACs, and that 3 percent of the money goes to DSHS to administer the program.

Comptroller Fund #5046

Commissioner Perkins explained the Permanent Fund for EMS and Trauma Care, #5046. After stating that the revenue source for Account 5046 is a portion of the interest from the $100 million Tobacco Endowment for Texas, the Commissioner observed that money from the account is allocated in the form of grants to the RACs for trauma systems development. Commissioner Perkins noted that money can also be allocated in the form of grants to licensed EMS providers for non-disposable equipment and non-disposable supplies. The monies can also be used to cover operating costs for the program.

TEXAS EMS/TRAUMA SYSTEMS FUNDING STREAMS



Source: Texas Department of State Health Services, Division for Regulatory Services (July 2008)

In addition to reviewing the funding structure used for trauma related monies, the committee heard detailed testimony describing the policies used for collecting those monies from offenders, and testimony describing the impact of DRP on the state trauma system. Testimony was provided by two panels of four members:

As it relates to Account 5111, the Comptroller reported that $109 million remained to be appropriated from the account, and projected the account to reach $200 by the end of 2008. Tom Suehs testified that the State of Texas may have the potential to receive a federal match in Medicaid spending through the appropriation of trauma funding under the federal formula. Under the Medicaid funding formula, Mr. Suehs indicated that when it comes to federal matching, state monies must be spent before they can be matched. By fully appropriating trauma system funds for their designated purpose, the state can optimize a potential federal match for Medicaid expenditures.

Panel Three consisted of Judy Brown, Chief of the Driver License Division at the Texas Department of Public Safety, Ed Serna, with the Texas Department of Transportation, the Honorable John Vasquez, a municipal judge from the City of Austin, and the Honorable Dale Jaecks, Precinct 3 Commissioner of Milam County.

Panel Four was comprised of Eric Epley, representing the Southwest Regional Advisory Council for Trauma (STRAC), Ron Stutes, of the John Peter Smith Health Network, Jim Springfield, of Valley Baptist Medical Center, and Tom Flanagan, of the Memorial Herman Texas Medical Center.

Chief Brown focused much of her testimony on describing DPS activities related to collection authorized SB 1723 (80R) by Ogden. She noted that SB 1723 authorized DPS:

- to reestablish installment payments after a single default;
- to change payment dates for the benefit of the offender;
- to utilize skip tracing to locate valid addresses; and
- to perform "customer-friendly" telephone contacts.

Chief Brown detailed amnesty programs authorized by SB 1723, including programs that allow surcharges to be reduced by 75 percent if an expired driver's license or lack of insurance resulting in the surcharge is remedied. She explained that the size of the surcharge could be reduced over time if no additional DRP convictions appear on an offender's record. Chief Brown noted that SB 1723 authorized DPS to institute programs for the indigent, but added that the agency does not anticipate implementing such programs due to potentially high administrative costs. Representative Garnet Coleman challenged the agency to take a closer look at the costs of programs for the indigent, and to find an innovative way to apply this legislatively-approved option.

In addition to describing steps used for collection, members of the third panel also took time to describe current barriers to collection. Judge Vasquez, a municipal judge for the City of Austin, noted that many defendants who plead guilty to DRP-related charges may only speak to a court clerk and may not be aware that by pleading guilty they expose themselves to statutorily-

mandated surcharges. He explained that even some defendants who come before a judge may not be informed of potential DRP liability. Dale Jaecks, a commissioner for Milam County, detailed how individuals surprised by DRP charges can come to feel a sense of helplessness and give up on any attempt to pay the fees.

Members of the fourth panel concluded testimony by describing the impact of DRP funds on the state trauma system. The panel uniformly described the impact as an important and positive one and stressed the important changes brought about by the infusion of additional funds. In testimony provided earlier in the hearing, Commissioner Perkins detailed the net impact DRP funds have had on the Texas trauma system infrastructure. She noted that there were 188 trauma facilities in Texas in 2003, covering 133 of 254 counties. By 2006, Commissioner Perkins testified about the "significant impact [to the trauma system] by the passage of these funds," noting that trauma facilities increased to 245, with 160 county coverage.

COMMITTEE FINDINGS

As the fining system stands, the surcharges for the Driver Responsibility Program are onerous to the average Texas driver. This is especially concerning given that drivers are also paying offense-specific fines in addition to the point-related surcharge. If a low-income driver is assessed a $3,000 surcharge, the driver may not be able to afford such a staunch fine, and will instead go to county jail, placing undue burdens on the county and the county court system. On the other hand, if that driver does attempt to pay the surcharges, it stands to reason that the driver could be giving up health or auto insurance to attempt to pay off an administrative penalty.

COMMITTEE RECOMMENDATIONS

The House Committee on Public Health recommends that all funding collected in Account 5111 (Designated Trauma Facilities and Emergency Medical Services) be appropriated and allocated, as intended by HB 3588 (78R) by Krusee/Ogden.

The House Committee on Public Health recommends that the 81st Texas Legislature streamline the Texas Trauma System funding mechanisms where possible to ensure minimal account redundancy and achieve full disbursement for intended purposes.

The House Committee on Public Health recommends that the 81st Legislature enable and encourage the DRP program to allow community service as an option to reduce surcharge fees. These community services options should include volunteering at local hospitals.

The House Committee on Public Health recommends that the base amounts of the surcharge fines be re-evaluated and lessened in order to adjust the burden on offending drivers to a reasonable level. This evaluation should take into account the cost the offender is bearing for any fine levied for the surcharge-triggering offense.

CHARGE # 9

HEALTH WORKFORCE ISSUES

Study the state's current and long-range need for physicians, dentists, nurses, and other allied health and long-term care professionals. Make recommendations regarding strategies related to geographic distribution and barriers to recruitment of high-need professions, especially for primary care providers and long-term care professionals. (Joint Interim Charge with the House Committees on Border and International Affairs and Appropriations)

BACKGROUND

The State of Texas faces significant current and future healthcare workforce challenges. Across the state in 2006, 28 counties had no primary care physician, six counties had no registered nurse, 46 counties had no dentist, and 25 counties had no pharmacist. Moreover, Texas ranks 45th in the nation in the number of physicians per capita. To study these challenges, on November 30th, 2007, Speaker Tom Craddick issued the following charge to the House Committee on Public Health: "Study the state's current and long-range need for physicians, dentists, nurses, allied health long-term care professionals. Make recommendations regarding strategies related to both geographic distribution and barriers to recruitment of high need professions, especially for primary care providers and long-term care professionals."

INTERIM STUDY

On November 30, 2007, Speaker Tom Craddick issued the "Health Workforce Issues" charge to the House Committees on Appropriations, Border and International Affairs, and Public Health. On June 30, 2008, a joint subcommittee hearing was held between the Appropriations, Border and International Affairs, and Public Health committees. In accordance with House Rule 4, Section 6, Subsection 2 (80th Legislature), Representative Dianne White Delisi served as the Public Health subcommittee chair, and was joined by Representatives Jodie Laubenberg and Veronica Gonzales.

In conjunction with subcommittees representing the House Committees on Appropriations and Border and International Affairs, the committee held a public subcommittee hearing on June 30th, 2008. Presentations were made by government officials and representatives of stakeholder groups. Over the course of the hearing, written and oral testimony presented to the committee revealed challenges in creating a healthcare workforce suited to the needs of Texas.

Oral testimony during the hearing was presented by a series of six panels, the first of which took steps to elucidate the challenges facing the Texas healthcare workforce.

> **Panel One** was composed of State Demographer Karl Eschbach, PhD, from the Texas State Data Center, Commissioner David Lakey, MD, from the Department of State Health Services, and Ben Raimer, PhD, from the State Health Coordinating Council.

Members of the first panel identified a broad range of current and emerging challenges facing Texas, including:

> *Demographic Challenges:* During testimony Dr. Eschbach noted that, between 2000 and 2007, Texas was the fastest growing state in the country. Dr. Eschbach also noted that Texas has a rapidly aging population and that the percentage of the population made up of older Texans will roughly double between the year 2000 and 2040 (from roughly 10 percent to roughly 18 percent). Dr. Lakey noted that these changes and others will increasingly strain the Texas healthcare system as demographic changes drive increases in demand for healthcare.

Supply-Side Workforce Challenges: Panelists also explained that the Texas healthcare system is significantly strained by barriers to increasing the supply of trained health care workers. Dr. Raimer explained during testimony that the current health workforce is aging and that increasing numbers of health workers are nearing retirement.

Distribution of Healthcare Workers: Panelists also explained that healthcare workers across Texas are mal-distributed. In his testimony, Dr. Lakey explained that more than 1/5th of Texans live in areas of the state designated by the federal government as health provider shortage areas. He also explained that these shortage areas are predominantly rural areas and that 516 primary care physicians would be needed to alleviate the mal-distribution.

Incidence of Chronic Disease: During testimony, Dr. Lakey explained that chronic disease poses a challenge to the healthcare system and that chronic disease sufferers require more healthcare resources than other patients. Thus, he explained, reducing incidence of chromic disease can significantly alleviate strain on the healthcare system.

Following the first panel, five additional panels discussed a broad range of potential solutions to the healthcare workforce shortage.

Panel Two consisted of Ben Raimer, PhD, from the State Health Coordinating Council, Nancy W. Dickey, MD, Chair of the Texas Health Care Policy Council, and Stacey Silverman, PhD, from the Higher Education Coordinating Board.

Panel Three consisted of Steven Sheldon, MBA, PA-C, Executive Director of the East Texas Area Health Center, Tom Pauken, Chairman of the Texas Workforce Commission, Larry Temple, Executive Director of the Texas Workforce Commission, and Harry Holmes, of the Health Services Steering Committee.

Panel Four was composed of Bohn Allen, MD, of the Texas Medical Association, Dan Stultz, MD, of the Texas Hospital Association, and Matthew B. Roberts, DDS, of the Texas Dental Association.

Panel Five consisted of LeAnn Wagner, MSN, RN, of the Texas Nurses Association, Catherine Judd, PA-C, of the Texas Academy of Physician Assistants, Karen Reagan, of the Texas Pharmacy Association, and Roland Goertz, MD of the Texas Association of Community Health Centers.

Panel Six consisted of Pearl Merritt, PhD, of the Texas Association of Homes and Services for the Aging, Deborah Berndt, of the Hogg Foundation, and Joe Lovelace, of the Texas Council for Mental Retardation and Mental Health Centers.

Together, these panelists discussed a broad range of potential solutions to healthcare workforce challenges including:

- *Increasing funding for nursing school faculty;* Panelists explained during testimony that a major limiting factor in the training of new nurses is a shortage of nursing faculty. Panelists also explained that the shortage of nursing faculty is due in part to an imbalance in the salaries available to nurses working in clinical practice settings and the salaries available for nurses working as faculty members.

- *Taking steps to increase the number of Graduate Medical Education (GME) openings*; Panelists explained that because a physician must go through a GME program to practice medicine, the availability of GME slots drives the supply of physicians.

- *Encouraging returning veterans from Iraq and Afghanistan, who may be skilled first-response practitioners, to work as healthcare professionals.*

- *Preventing "degree creep" from exacerbating existing shortages of health professionals.* Panelists explained that in some instances minimal education requirements for entry-level practitioners have increased, erecting barriers to entry into various health professions.

COMMITTEE FINDINGS

Various insurance and government mandates stifle physician ability to practice medicine as they see fit. This is especially true for Medicaid and Medicare providers. Anecdotal evidence points to a disturbing trend: aging physicians who have experienced the expansion of such mandates say that they would not become a medical professional in the current climate because they feel that they are unable to truly practice their profession.

The changing nature of the medical profession has geared more and more young people to choose specialized medicine rather than family or primary practice. These young physicians will be important for future generations because of the research they will generate. However, they will not address the needs Texas has for long-term primary care physicians.

Future state policy should embrace the changes that medicine is undergoing. Nurses as a group are highly skilled and trained. Advanced practice nurses and physicians assistants obtain the training and have the experience to care for the majority of an average person's medical needs. Importantly, they can provide quality and personal care to those who are the most underserved, in rural and poverty-stricken areas.

COMMITTEE RECOMMENDATIONS

The House Committee on Public Health recommends that the 81st Texas Legislature establish a process to ensure more stability and continuous funding for graduate medical education to make Texas a net-importer of physicians in graduate training.

The House Committee on Public Health recommends that the 81st Texas Legislature provide funding for nursing school faculties to the point that the supply of qualified nurses meets the needs of Texans.

The House Committee on Public Health recommends that the 81st Texas Legislature investigate the necessity of various scope of practice limitations, and eliminate such barriers where scope of practice eliminates opportunity and does not improve access to or quality of care.

The House Committee on Public Health recommends that the 81st Texas Legislature investigate barriers in insurance and reimbursement that do not enhance quality of or access to care and undermine the selection and practice of primary care medicine. Where possible, these barriers to physician-directed medicine should be eliminated.

The House Committee on Public Health recommends that the 81st Texas Legislature direct all agencies to collaborate on a process to encouraging returning veterans, who are trained and qualified, to work as healthcare professionals. At a minimum, the legislative guidance should include the establishment of an interagency workgroup between the Texas Workforce Commission, the Texas Veterans Commission, the Texas Higher Education Coordinating Board, and the Texas Statewide Health Coordinating Council.

CHARGE # 10

PUBLIC HEALTH COMMITTEE OVERSIGHT

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

INTERIM STUDY

On November 30, 2007, Speaker Tom Craddick issued the "Public Health Committee Oversight" charge to the House Committee on Public Health. The House Committee on Public Health did not hold public hearings in relation to this interim charge, and does not assert any findings or recommendations.

Susan L. King
State Representative
District 71

COMMITTEES
VICE-CHAIR, HUMAN SERVICES
PUBLIC HEALTH
RULES AND RESOLUTIONS

COUNTIES
TAYLOR & NOLAN

The Honorable Tom Craddick
Speaker, Texas House of Representatives
PO Box 2910
Austin, TX 78768

Dear Speaker Craddick,

As a member of the House Committee on Public Health, I congratulate and thank Chairwomen Laubenberg, her staff and previous leadership of Rep. Delisi for all the hard work that has been put forth into this report. It is because of this that I have signed the report, however it contains recommendations that I cannot completely support.

After careful consideration, it is my belief that there are legitimate concerns when we examine the possibility of eliminating scope of practice limitations. If barriers to scope of practice are removed, it would open up the state to an avalanche of potentially under qualified medical personnel. While many of these medical professionals may be able to perform these aspects of care that they currently are not legally able to perform, I think it is paramount that we have personnel that are properly educated and trained so the appropriate level of care is provided for every person in Texas. I look forward to the upcoming hearings during the 81st Legislative Session where this issue can be more fully explored to find an alternate avenue that will expand the medical workforce in Texas to meet the needs of the state.

Sincerely,

Susan L. King
State Representative
Member, House Committee on Public Health

CAPITOL OFFICE: P.O. BOX 2910 • AUSTIN, TEXAS 78768-2910 • (512) 463-0718 • TOLL FREE (866) 463-0718
DISTRICT OFFICE: P.O. BOX 2376 • ABILENE, TEXAS 79604-2376 • (325) 670-0384
SUSAN.KING@HOUSE.STATE.TX.US • WWW.HOUSE.STATE.TX.US

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[12] Texas Coalition for Worksite Wellness, *Who We Are* <http://www.txworksitewellness.org/whoweare.aspx>, January 2008.
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[14] Enrado, Patty, *Humana finds success in offering wellness incentives*, Health Care Finance News, January 1, 2008.
[15] ibid.
[16] Sabre Holdings, *Sabre Holdings Named One of America's 15 Fittest Companies by Men's Fitness*, <http://www.sabre-holdings.com/newsroom/pdfs/1_14_08.pdf>, January 2008.
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[18] In testimony given to the Subcommittee, two related subjects cropped up several times: the roles of public teaching hospitals in trauma and indigent care, as well the scope of care provided to illegal immigrants and legal non-citizens. The Subcommittee recognizes that public teaching hospitals provide the trauma infrastructure for the entire state, while being affected by local indigent populations. However, the Subcommittee believes this issue of funding should be addressed separately by policymakers.

The Subcommittee also acknowledges that the question of what care should be provided to legal and illegal non-citizens often pervades the subject of indigent care. However, the Subcommittee believes that this question is better left to another discussion, in order that the counties can be clearly evaluated for their efforts towards indigent health care. This subject should certainly be addressed at another time, as it impacts both the availability of health resources, and the finances of the State. Nevertheless, the Subcommittee believes this question is out of the scope of the charge at hand.
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[21] Centers for Medicaid & Medicare Services, < http://www.cms.hhs.gov>
[22] Texas Health and Human Services Commission, *Tamper-Resistant Prescriptions* <http://www.hhsc.state.tx.us/hcf/vdp/Tamper_Resistant_Rx_Provider_Notice_FAQ.pdf>, July 2008.
[23] Texas Medical Association, *Tamper-Resistant Prescription Pads Delayed*, < http://www.texmed.org/Template.aspx?id=6239>, July 2008.
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[30] ibid, pg. 1
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[34] *Position Paper on the Medical Examiner Release of Organs and Tissues for Transplantation*, National Association of Medical Examiners, J. Keith Pinckard, et al, February 21, 2006, page 12.
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[36] ibid, pg. 28
[37] ibid, pg. 31
[38] ibid, pg. 52
[39] *Texas Asthma Control Plan*, Texas Department of State Health Services, Asthma Control and Prevention Program, 2007, page 6.
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[41] ibid, pg. 6
[42] *Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma*, US Department of Health and Human Services, National Heart, Lung, and Blood Institute, National Asthma Education and Prevention Program, 2007, page 37.
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[45] ibid
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[47] ibid
[48] ibid, pg. 215
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