INTERIM REPORT

TO THE 88TH TEXAS LEGISLATURE

HOUSE COMMITTEE ON PUBLIC HEALTH

NOVEMBER 2022

HOUSE COMMITTEE ON PUBLIC HEALTH
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2022

A REPORT TO THE
HOUSE OF REPRESENTATIVES
88TH TEXAS LEGISLATURE

STEPHANIE KLICK
CHAIR

COMMITTEE CLERK
TERI AVERY

Committee On Public Health

November 21, 2022

Stephanie Klick
Chairman

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

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

Dear Mr. Speaker and Fellow Members:

The Committee on Public Health of the Eighty-seventh Legislature hereby submits its interim report including recommendations for consideration by the Eighty-eighth Legislature.

Respectfully submitted,

Stephanie Klick

R.D. "Bobby" Guerra

Steve Allison

Liz Campos

Nicole Collier

Jacey Jetton

Jolanda Jones

Tom Oliverson

Four Price

Reggie Smith

Erin Zwiener

R.D. "Bobby" Guerra
Vice-Chairman

Members: Steve Allison, Liz Campos, Nicole Collier, Jacey Jetton, Jolanda Jones, Tom Oliverson, Four Price, Reggie Smith, Erin Zwiener

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INTRODUCTION

At the beginning of the 87th Legislative Session, the Honorable Dade Phelan, Speaker of the Texas House of Representatives, appointed eleven members to the House Public Health Committee. The committee membership included: Stephanie Klick, Chair; R.D. "Bobby" Guerra, Vice Chair; Steve Allison, Liz Campos, Garnet Coleman, Nicole Collier, Jacey Jetton, Tom Oliverson, Four Price, Reggie Smith and Erin Zwiener.

On February 28, 2022, Garnet Coleman resigned from the Texas House. On May 7, 2022, Jolanda Jones won the Special election to fill his unexpired term and on May 18, Speaker Phelan appointed Representative Jones to the Public Health Committee.

House Resolution 4, enrolled on January 15, 2021, gives the Public Health Committee 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 and the Texas Behavioral Health Executive Council 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 Hearing Instrument Fitters and Dispensers Advisory Board, the Texas Health Services Authority, the Texas Optometry Board, the Texas Radiation Advisory Board, the Texas State Board of Pharmacy, [the Interagency Obesity Council,] the Texas Board of Nursing, the Texas Board of Chiropractic Examiners, the Texas Board of Physical Therapy Examiners, the Massage Therapy Advisory Board, the Podiatric Medical Examiners Advisory Board, the Texas State Board of Examiners of Psychologists, the Texas State Board of Examiners of Marriage and Family Therapists, the Behavior Analyst Advisory Board, the State Board of Dental Examiners, the Texas Medical Board, the Advisory Board of Athletic Trainers, the Cancer Prevention and Research Institute of Texas, the Texas State Board of Acupuncture Examiners, the Health Professions Council, the Office of Patient Protection, [and] the Texas Board of Occupational Therapy Examiners, and the Texas Child Mental Health Care Consortium.

ACKNOWLEDGMENTS

The Committee gratefully acknowledges the assistance of all who helped with these studies and this report. We would like to offer our gratitude to Sandra Talton for her work on the HB 4 section of Interim Charge #1 and to Theresa Shirley for Interim Charges #5 and #6. We would like to acknowledge and thank all of the witnesses who presented and submitted testimony to the committee. This report is mostly comprised of the testimony presented or submitted to the Committee.

INTERIM STUDY CHARGES

On June 29, 2021, Speaker Phelan issued a series of interim charges related to the Texas-Mexico border to twelve committees. The interim charges presented an opportunity for the Committees to better understand the impact of what is currently happening along the state's border with Mexico, and to study and make recommendations for the best course of action.

The Public Health Committee received the following charge:

> Consider issues involving access to health care along the Texas-Mexico border, including, but not limited to, the ability to access providers, hospital capacity, pharmaceutical adequacy and whether any particularized training or education is necessary or appropriate.

In March 2022, House Speaker Dade Phelan issued the following interim charges to the House Public Health Committee:

> 1. Monitor the agencies and programs under the Committee's jurisdiction and oversee the implementation of relevant legislation passed by the 87th Legislature. Conduct active oversight of all associated rulemaking and other governmental actions taken to ensure the intended legislative outcome of all legislation, including the following:
>
> - HB 4, relating to the provision and delivery of telemedicine and telehealth services; and
> - HB 1616, relating to the Interstate Medical Licensure Compact.
>
> 2. Complete study of assigned charges related to the Texas-Mexico border issued in June 2021.
>
> 3. Study the impact of fentanyl-related overdoses and deaths in Texas. Evaluate existing data collection, dissemination, and mitigation strategies regarding opioid abuse in Texas. Make recommendations to improve coordinated prevention, education, treatment, and data-sharing.
>
> 4. Study current telemedicine trends by assessing and making recommendations related to standardizing required documentation healthcare providers must obtain for consent for treatment, data collection, sharing and retention schedules, and providing telemedicine medical services to certain cancer patients receiving pain management services and supportive palliative care.
>
> 5. Examine existing resources and available opportunities to strengthen the state's nursing and other health professional workforce, including rural physicians and nurses.
>
> 6. Assess ongoing challenges in the rural health care system and the impact of legislation and funding from the 87th regular and special sessions on strengthening rural health care and the sustainability of rural hospitals and health care providers. Evaluate federal regulations authorizing the creation of a Rural Emergency Hospital provider type and determine if promoting this type of facility could increase local access to care in rural areas of the state.

INTERIM CHARGE I: MONITORING

Monitor the agencies and programs under the Committee's jurisdiction and oversee the implementation of relevant legislation passed by the 87th Legislature. Conduct active oversight of all associated rulemaking and other governmental actions taken to ensure the intended legislative outcome of all legislation, including the following:

- HB 4, relating to the provision and delivery of telemedicine and telehealth services; and
- HB 1616, relating to the Interstate Medical Licensure Compact.

HB 4
RELATING TO THE PROVISION AND DELIVERY OF TELEMEDICINE AND TELEHEALTH SERVICES

HB 4 Background

The country's shutdown and social distancing requirements during the SARS COVID-19 pandemic significantly increased utilization of telemedicine and telehealth and transformed the delivery of healthcare services. Provision of services for Medicaid recipients, CHIP enrollees, and recipients of other applicable public benefits programs through telemedicine and telehealth technology methods is not entirely new in Texas. However, the rules and policies in place at the Texas Health and Human Services Commission (HHSC) pre-pandemic would not allow for many of these teleservices to continue to be utilized as during the pandemic when the public health emergency (PHE) ends. According to both provider and client stakeholders, teleservices methods have proven to be safe and effective and, now in many cases, are the preferred method for the delivery of healthcare services.

The intent of House Bill 4 (87R) was to ensure the adoption of rules, policies, and procedures by HHSC to make the option of the delivery of healthcare services through telemedicine and telehealth permanent when the PHE ends. The COVID-19 related PHE has been extended multiple times, and therewith the expanded benefits of teleservices, but the PHE is not unending. House Bill 4 requires that the utilization of the technological methods for remote delivery of health services be: under the guidance and rules adopted by HHSC; and with the stipulations that the virtual delivery of healthcare services is deemed cost and clinically effective; within the extent allowed under federal and state laws; and only if the telehealth service is desired by the patient, unless during an emergency or state of disaster. House Bill 4 was signed into law on June 15, 2021.

Interim Study on House Bill 4

At the hearing on September 13, the following invited witnesses testified on the provision and delivery of telemedicine and telehealth services:

Nora Belcher, Chief Executive Officer, Texas e-Health Alliance
Jessica Lynch, Director of Policy and Medicaid Operations, Texas Association of Health Plans
Emily Zalkovsky, Deputy State Medicaid Director, Texas Health and Human Services Commission

Health and Human Services Commission

Emily Zalkovsky, Deputy State Medicaid Director for the HHS, reported that during the COVID-19 PHE, HHSC allowed the expanded utilization of telemedicine, telehealth, and audio-only for many services in Medicaid and other benefit programs, and House Bill 4 required HHSC to permanently allow many of these services via telemedicine or telehealth, if cost effective and clinically effective.

Ms. Zalkovsky commented that House Bill 4 primarily impacts the Medicaid program, but that other health and human services programs are being coordinated with the implementation of the bill. She also stated that House Bill 4 primarily applies to the fee-for-service (FFS) policy and opens-up teleservices in FFS. She referenced that during the 86th Legislative Session, Senate Bill 670 instructed that Medicaid managed care plans have some flexibilities related to teleservices. She reported that due to flexibilities implemented during the COVID-19 PHE, utilization of teleservices by Medicaid recipients dramatically increased from 72,490 in 2019 to 885,903 in 2020 to 1,151,329 in 2021.

Components of House Bill 4 for HHSC to address include: telehealth and telemedicine, rural health clinics, remote delivery, home telemonitoring, network adequacy, access to care, member communication, the Medicaid application and renewal form, managed care assessments, and chemical dependency treatment facilities. Ms. Zalkovsky reported that the commission took a phased approach to implementation of House Bill 4. In Phase 1, during winter of 2021-22, the commission completed the initial analysis on several services for cost and clinical effectiveness; issued interim guidance to providers and direction to managed care organizations (MCOs); began rule making and policy development; and posted initial draft rules for public comment for managed care assessment and service coordination.

In Phase 2, during spring of 2022, the commission implemented the rural health clinic (RHC) changes to allow for patient site and distant site visits; submitted state plan amendments to the federal government; posted draft rules for public comment for teleservices, including behavioral health audio-only delivery; and issued some additional interim guidance. Chemical dependency treatment facility rules became effective March 3, 2022.

In Phase 3, during summer of 2022, the commission posted medical benefit policies for public comment and issued final provider notices about medical benefit policy changes.

In Phase 4, during fall of 2022 through the winter of 2022-23, the commission will implement MCO contract changes, and Medicaid provider manual and 1915c waiver manual changes; post proposed rules for public comment for managed care assessment and service coordination and behavioral health audio-only services in Medicaid; and adopt the rules in early 2023.
Ms. Zalkovsky emphasized that stakeholders, including advisory committees and clinicians, have been engaged throughout all phases. HHSC created a dedicated e-mailbox to receive input, HHSC_MCS_House_Bill_4@hhs.texas.gov and a website to keep stakeholders informed about comment opportunities, https://www.hhs.texas.gov/services/health/medicaid-chip/provider-information/medicaid-chip-teleservices.

She referenced a rubric chart entitled "Framework for Assessing Services" being utilized by HHSC to review considerations for assessing teleservices. She stated that for the services evaluated, if no evidence was found that something was not cost effective or clinically effective, or if no evidence was found that something was not going to work for patient health and safety, HHSC allowed that service in its policies.

Framework for Assessing Services

Evaluation Category	Assessment Question
Clinical Effectiveness	Are there indications (standards of practice, expert clinical opinion, professional judgement of subject matter experts, clinical guidance, medical evidence) that the service is **less** clinically effective when provided via audio/audio-visual than in person?
Cost Effectiveness	Is there any data indicating that the service itself is **more expensive** when provided via audio/audio-visual than in person?
Health & Safety	Are there reasons to believe that the service would pose **a health and safety risk** to clients if provided via audio/audio-visual rather than in person?
Client Choice & Access	Would client choice and access be **negatively impacted** if the service is provided via audio/audio-visual rather than in person?
Federal/State Laws (includes licensure)	Are there federal or state laws or regulations (including licensure requirements) that **prevent** the service from being delivered via audio/audio-visual?
Other	Are there any other **reasons for concern** about offering the service via audio/audio-visual rather than in person?

Ms. Zalkovsky identified numerous HHSC rule changes impacting remote delivery of Medicaid behavioral health services in FFS policy. New allowances include:

- Screening, brief intervention, and referral to treatment services;
- Health and behavior assessment and intervention services;
- Psychiatric diagnostic evaluation services;
- Mental health rehabilitation services;
- Peer specialist services; and
- Substance use disorder (SUD) counseling.

She also referenced HHSC behavioral health services rule changes in the youth empowerment services (YES) and home and community-based services – adult mental health (HCBS-AMH) FFS waiver programs.

Ms. Zalkovsky informed that changes in teleservices allowances in other state plan FFS policy, include:

- Case management for children and pregnant women (CPW);
- Several physical, occupational, and speech therapy services;
- Certain school health and related services, including physical, occupation, and speech therapy; and
- Early childhood intervention (ECI) targeted case management.

Additionally, changes impacting providers of services through waiver programs for persons with IDD in the community include:

- Severe physical, occupational, and speech therapy services; and
- Renewal assessments and focused nursing assessments in some programs.

House Bill 4 also included HHSC's adoption of rules impacting a managed care organization (MCO).

Ms. Zalkovsky explained that the HHSC draft rules allow flexibilities for MCOs for audio-visual delivery of managed care assessments and service coordination visits. A service coordination visit via teleservices would be allowed if the visit does not include an assessment or a resource utilization group (RUG) change. She further commented that assessments that must be done in-person are for people in a waiver, such as MDCP or STAR+PLUS HCBS. Initial assessments and annual functional reassessments are to be in-person as the environment needs to be analyzed. Also, in-person assessments are required for determining attendant care and in STAR Kids screening to determine nursing attendant care needs and for change-in-condition assessments that could require a change in the RUG level.

Related to the bill's requirement for HHSC's adoption of guidance for the option of MCOs to communicate with their members via text and email, Ms. Zalkovsky informed that HHSC has provided preliminary direction to the health plans. An IT system change is required by HHSC to transfer information to the health plan; the IT change should be finished, and this item completed by the end of the year.

Ms. Zalkovsky advised that the Center for Medicare and Medicaid Services (CMS) office was contacted by HHSC for guidance related to the requirement in House Bill 4 that Medicaid managed care plans be allowed to deliver home telemonitoring services to people with conditions that are not outlined in the state's statute and in HHSC's policy. She stated that HHSC was told by CMS that MCOs could not vary from the regular HHSC policy and be paid, but that the MCOs could provide the service voluntarily.

Ms. Zalkovsky expressed that since HHSC cannot allow for additional remote telemonitoring services, HHSC is reviewing home telemonitoring policies regarding flexibilities or adding services beyond what is currently allowed.

Chair Klick inquired about the state's current allowance for telemonitoring services. Ms. Zalkovsky advised that HHSC has a list of conditions that permit Medicaid payment for telemonitoring services, which includes hypertension and diabetes and some conditions of very high needs children.

Chair Klick asked if home dialysis telemonitoring is currently allowed. Ms. Zalkovsky responded that it is not currently allowed in their Medicaid covered telemonitoring services. Chair Klick emphasized the importance of blood pressure and weight monitoring in managing dialysis patients. She explained that changes in these can lead to more easily identifying changes in the condition of the dialysis patient. She asked Ms. Zalkovsky to investigate the including these services which could save substantial tax payer dollars.

Ms. Zalkovsky relayed that, related to the requirement in House Bill 4 concerning network adequacy standards, HHSC's network adequacy standards are based on time and distance. Thus, HHSC is changing the existing performance report and corrective action plan (CAP) process to incorporate teleservices into network adequacy access standards.

In closing, Ms. Zalkovsky referenced that HHSC will be issuing a telehealth report with additional data at the end of the year. She also said that HHSC will continue to review guidance from CMS, other research, and feedback from stakeholders in relation to teleservices. She reiterated that two draft rules related to House Bill 4 are still moving through the rulemaking process, and HHSC will continue to consider public comments.

Representative Price, author of House Bill 4, expressed appreciation for HHSC's work on implementation of the bill and commented that positive things are taking place and that a lot of good is being implemented and more is to come.

Representative Price asked questions to expound on requirements for in-person meetings, specifically, about which assessment meetings are not required to be in-person. Ms. Zalkovsky responded that the only one not required to be in-person is for a change-in-condition that does not lead to a change in someone's level of care, and thus, impact the cost ceiling. She added that the once-a-year waiver assessment and once-a-year assessment for services, such as attendant care, are to be in-person. However, MCOs have flexibility on service coordination visits.

The three levels of care were referenced. Regarding Level 3, Ms. Zalkovsky commented that in-person meeting requirements depend on the program, whether STAR+PLUS or STAR Kids. With STAR+PLUS at Level 3, no in-person is required, unless requested by the client. Level 3 for STAR Kids requires a minimum of one in-person for the STAR Kids annual assessment; the other three can be telephonic.

She continued that at Level 2, STAR Kids requires one minimum in-person service coordinator visit annually; the other visit can now be audio-visual. STAR Kids, Level 1, previously required four in-person meetings but now one in-person is required for the assessment, and the other three visits can be audio/visual unless for instance, a RUG change is needed, or the client chooses in-person. Ms. Zalkovsky further explained that MDCP and STAR+PLUS waiver clients must have one annual in-person waiver assessment and the other three visits could now be audio/visual. Regarding FFS and MCO requirements, Ms. Zalkovsky informed that the requirements differ; STAR Kids and STAR+PLUS are through managed care. Assessment visits for IDD waivers differ by program.

When asked about assessments after the PHE ends, and whether everyone will need an in-person assessment at that time, Ms. Zalkovsky responded that each client will need an in-person assessment and that HHSC is working with the health plans to coordinate and assess the length of time needed for compliance.

When asked about costs and the need for additional nurses, since the assessment and service coordination visits are by RNs and LVNs, Ms. Zalkovsky responded that additional staff may be needed, but that costs should not be different from pre-pandemic, as pre-pandemic the visits were in-person; rates were not adjusted for virtual.

Representative Price asked for clarification in areas of HHSC's analysis in determining clinical and cost effectiveness. Ms. Zalkovsky stated that HHSC asked CMS for guidance about assessments, and CMS responded that the state must obtain enough information to make a person-centered service plan and ensure health and safety/welfare. She relayed that for MDCP and STAR+PLUS clients, in-person provides the best assessment to see the environment to determine what equipment is needed and the abilities of the patient.

Representative Price expressed that some circumstances require an in-person assessment, but that sometimes the patient environment can be reviewed with an iPad, and asked if, in a lot of cases, assessments and investigations can be conducted with the use of technology. Ms. Zalkovsky responded that some questions could be addressed through audio-visual, but HHSC felt overall, that some items would not be clinically effectively if not done in-person. Representative Price commented that Texas has been a leader in utilizing telemedicine/telehealth to provide care and that some guidance by CMS has given permission for flexibility to use discretion. He urged utilization to the most flexible means possible.

Chair Klick mentioned that there are some very rare medical specialists. There may only be a few such specialists in the entire country with experience to care for certain rare conditions. She would hope that if a renown expert is in another region of the country that telemedicine would allow their services to be used here. Ms. Zalkovsky agreed and said they are allowed to fill in those gaps.

Chair Klick asked if assessments are considered clinical or administrative. Ms. Zalkovsky responded that she would need to ask the medical director – that a service coordinator is not a provider but does look at more than just administrative. [1] [2]

Texas Association of Health Plans

Jessica Lynch, Director of Policy and Medicaid Operations for the Texas Association of Health Plans (TAHP) expressed appreciation for HHSC's work on implementing rules for House Bill 4. Ms. Lynch commented that HHSC's proposed rules for implementing House Bill 4 do not take advantage of the opportunity to fully modernize Medicaid service coordination, and that families' preference to continue with telehealth service coordination and assessments is being ignored. She stated that telehealth is a safe and effective way to provide service coordination and assessments and that both the health plans and the Medicaid families want to keep the telehealth option.

She mentioned that the health plans are experiencing resistance to in-person visits and the most common reason is exposure to contagions. She commented that 80% of STAR Kids families, including MDCP families, are proactively choosing telehealth.

Ms. Lynch referenced the serious nursing workforce challenges. She stated that 170,000 kids in STAR Kids will need to be reassessed in-person at the end of the PHE. This will be very difficult with the shortage of nurses.
Representative Price asked how she reconciles HHSC's comment that costs should not increase as requirements are the same as pre-COVID. Ms. Lynch responded that more nurses will be needed and at a higher cost, as nursing salaries have increased due to the pandemic.

Responding to a question from Representative Guerra about where a pool of nurses would come from, Ms. Lynch advised that the action of hiring the number of needed nurses will take 6-12 months, and the impact will divert nurses away from clinical care.

Representative Collier asked when an in-person visit should be required. Ms. Lynch responded that an in-person assessment at the initial intake is appropriate, but beyond, the expectation is that the health plan and the member would discuss and determine what is appropriate.

Representative Collier asked about visits for the MDCP population and if they should be more eligible for telehealth. Ms. Lynch responded that the MDCP population is utilizing telehealth the most and that service coordinators talk to the patients' care attendants and service providers.

Representative Price asked for confirmation on a statement made in TAHP's written testimony about "There is no evidence that conducting assessments via telehealth jeopardizes the safety or welfare of patients…and in reality, many Medicaid members will be put at a greater risk if in-person visits are required." Ms. Lynch responded that she has not heard of any issues and that with the opportunity to have a different type of touch point with members, compliance is skyrocketing.

Ms. Lynch closed with statements referencing if teleservices are considered to be safe and effective for medical and psychiatric care, teleservices should be a safe and effective tool for assessments which are not clinical. She also referenced that service coordinator visits do not involve physical assessment, medical care, nor hands-on care, and is not clinical care. [3] [4]

Texas eHealth Alliance

Nora Belcher, Chief Executive Director for Texas eHealth Alliance, thanked the House Public Health committee for constantly being a champion for the use of telemedicine and telehealth. She stated that this journey did not start with House Bill 4. She also thanked HHSC staff and commented that at the beginning of the pandemic, HHSC embraced telehealth to promote social distancing and continue healthcare services for patients. She said that HHSC has been inclusive of stakeholders and has been communicative during the House Bill 4 implementation process.

She referenced continuity of care and stated that the beginning of the pandemic caused a pivot to virtual care. She relayed that the telemedicine and telehealth visits that started because of lockdowns and social distancing have become required to preserve access and continuity of care. She commented that telehealth and telemedicine should be viewed as being about integrating healthcare services for continuity of patient care. Ms. Belcher informed that Senate Bill 1107 (85R) required the standard of care for in-person visits and virtual visits to be the same.

She stated that stakeholders know that all medical care cannot be virtual and stressed that clinical effectiveness and cost effectiveness are important standards that can be met through teleservices. She referenced that thought has been put into how to provide virtual clinical care, and now thought should be put into how to perform virtual assessments. She expressed that House Bill 4 gives the tools to do so.

Ms. Belcher stated that technologies are the tools needed to continue to integrate healthcare services – the provider community wants to keep people out of higher cost levels of care, the patients want to be at home, and Medicaid is not shrinking. She stressed that every tool, including technology, is needed to deliver good clinical care and to be good stewards of tax dollars.

Representative Price commented about the language of bill being written with the desire to allow as many future technological flexibilities as possible, within the extent permitted by law. He asked if we are going far enough, what changes are needed, and if we are headed in the right direction. Ms. Belcher responded with reference to the state's remote patient monitoring (RPM) statute. She expressed that restricting the ability to monitor people in their homes to certain conditions is not reflective of needs in 2022.

She also mentioned standards of virtual assessment and possible clarification of the legislative intent, but that HHSC's final rule packet needs to be considered. She referred to new technology that will push the bounds of what has traditionally been considered telemedicine and telehealth. Ms. Belcher indicated that the Texas clinical services package is the best in the country and that "the envelope needs to be pushed" to go beyond traditional care for populations given provider shortages, etc. [5] [6]

IMPLEMENTATION RECOMMENDATIONS FOR HB 4

1) Ensure HHSC continues to review opportunities for delivery of services via technology. As the population of the state grows and the demand on finite healthcare resources becomes more stretched, and as technology advances and introduces products for more effective and efficient methods of delivery of healthcare services, HHSC should, via statute, have the authority to quickly adopt and allow for the greater utilization of teleservices, provided the service(s) is found to be clinically appropriate and cost effective, and has evidence of a positive impact on patient health and safety.

2) Review and address current laws relating to remote patient monitoring (RPM). Technology has advanced greatly over the past few years, and the opportunity for improved care, is now available. Additionally, people have become familiar with technology, and many prefer teleservices whether for convenience or to decrease the risk of infection from outsiders in the home or in an office visit. Texas' current law is very restrictive on conditions allowed for the utilization of RPM.

HB 1616
RELATING TO THE INTERSTATE MEDICAL LICENSURE COMPACT

Interim Study on House Bill 1616

At the hearing on September 13, the following invited witnesses testified on the Interstate Medical Licensure Compact:

Stephen Carlton, Executive Director, Texas Medical Board
Welela Tereffe, MD, MPH, The University of Texas M.D. Anderson Cancer Center

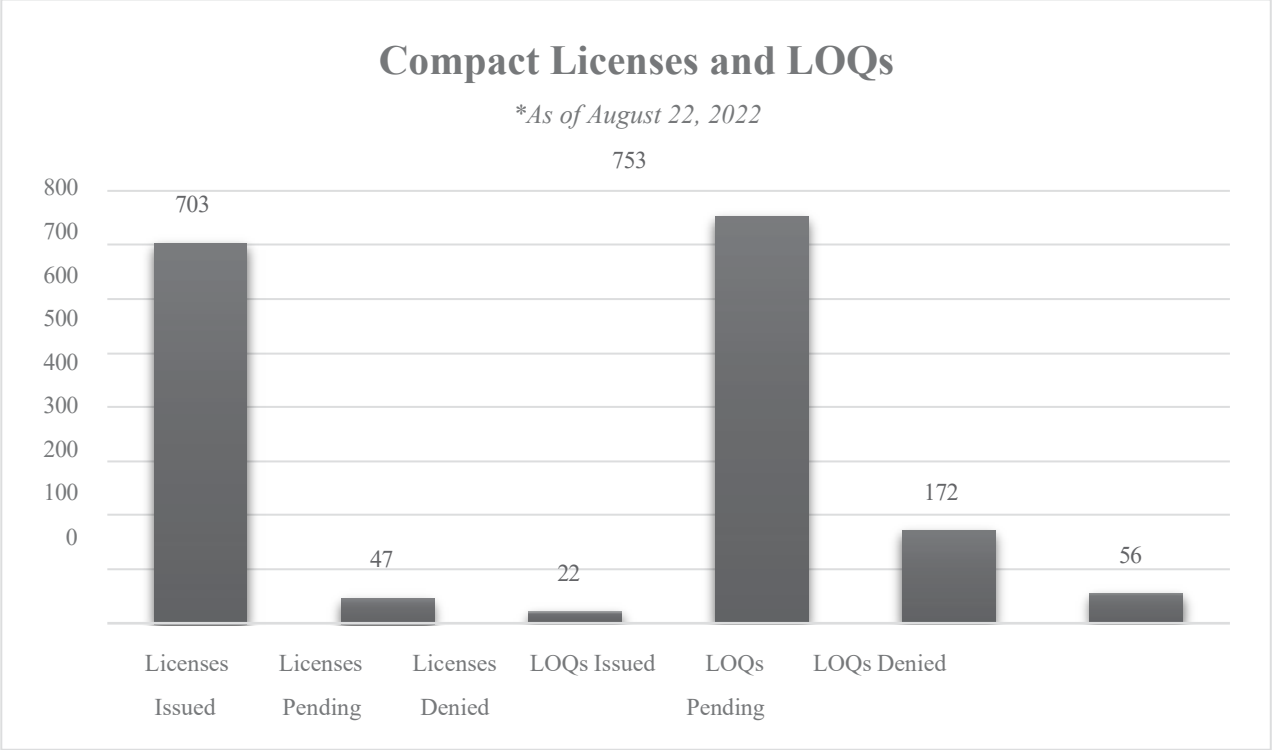
Stephen Carlton gave the committee background information and an update on the Interstate Medical Licensure Compact (Compact). The Compact is an agreement among participating U.S. states to work together to significantly streamline and expedite the licensing process for physicians who want to practice in multiple states. The mission is to increase access to health care – particularly for patients in underserved or rural areas. The goal is to extend the reach of physicians, improve access to medical specialists, and leverage the use of new medical technologies, such as telemedicine. While making it easier for physicians to obtain licenses to practice in multiple states, the Compact also seeks to strengthen public protection by enhancing the ability of states to share investigative and disciplinary information.

House Bill 1616 established the Compact in Texas. As of July 2022, 32 states and one territory were currently accepting applications for expedited licensure. Another five states and the District of Columbia were part of the compact but had not yet implemented full participation.

Physicians can qualify to practice medicine in participating states, if they meet certain eligibility requirements, by completing just one application within the Compact. The physician then receives separate licenses from each state in which they intend to practice. Although licenses are still issued by the individual states, the overall process of gaining a license is significantly streamlined because the application for licensure in each state is routed through the Compact. The Compact does not issue a “Compact license” or a nationally recognized medical license for physicians.

Before physicians can participate in the Compact, they must designate a State of Principle Licensure eligibility, complete an application, and then receive a formal Letter of Qualification from that state, verifying that they meet the Compact's strict eligibility requirements. The TMB's first Compact licensing date was March 18, 2022. As of August 22, 2022, the TMB had issued 703 licenses and 753 Letters of Qualification (LOQs). More than a half million dollars in applications fees and a quarter million dollars in LOQ fees had been generated in that same time. It takes an average of nine days to issue a Compact license and the 26 days to issue a Letter of Qualification. The following chart provides the most recent statistics on licenses and LOQs issued, pending, and denied.

Texas Medical Board: HB 1616 Update – September 13, 2022



Dr. Welela Tereffe gave the committee an overview of the positive benefits from the Compact. The Center saves time and money, and patients have increased access to their world class cancer care because of the Compact. The Center cares for patients in 14 states. The Compact will support licensure in eight of those. Compact licensure takes up to 30 days, whereas state-by-state licensure can take 10 months or more. Additionally, there has been a 45% cost reduction in licensing fees

versus licensing state by state. For the Center, this translates to at least $7 Million in savings in the first year alone.

About 550 of the Center's physicians chose to enroll in the Compact when it opened in March 2022. 136 licenses were secured across eight states in the first three months. Word has spread. The highly efficient process has attracted more physicians to enroll. As a result, the Center's on site and virtual capacity has increased. While Texans still receive the overwhelming majority of the Center's services, their strategy to maximize patient access to their world class cancer care has been boosted by the Compact.

UT M.D. Anderson and the TMB are collaborating to develop new efficiencies. UT M.D. Anderson's Medical Staff Office is developing relationships with medical boards and state officials to create further efficiencies across all states, for the benefit of all Texas physicians and hospitals. Additionally, UT M.D. Anderson's Legal Office is analyzing telemedicine and licensure regulations nationwide.

TMB laid out a goal to automate various processes associated with the administration of the Compact. Specifically, the agency is exploring ways to automate payment transactions, as well as the transfer of data between the TMB and the Compact Commission for applications, renewals, and LOQs. The agency is also seeking to scan and index existing TMB records (i.e., microfiche and microfilm) that currently require manual searching in order to validate LOQs. The automation of these activities will allow customers to benefit from a truly expedited application process by reducing manual searching and data entry work for agency staff.

MONITOR THE PROGRAMS UNDER THE COMMITTEE'S JURISDICTION

At the hearing on September 13, as part of Interim Charge 1 to monitor the agencies and programs under the Committee's jurisdiction and oversee the implementation of relevant legislation passed by the 87th Legislature, the Committee heard public testimony on the Compassionate Use Program (CUP). In 2015, SB 339 created CUP under the Department of Public Safety (DPS). CUP allowed for low-THC cannabis to be prescribed to patients with intractable epilepsy, a seizure disorder treated with two or more anti-epileptic medications without relief from seizures. After going through the rule making process, three dispensing organizations were licensed in 2017 and patients began receiving this medication in 2018. In 2019, HB 3703 expanded qualifying conditions to all epilepsies, added seven other conditions including terminal cancer and autism, and made minor statutory adjustments to the program. This past session, HB 1535 expanded qualifying conditions to include all cancers and post-traumatic stress disorder (PTSD), allowed institutional review boards to research the efficacy of low-THC cannabis on treating certain approved medical conditions, and increased the cap of THC in the medication from .5% to 1% THC.

Mike Thompson, a CUP patient, explained his experience and offered his gratitude to the Committee for establishing and expanding the program. He is a cancer survivor who has had 75 surgeries since the age of 10. Mr. Thompson lost six years of his life to prescription opioids as a result. The fog of opioids erased his work ethic, damaged relationships, and forced an early withdrawal from college. Since being on low-THC cannabis to treat chronic discomfort, his pain is kept in check, and he has experienced unprecedented levels of function and focus. He graduated from college with honors, earned a master's degree, returned to work, and lives a life completely free of opioids. Most importantly, he joyfully told the Committee, he married the woman of his dreams. The original version of the law did not allow him to use low-THC cannabis; he is very appreciative that all stages of cancer are now included.

Matthew Brimberry, a hospice and palliative care physician, a certified hospice medical director, and a palliative medical director for Austin Geriatrics also addressed the committee. He offered profuse gratitude for CUP in Texas. In his experience, it was a tremendous win for patients when

palliative care patients qualified to utilize CUP and qualifying conditions were expanded to cover such diagnoses as PTSD and all stages of cancer.

These witnesses did have three requests for the committee. First, expand CUP to allow low-THC cannabis to be a safe alternative to opioids for all patients suffering from chronic pain. They would like physicians to be able to prescribe this medication as they do all others. Chronic pain is not a qualifying condition for low-THC cannabis in Texas, so these patient's treatment options are limited to Tylenol and opioids. These can have negative side effects on their personal lives and physical health. Dr. Brimberry has a patient with pancreatitis that flairs up every couple of months, causing the patient to experience intense pain, nausea, weight loss and the inability to work. He treats them with anti-nausea medication and high doses of opioids. They'd like to try an antiemetic that is cannabinoid-based, but current law does not allow it. Additionally, he has many pediatric patients in his palliative care program who have rare genetic mutations that are not found in books and cannot be written into the law. He believes it is a disservice to not be able to give them a chance to try a medication that may work for them.

Second, lift the THC cap so that the best dosage can be prescribed without unnecessary side effects and expense to the patient. The current 1% THC cap does not restrict the amount of THC a physician may prescribe. Instead, it just requires the patient to consume an increasing amount of carrier oil to achieve symptom relief, which can lead to digestive issues and other side effects. Dr. Brimberry spoke of a colleague who was using another state’s concentrated cannabis and asked their assistance with a patient's pain. However, operating under current CUP limitations, the patient had to ingest so much of the oil that it made him secrete more digestive enzymes and caused more pain. Brimberry had to resort to opioids, which dulled the patient's mental capacity and made them sleepy. Another example he gave the committee included autistic adults who are quite aggressive. Medication from CUP has helped quell their aggressiveness so that their families can take them outside of their homes and pursue normal activities, like going on vacations. However, because of the current 1% THC cap, the additional carrying oil ingested causes gastrointestinal distress.

Third, ensure that patients have easy statewide access to their medication. For other prescriptions, patients can go to their local pharmacy. For CUP patients, the patient or caregiver must drive to

one of the three current dispensing organization's location to get their medication or have the dispensing organization deliver it to them. It would be a terrific service to the patients, living all over the state of Texas, if the dispensing organizations could have secure remote locations from which to store and dispense prescriptions. Many Texas patients live in rural parts of the state that are not close to one of these three locations, and they must rely on the dispensing organization's drivers to drop off their medication. This comes at a steep price to the dispensing organization, and the time delay for the patient can prove disruptive and very detrimental to the patient's health.

INTERIM CHARGE II: Border Health

Consider issues involving access to health care along the Texas-Mexico border, including, but not limited to, the ability to access providers, hospital capacity, pharmaceutical adequacy and whether any particularized training or education is necessary or appropriate.

BACKGROUND

About 2.8 million Texans live and work along the border with Mexico. The border encompasses diverse cultural, geographic, and socioeconomic populations. The border is geographically vast, spanning more than 1,254 miles. It is a gateway to the rest of the state with 28 international bridges and border crossings that facilitate not only trade and commerce but also the inevitable exchange of contagious diseases, such as tuberculosis, Zika, hantavirus, and COVID-19 – pathogens that do not stay along the border but instead quickly migrate throughout the state. While the border region's vibrant economy continues to grow, immense economic variation among border cities and counties remains, causing a lack of resources to address the living and working conditions, such as poverty, food insecurity, and environmental hazards, all of which contribute to higher rates of chronic disease and poor health outcomes.

The Department of State Health Services (DSHS) includes 32 counties as Texas border counties. These counties are within 100 kilometers of the Texas-Mexico Border. Four are metro counties; nine are rural; and 19 are frontier counties. Of those, 29 do not have a local health department. 12 counties have only a Federally Qualified Health Center (FQHC); two counties have only a DSHS office; and six counties have no public health provider. Overall, 26% of the Texas-Mexico Border population lives below the poverty level. 30% of those aged 25 or older have no high school diploma. The incidence of depression, diabetes mellitus and obesity are disproportionately high.
The Rio Grande Valley (RGV) encompasses the four southern-most counties in Texas including Cameron, Hidalgo, Starr, and Willacy with a population of somewhere between 1.5 and 1.8 million. The RGV is one of the most economically disadvantaged regions of the country, regularly ranking in the top ten most impoverished counties of the nation. 40% of all families in the region live below the federal poverty rate, which is twice the rate for the State of Texas as a whole. Unemployment ranges from 12 to 17%. Additionally, approximately 240,000 residents in the RGV live in informal settlements (colloquially referred to as "colonias") in unincorporated county areas with little or no infrastructure, substandard housing, and minimal or no access to essential services such as public utilities, health care, electricity, water, and fire and police protection. Lack of healthcare access for a large proportion of the RGV's population is rooted in extreme levels of economic and health disparities and compounded by unprecedented epidemics of chronic disease including diabetes and depression, fueled in part by high levels of adult and childhood obesity.

Statewide, 25% of Texans lack health insurance coverage. However, along the border, the numbers are worse. Hidalgo County has the highest overall uninsured rate in Texas – 31% – while South Texas is home to six of the most uninsured cities in the country. Among working-age border Texans, 46% lack health care coverage. Growing rates of uninsured imperil the border health care system, including the ability to attract and retain physicians. Prior to the COVID-19 pandemic, many small physician practices operated on exceptionally narrow margins because most of their patients are underinsured, uninsured, on Medicaid or Medicare, or dual-eligible. As the number of uninsured continues to increase, so too does uncompensated care, an unsustainable economic situation.

Border Health Care Workforce

Good health is dependent on access to medical care. While the Texas physician workforce trends are positive, Texas continues to experience physician shortages because of geographic and specialty maldistributions and continued population growth. Most of the counties along the border have no physicians and are categorized as both a health professional shortage area and a medically underserved area. When all the border counties are considered together, the ratio of people per physician is 1.7 times greater than for non border areas of Texas (868 people per border-area physician vs. 506 for non border). Even counties along the border that do have physicians lack physicians in many specialties. A recent state report indicates the RGV is projected to face growing critical shortages of physicians specializing in anesthesiology, family medicine, pediatrics, and psychiatry.

Pre-pandemic, there were 7,392 Registered Nurses (RN) in the RGV or about 507/100K population. This number is 37% less than Texas overall which averages 795/100K. Likewise, the ratio of Nurse Practitioners (NP) in the RGV to population, 28.9/100K, is more than 40% less than the Texas average of 50.2/100K. Texas has one of the lowest ratios of psychiatrists of any state in the nation. The RGV has 2.8 psychiatrists per 100K population, or about a third of Texas' low level of 7.5 per 100K. Interestingly, the lack of dentists is second only to psychiatrists. Texas, on average, has 46.8 dentists per 100K, whereas in the RGV it is 22.9 per 100K.14 The number of RNs and other health care workers is believed to have decreased even more since the pandemic. However, at the time of this writing numbers were not available.

Other areas of the Texas-Mexico border are more barren and rural than the RGV. The Big Bend

Regional Medical Center serves Alpine, Marfa, Presidio and the rural areas around it. In 2021, five family physicians, a family nurse practitioner, and a physician assistant left the Big Bend area of Texas. This loss accounted for over 50% of the health care provider workforce. More than half of all the health care providers in the region left. The size of the entire health care provider community was cut in half. As a result, next available appointments were 3 weeks out. Additionally, one of two sonogram technicians left the hospital, resulting in a reduction in the availability of both routine and emergent sonogram services at the hospital.

A reliable, safe, and cost-effective delivery system needs an ample supply of other health care professionals, including nurses. The border region struggles to attract and retain all health care workers. Rural health care organizations such as critical access hospitals and rural clinics have very few, if any, additional staff on reserve.

Public Health Infrastructure

Along the border there is a significant risk of infectious diseases such as Zika, tuberculosis, Chagas disease, and chikungunya due to environmental health factors such as improper wastewater and sewer services, greater internal and external migration, poor nutrition, and poor access to health care and health education. The risk of so many communicable and vector-borne diseases along the Texas-Mexico border continues to highlight the need for appropriate public health infrastructure, surveillance, and infectious disease response. Vulnerabilities of border counties' public health infrastructure was evident during the first stages of the COVID-19 pandemic. The Texas border experienced devastatingly high numbers of COVID-19 hospitalizations and deaths during the early stages of the pandemic compared with the rest of Texas and the entire nation. According to a joint report from Kaiser Health News and El Paso Matters, COVID-19 death rates of Texas border residents younger than 65 were three times higher than the national average and twice as high as the state average. The combination of such a high uninsured rate, large numbers of residents suffering from chronic diseases, and a shortage of health care workers along much of the border compounded the crisis. Physician and patient access to broadband remains a challenge. In rural areas along the border, particularly those areas lacking physicians or specialists, broadband could allow patients to receive the timely care, via telehealth, so important to good overall health.

INTERIM STUDY

On June 29, 2021, Speaker Phelan issued a series of interim charges related to the Texas-Mexico border to twelve committees. The interim charges presented an opportunity for the committees to better understand the impact of what is currently happening along the state's border with Mexico, and to study and make recommendations for the best course of action.

The Public Health Committee received the following charge:

> Consider issues involving access to health care along the Texas-Mexico border, including, but not limited to, the ability to access providers, hospital capacity, pharmaceutical adequacy and whether any particularized training or education is necessary or appropriate.

The Committee held a hearing in Austin on October 5, 2021, to gather information regarding the charge. The following persons testified:

Linda Villareal, MD, President, Texas Medical Association
Alberto H Gutierrez, MD, Medical Director, HOPE Family Health Center, Assistant Medical Director, DHR Health Hospice, Texas Hospital Association
Adrian Billings, MD, PhD, FAAFP, Chief Medical Officer, Preventative Care Health Services
Christina Paz, DNP, RN, FNP-C, Chief Executive Officer, San Vicente Family Health Center, Texas Nurse Practitioners
W. Terry Crocker, Chief Executive Officer, Tropical Texas Behavioral Health
Eddie Olivarez, Chief Administrative Officer, Hidalgo County Health & Human Services
Cindy Zolnierek, PhD, RN, CAE, Chief Executive Officer, Texas Nurses Association
Debbie Garza, R.Ph., Chief Executive Officer, Texas Pharmacy Association
Mack Gilbert, MedCare EMS
George Linial, President & CEO, LeadingAge Texas
Jamie Dudensing, CEO, Texas Association of Health Plans
David Gruber, Associate Commissioner, Regional and Local Health Operations Texas Department of State Health Services

Many witnesses addressed similar concerns in the Texas-Mexico Border area. In both the rural and urban areas of the border, there is a high incidence of poverty, serious chronic health conditions such as diabetes and obesity, infectious diseases and a lack of health care workers.

Dr. Billings gave the committee an eye-opening account of his first hand experience in the Big Bend area - including the towns of Alpine, Marfa and Presidio. He grew up in Del Rio and has a strong affection for the people, area and rural health. His rural exposure to frontier medicine during

training demonstrated the critical health care needs of the area to him. Since arriving in Alpine in 2007, he delivered babies, saw patients in the hospital, worked in the emergency room, performed house calls, traveled to outlying smaller communities without physicians to provide health care, stood on the sidelines of high school football games, hosted medical student and resident physician trainees, and saw patients in the now closed nursing home. While this type of practice can be incredibly rewarding, it is exhausting. The astonishing demand for health care in these rural communities far outweighs the number of providers. Of his six physician partners over the past decade, only two of them remain.[7]

Dr. Billings told the committee there are no extra or back-up health care workers in the rural health care system. Between February 2021 and October 2021, five family physicians, a family nurse practitioner, and a physician assistant left the Big Bend area. This loss accounted for over 50% of the area's health care provider workforce. As a result, next available appointments are three weeks out. Additionally, one of only two sonogram technicians left the hospital, resulting in a reduction in the availability of both routine and emergent sonogram services at the hospital. Multiple local nurses have relocated to higher paying positions in urban areas. The loss of nurses has been significant and most acute in the labor and delivery unit at the hospital. On July 5th, the hospital had to close the only labor and delivery unit between El Paso and Del Rio (which are over 400 miles apart) due to the shortage of labor and delivery nurses. Pregnant women in labor had to be diverted or transferred to the next available labor and delivery units in Ft. Stockton or even further to El Paso or Midland-Odessa. Those women whose labor was too far advanced for transport had to be delivered in the emergency room without labor and delivery trained nurses. The labor and delivery unit diversion to Ft. Stockton added a longer transport time for the lone ambulance from Presidio (90 miles away from Alpine). The additional 180 mile round trip for labor and delivery meant the Presidio ambulance was out of service for up to seven hours at a time for any additional emergency calls in the Presidio area. On one occasion during a diversion transport, a second 911 call came in for the same ambulance. There was not a crew or ambulance to respond to that emergency. This diversion increased the possibility of poor maternal and neonatal outcomes because of the extra time needed to transport patients to the safety of an adequately staffed labor and delivery unit, and the lack of services increased the possibility of poor medical outcomes for patients experiencing other emergencies in the Presidio area served by this one ambulance. One

patient in labor and in need of a repeat cesarean section left the emergency room to drive in a private vehicle to the hospital in Ft. Stockton because she was worried about the cost of the air medevac flight.

Mack Gilbert, representing the Texas Ambulance Association, concurred with Dr. Billings. There is widespread staffing shortages of certified emergency medical personnel for ambulance services. Additionally, the few employees they have are being recruited from them. Federal agencies and government contractors are actively recruiting these personnel for higher wages. [8]

At the time of the hearing, the labor and delivery unit was staffed in the short term with both FEMA nurses and nurses filling in from Odessa. Recently, owing to the loss of admitting physicians to the hospital and the increased workload for the remaining five family physicians in the Big Bend area, the hospital started a tele-hospitalist program for medical admissions at night so the local physicians can get more sleep. This telehealth service provides some virtual access to care but it is not as ideal as having physicians living locally and physically examining patients, according to Dr. Billings. Furthermore, recruitment and retention of rural physicians and the entire rural health workforce has become incredibly more challenging since the start of the COVID-19 pandemic.

Dr. Gutierrez explained to the committee that urban areas on the Texas-Mexico Border have health care access challenges as well. The RGV encompasses the four southern-most counties in Texas including Cameron, Hidalgo, Starr, and Willacy. These counties regularly rank in the top ten most impoverished counties of the nation and 40% of all families in the region live below the federal poverty rate, which is twice the rate for the State of Texas as a whole. Additionally, approximately 240,000 RGV residents live in informal settlements (colloquially referred to as "colonias") in unincorporated county areas with little or no infrastructure, substandard housing, and minimal or no access to essential services such as public utilities, health care, electricity, water, and fire and police protection. According to the latest U.S. Census, the RGV has a population of approximately 1.3 million. According to some, there was a significant undercount during the census, and it is believed that the actual population is somewhere between 1.5 and 1.8 million. Approximately 90% of RGV residents are Hispanic.[9]

For the past fifteen years, Dr. Gutierrez has served as the Medical Director for the HOPE Family

Health Center, a non-profit charitable clinic that provides free integrated medical and behavioral services to low-income and indigent residents of the RGV. During his tenure, the clinic has grown to include strong community partnerships and has more than 5,000 patient encounters a year.

According to Gutierrez, lack of healthcare access for a large proportion of the RGV's population is rooted in extreme levels of economic and health disparities and compounded by unprecedented epidemics of chronic disease (including diabetes and depression), fueled in part by high levels of adult and childhood obesity. The high poverty rate, high uninsured rate, and physician shortages faced in the RGV create significant obstacles to accessing healthcare which in turn results in many patients seeking care while in crisis at hospital emergency departments with advanced manifestations of disease. Consequently, the overall cost of treatment increases as does the demand and need for inpatient acute beds.

Poverty presents significant challenges to accessing preventative and primary health care services to manage chronic disease. Additionally, many simply go without medical care or medicines required to manage their chronic disease because of a lack of transportation, or they cannot afford the out-of-pocket costs for medical services, prescription medications, and co-pays and deductibles associated with having insurance.

Like the frontier areas of Big Bend, the RGV faces substantial shortages of physicians and nurses. All four counties of the RGV have long been classified as both Medically Underserved Areas (MUA) as well as Health Professional Shortage Areas by the Health Resources Service Administration (HRSA). In terms of the number of physicians, the RGV ranks 42% less than the Texas average.

In regards to nursing, the RGV is facing severe shortages. Prior to the pandemic, the RGV faced a nursing shortage, ranking 37% fewer registered nurses (RN) and 50% fewer Nurse Practitioners (NP) compared to the Texas average. During the COVID-19 pandemic, the RGV lost many nurses. One hospital, DHR Health, operates 519 licensed beds. As of the time of his testimony, that hospital alone had approximately 120 nursing positions open. Nurses are the backbone of the healthcare industry and nursing shortages will only exacerbate already significant access to

healthcare issues along the border region. Additionally, and importantly, the region has 40% of the rate of mental health professionals compared to the Texas average. With the COVID-19 pandemic taking a heavy toll on the mental health of all of us, the need for mental health professionals has only increased.

Dr. Gutierrez also brought nutrition to the committee's attention. Due to a lack of education regarding nutrition or simply a lack of affordable healthy food options, and food insecurity, there is a pandemic of chronic disease linked to obesity. Approximately 30% of children are food insecure, and most often the cheapest food available can be categorized as junk food. The prevalence of obesity and diabetes is an overwhelming determinant of health conditions in the region, including cardiovascular disease, chronic liver disease and liver cancer, peripheral artery disease leading to amputations, bone disease in older people, renal failure resulting in dialysis, retinopathy, and depression. Obesity alone is a significant health risk factor, and results in increased hospital admissions. The Rio Grande Valley suffers from high-rates of diabetes and associated health issues. People with diabetes are 2.6 times more likely to be hospitalized than a person without diabetes, and 30% of persons with diabetes were hospitalized two or more times in the past year.

Dr. Linda Villarreal, president of the Texas Medical Association and a practicing internist with 30 years of experience in Edinburg, a city within Hidalgo County, reiterated the health care conditions in the border region. In addition to the demographics, landscape, access to care and health care workforce issues. [10] Along the border there is a significant risk of infectious diseases such as Zika, tuberculosis, Chagas disease, and chikungunya due to environmental health factors such as improper wastewater and sewer services, greater internal and external migration, poor nutrition, and poor access to health care and health education. The sheer risk of so many communicable and vector-borne diseases along the Texas-Mexico border continues to highlight the need to ensure strong funding for appropriate public health infrastructure, surveillance, and infectious disease response according to Dr. Villareal.

She emphasized the effective use of health information technology to accelerate, streamline, and benefit patient care delivery and outcomes in the Texas health care system. Electronically sharing patient information includes the ability to access and confidentially share a patient’s medical

history regardless of when and where patients receive care. This improves timeliness, quality, and safety of patient care by reducing medical and medication errors; improves public health reporting; and reduces health-related costs. In 2019, HHSC released a health information technology strategic plan to comply with the 1115 Medicaid waiver renewal, citing the increased benefits of health information exchange (HIE) connectivity. Today, HIE connectivity remains a priority in the state's quality improvement metrics in the latest waiver negotiations. Connecting physicians to HIEs is vital to achieving interoperability across Texas, meaning physicians and health care facilities – such as hospitals, ambulatory care centers, and laboratories – can transfer patient record data so the most current information is available at the point of care. Establishing and implementing a "gateway" to modernize, standardize, and integrate existing state agency systems such as the prescription monitoring program and numerous registries and systems at the Department of State Health Services would provide a single connection point for physicians and health care providers to share and access crucial state data, improving patient care and outcomes. The passage of House Bill 5 during the 87th legislative session, which led to the establishment of the Broadband Development Office within the Office of the Comptroller, presents opportunities for improving the state's physical infrastructure, which impacts access to health care. Physician and patient access to broadband remains a challenge, particularly in rural areas; full implementation of HB 5 and the build-out of a truly statewide broadband network will help ensure all patients who need care, particularly along the border where fewer physicians practice, can receive the timely care so important to good overall health.

Christina Paz, representing the Texas Association of Nurse Practitioners, spoke to the committee about her experience in El Paso and at Centro San Vicente specifically. Dr. Paz is a Family Nurse Practitioner and Chief Executive Officer for Centro San Vicente in El Paso, one of three Federally Qualified Health Care Centers located in El Paso County. The purpose of FQHCs is to provide evidence-based, high quality, primary health care to any and every individual regardless of ability to pay.[11]

The city of El Paso has a population of 680,000, while El Paso county has 837,000 residents. The poverty rate for the area is 20%. To serve those residents, there are approximately 633 Nurse Practitioners and 512 primary care physicians. Access to care is limited.

El Paso made headlines as one of the worst-hit communities during the height of the COVID-19 crisis. During the pandemic, in 2020, Centro San Vicente cared for over 14,000 patients, with 60% of those individuals either unfunded or underfunded. Nurse practitioners were at the forefront of providing primary care. The proactive nurse practitioners understood the importance of educating the community on safe practices and vaccinations. By the time of the hearing, the community made headlines of a different nature: a success story, a community with one of the highest vaccination rates and lowest infection rates. Border communities like El Paso face unique socioeconomic, environmental, and regulatory challenges. To improve border health, these issues must be addressed, as well as the social determinants of health that impact patients. Dr. Paz told the committee that nurse practitioners are in a unique position to do that.

Jamie Dudensing, CEO, Texas Association of Health Plans, addressed the physician and provider shortages along the border. Health plans are required to provide adequate networks for their service areas based on time and distance standards and be capable of providing all covered services. If no providers are available in the service area, health plans assist enrollees in finding care through short or long-distance travel, providing assistance in scheduling appointments or telemedicine. The vast majority of health plan network "gaps" are because there is no licensed provider available in the service area. Health plans continuously monitor for new providers. According to the recent DSHS report - *Texas Physician Supply and Demand Projections, 2018 - 2032*: – the RGV region is projected to face critical shortages of physicians specializing in anesthesiology, family medicine, pediatrics, and psychiatry. Critical shortages in West Texas include family medicine, pediatrics, and psychiatry.[12]

According to Dudensing, Advance Practice Registered Nurses (APRN) are a key part of the solution to increasing access and options for Texas. Removing outdated delegation barriers will lead to increased health care access and quality care, especially in primary care, mental health care, and in rural and underserved areas. Under current Texas law, APRNs, such as nurse practitioners, are required to sign and often pay thousands of dollars for a contract with a physician before they can do the job they have been trained and licensed to do. But a large and growing mountain of evidence shows that removing these requirements for APRNs eases health care providers shortages, improves quality of care, and reduces health care costs.

The National Academy of Medicine, one of the most respected physician advisory boards in the United States, recently renewed their recommendation that "All organizations, including state and federal entities and employing organizations, should enable nurses to practice to the full extent of their education and training by removing barriers that prevent them from more fully addressing social needs and social determinants of health and improving health care access, quality, and value." States with APRN delegation requirements, like Texas, have up to 40% fewer primary care nurse practitioners than states that have eliminated these barriers. 7.4 million Texans live in a primary care health professional shortage area. Eliminating the required delegation in Texas immediately improves most of the primary care provider gap.

31 States and the District of Columbia have ended outdated physician delegation barriers for APRNs. 19 additional states, including Texas, waived delegation during the pandemic. More than 30 Texas organizations support ending these outdated regulatory barriers.

Debbie Garza, R.Ph, and Chief Executive Officer of the Texas Pharmacy Association, informed the committee of the role pharmacists fulfill along the border and in other rural areas of the state. According to Garza, pharmacists are the state's most accessible healthcare providers, and interact with patients more often than other types of providers on average. For residents of sparsely populated areas, including many parts of the border, pharmacists may be the only accessible healthcare provider. Pharmacists often help fill the gaps in healthcare. During the pandemic, pharmacists administered 70% of vaccines nationwide. [13]

Garza told the committee that medication non-adherence costs the United States more than $300 billion annually. In Texas alone, non-adherence associated with diabetes, high blood pressure, and high cholesterol costs Texas $10 billion annually. 50% of people with chronic disease do not take their medications correctly. Pharmacists are well qualified to provide medication management services, which can include things like programs to increase medication adherence, programs designed to manage asthma patients to reduce emergency room utilization, and diabetes management programs. In a pharmacy initiative in rural Maryland, pharmacists were deployed to manage the pharmacy's diabetes education and training clinic to help identify medication-related events such as medication adherence issues and drug-drug interactions. The pharmacists

discovered that roughly a quarter of medications taken by the patients were over-the-counter, which many patients did not believe they needed to disclose when asked about their medication history. The initiative helped identify a strong correlation between OTC medications and adverse drug events.

George Linial, President & CEO of Leading Age Texas which represents the full continuum of not-for-profit aging services providers, expounded on the concerns facing nursing facilities. Texas nursing facilities have struggled with a statewide direct-care workforce shortage for many years according to the Texas Center for Nursing Workforce Studies. COVID-19 increased demand for direct care staff across the health care sector making the situation dire for long-term care providers. Mr. Linial stated that these challenges are not particularly regional. Recruiting and retaining qualified staff has become more difficult than ever, having a downstream impact on access to care, quality of services, and operating costs. LeadingAge Texas and the Texas Health Care Association recently conducted a workforce-focused survey of its members. The survey found that long-term care communities experienced a 12% decline in employment since the start of the pandemic. 30% of long term care facilities have limited new admissions due to staffing shortages. All of them have unfilled Certified Nurse Aide positions; 94% have unfilled Licensed Vocational Nurse positions; 22% have unfilled Registered Nurse positions; and 90% have unfilled dietary, laundry, and housekeeping positions. Due to these shortages, 76% are using more overtime and double shifts than one year ago. To adequately staff, 61% are using temporary staffing agencies, 28% of those using staffing agencies said they have staffing requests unable to be met. When asked why positions are vacant, 70% said they cannot compete with other employers, 63% had no applicants, and 54% had no qualified applicants. Other common responses included staff leaving to work for higher paying staffing agencies and staff resignations due to the federal vaccination mandate. In August 2021, there were 1,358 staff resignations compared to 1,403 new hires.[14]

Using federal relief funds, Texas spent just over $5 billion to support staffing needs in healthcare facilities throughout the pandemic. According to DSHS, only $57.6 million or about 1% was reported for nursing facility medical staffing and assessments. Stable staffing is the number one indicator of quality of care in nursing homes, Linial said. Additionally, the increasing cost of staff turnover diverts resources from actual patient care. The current situation facing long term care

services and supports, particularly as it relates to staffing is unsustainable. Utilizing staffing agencies to temporarily fill positions is not financially feasible for most providers and it doesn't solve the staffing crisis in the RGV or in any other region of Texas.

David Gruber, Associate Commissioner, Regional and Local Health Operations, Texas Department of State Health Services, gave an overview of the demographics of the region and the border health commissions, councils and programs at DSHS. He reiterated the demographics in the border region including chronic diseases and high poverty rates. Additionally, he outlined the mission of the Office of Border Pubic Health - to improve health and well-being along the Texas-Mexico border and its goals.[15]

All four U.S. southern border states - Texas, California, Arizona, and New Mexico - have border health offices. In 1991 Texas required DSHS to maintain an office in the department to coordinate and promote health and environmental issues between this state and Mexico. DSHS is involved in the binational health councils, a tuberculosis program and infectious disease surveillance. The Task Force of Border Public Health Officials identifies and raises awareness of health issues impacting border communities and establishes policy priorities to enhance border public health and create a healthy binational community. The Task Force makes recommendations to the DSHS commissioner for short-term and long-term border health improvement plans. Their primary topics of interest include access to preventative and specialized healthcare services, lack of transit systems and transportation, especially in rural areas, high population of elderly living alone and high population of uninsured or underinsured residents.

RECOMMENDATIONS

Creation of a Texas Center for Rural Health Education.

A Texas Center for Rural Education should be established. The Center should be based on programs such as the National Center for Rural Health Professions (NCRHP) at the University of Illinois Health Sciences Campus-Rockford. NCRHP seeks to address the health care professional needs of rural residents in Illinois, as well as around the nation and the world. Along with research, they recruit, educate and train students beginning in high school. Through partnerships among high schools, higher education institutions, health centers and hospital systems, rural students are given the opportunity to learn and train where they live. By establishing this model in Texas, more rural recruits would be able to obtain the education needed in their own communities and then provide professional health care services in those same communities once they graduate and are licensed.

Texas has a patchwork of programs spread across a number of agencies. They are either unfunded or underfunded. At the Higher Education Coordinating Board, there are multiple student loan forgiveness and reimbursement programs for physicians, nurses and specialty areas. The Outstanding Rural Scholar Recognition Program at the Texas Department of Agriculture (TDA) is a competitive loan forgiveness program for rural health care professionals. The State Office of Rural Health (SORH) at the TDA provides services, programs and grants for rural health in the amount of approximately $3.5 million per year. These programs use both federal funds and state general revenue. The federal government provided some assistance from the American Rescue Plan Act disbursed by the Office of the Governor as well. These are just a few of the disparate programs in Texas.

Already some community colleges and university systems in Texas are partnering with high schools and local medical systems to provide nursing education in these vastly underserved areas. These programs should be expanded to include other health care professionals. More graduate medical education opportunities in rural areas and needed ancillary services such as emergency medical technicians and imaging specialists should be trained locally if possible. Establishing one, coordinated center for rural health education, partnering with university and hospital systems

throughout the state is an enormous undertaking. By having a centralized program that examines the needs and resources available throughout the entire state, much of the rural health disparities in the state could be alleviated.

Fund border and frontier health care loan and tuition reimbursements

Although there is a shortage of some health care professionals throughout the state, adequately amending and funding existing loan forgiveness and tuition reimbursement programs to target health care professionals who serve in border or frontier health care areas would augment the workforce in those regions. The program eligibility should be amended to require service in frontier or border areas for a specific amount of time for increasing loan forgiveness and tuition reimbursement and give preferential treatment to students from these geographic areas.

Codify specific public health emergency waivers

During the COVID public health emergency, facilities like federally qualified health centers (FQHC), providers, and patients benefited from a number of regulatory waivers. The committee heard testimony regarding sole health care providers that were 50 or 100 or more miles apart. Additionally, these same providers told the committee of other upcoming regulatory burdens. By maintaining these waivers for specific rural and underserved areas and allowing health care providers to practice up to their education and training level, local residents would not be in fear of losing their current level of health care.

Boost Technical Infrastructure

With the COVID pandemic came rapidly increasing telemedicine options. These telemedicine options could increase and improve health care access for Border residents. Appropriate broadband and technical infrastructure needs must be addressed. Boosting the technical infrastructure in the state must be a priority to improve access to health care through virtual visits and increase the robust exchange of health information ensuring the right information at the point of care to enhance care decisions for better outcomes.

Socioeconomic Factors

The committee heard repeatedly from witnesses that a variety of factors contributed to certain chronic health problems in the border region. It is important to treat the whole person. Oftentimes, the community health clinic staff recognize the many socioeconomic factors impacting the health of their clients. Lack of fresh healthy food options, lack of a refrigerator to refrigerate medicines that require refrigeration, lack of mental health services, and lack of adequate housing with appropriate plumbing and utilities all contribute to chronic disease and increase hospitalizations and health care costs. The committee should continue to study these socioeconomic contributing factors and urge the various public and private health care providers to analyze the cost benefit of addressing these issues.

Transportation

The committee urges HHSC to research grants and other sources of revenue to fund more emergency medical transportation in the border area.

INTERIM CHARGE III: Fentanyl and Opioid Overdoses

Study the impact of fentanyl-related overdoses and deaths in Texas. Evaluate existing data collection, dissemination, and mitigation strategies regarding opioid abuse in Texas. Make recommendations to improve coordinated prevention, education, treatment, and data-sharing.

BACKGROUND

Fentanyl is a potent synthetic opioid drug approved by the Food and Drug Administration for use as an analgesic and anesthetic. It was first developed in 1959 and its use as an intravenous anesthetic began in the 1960s. Fentanyl is approximately 100 times more potent than morphine and 50 times more potent than heroin. It is legally manufactured and used in the United States.[16] Fentanyl is also illegally manufactured and brought into Texas. According to the US Customs and Border Protection (CBP), fentanyl seizures along the Texas border have increased dramatically in recent years. In calendar years 2019 and 2020 the weight of their seizures was 107 pounds and 126 pounds respectively. However, in 2021 their seizures increase almost ten fold. CPB seized 1,100 pounds of fentanyl on the Texas Border in 2021. At the time of this writing, their seizures were on par with those of the previous calendar year.[17]

About two-thirds of Texas Department of Public Safety (DPS) fentanyl cases involve pills that are made to look like other pharmaceuticals. More than half of those are made to look like oxycodone. However, not all fentanyl deaths have occurred from fake pills. It is occasionally found in illicit drugs such as heroin and cocaine. Of the altercated hydrocodone tablets that DPS tested, the average concentration of fentanyl was 0.717 mg. Oxycodone tablets are smaller than Hydrocodone tablets. The fentanyl concentration of the seized counterfeit Oxycodone that DPS tested, ranged from 0.125 mg to 5.127 mg per tablet.[18] A 2 milligram dose of fentanyl is lethal. For comparison, a gram of sugar is only a quarter of a teaspoon. The equal weight of fentanyl contains 500 lethal doses. Enough fentanyl was seized in Texas last year for nine lethal doses for every man, woman, and child in the state.

Fentanyl overdoses are the number one cause of unintentional deaths for adults ages 18-45 in the United States. Texas is in the third and most severe wave of the overdose crisis. In the late 1990s, prescription opioids caused a spike in overdose deaths. This transitioned to increasing heroin deaths as prescribing policies tightened. We are now experiencing the worst increase yet, driven by potent synthetic opioids like fentanyl that are produced illicitly and sold on the street. In Texas there was a 78% increase in opioid-related overdose mortality for the 12-month period ending March 2022 when compared to March 2020. [19]

Data show that many individuals without substance abuse disorders are dying from fentanyl overdoses. According to some, most fentanyl-related deaths occurred to individuals who did not realize they were taking fentanyl. These persons took fatal, look alike counterfeits that they most likely believed were prescription pharmaceuticals, purchased or obtained outside of the healthcare system. Drug cartels supply most fentanyl in Texas. Many are manufactured to look like prescription pharmaceuticals. Others are made to look like candy. [20]

INTERIM STUDY

The Committee held a public hearing in Austin on September 13, 2021 to gather information regarding the following charge:

> Study the impact of fentanyl-related overdoses and deaths in Texas. Evaluate existing data collection, dissemination, and mitigation strategies regarding opioid abuse in Texas. Make recommendations to improve coordinated prevention, education, treatment, and data-sharing.

The following persons were invited to testify:

Debbie Garza R.Ph., Chief Executive Officer, Texas Pharmacy Association
Brady Mills, Chief, Crime Laboratory Division, Department of Public Safety
Lisa Wyman, Director, Center for Health Statistics, Department of State Health Services
Brad Fitzwater, MD, Substance Use Medical Director, Texas Health & Human Services Commission
Kasey Strey, Director, Texas Targeted Opioid Response, Texas Health & Human Services Commission
Jennifer Potter, MD, Vice President for Research, Professor of Psychiatry and Behavioral Sciences,The University of Texas Health Science Center at San Antonio
C. M. Schade, MD, PhD, PE, representing the Texas Medical Association
Brittany Jones representing the Opioid Treatment Coalition

The following persons provided public testimony:

Brittney Ackerson representing herself and Corazon Ministries Harm Reduction
Kristin Aldred Cheek representing Stericycle
Scott Dion representing himself and Corazon Ministries Harm Reduction
Monica Dyer representing herself and Yanawana Herbolarios
Cynthia Humphrey representing the Association of Substance Abuse
Maggie Luna representing herself and the Statewide Leadership Council
Sam Mayfield representing Texans for Strong Borders
Jake Neidert representing Parker County Conservatives
Sarah Reyes representing Texas Center for Justice & Equity
Kevin Roy representing Shatterproof
Madelein Santibañez representing herself and Corazon Ministries Harm Reduction
Steve Smith representing himself and Texas Harm Reduction Alliance
Paulette Soltani representing herself and Texas Harm Reduction Alliance
Becky Stewart representing herself and A Change for Cam
Stefanie Turner representing herself

Debbie Garza R.Ph., Chief Executive Officer, Texas Pharmacy Association reminded the committee of the Texas Prescription Drug Monitoring Program (PMP) which was legislatively enacted during the 85th Legislature (2017). The legislature funded enhancements to the PMP in 2019 that provided for statewide integration to allow for immediate access through the electronic health record and/or pharmacy management system, as well as a visualized analytics. The PMP requires all Texas licensed pharmacists to report all controlled substances that are dispensed within one business day. The program collects and monitors outpatient prescription data for all Schedule II, III, IV and V controlled substances (CII-CV) dispensed by a Texas pharmacist. Having one central, accessible repository of this information allows prescribers and dispensers to identify potential signs of misuse by examining a patient's complete controlled substance history. Patients who attempt to obtain prescriptions for controlled substances from multiple physicians and filling those prescriptions at multiple pharmacies can be quickly identified through the PMP. Since March 1, 2020, pharmacists and prescribers are required to check the patient's PMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol. In 2019, the legislature passed a number of wide ranging bills addressing opioids. One omnibus bill, HB 2174 from 2019, mandated electronic prescribing for all controlled substance (II-CV) prescriptions, with exceptions for certain situations like emergencies and under a waiver program. By eliminating the use of paper prescriptions, it greatly reduced the incidence of fraudulent paper prescriptions presented at a pharmacy. Perhaps most significantly, the legislation mandated that a practitioner may not prescribe more than a 10-day supply of an opioid for acute pain, nor may they provide for a refill of an opioid for acute pain. This provision received considerable discussion and debate at the time, and it has had a positive impact to reduce the amount of unused prescription opioids.

Also in 2019, the legislature passed House Bill 2088 to increase awareness regarding the safe disposal of controlled substances. The law requires pharmacies to provide written notice regarding the safe disposal of controlled substances when dispensing an opioid prescription. The Drug Enforcement Administration (DEA) maintains an up-to-date, user-friendly site for such purposes. In addition to pharmacies that maintain collection receptacles, many pharmacies provide with the dispensing of an opioid prescription DisposeRx which is a non-toxic solution for the disposal of unused or expired medications. When water and the DisposeRx powder are added to prescription pills, tablets, capsules, liquids or powders, they are chemically and physically isolated in a polymer

gel made from materials that are FDA approved can then be thrown away in the household trash. At some pharmacies, customers can purchase pre-paid mailers for unwanted medicines.

Since 2015 pharmacists in Texas have been able to dispense opioid antagonists such as naloxone, which includes amongst others brand name Narcan, under a standing order. Opioid antagonists are drugs that block the effects of opioids, and are commonly referred to as overdose reversal drugs. Currently there is a physician-signed standing order that is available to any Texas pharmacist to allow for this.

Brady Mills, Chief, Crime Laboratory Division, DPS, gave the committee current statistics he had with regards to fentanyl cases and seizures. DPS has had a significant increase in the number of cases involving fentanyl, but not in the amounts by weight seized. There is no central data repository in the state for the amount of fentanyl seized. CPB provides monthly updates online of their fentanyl seizures in Texas. DPS does not provide their information online. Also, some local law enforcement agencies have crime laboratories that are capable of processing seized drugs. Those local agencies do not compile data for the state. Other local law enforcement agencies that do not have the proper facilities send their seized drugs to DPS.

Lisa Wyman, Director, Center for Health Statistics, Department of State Health Services (DSHS) informed the committee about death statistics. DSHS collects data from local medical examiners and justices of the peace. DSHS analyzes the data based on ICD-10 codes. The International Classification of Diseases, Tenth Revision, Codes is a classification system of diagnosis codes representing conditions and diseases, related health problems, abnormal findings, signs and symptoms, injuries, and external causes of injuries and diseases. ICD-10 codes were developed by the World Health Organization (WHO) . ICD-10-CM (codes) are maintained by CDC's National Center for Health Statistics under authorization by the WHO.[21]

There are codes used for cause of death - unintentional, suicide, homicide and undetermined - and separate codes for specific drug - opium, heroin, methadone, other opioids. There is no specific code for fentanyl. Fentanyl and its analogues are classified under the code for other synthetic narcotics. Unless the death certificate specifically identifies 'fentanyl' in the cause of death field

and is not misspelled, fentanyl as cause of death will not be recorded by the DSHS. Even with those cracks in the system, the number of deaths attributed to fentanyl in the state are growing exponentially as shown in the table below.

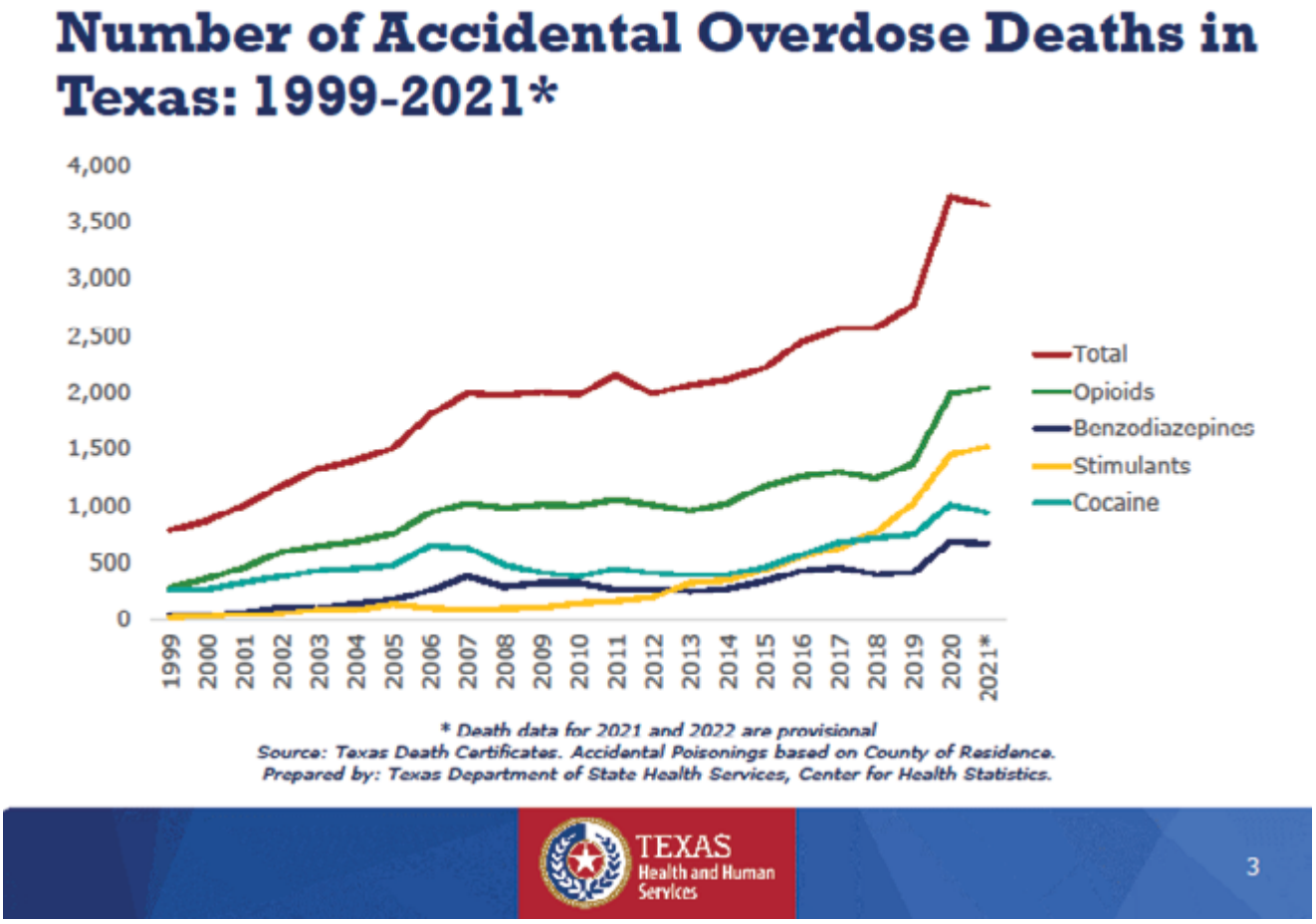
Percentage of Unintentional Synthetic Opioid Deaths where Fentanyl was Involved, 2018-2022

By Residence

"Fentanyl" present		2018	2019	2020	2021^	2022^
No	Total	94	64	95	80	19
	Percentage	30.92	16.80	9.68	4.73	2.73
Yes	Total	210	317	886	1,612	676
	Percentage	69.08	83.20	90.32	95.27	97.27

Department of State Health Services, Written Testimony presented to the House Committee on Public Health, September 13, 2022

Brad Fitzwater, MD, Substance Use Medical Director, Texas Health & Human Services Commission (HHSC) repeated the latest opioid death statistics to the committee. Opioid-related overdose deaths increased 56% from December 2019 to March 2022. Data on deaths from specific type of opioid overdoses varied substantially. Deaths from heroin decreased during this period and deaths from prescribed opioids continued at about the same rate. Deaths from synthetic opioids dramatically increased. The chart on the following page illustrates the data.



Dr. Fitzwater stated that people with opioid use disorder who receive medication treatment are 75% less likely to die from any substance use disorder than those who do not receive those medications. Medication treatment decreases overdose and death, relapse, withdrawal symptoms, craving, criminal justice involvement and infectious disease transmission.

In follow-up documentation to the committee from Jennifer Sharp Potter, PhD, MPH, Professor of Psychiatry and Behavioral Sciences, Long School of Medicine; Executive Director, *Be Well Texas;* Vice President for Research, *UT Health San Antonio*, evidence-based treatment for opioid

use disorder was further explained. These treatments include both medication and behavioral therapies. Office Based Opioid Treatment (OBOT) uses medications include buprenorphine, methadone, and naltrexone. OBOT allows primary care prescribers to dispense or prescribe buprenorphine and naltrexone. Opioid Treatment Programs provide medication-assisted treatment for opioid use disorder under federal (42 Code of Federal Regulations section 8) and state (25TAC, Part 1, Chapter 229, Subchapter J) guidelines. Behavioral therapies include cognitive behavioral therapy and contingency management.

Potter's testimony to the committee focused on the growing threat of overdose deaths resulting in the influx of fentanyl contaminants in the illicit drug supply in Texas. She told the committee that in Texas, it is estimated that one in five people over age 12 have used illicit drugs in the past year and that one in 10 Texans meets criteria for a substance use disorder. Of those, only 10% will receive treatment and even fewer will have access to an evidence-based treatment, that is demonstrated to work by a preponderance of the evidence, according to Potter. She highlighted solutions for accessible drug treatment through *Be Well, Texas* (https://txmoud.org/) and addressed the challenges drug paraphernalia laws create to drug testing for overdose prevention.

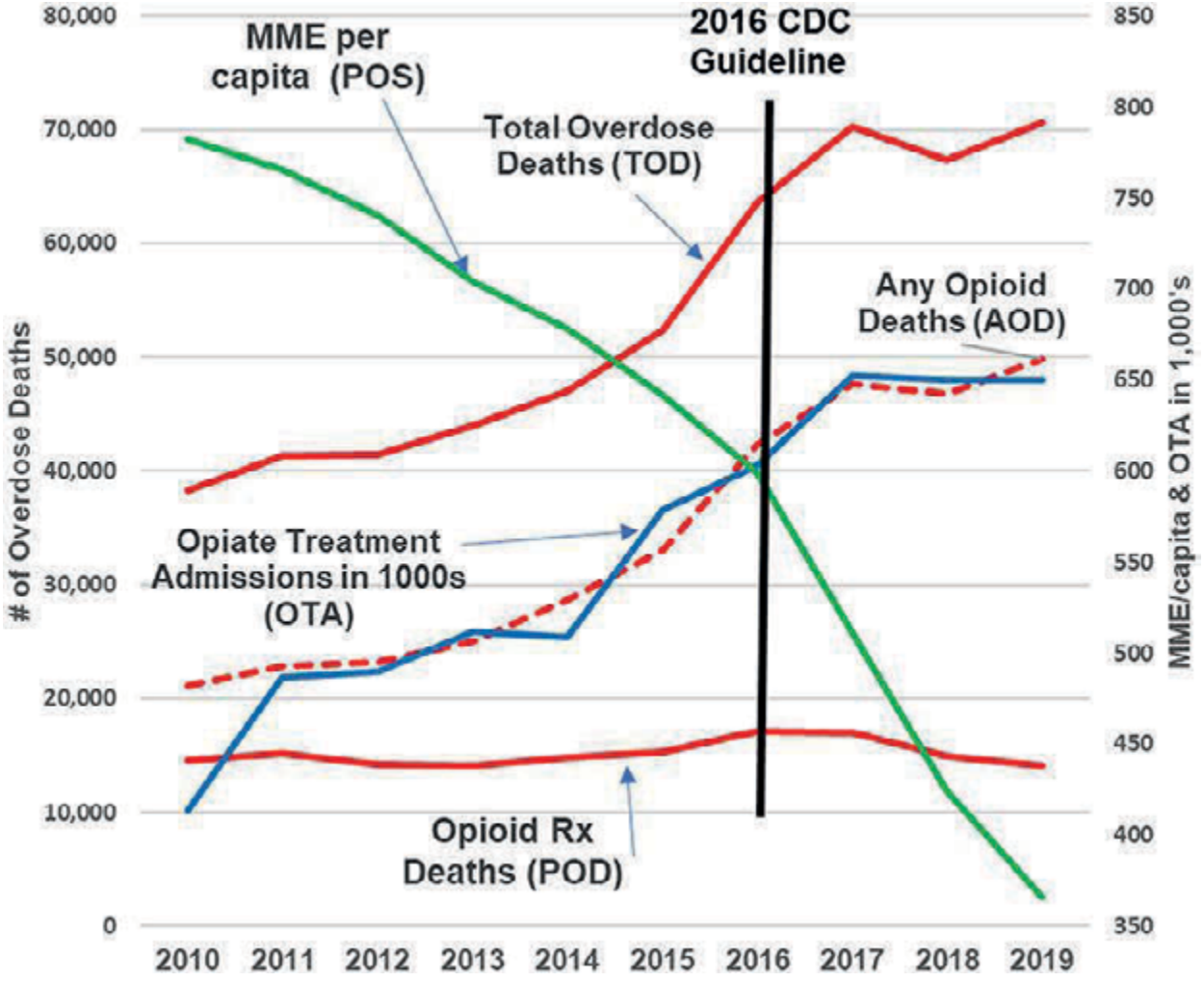
Kasey Strey, Director, Texas Targeted Opioid Response Program (TTOR), at Texas Health & Human Services Commission gave the committee an overview of the program. Established in 2017, TTOR is federally and state funded and seeks to increase access to Medication-Assisted Treatment (MAT) for OUD and decrease opioid overdoses. The program partners with academic institutions and local mental and behavioral health authorities throughout the state. TTOR takes a wholistic approach to OUD. It includes prevention strategies, such as workforce training and development, opioid misuse prevention and Naloxone distribution; integrated services including interventions in traditional health care, community care and the community justice system; medication treatment services; and recovery services including recovery support and housing. These services are provided in regions throughout the state. Before TTOR was established, about 50% of Texans lived within a 30 minute drive of MOUD services. Currently, 76.4% of Texans are within a 30 minute drive of these services. The percentage of persons entering evidence-based treatment since the programs inception has more than doubled. In 2016, 32% of OUD admissions entered MAT; in 2020, 66% of OUD admissions entered (MAT).

Dr. C.M. Schade, a board-certified physician with more than five decades of experience managing patient pain and specializing in pain management, testified on behalf of the Texas Medical Association (TMA). His testimony focused on the impact of illegally manufactured fentanyl (IMF) related overdoses and deaths in Texas. The opioid crises is no longer just about prescription opioids. Over the past several years, the federal government has enacted stringent opioid regulations and Texas followed suit. However, opioid deaths continue to rise, and IMF has been identified as the main culprit by the Centers for Disease Control and Prevention (CDC). Valid opioid prescriptions have continued to decrease, even as opioid deaths caused by IMF have risen dramatically.

Dr. Schade told the committee that the decrease in opioid prescriptions is a success for Texas in the battle against opioid misuse. While opioid prescriptions are dropping, another serious problem has arisen. Pain management patients cannot get proper, medically indicated prescriptions. Physicians hesitate to prescribe medication for pain management because overburdensome enforcement actions from state and federal agencies. Among concerns raised by pain management patients are having to drive hours to be seen by a physician for pain management, patients are unable to find a physician to treat their chronic pain because of regulatory enforcement concerns and many surgeons, emergency department physicians, and others are referring patients to physicians who specialize in pain management instead of following standard of care protocols and prescribing it themselves.

Pain management medications, such as opioids, are necessary in the modern practice of medicine. New research questions the applicability of current regulatory guidelines and previous correlations between opioid prescribing rates and overdose rates in the U.S. A recent CDC study examined data from 2010 through 2019 to study the relationship between prescription opioid sales (POS), measured by morphine milligram equivalents (MME) per capita, and four outcomes: 1. Total overdose deaths (TOD); 2. Any opioid-related deaths (AOD); 3. Deaths tied specifically to prescription opioids (POD); and 4. "Opioid use disorder" treatment admissions OTA. The analyses revealed that the direct correlations (i.e., significant, positive slopes) reported by the CDC based on data from 1999 to 2010 no longer exist. Instead, for a majority of states, the relationships

between the outcome and Annual Prescription Opioid Sales are either non-existent or significantly negative/inverse. A graph from the study illustrates this point:



Dr. Schade gave examples of patients who were helped tremendously by opioid pain management. He explained the Texas Medical Board Rule 170 for pain management which requires signed pain management agreements, random urine drug screens, the prescription monitoring program and multimodal and multidisciplinary treatments to arrive at the lowest effective opioid dose. Dr. Schade told the committee that in the past decade, an increased number of patients receiving treatment for chronic pain have committed suicide because they couldn't get their pain medications.

Brittany Jones, the Texas Regional Director of Operations for Baymark Health Services, addressed the committee on behalf of the Opioid Treatment Provider Coalition. She reiterated the positive outcomes associated with evidenced based treatment programs. Opioid treatment programs (OTP) are highly-structured and regulated outpatient facilities where our multi-disciplinary healthcare team deliver high-quality, evidence-based treatment services to people with OUD. OTPs are the only facility type where all FDA-approved medications for OUD can be used pursuant to federal regulations. The core service provided, called medication-assisted treatment (MAT), is the combination of medications and psychosocial support services, including individual and group therapy as well as case management, to provide a comprehensive treatment model that addresses the biopsychosocial nature of addiction. OTPs are required to maintain and implement robust diversion control plans for the powerful medications dispensed. Counseling and case management is required and OTPs coordinate referrals to other community services and resources, such as medical and dental care, housing, mental health services, vocational services and screening and treatment for communicable diseases. Patient progress is monitored and reported to HHSC. Their services are often referred to as "the gold standard" in treating OUD because of the very strong scientific body of evidence supporting the work. 85% of their patients consistently prove to be illicit opioid free after one year. If a patient continues treatment for at least 90 days, 90% will continue for at least one year. There is an 18% increase in employment for those who remain in treatment for 90 days or more.

Kevin Roy, representing Shatterproof, a not for profit began by a parent who lost his son to a substance abuse disorder, addressed the committee. Shatterproof is committed to advancing three main principles to address the addiction crisis, in Texas and throughout the United States. They seek to transform addiction treatment, ending the stigma surrounding addiction, and educating and empowering communities to address this scourge. They encourage changes to the health care system so that all Americans have access to evidence-based treatment that works. They created a quality treatment locator called ATLAS to help people struggling with addiction find and access treatment to meet their needs. They combat stigma by challenging the attitudes and behaviors that prevent loved ones from seeking treatment. And they educate and empower communities by providing resources to support those struggling with addiction, giving them the greatest opportunity to achieve sustained success on their recovery journey.

Mr. Roy stressed that data collection and sharing are key. Collection and publication of data in real-time is possible. During the height of COVID, the CDC issued daily updates on hospitalizations and deaths. Real-time overdose data would similarly enable prevention resources to be directed to areas of highest need. Real-time data on fentanyl-related deaths and the number of times naloxone (Narcan) is administered would allow Texas officials to better grasp the scale of fentanyl's presence in the state and take actions to save lives. Researchers at the University of Texas are testing a program that would tackle just this issue. After a one year pilot, TXCope was just expanded statewide at the beginning of September, and aims to crowdsource data from individuals and harm reduction organizations on nonfatal overdoses. It is this type of innovation that promises the potential to acquire more real-time, actionable data that can be used to proactively target resources.

The committee heard the tragic stories of two young people who died from fentanyl overdoses. Additionally, a number of people in recovery addressed the committee and gave their opinion regarding what they believe would be helpful in decreasing the number of fentanyl overdoses. They found that providing needles helped them build trust with people who suffer from SUD. Generally they all agreed that peer to peer counseling is the most effective first step to getting people into treatment.

POST HEARING INFORMATION

Since the hearing, the committee was made aware of increased levels of xylazine overdoses. Xylazine is a large animal sedative used by veterinarians. It is not intended for humans. It is neither approved nor regulated by the Food and Drug Administration (FDA) for human consumption. The drug can cause hypotension and slow the heart, respiratory and central nervous systems. As xylazine appeared in more drug overdose deaths concerns grew and the CDC began to investigate.[22]

From 2015 to 2020, the percentage of all drug overdose deaths involving xylazine increased from 2% to 26% in Pennsylvania. Xylazine was involved in 19% of all drug overdose deaths in Maryland in 2021 and 10% in Connecticut in 2020.[23] To determine the impact of xylazine in

overdoses, the CDC used data from the State Unintentional Drug Overdose Reporting System (SUDORS) in 38 states and the District of Columbia (DC).[24] Out of 45,676 overdose deaths reported to the system in calendar year 2019, there were 826 xylazine-positive cases and 531 xylazine-involved cases identified. Xylazine was listed as a cause of death in 64.3% of deaths in which it was detected.

There are limitations to the data. Oftentimes, no screening is performed for Xylazine. It is not regularly included in drug panel testing. Just like fentanyl, xylazine can be ingested unknowingly. It can be added to other opioids to lengthen and strengthen their effects. Naloxone is not effective for xylazine overdose.

RECOMMENDATIONS

Update Texas Rules to allow for out of state employees at OTPs

Currently, 25 TAC §29.148(a)(1)(B) requires all new OTP employees to have a Texas driver's license. OTPs, like most employers, especially health employers, are having a difficult time recruiting staff. The committee urges the HHSC to remove the state residency requirement for OTP staff to allow recruitment of properly licensed providers from neighboring states.

Update Texas Rules to synchronize with federal rules regarding buprenorphine

There are differences between the state and federal rules for time in treatment requirements on the use of buprenorphine "take home" dosages. When SAMHSA revised 42 CFR Part 8 to allow an expedited take home schedule for use of Buprenorphine in OTPs, most states revised their state requirements to match the federal change. Texas did not. Currently the TAC Title 25, Part I, Chapter 229, subchapter J, only allows for Methadone to be dispensed for treatment. However, federal regulations at 42 CFR Part 8.12 allow Buprenorphine to be dispensed and provides an expedited take-home schedule for use of Buprenorphine in OTPs. Buprenorphine does not require the high level of oversight that applies to Methadone. Texas should update their rules and make them consistent with federal regulations.

Allow Nurse Practitioners to prescribe opioid treatment medications at OTPs

Texas has strong restrictions that prevent nurse practitioners from prescribing medications to treat opioid addictions, even under delegated authority. The Journal of the American Medical Association (JAMA), in April, 2019, recommended that these restrictive scopes of practice be reformed. There is a shortage of all health care workers. There is a critical shortage of practitioners authorized to prescribe opioid treatment medications. The results of a 2019 JAMA study concluded that states that have restrictive NP practices are, logically, less able to expand opioid treatment services.

Legalize fentanyl testing strips

Fentanyl testing strips are currently considered drug paraphernalia. The committee heard from several witnesses, including law enforcement, that there is no logical reason for this. Fentanyl testing strips do not increase illicit drug use. In fact, federal grantees may use funds to purchase fentanyl testing strips. Research shows that they can be used as a harm reduction intervention. Although some people actively seek out fentanyl because of their own SUD, others seek out drugs other than fentanyl. Those seeking drugs other than fentanyl could use the test strips to avoid tainted street drugs. Many overdose deaths have been caused by drugs that were laced with fentanyl, unbeknownst to the user.

Urge the CDC to update ICD 10 codes to improve accessible overdose data

Currently, data on fentanyl overdose deaths is not accurate. DSHS collects and analyzes data from local medical examiners and justices of the peace based on death certificate notations. While there are ICD 10 codes used for cause of death - unintentional, suicide, homicide and undetermined - and separate codes for certain, specific drugs - opium, heroin, methadone, other opioids - there is no specific code for fentanyl. Unless the death certificate specifically identifies 'fentanyl' in the cause of death field and is not misspelled, fentanyl as cause of death will not be recorded by the DSHS. Once ICD 10 codes are updated, DSHS will be able to more readily gather and publish more accurate fentanyl overdose data.

Encourage widespread naloxone availability and education

Every middle school and high in the state should have several doses of naloxone available. It's shelf life is 36 months. Approved by the FDA since the 1970s, naloxone is safe and effective in treating many opioid overdoses. Additionally, if it is given to a person who did not take an opioid, it does not have negative side effects.

Promote and Improve Immediate overdose data

No immediate, central, coordinated data on overdoses or tainted street drugs is currently available. Technology should be used by law enforcement and emergency medical services to notify each other and surrounding jurisdictions about increased overdoses and the appearance of particularly harmful drugs in specific geographic areas. A University of Texas project, Texans Connecting Overdose Prevention Efforts (TxCOPE), is one attempt to improve immediate, accessible overdose data. The project pools crowdsourced overdose data from harm reduction groups in a systematic way. By using a crowdsourcing platform, TxCOPE uses data dashboards and heat maps to see where overdoses are spiking. Once those hot spots are detected, targeted prevention efforts such as law enforcement and medical notification, social media warnings, public service announcements and naloxone training and supplies can be dispersed.

Establish a coordinated social media campaign

State education, health and law enforcement agencies should work together to establish a coordinated, wide ranging social media campaign on fentanyl. The campaign should include education, prevention and treatment options.

INTERIM CHARGE IV: Telemedicine

Study current telemedicine trends by assessing and making recommendations related to standardizing required documentation healthcare providers must obtain for consent for treatment, data collection, sharing and retention schedules, and providing telemedicine medical services to certain cancer patients receiving pain management services and supportive palliative care.

BACKGROUND

Telemedicine is the delivery of health care by connecting a health care provider with a patient in a distant location by way of technology. It is the use of advanced telecommunications technology that differentiates telemedicine from the in person practice of medicine. Telemedicine began to be used for certain difficult to reach groups of people in Texas in the 1980s. Initially, it was used to transfer health data from the patient to the distant health care provider. As internet speed and connections improved, the possibility of the use and scope of telemedicine grew. The Texas legislature passed a number of grants during the 76th Legislative session (1999) that sought to improve the delivery of health care to rural populations. The implementation of that legislation led to the increased use of telemedicine in Texas' health science centers and nonprofit health care facilities.[25]

During the 2017 Texas legislative session, Senate Bill 1107, that formed a framework for telemedicine in Texas, was enacted. Among other things, that law required important clinical components when providing telemedicine. It specified that the standard of care that applies for telemedicine is the same as would apply to the provision of the same health care service or procedure in an in-person setting.[26]

While there have been some marginal increases in telemedicine delivery in the intervening decades between the 1999 and the 2017 enactments, the COVID-19 pandemic fast forwarded the use of telemedicine. It became a critical method for healthcare delivery. Because of social distancing measures that were implemented, the only way many patients were able to make health care visits was through telemedicine. This was an important measure to promote receipt of needed medical services while mitigating the risk of spread of COVID-19. Today, more patients have experienced the convenience of telemedicine and want to continue receiving care this way.

According to Texas Health and Human Services telemedicine utilization data, in all of 2019, Texas Medicaid clients participated in 242,857 telemedicine visits. However, in just the first five months of 2020, that number ballooned to more than a million visits.[27]

According to a joint report by the Peterson Center on Healthcare and Kaiser Family Foundation, the number of telemedicine visits prior to the pandemic was a negligible share. In the first six months of the pandemic, outpatient telemedicine visits rose to 13%. A year later, the number of visits leveled off to 8% of all outpatient visits.[28]

A recent American Medical Association (AMA) survey asked physicians if they currently use telehealth to care for their patients. They found that 85% of physicians are. Physicians are very comfortable delivering virtual care when appropriate, and many patients have come to expect it.[29] Many state and federal waivers and flexibilities were implemented during the pandemic allowing providers to quickly pivot and see patients via telemedicine visits. Additional positive outcomes from telemedicine were noted.

In March 2020, the Texas Medical Board, with direction and assistance from the Governor's Office, implemented procedures to waive certain requirements to assist health care professionals respond to COVID-19. Governor Abbott temporarily suspended Title 22, Chapter 174.5 (e) (2)(A) of the Texas Administrative Code. This waiver allowed telephone refill(s) of a valid prescription for treatment of chronic pain by a physician with an established chronic pain patient. Due to the seriousness of the opioid crisis and the need to ensure there is proper oversight of chronic pain management, the initial suspension was only in effect until April 10, 2020. The waiver was then extended monthly until September 2020 or for the duration of the Governor's disaster declaration. This measure protected public health and curbed the spread of COVID-19, by providing patients access to ensure on-going treatment of chronic pain and avoided adverse consequences of abrupt cessation of pain medication. Additionally, this waiver enabled health care providers to provide necessary continuity of care for their chronic pain patients, while at the same time better preventing the risk of unnecessary exposure of the physician or their delegates to COVID-19.

To continue the positive strides in palliative care for certain oncology patients, Rider #10 Telemedicine Medical Services to Certain Cancer Patients Pilot Program was added to the Fiscal Year 2022-2023 General Appropriations Act. The rider instructs the University of Texas M.D. Anderson Cancer Center, in conjunction with the Texas Medical Board, to develop and implement a pilot program authorizing a physician or other health care provider to prescribe, through a

telemedicine medical service, drugs for pain management or supportive palliative care to a patient with a current or previous cancer diagnosis and to provide other telemedicine medical services to those patients. The University of Texas M.D. Anderson Cancer Center shall submit a report on their findings to the Texas Medical Board and to the Legislature. The report shall include the number of patients who receive pain management services or supportive palliative care through telemedicine medical services under the pilot program; an estimate of patient attendance rates during the two biennia preceding August 31, 2021, for scheduled in-person visits compared to telemedicine medical service appointments for pain management services or supportive palliative care; an evaluation of and recommendations for improvements to the pilot program; and recommendations for the expansion of the pilot program.[30]

INTERIM STUDY

The Committee held a public hearing in Austin on September 13, 2021 to gather information regarding the following charge:

> Study current telemedicine trends by assessing and making recommendations related to standardizing required documentation healthcare providers must obtain for consent for treatment, data collection, sharing and retention schedules, and providing telemedicine medical services to certain cancer patients receiving pain management services and supportive palliative care.

The following persons were invited to testify:

> Nora Belcher, Chief Executive Officer, Texas e-Health Alliance
> Stephen Carlton, Executive Director, Texas Medical Board
> Welela Tereffe, MD, MPH, The University of Texas M.D. Anderson Cancer Center

Nora Belcher gave an overview of telemedicine in Texas. The rapid increase in telemedicine exposed some areas that need to be addressed. She reiterated that HIPAA privacy forms and consent to share data forms must still be signed. The practice of medicine, nursing, counseling, or any other health service is expected to respect those same requirements when being provided virtually. Texas law provides that a health professional who provides or facilitates the use of telemedicine services "shall ensure that the informed consent of the patient, or another appropriate individual authorized to make health care treatment decisions for the patient, is obtained before telemedicine services … are provided."[31] Health professionals providing telemedicine services are under the same obligation to keep and maintain an "adequate medical record" as they are if the services are provided in person.[32]

Belcher told the committee that telemedicine grew so quickly in 2020 that it is not surprising that some medical providers found themselves scrambling to update and transition their required forms systems in the absence of a physical check-in counter. This was further complicated using audio-only technologies. Audio-only for certain telehealth visits continued to be needed because not all patients had access to broadband according to Belcher. She heard from stakeholders over the

course of spring 2020 that they were concerned about how to appropriately obtain the needed documentation, particularly if they were providing treatment in an audio only format to a patient that did not have a computer. There also seemed to be some places in the system that still required "written" signatures, although there seem to be less of that today according to Belcher.

With the rapid increase in telemedicine trends, assessing the use and implementation of standardized, required documentation by healthcare providers for consent for treatment, data collection, sharing and retention schedules is useful. Telemedicine and telehealth must meet the same standard of care as in-person services, and that framework includes compliance with all requirements for collecting consent to share, consent to treat, records retention and other documentation.

Welela Tereffe, MD, MPH, University of Texas M.D. Anderson Cancer Center, briefed the committee on the Center's Telemedicine Pilot Program. Telemedicine's use for palliative care patients had positive benefits according to Dr. Tereffe. It increased patient visits and led to fewer missed visits which in turn led to increased symptom control and medication adherence. Cancer patients in palliative are in the advanced stages of cancer and are expected to survive for less than a year. They exhibit high symptom burden including frequent or chronic pain and severe fatigue. These patients usually require a walker or wheelchair to leave the home and depend on caregivers to get them to appointments.

Telemedicine benefits for cancer patients receiving palliative care included greater overall satisfaction with care, more frequent medical visits, fewer missed medical appointments and more family members joining their visits. This led to decreased financial strain and better adherence to pain regimens. Whereas in-patient visits were missed about 20% of the time, virtual visits are missed only about 10% of the time Tereffe told the committee.

Dr. Tereffe informed the committee that although not mandatory for cancer patients, M.D. Anderson physicians routinely review the prescription monitoring program database for all patients receiving opioids. They use CAGE-AID to screen all palliative care patients. CAGE-AID is a validated and widely used tool to identify patients at risk for non-medical opioid use.

Telemedicine allowed for frequent follow-up of CAGE-AID positive patients. Physicians can and do conduct pill counts via virtual visits. Frequent visits allow for early identification of suspected non-medical opioid use. Patients with suspected non-medical opioid use are identified during telemedicine visits and subsequently seen in-person. No safety issues have been encountered since the launch of the pilot program according to Tereffe.

Texas Oncology provided written comments to the committee that echoed those of M.D. Anderson. The result of their investment into expanding telehealth services demonstrated many positive benefits for oncology patients who require continuous medical oversight or assessment for further evaluation. Among these benefits are easy medication dose adjustments, the ability for patients to have their cancer managed while not having to travel to the clinic daily, the ability to provide acute care to patients quickly and control symptoms that avoid emergency room visits and hospitalizations and the ability to bring subspecialty services to patients in remote areas.

Stephen Carlton, Executive Director, Texas Medical Board, testified that the TMB passed a permanent rule last fall which took effect on October 7, 2021. This particular rule was especially beneficial for cancer patients in the state during the pandemic and it was ultimately determined that this benefit should exist regardless of the pandemic. The rule directly addressed the goal of the rider and made the development of the pilot program it references unnecessary. Based on previous meetings with M.D. Anderson, it is TMB's understanding that they will still be submitting a report per the rider language to the Legislature. The report will be based on their findings/experience with the fully implemented initiative as opposed to just a pilot.

RECOMMENDATIONS

Medical record documentation and retention requirements for telemedicine and in-person services should be addressed.

Chapter 111, Occupations Code, should be amended to require that the health professional boards, by rule, include compliance options and standardized formats, modalities, and retention schedules for telemedicine documentation that enable both video and audio-only care. Retention schedules should follow the same schedule as in person retention schedules.

Require M.D. Anderson to submit a report per the rider language to the Legislature

Although it is TMBs understanding that M.D. Anderson will submit the required report, it should be communicated that the rider requires the University of Texas M.D. Anderson Cancer Center to submit a report on their findings to the Texas Medical Board and to the Legislature. Although the TMB passed a permanent rule, it is still useful for them to submit their report to include the number of patients who receive pain management services or supportive palliative care through telemedicine medical services under the pilot program; an estimate of patient attendance rates during the two biennia preceding August 31, 2021, for scheduled in-person visits compared to telemedicine medical service appointments for pain management services or supportive palliative care; an evaluation of and recommendations for improvements to the program; and recommendations for the expansion of the program.

INTERIM CHARGE V: Workforce Shortage

Examine existing resources and available opportunities to strengthen the state's nursing and other health professional workforce, including rural physicians and nurses.

BACKGROUND

For several years Texas has been facing a growing health care workforce shortage. These shortages have reached alarming levels, with current projections showing critical shortages across the state by 2032. These shortages include physicians, nurses, and other vital health care professionals. Current projections from the Department of State Health Services show the current shortage of Family Medicine practitioners will grow from a deficit of 1,209 to 2,495 by 2032. Demand also continues to outpace supply in the practice of Pediatrics, with current shortages around 1,695 and a projected shortage of 1,912 pediatricians by the year 2032.

Additional studies show that for these gaps to narrow a significant number of clinical residency positions must be added each year in these specialties. Current projections show that an additional 31 clinical residency positions per year are needed for psychiatry, 55 per year in pediatrics, and 61 per year in family medicine. The study showed that altogether an additional 1,470 clinical residency positions for physicians need to be opened by 2032 to address projected deficits.
Projections for nursing show some equally concerning numbers. Based on the agency's current projections, the demand for Licensed Vocational Nurses is on track to outpace supply by 2025, ultimately leading to a deficit of 12,572 LVNs by the year 2032. While Texas's supply of Registered Nurses continues to grow, demand is accelerating rapidly. Current projections show the deficit growing from 29,165 to 57,012 by 2032. The only professionals that are currently projected to exceed demand are Advanced Practice Registered Nurses (APRNs). This underutilized resource is currently expected to reach a surplus of 19,271 APRNs.

These numbers are startling, but they do not even begin to account for the effects that COVID-19 has had on the healthcare workforce. Ultimately these numbers are a small snapshot of a larger issue that is affecting all health care professions and must be addressed to help ensure the health and wellness of all Texans.

INTERIM STUDY

The Committee held a public hearing in Austin on September 14, 2021, to gather information regarding the following charge:

> Examine existing resources and available opportunities to strengthen the state's nursing and other health professional workforce, including rural physicians and nurses.

The following persons were invited to testify:

Lisa Wyman, Director, Center for Health Statistics, Department of State Health Services
Stephen 'Brint' Carlton, Executive Director, Texas Medical Board
Monica Martinez, Associate Commissioner of Standards and Support, Texas Education Agency
Brad Holland, President and CEO, Hendrick Health System, Texas Hospital Association
Susan Greenwood, CNO, Hendrick Health System
Pearl Merritt, Dean, TTUHSC School of Nursing, Abilene
Heather Hicks, Vice President of Instruction, Cisco College, Abilene
Cindy Weston, President, Texas Nurse Practitioners
Paul Kennedy III, DDS, Texas Dental Association
Cindy Zolnierek, PhD, RN, CAE, Chief Executive Officer, Texas Nurses Association
Debbie Garza, R.Ph., Chief Executive Officer, Texas Pharmacy Association
Ryan English, Texas Academy of Physician Assistants
Anthony Ormsbee-Hale, Vice President, People Operations, Civitas Senior Living, Texas Assisted Living Association (TALA)
Alyse Meyer, VP of Advocacy, Leading Age Texas

The following persons offered public testimony:

Jackie Brock, Chief Nurse Executive, Harris Health Care System
Dan Hahn, Physician, Community Medical Services
Jessica Boston, Director of Government Affairs, Texas Association for Home Care and Hospice
Jair Soares, University of Texas Health Science Center Houston
Jessie Howard, Girling Health Care
Bryan Mares, Government Relations Director, National Association of Social Workers- Texas Chapter
Maggie Ortiz, RN, MSN

Lisa Wyman, Director, Center for Health Statistics, Department of State Health Services reviewed current projections the agency has for the growing deficit of healthcare professionals. She briefly outlined the current physician pipeline and stated that current model shows that the number of medical students and residency slots need to grow substantially to be able to meet the growing demand. She also spoke briefly on the growing demand for nurses at all levels. Finally, she did share that the current models the agency has do not account for changes in workforce that have occurred due to the pandemic.

Stephen 'Brint' Carlton, Executive Director, Texas Medical Board, spoke regarding the current licensing process and the growing number of individuals applying for licensure. Carlton stated that they have seen a shift that suggests the current emergency licensing process is now more often being used to expedite a regular licensure applicant's ability to practice. His primary recommendation would be to address some of the substantial hurdles International Medical School Graduates face when seeking to practice in the state. One way this can be addressed is by changing the emphasis of licensing evaluations from a focus on medical education to post-graduate training, allowing consideration of the completion of any accredited residency program in the U.S. or Canada.

Monica Martinez, Associate Commissioner of Standards and Support, Texas Education Agency, discussed the programs and opportunities that are currently being offered to high school students in Texas. She shared specifically about the Career and Technical Education (CTE) program, which offers a Health Sciences subject option. Previous legislative actions have made changes to funding formulas to better support the CTE programs. Under the Health Sciences Cluster there are pathways for students to enter into several high wage, in demand, high skill vocational opportunities such as Nursing Science, Healthcare Diagnostics, and Healthcare Informatics. When a student is considering these opportunities, they are given clear information about the topics required, additional activities needed, and the potential outcomes for completion of these courses. Models are also offered that give students a fast-track to completing post-secondary education opportunities. Martinez also discussed the Texas Regional Pathways Network that helps connect public schools, colleges, and local industries to work together to create career pathways to ensure that needed positions are filled and students have the opportunity to pursue these career options.

These pathways have had several positive outcomes including cover the expenses for 150 students to receive CNA certification.

Brad Holland, President and CEO, Hendrick Health System, Texas Hospital Association, highlighted the lack of nursing faculty to accommodate the growth in the student population. Holland states that growth in the RN pipeline will address the hospitals' need for nurses and develop the future faculty to teach new nurses. He highlighted the growing need for workers as well as the cost of care, describing how income is not meeting expense levels. Overall, Holland emphasized the need for Texas to significantly grow the nurse pipeline that will ultimately supply the State with the needed workers.

Susan Greenwood, CNO, Hendrick Health System, shared the approach that their health system has taken to attempt to replenish their workforce and grow the nursing workforce. Greenwood described how Hendrick Health System has partnered with Texas Tech to allow nursing students to train in their hospitals as Nurse Techs to continue their training and give these schools the ability to open additional student slots. Additionally, they have partnered with Cisco College to work with high school students to pursue their career in nursing. Students complete the required dual-credit courses while in high school, with sponsorship opportunities available to low-income students, culminating in the completion of their CNA certification the summer after graduation. From there students continue through Cisco College to achieve their LVN and later their associates degree RN. Ultimately, students who complete this program are granted automatic acceptance into the TTUHSC online RN-to-BSN program where they can then complete their bachelor's degree and enter the Nurse Tech program.

Heather Hicks, Vice President of Instruction, Cisco College, Abilene, urged support for the innovative models addressing the nursing shortage and discussed the challenges their community college and other rural community colleges face with adequate funding. Specifically, Hicks emphasized the need for an increase in the core operations funding currently given to community colleges. She stated that these funds, not tied to a grant program, would enable their school to serve more students across the nine counties they currently serve.

Pearl Merritt, Regional Dean, TTUHSC School of Nursing, Abilene, continued the discussion by talking about the challenges that community colleges, like Cisco, face when they are not able to adequately pay their faculty. The continued need for resources makes public/private partnerships helpful, but they are not filling the whole funding gap. Another concern is that some funds are awarded based on graduation output but do not address the need for funds at the beginning of the process in order to enable colleges to empower more students.

Cindy Weston, President, Texas Nurse Practitioners, urged the use of nurse practitioners as key practitioners to address the workforce challenge, especially in rural areas. She first suggested that the state update licensing and practice regulations to align with several other states and the U.S. Military who already allow qualified nurse practitioners to offer care. She referenced outcome metrics other states have experienced from this action, including decreased cesarean rates, and overall lower healthcare costs. She next suggested expanding funding for certain grant programs that have already proven successful to help grow student enrollment and faculty retention. She mentioned the success of the Nursing Shortage Reduction Program, the Nurse Faculty Loan Repayment Program, and the Nursing Innovation Grant Program. Weston then spoke about the Loan Repayment Program for Mental Health Professionals, which includes psychiatric mental health nurse practitioners. This program requires recipients to make a five-year commitment to serve in their designated area. This program has suffered because of the limited funding available and the uncertainty of continued funding. She emphasized the importance of an interdisciplinary approach to addressing the shortages of healthcare workers as the best way to make real progress. Finally, she focused on the need to have clinical opportunities available in rural areas as one of the best ways to increase access to care while increasing the likelihood of a new nurse choosing to practice in these traditionally underserved areas. Weston discussed several locations where these programs have been setup and the positive outcomes they have provided as they have increased care to these populations. She then mentioned that there are currently no funding streams for graduate nursing education and re-emphasized the need to modernize licensure laws to serve communities well.

Paul Kennedy III, DDS, Texas Dental Association, addressed the committee regarding the importance of addressing dental health when considering healthcare as proper dental care can

influence the whole body. He spoke specifically regarding the unique challenges faced by rural Texans with the shortage of providers. He described how the pandemic created interruptions to dental care, sending many with urgent needs to emergency rooms where care is significantly more expensive, and negatively impacted dentists. The increase in supply costs and workforce disruptions have created a challenging financial burden for dentists working to provide care to low-income and Medicare populations. Kennedy went on to discuss opportunities that have already been established to address tuition costs and with proper funding can move Texas towards meeting the need for additional providers. He additionally made brief mention of the possibility of instating a loan repayment program to encourage care providers to serve in the areas where they are most needed.

Cindy Zolnierek, PhD, RN, CAE, Chief Executive Officer, Texas Nurses Association, noted that even pre-pandemic we were on track to be short almost 60,000 nurses short by 2032. With the nurses that left during the pandemic, including many who were well below retirement age, this problem has been exacerbated. In addition to educating new nurses, there is a clear need to address nurse retention because they are leaving. While some nurses who have served as travel nurses have earned higher wages, this alone is not the cause of the overall rise in healthcare costs. Zolnierek discussed the current grant programs Texas offers to support the nursing pipeline for new nurses. She encouraged fully funding all grants within the Nursing Shortage Reduction Program. After this she discussed the imperative need to address the workplace challenges that nurses face every day. The two main concerns that their surveys have shown are adequate staffing and workplace violence. When nurses feel overworked and unsafe, they begin to seek a way out of these overwhelming environments. Zolnierek then mentioned work that the legislature has done to try and address the problem of workplace violence for our healthcare workforce and that a similar bill will be submitted for the next legislative session.

Debbie Garza, R.Ph., Chief Executive Officer, Texas Pharmacy Association, shared the continued importance of pharmacists in continuing to provide access to certain care where there may be no other service opportunities. Specifically of note was the role that pharmacists and certain specialized pharmacy techs played in distribution of vaccinations. These services are uniquely important, especially for those who do not otherwise have an identified primary care physician.

Garza emphasized the value that the timely access to vaccinations has on the continued health of all Texans. There has been a noted drop, however, in the number of individuals seeking licensure as a pharmacist and pharmacists currently practicing are struggling to find qualified pharmacy techs to fill needed roles. One of Garza's primary recommendations is to continue to allow pharmacists to provide vaccinations for individuals. Like other practitioners, pharmacists have also faced growing financial challenges due largely to the reduced reimbursement rates being given by PBMs. These financial challenges contribute heavily to the challenges to staffing and maintaining a practice. This loss is felt most starkly in rural areas where the loss of their sole pharmacy removes a critical healthcare access point. Garza concluded by encouraging the use of licensed providers to the full extent of their training.

Ryan English, President, Texas Academy of Physician Assistants, testified to the committee regarding the training Physician Assistants (PA) receive and the ways that reasonably empowering these practitioners can affect the provider shortages the state is facing. English began by indicating the overly burdensome list of required paperwork related to providing care. He pointed directly to the need to modernize these cumbersome requirements to reflect current practice and look at what requirements best serve patients. Next English discussed the difficulties related to prescriptive authority and PAs. He discussed specific instances where a PA may be working with a patient but need to have a physician write the prescription, regularly without the physician having any familiarity or relationship with the patient. When unable to fulfill these requirements, a patient can suffer from delays in receiving their medications and hinderance to the continuity of care. English then spoke of the current requirement that any established practice where a physician and a PA are co-owners, a PA is prohibited from being a majority owner. Further, the PA is also required to be a silent member, making them unable to maintain any voting rights or hold an officer position in that medical practice. He explained how this places PAs in a position of fiduciary responsibility but simultaneously prohibits them from acting within this responsibility. PAs need to be able to speak to their investment. English then described the difficulties patient families face in certain settings when a PA is tasked with having a conversation regarding a Do Not Resuscitate Order (DNR). If a PA has this conversation and a family elects to establish a DNR, the PA must still go to a physician and have them either sign off without meeting with the family or speak with the family again. He suggested that this repetition, causing more grief for families, should not be

necessary. Ultimately, English suggested that simplifying practice processes and allowing PAs the ability to fully participate in medical practices they share ownership in can play a crucial role in expanding the accessibility of care.

Anthony Ormsbee-Hale, Vice President, People Operations, Civitas Senior Living, Texas Assisted Living Association (TALA), spoke to the continued challenges facing the healthcare workforce at all levels, with large numbers of workers leaving due to burnout each month. Pandemic investments in recruiting and technology created opportunities for new career opportunities for those who had lost other positions due to the COVID layoffs. Ormsbee-Hale emphasized the critical role Assisted Living facilities play in developing the healthcare workforce pipeline. Some facilities offer tuition benefits for their workers, enabling them to pursue further education while working. Long-Term Care providers, however, faced many challenges during the height of the pandemic, often having to demonstrate extreme need to receive assistance finding and hiring certain qualified staff positions. Among the recommendations presented, Ormsbee-Hale encouraged future State contracts for healthcare workforce include all providers. Additionally, it was suggested that including these facilities in training rotations for healthcare workforce students would be beneficial for both the students and the facility.

Alyse Meyer, VP of Advocacy, Leading Age Texas, discussed the disproportionate impact of COVID-19 on nursing residents and staff and how this has highlighted the long-standing workforce issues this field has faced. Prior to the pandemic major staff shortages had been reported, with nursing facilities in 2019 showing the highest vacancy rates for both RNs and CNAs. In the same year, turnover for CNAs was reported to be around 67%. Surveys conducted recently have shown that a majority of facilities have needed to limit admissions due to the ongoing staffing shortages. Meyer shared that there has been a reported 18% decrease in RN employment in Texas nursing homes in 2021. It has also been reported that, nationwide, more than 400,000 nursing home and assisted living staff have quit since January 2021. Home healthcare services have felt this loss acutely, with the industry growing rapidly every year. To strengthen the long-term care workforce, Meyer shared recommendations including consideration of establishing a loan repayment program, available to RNs and LVNs who commit to working in nursing homes. Additionally, she emphasized the opportunities that exist in current programs and the ability for nursing schools to

include these facilities as clinical sites, describing the many benefits of exposing students to these environments. She then recommended reviewing current rules and regulations to ensure that there are no unnecessary barriers for individuals completing training and licensing to move into the workforce without delay.

Jackie Brock, Chief Nurse Executive, Harris Health Care System, Teaching Hospitals of Texas, offered public testimony expressed support for funding clinical sites for nursing students, support post-graduate residency positions for new nursing graduates, invest in nurse retention strategies, and provide grant funding to clinical sites to create training and retention policies amongst these facilities. Brock discussed the challenge that can arise from adding a nursing student to the nurse's job. She specifically discussed the way teaching can slow down the care process. Texas Teaching Hospitals are currently unable to compensate bedside nurses for these additional responsibilities. In addition, she discussed briefly the importance of partnering closely with academic institutions to prioritize placements for nursing students that will offer the maximum benefit to both the student and the facility. Brock continued on to call for recognition and funding for nurse residency programs that certain facilities provide where further specialized training is necessary for a nursing graduate to be able to care for patients properly in complex settings. Finally, she discussed the importance of retaining nurses in the workforce. High turnover rates are detrimental to quality nursing practice. Brock expressed the necessity of looking at the variety of innovative solutions available to support retention efforts without costs becoming overly burdensome.

Dan Hahn, Physician, Community Medical Services, provided public testimony regarding the challenges that can be faced when certain staff are unable to quickly get patients necessary medications to support recovery. Hahn spoke specifically about the work some clinics are doing to address the opioid epidemic and the challenges they are facing regarding treatment and preferential funding of the necessary medications. These treatments are necessary to remove the symptoms of opioid withdrawal and different medications and dosages will have different effects on recovery patients. In addition to these medication hurdles, clinics treating these patients have not been able to use non-physician staff to help treat patients. Nurse Practitioners would be able to work with these clinics based on their training, under supervision, and Hahn recommended allowing supervised prescriptive authority for NPs working in these situations. Overall, Hahn

stressed the importance of having these qualified practitioners in place to meet the demand for care. He further recommended a rule change that would implement a mid-level exemption process to allow these practitioners the ability to practice in opioid treatment clinics. Additionally, continued grant funds should not include limitations on the medications qualified for coverage.
Alexa Schoeman, Deputy State Ombudsman, Texas Long Term Care Ombudsman, provided public testimony shared about the reports they have been receiving of the negative impacts on residents that have come from the extreme staffing shortages. She emphasized the importance of taking actions to improve hiring and retention rates. She specifically recommended setting a minimum percentage of funds being allocating to facilities be used for direct care staffing. She further suggested created minimum staff to patient ratios and strengthening current loan repayment programs for relevant staff areas.

Jessica Boston, Director of Government Affairs, Texas Association for Home Care and Hospice (TAHCH), provided public testimony on the importance and value home care brings to the healthcare space, especially when facilities are overwhelmed by crises. She emphasized the importance of provider rates in hiring in retention. Specifically, TAHCH has called on HHSC to set up a Community Care Payment Advisory Committee to create a viable and sustainable payment methodology as well as develop a long-term strategic plan for community care. Boston expressed the critical nature of these actions to create a stable workforce. She further emphasized the growing shortage of nurses has impacted home care, giving the example of medically fragile children who are hospitalized and then must remain for extended times because there are no nurses available to continue care at home. Among recommendations shared, she mentioned the value of home care as an option for clinical training of nurses.

Jair Soares, University of Texas Health Science Center Houston, provided public testimony updated the committee on the current activities that their center has undertaken to serve the healthcare needs of various populations. After a large investment from the State, they have been able to build a new behavioral health center, which is currently experiencing the staffing challenges that many providers face. When fully staffed this center will have 538 inpatient beds. The school also operates 37 community clinics and serves in 15 state hospitals. All of these are seeing the challenges of staffing mental health professionals. Soares pointed to the backlog of competency

evaluations needed as an example of the consequences of these staffing shortages. He then emphasized the need to continue expanding the availability of training slots. Additionally, he spoke of the importance of growing specific sub-specialties that are especially in need. Finally, he echoed previous testimony regarding the need for more clinical training locations to increase the rate that students can graduate and move into the workforce. He also briefly shared with the committee the Center's current 10-year plan.

Jessie Howard, Girling Health Care, provided public testimony regarding their organization's unique experiences providing Medicaid services in the home. He discussed the repeated occurrence of new attendants failing to come in for their first shift, with these individuals often citing the decision to leave as soon as they find a higher paying job. With this in mind, Howard emphasized the need for higher compensation rates to hire and retain attendants. He stated that the workforce shortage rates will continue to increase as long as these compensation rates remain unaddressed. He concluded his testimony by sharing a patient's story of the difference their attendant made in their quality of life.

Bryan Mares, Government Relations Director, National Association of Social Workers - Texas Chapter, provided public testimony specifically addressing the need for behavioral health workforce. He specifically expressed support for increased funding for the Mental Health Loan Repayment Program, as the limited funding has hindered the influx of new applicants. He further suggested support for Pay Parity for psychotherapy services in Medicaid. Mares explained that, at present, the rate paid out by Medicaid for the same services is determined based on the provider type, regardless of the equivalence of services.

Maggie Ortiz, RN, MSN, gave public testimony detailing her personal experiences with the inability for facilities to offer timely care due to lack of staffing. She then focused specifically on nurses whom she states are being wrongly sanctioned and removed from the workforce and recommended several reforms for the Nursing Board.

RECOMMENDATIONS

Fund Loan Repayment Programs

Adequately amending and funding existing loan forgiveness and tuition reimbursement programs would help augment current health care workforce shortages. Ensuring these programs are funded will provide incentive for students who may otherwise be deterred by the extensive loan burdens. Further consideration for reimbursement programs targeting border or frontier health care areas should also be explored.

Develop a strategic plan to open additional nursing clinical sites

Current agency data shows that, in order to close the nursing workforce gap, Texas will need more than 1,400 new clinical slots by 2032. While most clinical sites are found in traditional, urban settings, there seems to be several untapped resources for additional clinical locations to be opened. Additional clinical sites in rural areas, long term care facilities and home care settings seem to be currently under-utilized opportunities. Further, support for current clinical opportunities and expanding these options should be encouraged.

Address workplace violence and other challenges facing health care practitioners

Incidents of violence against health care workers have been on the rise over the past decade, but it accelerated during the COVID-19 pandemic. These challenges can contribute to higher rates of burnout and ultimately leaving the health care workforce. Implementation of adequate workplace violence prevention policies and best practices is needed.

Consider innovative solutions to ensure use of all resources

The committee heard testimony from several associations regarding the ways they have been able to help ensure continued care for patients during the COVID-19 pandemic. These practices, such as lessening administrative burdens for practice or offering certain services in non-traditional settings. These innovative and proven solutions should be considered to address access to care and to utilize the existing health care workforce to the fullest extent.

Address hurdles International Medical Graduates face to reasonably gain State Licensure

Physicians who are licensed and practice in Canada are able to apply for a Texas medical license without fulfilling another clinical residency in Texas. All other International medical graduates who have been granted a medical doctorate, in good standing with the medical licensing of their resident country, have completed a residency training in their country or has practiced as a physician in their resident country for no less than two years, and possesses basic fluency in the English language, must fulfill a clinical residency in the United States before they are able to apply for a Texas medical license. However, Canada allows any applicant international medical graduate who is a resident of and licensed to practice in any of the following countries Australia, Ireland, Israel, New Zealand, Singapore, South Africa, Switzerland, and The United Kingdom to apply for licensure. The Legislature should allow these physicians to apply for a Texas medical license.

Review COVID-19 practice waivers for long term solutions

During the COVID public health emergency, facilities like federally qualified health centers (FQHC), providers, and patients benefited from a number of regulatory waivers. By maintaining these waivers and allowing health care providers to practice up to their education and training level, Texas residents would benefit by an increase in easily accessible health care.

Consider ways to hire and retain qualified faculty

There are nurses who would enjoy both teaching nursing students and continuing to practice nursing. Currently, nursing school instructors are paid considerably less than practicing nurses. While many of these instructors would like to both teach and maintain up-to-date clinical skills, they often risk losing benefits such as health care insurance if they only teach part time. Texas public nursing school programs should consider allowing nursing faculty to obtain full benefits if they also work part time as a nurse.

INTERIM CHARGE VI: Rural Health Care

Assess ongoing challenges in the rural health care system and the impact of legislation and funding from the 87th regular and special sessions on strengthening rural health care and the sustainability of rural hospitals and health care providers. Evaluate federal regulations authorizing the creation of a Rural Emergency Hospital provider type and determine if promoting this type of facility could increase local access to care in rural areas of the state.

BACKGROUND

More than three million Texans live in rural areas and the health care systems in these areas face a variety of unique challenges. The presence of both doctors and hospitals have been sparse in these areas, causing challenges for residents seeking care. While during the past two years there has not been any closures, more than 20 rural hospitals have closed since 2013 - more than any other state.[33]Further concerns surround the services these hospitals are able to provide. Only around 66 of the 160 rural hospitals in Texas provide labor and delivery services.

By the year 2032, the Department of State Health Services (DSHS) projects unmet demands for many healthcare workers, with rural Texas taking the brunt of these shortages. Family Medicine physicians are anticipated to be at 42.1% unmet demand in the Rio Grande Valley, with West Texas close behind at 38% unmet demand. Similarly alarming numbers can be seen for pediatricians, psychiatrists, and registered nurses.

With these issues current and growing, the strength and sustainability of the rural health care system is crucial. During the 87th regular and special sessions legislators addressed some of these concerns through the expansion of telemedicine. Additional funds were also distributed through the American Rescue Plan Act (ARPA), with that support being vital with the effects of inflation.

In 2021, Congress passed HR133, which, among other things, created the designation of Rural Emergency Hospital (REH) to reinforce access to outpatient services and reduce health disparities. REH-designated facilities will continue to provide outpatient services, including emergency care, observation care, and other services including provider-based clinics, radiology, therapies, and more. These facilities will no longer provide inpatient acute care services. The Center for Medicare and Medicaid Services (CMS) will begin taking applications for the REH designation in January of 2023 for existing Critical Access Hospitals (CAH) and rural prospective payment system (PPS) Hospitals with 50 beds or fewer. Several eligibility requirements are already in place, including 24-hour emergency services and a transfer agreement with a Level I or Level II trauma center. This designation would offer these hospitals an opportunity to receive additional reimbursement benefits and additional monthly facility payments from the program.[34]

INTERIM STUDY

The Committee held a public hearing in Austin on September 14, 2021, to gather information regarding the following charge:

> Assess ongoing challenges in the rural health care system and the impact of legislation and funding from the 87th regular and special sessions on strengthening rural health care and the sustainability of rural hospitals and health care providers. Evaluate federal regulations authorizing the creation of a Rural Emergency Hospital provider type and determine if promoting this type of facility could increase local access to care in rural areas of the state.

The following persons were invited to testify:

> Nancy Dickey, MD, FAAFP, Executive Director, Texas A&M Rural and Community Health Institute
> Lisa Wyman, Director, Center for Health Statistics, Department of State Health Services
> John Henderson, President/CEO, Texas Organization of Rural and Community Hospitals
> Adrian Billings, MD, PhD, FAAFP, Texas Medical Association

The following persons offered public testimony:

> Alina Sholar, MD, TX400, Texas Physicians for Patients PAC
> Michael Magoon MD

Nancy Dickey, MD, FAAFP, Executive Director, Texas A&M Rural and Community Health Institute began by stating that approximately three million people live rurally, and their healthcare access is being threatened by the closing of rural hospitals. Over the last two years there have been no closures, an improvement over the average of three per year during the last decade. There is some question about how the federal funds during the pandemic have impacted this number. Additionally, staffing challenges that plague the state have been especially hard on small and rural hospitals. When a rural hospital closes, some studies show that there is a 5-6% increase in mortality in that service area. Dickey urged the committee to prioritize the recruiting, admission, and training of students in rural areas while sending them back to those areas to serve and practice. One approach that A&M is taking to address this challenge is building a nursing program that will allow nurses serving in these low-service areas to pursue their Advanced Practice Registered Nurse

(APRN) certification while remaining in their location. Dickey also discussed the benefits of telemedicine. This has significantly expanded access to care, but rural areas still face challenges with access to adequate broadband. Finally, Dickey stated that the $75 million in rescue funds for rural hospitals have been helpful but urges that funding mechanisms be addressed to avoid a steep financial drop off. [35]

Lisa Wyman, Director, Center for Health Statistics, Department of State Health Services shared with the committee projections gathered from pre-pandemic data relating to expected healthcare workforce shortages. This data consistently found that areas like the Rio Grande Valley and other rural areas are expected to have large unmet healthcare needs in both physician and nursing care. One healthcare profession, APRNs, were projected to be in surplus by 2032 and Wyman did note that this surplus can be leveraged to address primary care needs throughout the state. On a federal level, Wyman told the committee about health professional shortage area (HPSA) designations, noting that the majority of Texas counties without a large urban center fall under this designation, with certain areas holding some of the highest HPSA scores indicating the greatest need for care and services. Additionally, Wyman briefly mentioned some federal grant opportunities, noting that Texas typically maximizes the use of the opportunities.[36]

John Henderson, President/CEO, Texas Organization of Rural and Community Hospitals expressed agreement with Dickey's testimony and further iterated the need for funding support, especially as rural hospitals come to the end of the federal stimulus money distributed during the COVID-19 pandemic. Much like everything else, inflation has caused costs to rise, increasing internal staffing costs by an estimated 40% as compared to pre-pandemic numbers. Henderson also spoke briefly about the challenges faced by students at local community colleges training in the healthcare field. The need to sometimes travel long distances to certain training locations can create challenges for student completion. Henderson made reference to legislation from the previous sessions which led to a 32-month period of no rural hospital closures. He also expressed optimism regarding proposed rules and payment mechanics relating to the latest federal hospital designation, known as Rural Emergency Hospitals (REH). Henderson stated that this designation will offer rural hospitals with very low inpatient census to move into a more sustainable model. He also made sure to mention the benefits seen from the expansion of telemedicine services and

expressed support for the continued efforts to expand broadband access to allow rural citizens better access to quality care.[37]

Adrian Billings, MD, PhD, FAAFP, Texas Medical Association spoke about the results of critical staffing shortages, including in the local labor and delivery unit, where staff are being diverted and numbers are so low that some mothers have had to deliver in the ER, potentially compromising the standard of care. Billings expressed strong support for loan repayment programs to incentivize growth in the healthcare workforce. He also suggested the development and support of rural education and training tracks for physicians and nurses to encourage practice in these specific areas. Finally, Billings emphasized the need for Texas to continue to embrace innovations in healthcare delivery models. He encouraged all interested parties to work collaboratively on a project that would address the challenges that rural Texans face in access to care. [38]

Alina Sholar, MD, TX400, Texas Physicians for Patients PAC shared with the committee how her parents, living in deep East Texas, cannot find anywhere in their county to get prescriptions filled. Additionally, as a physician, her father knows that once he retires his area will have no replacement. Sholar also referenced the shortages of physicians in emergency rooms and primary care. She states that while there is an increase in the number of physicians retiring, much of the shortage is from a supply and demand imbalance. The population in Texas is undeniably growing, and these new residents need physicians. Even with this population growth, those training and entering physician practice has remained a stagnant number. Sholar stated that 98% of Texas is in a shortage area. To address this issue, Sholar recommends an increase in financial incentives as well as an increase in awareness campaigns. She states that creating more medical schools will not necessarily address the whole problem. Sholar suggests that including an expansion in rural residency positions is necessary to move the needle. She stated that a person who is in one location for 8 years is highly likely to remain in that location. Sholar also recommended taking unmatched medical school graduates and creating a practice pathway, pairing students with rural family practice doctors, while seeking a future residency match. She suggests this become a program that would give preference to rural tracks and be time limited by the Medical Board.[39]

Michael Magoon, MD shared his experience as a rural emergency physician, describing how they often must evaluate a patient to determine the best transport method to San Antonio to receive further care. In his service area there is no 24-hour emergency room currently available. Magoon suggests that freestanding ERs should be considered when discussing ways to support rural area healthcare.[40]

RECOMMENDATION

Monitor Rural Emergency Hospital Status Implementation

DSHS should continue to monitor and assess the REH opportunity and evaluate whether this new designation would serve to decrease health disparities in the rural areas of the state.

ENDNOTES

[1] Zalkovsky, Emily, Texas Health and Human Services Commission, Oral Testimony to the Texas House of Representatives Committee on Public Health, September 13, 2022, https://tlchouse.granicus.com/MediaPlayer.php?view_id=46&clip_id=23534.
[2] Zalkovsky, Emily, Texas Health and Human Services Commission, Written Testimony to the Texas House of Representatives Committee on Public Health, September 13, 2022, https://capitol.texas.gov/tlodocs/87R/handouts/C4102022091311001/bb2cc75d-5e3a-459b-a4d0-d59615092793.PDF.
[3] Lynch, Jessica, Texas Association of Health Plans, Oral Testimony to the Texas House of Representatives Committee on Public Health, September 13, 2022, https://tlchouse.granicus.com/MediaPlayer.php?view_id=46&clip_id=23534.
[4] Lynch, Jessica, Texas Association of Health Plans, Written Testimony to the Texas House of Representatives Committee on Public Health, September 13, 2022, https://capitol.texas.gov/tlodocs/87R/handouts/C4102022091311001/e53000de-0307-4674-8b98-fcc0dfe5f443.PDF.
[5] Belcher, Nora, Texas eHealth Alliance, Oral Testimony to the Texas House of Representatives Committee on Public Health, September 13, 2022, https://tlchouse.granicus.com/MediaPlayer.php?view_id=46&clip_id=23534.
[6] Belcher, Nora, Texas eHealth Alliance, Written Testimony to the Texas House of Representatives Committee on Public Health, September 13, 2022, https://capitol.texas.gov/tlodocs/87R/handouts/C4102022091311001/9c591447-dc8c-4dbf-aec6-a822e527a962.PDF.
[7] Billings, Adrian, MD, PhD, FAAFP, Chief Medical Officer, Preventative Care Health Services, Testimony to the Texas House of Representatives Committee on Public Health, June 29, 2021.
[8] Gilbert Mack, MedCare EMS, Testimony to the Texas House of Representatives Committee on Public Health, June 29, 2021.
[9] Gutierrez,Alberto H, MD, Medical Director, HOPE Family Health Center, Assistant Medical Director, DHR Health Hospice, Texas Hospital Association, Testimony to the Texas House of Representatives Committee on Public Health, June 29, 2021.
[10] Villareal, Linda, MD, President, Texas Medical Association, Testimony to the Texas House of Representatives Committee on Public Health, June 29, 2021.
[11] Paz, Christina, DNP, RN, FNP-C, Chief Executive Officer, San Vicente Family Health Center, Texas Nurse Practitioners, Testimony to the Texas House of Representatives Committee on Public Health, June 29, 2021.
[12] Dudensing, Jamie CEO, Texas Association of Health Plans, Testimony to the Texas House of Representatives Committee on Public Health, June 29, 2021.
[13] Garza, Debbie, R.Ph., Chief Executive Officer, Texas Pharmacy Association, Testimony to the Texas House of Representatives Committee on Public Health, June 29, 2021.
[14] Linial, George, President & CEO, LeadingAge Texas, Testimony to the Texas House of Representatives Committee on Public Health, June 29, 2021.
[15] Gruber, David, Associate Commissioner, Regional and Local Health Operations Texas Department of State Health Services, Testimony to the Texas House of Representatives Committee on Public Health, June 29, 2021.
[16] https://www.cdc.gov/mmwr/volumes/70/wr/mm7037a4.htm
[17] https://www.cdc.gov/mmwr/volumes/70/wr/mm7037a4.htm
[18] Mills, Brady, Chief, Crime Laboratory Division, Department of Public Safety, Testimony to the Texas House of Representatives Committee on Public Health, September 13, 2022.
[19] Potter, Jennifer, M.D., Vice President for Research, Professor of Psychiatry and Behavioral Sciences,The University of Texas Health Science Center at San Antonio, Testimony to the Texas House of Representatives Committee on Public Health, September 13, 2022.
[20] Abbott, Greg, Letter to Agency Heads, September 20, 2022 https://gov.texas.gov/uploads/files/press/O-AgencyHeads202209200176.pdf
[21]https://www.cdc.gov/nchs/icd/icd10cm_pcs_faq.htm#:~:text=ICD%2D10%20codes%20were%20developed,under%20authorization%20by%20the%20WHO.
[22] Kuehn, Bridget M., MSJ. News From the Centers for Disease Control and Prevention. JAMA, October 26, 2021; Volume 326, Number 16.
[23] Friedman J, Montero F, Bourgois P, et al. Xylazine spreads across the US: A growing component of the increasingly synthetic and polysubstance overdose crisis. Drug Alcohol Depend. 2022;233:109380. doi:10.1016/j.drugalcdep.2022.109380

[24] https://www.cdc.gov/mmwr/volumes/70/wr/mm7037a4.htm
[25] House Research Organization Focus Report, March 10, 2017.
https://hro.house.texas.gov/pdf/focus/telemed2017.pdf
[26] https://tlis/BillLookup/History.aspx?LegSess=85R&Bill=SB1107
[27] https://www.hhs.texas.gov/sites/default/files/documents/about-hhs/communications-events/meetings-events/smmcac/aug-2021-smmcac-agenda-item-5c.pdf
[28] https://www.healthsystemtracker.org/brief/outpatient-telehealth-use-soared-early-in-the-covid-19-pandemic-but-has-since-receded/
[29] https://www.ama-assn.org/system/files/telehealth-survey-report.pdf
[30] General Appropriations Act, Article III, Rider #10, Pp 186-187 (2021).
[31] Tex. Occ. Code §111.002.
[32] 22 TAC §174.6(a)(3); §165.1.
[33] https://www.tha.org/issues/rural-issues/
[34] https://www.ncsl.org/research/health/rural-emergency-hospitals.aspx
[35] Dickey, Nancy, MD, FAAFP, Executive Director, Texas A&M Rural and Community Health Institute, Testimony to the Texas House of Representatives Committee on Public Health, September 14, 2022.
[36] Wyman, Lisa, Director, Center for Health Statistics, Department of State Health Services, Testimony to the Texas House of Representatives Committee on Public Health, September 14, 2022.
[37] Henderson, John, President/CEO, Texas Organization of Rural and Community Hospitals, Testimony to the Texas House of Representatives Committee on Public Health, September 14, 2022.
[38] Billings, Adrian, MD, PhD, FAAFP, Texas Medical Association, Testimony to the Texas House of Representatives Committee on Public Health, September 14, 2022.
[39] Sholar, Alina, MD, TX400, Texas Physicians for Patients PAC, , Testimony to the Texas House of Representatives Committee on Public Health, September 14, 2022.
[40] Michael Magoon MD, Testimony to the Texas House of Representatives Committee on Public Health, September 14, 2022.