



**Texas Council on
Cardiovascular
Disease and Stroke**

**Annual Legislative
Report
January-December
2007**

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Chair, Texas Council on
Cardiovascular Disease and
Stroke**



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Message From the Chair

Heart disease and stroke, commonly referred to as cardiovascular disease, are the number one and three causes of death among Texans. In response to ensuing costs at both the individual and public health levels, the 76th Texas Legislature established the Texas Council on Cardiovascular Disease and Stroke in 1999. The fifteen-member council consists of eleven Governor-appointed, Senate-approved voting members and four state-agency appointed non-voting members. The council is responsible for developing and implementing a plan to reduce heart disease and stroke in Texas and working with partners to carry out that plan. The council's dedicated members continue to combine their skills to address chronic diseases of the heart and brain. These council members are outstanding leaders in their respective fields, and provide their expertise to improve the overall health of Texans.

The *Texas Plan to Reduce Cardiovascular Disease and Stroke*, May 2002 and May 2005, 2nd edition contain goals and objectives to reduce heart disease and stroke, many of which have been achieved. Some of the notable achievements of the council during the past year include:

- The implementation of two pilot projects with grant funds received by the council. The Secondary Prevention of Cardiovascular Disease in Medicaid Clients and the Awareness, Control and Treatment of High Blood Pressure in Hispanics projects will provide the council with information on the quality of care provided to patients with heart disease or stroke and the barriers that exist for those clients to continue controlling their cardiovascular conditions.
- The continuation of the Heart and Stroke Healthy City Recognition Program, which encourages and recognizes cities for implementing local policies and systems changes to support their citizens in living a heart and stroke healthy lifestyle. The program

has been in effect since 2002 and has led to cities assessing their city structure and developing action steps to implement policies such as no smoking ordinances and improving their 911 response times.

- Participation as a co-sponsor of the Texas Heart Disease and Stroke Prevention Partnership, a new statewide group of stakeholders brought together to assess the current state of the heart disease and stroke public health system and identify action steps to improve that system within Texas.

Future plans of the council include continued surveillance to monitor the burden of heart disease and stroke and promoting the implementation of intervention activities with partners conducted at both the clinical and public health levels. These activities will help to impact the council's work on morbidity and mortality from heart and stroke-related diseases.

This effort could not be accomplished without the support of staff from the Texas Department of State Health Services (DSHS), including Jennifer Smith, Dr. Philip Huang, Casey Blass, Janna Zumbrun, Barbara Keir, Brett Spencer, Reuben Parrish, Weihua Li and Velma Ortega. Their tireless work has been an inspiration to the council. I would also like to thank the DSHS for support of the council's mission: "to educate, inform, and facilitate action among Texans to reduce the human and financial toll of cardiovascular disease and stroke." It has been a privilege and honor to serve as Chair of the Texas Council on Cardiovascular Disease and Stroke for the past three years. The council members join me in the continued commitment to reduce the morbidity and mortality caused by Texas' greatest health burdens, cardiovascular disease and stroke.

A handwritten signature in black ink that reads "Michael Hawkins MD". The signature is written in a cursive, flowing style.

Michael M. Hawkins, M.D.
Chair, Texas Council on Cardiovascular Disease and Stroke

Council Charges, Membership and Meeting Dates

The Texas Council on Cardiovascular Disease and Stroke (council), authorized by House Bill 2085 during the 76th Legislature, was charged with three main duties (Appendix 1):

- 1) Development of an effective and resource-efficient plan to reduce the morbidity, mortality, and economic burden of cardiovascular disease (CVD) and stroke in Texas,
- 2) Review available clinical resources and develop a database of recommendations for appropriate care and treatment of patients with CVD or who have suffered from or are at risk for stroke, and
- 3) Collect and analyze information related to CVD and stroke at the state and regional level and, to the extent feasible, at the local level, and maintain a database of this information.

The council has worked continuously since February 2000 to address these duties. This report highlights the council's accomplishments in 2007.

Council Membership and DSHS Support

The council consists of 15 members including 11 appointed public voting members and 4 state-agency appointed nonvoting members.

Voting Members

The governor, with approval by the senate, is responsible for appointing the 11 public voting members. The 11 public voting members consist of the following: three medical doctors with backgrounds in cardiology, neurology, and primary care; a registered nurse with a background in quality improvement processes; a registered dietitian; two consumers with backgrounds in either volunteer heart and stroke organizations or work in hospital or managed care administration; two persons with experience in public health research, practice or policy; and two members from the general public that represent persons with CVD or stroke and their caregivers. Members come from a variety of communities, locales, and demographic groups providing sufficient representation of the overall burden of

CVD and stroke in Texas. Appendix 2 provides a list of members and their contact information.

Non-Voting Members

Four non-voting members represent state agencies that oversee services for health, aging and disabilities, education, and assistive and rehabilitative. The state agency commissioners are responsible for designating these representatives.

Reimbursement for Services

The council does not receive any state appropriation and therefore does not receive reimbursement for their costs to participate as a member of the council. The council conducts four meetings a year, with an additional one to two special called meetings. The average yearly financial contribution per voting council member ranges from \$2,000 to \$31,000, including the direct costs of travel, per diem, incidentals, and the indirect expenses including time from work, loss of income, and after-hours work on council-related projects. Council members donate between 30 and 125 hours per year on council business.

Administrative Support

The council is administratively supported by the Texas Department of State Health Services (DSHS). DSHS does not receive appropriated funds for this purpose; however it provides support for the council through other state and federally funded positions and services. The program manager of the Adult Health and Chronic Disease Group, which includes the Cardiovascular Health and Wellness (CHW) Program, serves as the director of the council, overseeing arrangement of council meetings, communications with stakeholders and conducting the business activities developed by the council members. Staff from the CHW Program, Chronic Disease Prevention Branch and other programs within the department, including program specialists, medical consultants, epidemiologists and statisticians provide support during the council meetings, participate in implementation of council programs, and work with stakeholders within the state to ensure coordination of programs that work to reduce heart disease and stroke in Texas.

Council Members

Term Expiration Dates, Attendance and Categories for 2007 Council Representation

2007 Council Meetings: February 23, June 8, September 8, November 9

Appointed Voting Members

Walter F. Buell, M.D.
02/01/09; Feb., June, Sept., Nov.
Consumer

Kate Darnell, M.S.
02/01/07; Feb., Sept., Nov.
General Public

Michael M. Hawkins, M.D. (Chair)
02/01/07; Feb., June, Sept.
Consumer

Melbert C. (Bob) Hillert,
Jr., M.D.
02/01/09; Feb., June, Sept., Nov.
Cardiologist

Deanna Hoelscher, Ph.D., R.D.
02/01/11; June, Sept., Nov.
Registered Dietitian

Carolyn Hutchison, R.N., B.S.N.
02/01/09; Feb., Sept.
Registered Nurse

J. Neal Rutledge, M.D.
02/01/11; Feb., June, Nov.
Neurointerventionist

Martha Simien, M.Ed.
02/01/07; June
Public Health Member

Erica Swegler, M.D.
02/01/11; Feb., June, Sept., Nov.
Primary Care

Sheila Tello, R.N.
02/01/11; Nov.
Consumer

Thomas E. Tenner, Jr., Ph.D. (Vice-
Chair)
02/01/09; Feb., June, Sept., Nov.
Public Health Member

State Agency Non-Voting Members

Barbara Keir, Feb., June, Sept., Nov.
Health Services

Michael Wilson, Ph.D., Nov.
Aging and Disabilities Services

Marissa Rathbone, Sept.
Education

Grace Elinsway, M.Ed., Feb., Nov.
Assistive and Rehabilitative Services

Texas Council on Cardiovascular Disease and Stroke Legislative Priorities for the 2010- 2011 Biennium

Heart disease and stroke continue to rank as the first and third leading causes of deaths in the U.S. and Texas. In 2005, almost 50,000 Texans died from heart disease or stroke. In 2006, an estimated 1.4 million Texans aged 18 years and older had cardiovascular disease or had had a stroke. Hospital charges in Texas in 2005 for these conditions were reported to be over \$10 billion dollars and the state of Texas paid out over \$200 million dollars in Medicaid reimbursement claims.

In 1999, the 76th Legislature passed House Bill 2085 which created Chapter 93 of the Health and Safety Code and the Texas Council on Cardiovascular Disease and Stroke. The council's charge is to create a state plan to reduce the burden of cardiovascular disease and stroke in the state. In 2005, the 78th Legislature passed Senate Bill 330 creating the Texas Stroke Act and House Bill 2344 amending Chapter 93 and allowing the council to make written recommendations for performing its duties and to advise the legislature on legislation that is needed to develop further and maintain a statewide system of quality education services for all persons with cardiovascular disease or stroke. No funding has been appropriated to the council to discharge its duties.

The council, in collaboration with partners, has identified two priority issues that require immediate attention during the 2010-2011 biennium:

- Reduce the incidence of stroke in Texas by implementation of a Statewide State Stroke Prevention Plan. Request new appropriations of \$500,000 in 2010 and \$1,000,000 in 2011 and 4 new FTE's.
- Prevent, treat and control heart disease and heart attacks by providing grants to cities to improve their ability to implement evidence-based policies and programs for their citizens. Request new appropriations of \$500,000 in 2010 and \$1,000,000 in 2011 and 2 FTEs to further develop the "Heart and Stroke Healthy Communities and Worksites" (HSHCW) Initiative.

Both priority issues include actions to collect data. The council will use this data to identify best practices, as well as gaps in services and to inform decision makers at a state and local level on the availability and effectiveness of evidence-based, quality education services to reduce heart disease and stroke in Texas. The council intends to support state and local implementation of these evidence-based, quality education services to assist in attracting new businesses to Texas by emphasizing the benefits of a healthy workforce and the availability of heart disease and stroke prevention services within the state that will assist employers in maintaining a healthy workforce.

Texas Council on CVD and Stroke Priority Issues and Funding Requests

1. Reduce the incidence of stroke in Texas by implementation of a Statewide State Stroke Prevention Plan. Request new appropriations of \$500,000 in 2010 and \$1,000,000 in 2011 and 4 new FTE's to facilitate:
 - a. Creation of a Stroke Plan Implementation Work Group by the CVD/Stroke Council to coordinate activities among public and private entities. The council will ensure stakeholder input into the activities of the work group.
 - b. Implementation of the Stroke Plan including:
 - i. Development of an action plan to implement the Governor's EMS and Trauma Advisory Council, 2007 Stroke Committee Recommendations on Stroke Facility Designation, Emergency Transport Plan, EMS Training and Community Education per Senate Bill 330 passed in 2005.
 - ii. Convene partners in a collaborative process to develop a plan and implement a state public awareness and community outreach program on the recognition, prevention and emergent care of stroke (FAST).
 - iii. Development of a new data collection system, called the Stroke QA/QI Information Depository (provided in the stroke facility designation process) to collect aggregate information from health care entities on the level of care provided to stroke patients. This includes:
 - convening health care entity partners to identify the data to be collected.
 - developing the collection mechanism.
 - providing training and technical assistance to health care entities in data collection and submission.
 - creating and disseminating data reports.
 - iv. Development of a new database of the types of heart disease and stroke services or procedures provided by health care facilities.
2. Prevent, treat and control heart disease and heart attacks by providing grants to cities to improve their ability to implement evidence-based policies and programs for their citizens. Request new appropriations of \$500,000 in 2010 and \$1,000,000 in 2011 and 2 FTEs to further develop the "Heart and Stroke Healthy Communities and Worksites" (HSHCW) Initiative to include:
 - a. Creation of a HSHCW Work Group by the CVD/Stroke Council to coordinate activity among public and private entities.
 - b. Validation of community indicators (criteria for designating cities as "heart and stroke healthy").
 - c. Provision of input on the creation of a database of community indicators for each city.
 - d. Development of an implementation plan by the Work group to include:
 - i. Training for community and worksite leaders on the indicators.
 - ii. Assistance for the development of local planning committees.
 - iii. Provision of resources to support initial assessment and planning efforts in local communities.

- iv. Evaluation of community metrics (medical and systems) in reducing heart disease and stroke through implementation of the Heart and Stroke Healthy Indicators.

3. Hire a chronic disease epidemiologist. Request new appropriations of \$75,000 in 2010 and \$150,000 in 2011 and 1 FTE to coordinate the development of the data collection systems, coordinate with internal and external data sources and manage the data assessment and reporting.

Supporting Issues

The council finds that the implementation of policies and programs that prevent or reduce the number of persons engaging in risky behaviors that negatively affect their health can significantly affect the number of persons developing or living with chronic conditions and the eventual costs for treating or controlling those conditions.

In the 2008 American Heart Association Heart Disease and Stroke Statistics report it states that “it is estimated that more than 90 percent of coronary heart disease events will occur in individuals with at least one elevated risk factor (major risk factors include cigarette smoking, abnormal blood lipid levels, hypertension, diabetes, abdominal obesity, a lack of physical activity, low daily fruit and vegetable consumption, alcohol over-consumption and psychosocial index) and approximately 8 percent will occur in people with only borderline levels of multiple risk factors.”

Tobacco use remains the number one preventable cause of death and disease in Texas, yet we know that we can reduce tobacco use through implementation of evidence-based comprehensive tobacco prevention and control programs. Texas has demonstrated significant reductions in youth and adult tobacco use in areas of Southeast Texas that received a comprehensive tobacco prevention and control program funded at \$3 per person. Between 2000 and 2004, 6th-12th grade tobacco use was reduced 37 percent and adult tobacco use dropped 27 percent.

The council recommends that legislators:

1. Enact Legislation for a Smoke-Free Texas.
2. Appropriate funding in the amount of \$3 per person to implement a statewide Comprehensive Tobacco Prevention Program.
3. Appropriate adequate funding to implement obesity and worksite wellness policies and budgetary requests related to chronic diseases, supported by groups such as the Live Smart Texas, Partnership for Healthy Texans, and the Texas Public Health Coalition.

The Current Burden of CVD in Texas and the United States

Cardiovascular disease is the leading cause of death in Texas and has been since 1940. It accounts for 2 out of every 5 deaths in Texas, and in 2005 more than 1,419,000 Texas adults reported having had a diagnosed heart attack, a stroke, angina or coronary heart disease. In 2002, the DSHS Cardiovascular Health and Wellness Program created the Texas Cardiovascular Disease Surveillance System and Report to monitor specific trends in risk factors related to CVD and stroke. The program continually collects and provides CVD and stroke health data and information and makes these data available to the council and other state partners. These data serve as a benchmark and determinant of progress toward stated goals and objectives as outlined in the council's *Texas State Plan to Reduce Cardiovascular Disease and Stroke* - May 2005. The data are available on the council's Web site at www.texascvdcouncil.org.

Definition

Cardiovascular disease refers to a group of diseases that target the heart and blood vessels. It is the result of complex interactions between multiple inherited traits, behaviors, and environmental issues that impact cholesterol, body weight, blood pressure, and lifestyle habits. Common forms include heart disease, stroke, and congestive heart failure.

A major cause of CVD is atherosclerosis, a general term for the thickening and hardening of the arteries. It is characterized by deposits of fatty substances, cholesterol and cellular debris in the inner lining of an artery. The resulting buildup is called plaque, which can partially or completely occlude a vessel and may lead to heart attack or stroke.

National Figures

In their *Heart Disease and Stroke Statistics-2008 Update*, the American Heart Association (AHA) reported that 80.7 million are estimated to have one or more forms of cardiovascular disease. The most prevalent forms of heart disease and stroke in which narrowed or blocked arteries result in decreased blood supply to the heart or brain are referred to as ischemic heart disease and ischemic stroke. If all forms of major CVD were eliminated, life expectancy would rise by almost seven years. The estimated direct and indirect costs of CVD in the United States in 2008 are \$444.8 billion.

State Figures

Heart disease and stroke are not only the number one and number three killers in the nation and Texas, but together they are the "number one drain" on health care resources.

Highlights of the *Burden Report: Cardiovascular Disease in Texas, November 2007*, include:

- 1) Cardiovascular disease accounted for 33 percent of all deaths in Texas in 2004.
- 2) Total hospitalization charges for CVD and stroke in 2005 were more than \$10 billion.
- 3) The Texas Medicaid Program paid over \$200 million dollars in medical claims for CVD in 2005.

In 2004, 49,922 deaths were attributed to heart disease and stroke as the leading cause of death. Among these deaths, 80 percent were due to ischemic heart disease (IHD) and 20 percent were due to stroke.

CVD mortality rates have been declining over the years. Factors affecting this decline may include more effective disease management, more emphasis on reducing controllable risk factors, and better treatment for heart attack and stroke patients. In the *Burden Report: Cardiovascular Disease in Texas, November 2007*, developed by the DSHS Cardiovascular Health and Wellness program, data show that while mortality rates due to IHD are declining, males still have a significantly higher risk of dying from IHD than females. Nonetheless, CVD continues to be the major cause of death, particularly among Texas' minority populations. African Americans have a higher risk of dying from IHD (231deaths/100,000 population) than whites (182/100,000), Hispanics (151/100,000) and other racial/ethnic groups (79/100,000).

Risk Factors

There are several factors that increase the risk of heart disease and stroke. The major non-modifiable risk factors are *heredity, male gender, and increasing age*. The modifiable risk factors are *smoking, high cholesterol, high blood pressure, overweight and obesity, and physical inactivity*. Another risk factor that contributes to one's risk of developing CVD is diabetes mellitus.

The prevention and control of the major modifiable risk factors for heart disease and stroke are critical to achieving a heart-healthy and stroke-free Texas. The council, DSHS, and collaborating partners are working to reduce these risk factors, eliminate disparities in health, and promote policy and environmental change in Texas communities.

Charge 1 - Develop a State Plan

Texas Plan to Reduce Cardiovascular Disease and Stroke - First Edition, May 2002 and 2nd Edition, May 2005

The council, in partnership with public and private entities, developed the first state plan in May 2002, and subsequently updated the plan in May 2005. Both plans are available on the council Web site. A list of accomplishments during the years 2002-2005 and identification of 22 short and long-term action steps for the years 2005-2010 are provided in the May 2005 2nd Edition. A new state plan is in the process of being developed with partners and is scheduled to be released in June 2008.

Four key strategies have been adopted by the council, as well as action steps for approaching the awareness, detection, prevention, treatment and control of heart disease and stroke in Texas. The council meets in workgroups to review information and plan activities that will be implemented in the state. The four workgroups correspond to the four strategies and are:

- 1) Surveillance, Data and Outcome Management**
- 2) Health Education and Outreach**
- 3) Community Policy and Environmental Change**
- 4) Clinical Prevention and Treatment Services**

The council focuses its planning efforts on the legislated responsibilities of the council located in Appendix 1. The quarterly meetings are open to the public. Stakeholders from across the state are encouraged to participate in the four workgroups that address each strategy.

Over 390 partners worked with the council to implement state plan activities. These partners include organizations such as the American Heart Association; American Cancer Society; Texas Action for Healthy Kids Coalition; Texas Legislature; Texas Association of Local Health Officials; Texas Public Health Association; Governor's EMS and Trauma Advisory Council (GETAC); Regional Advisory Councils (RACs); small, medium and large cities in the state; DSHS programs that focus on school health, nutrition, physical activity, obesity, diabetes, tobacco prevention and control, women's health and elimination of health disparities; 267 churches; and 105 worksites. The state plan activities implemented during this time include the Search Your Heart Program, Go Red Sunday, State Stroke System of Care Initiative, the Cardiovascular Health Promotion Awards, and the Heart and Stroke Healthy City Recognition Program which encourages adoption of policies for physical activity and nutrition, smoking ordinances, promotion of coordinated school health programs and improvement

of emergency response and adherence to national secondary prevention guidelines in health care settings.

Texas State Assessment of the Public Health System for Heart Disease and Stroke

On November 1-3, 2006, the council co-sponsored the Fourth CVD and Stroke Summit and the first meeting of the Texas Health Disease and Stroke Partnership (THDSP) with the American Heart Association, South Central Affiliate; the Texas Public Health Association; Texas Association of Local Health Officials; and DSHS. The council subsequently co-sponsored two additional meetings of the THDSP in May and October 2007.

The November 2006 summit was very successful in convening partners to assess the Heart Disease and Stroke State Public Health System (HDSSPHS) in Texas using the National Public Health Performance Standards (NPHPS). (For information about NPHPS, refer to: www.cdc.gov/od/ocphp/nphps/). This system collectively, rather than the DSHS, was the focus of the assessment summit.

Four recommendations were created by the partnership during the November assessment:

1. **Maintain Communication with System Partners Identified Through this Assessment.** A Web site was created for the THDSP. Materials used during the THDSP meetings are posted at “insert the URL here”. Additionally, email messages are sent on a regular basis to inform partners of upcoming meetings, trainings and information.
2. **Determine Priorities for System Improvement.** Between November 2006 and May 2007, a planning group was created by partners to develop the prioritization process to be used at the May 2007 THDSP Partner Planning Meeting. Partners attended the May meeting and identified and prioritized action steps for improving the system components that were found to be below standards.
3. **Develop Strategies for Performance Improvement.** Between May 2007 and October 2007, partners began planning the October meeting, at which they developed strategies for implementing the action steps developed during the May 2007 meeting. Partners identified the strategies and action steps that their organizations could implement as a part of their current organizational plans.
4. **Convene Partners around Priorities.** Two meetings of the THDSP were held during May and October of 2007. The October meeting not only developed strategies for improving the performance of the system, but also met in four groups that match the four goals of the Healthy People

2010 and the National Heart Disease and Stroke Forum. The four goals are:

- a. Prevention of Risk Factors
- b. Detection and Treatment of Risk Factors
- c. Detection and Treatment of Heart Attacks and Stroke and
- d. Prevention of Recurrent Events

Partners reviewed national, state and local objectives for heart disease and stroke and prioritized those objectives seen to be the most feasible and attainable for the TDHSP. These prioritized objectives will be included in the new state plan.

Description of Council Activities by Strategy

Key Strategy: Surveillance, Data and Outcome Management

The council continually reviews data pertaining to the impact of CVD and stroke on the Texas population including, but not limited to:

- **Mortality Review:** reviewing trend data.
- **Medicaid Data:** reviewing costs paid for services.
- **Behavioral Risk Factor Surveillance System Review (BRFSS):** reviewing behaviors and risk factors that place adults in Texas at risk of CVD and stroke.
- **Heart and Stroke Healthy City Review:** setting a baseline and reviewing progress towards the initiation of policy and environmental supports.
- **Program Review:** developing individual program evaluations to assess the implementation, participation and results of each program.
- **Texas Health Care Information Collection:** reviewing trends in hospital discharges for four main conditions of CVD and stroke, ischemic heart disease, congestive heart failure, ischemic stroke, and hemorrhagic stroke.
- **Youth Risk Behavioral Survey (YRBS):** reviewing behaviors among youth in grades nine through 12 that put them at risk for CVD and stroke.

Additionally, the council reviews local community indicator data related to risk factors/conditions for CVD, existing policies, and evidence-based programs through the Heart and Stroke Healthy City program. This review of data assists in assessing programmatic impact.

Key Strategy: Health Education and Outreach

The council collaborated with state and national partners to promote health education, public awareness, and community outreach activities in 2007. These include:

Texas Cardiovascular Health Promotion Awards

The Texas Cardiovascular Health Promotion Awards have been given annually since 2002. These awards identify and recognize entities in the categories of healthcare, school, worksite, and community that have implemented innovative and effective programs that improve treatment, prevention and public awareness of heart disease and stroke. Programs competing for the awards must demonstrate efforts to help targeted audiences recognize the impact of the risk factors for heart disease and stroke.

2007 Cardiovascular Health Promotion Award Winners

The following organizations were recognized at the 2007 Texas Public Health Association Annual Conference held in February 2007.

Outstanding Program Recognition:

Houston Park and Recreation (Houston)
American Heart Association (Statewide)
Paso del Norte Foundation (El Paso)
Texas Medical Foundation (Seven Counties)
University of Houston College of Pharmacy, Kelsey Seybold Clinic and Kelsey Research Foundation (Houston)
West Texas AHEC (99 counties of West Texas)

Honorable Mention Program Recognition:

American Heart Association (Statewide)
Smith County Medical Society Alliance (Tyler)
The Inter-Religious Faith and Health Alliance (Galveston)
Hillcrest Baptist Medical Center (Waco)

Outstanding programs received an engraved plaque and recognition on the council Web site.

Honorable mention programs received a mounted certificate and recognition on the council Web site.

Risk Factor Awareness

Tobacco - The council continues to promote tobacco cessation in partnership with DSHS, AHA and ACS, specifically through an indicator in the Heart and Stroke Healthy City Program that recognizes cities for moderate to strong smoking ordinances.

Physical Activity - The council supports the Texas Round-Up, the Governor's statewide physical activity program, as well as physical activity initiatives of other DSHS programs and partner organizations.

Women and Heart Disease - The council, in conjunction with DSHS, continues to promote reduction of heart disease and stroke in women through support of the AHA Go Red Program and the National Heart, Lung and Blood Institute's Red Dress Campaign. Information and materials for these programs are available on the DSHS Web site for entities to download.

Key Strategy: Community Policy and Environmental Change

Heart and Stroke Healthy City Recognition Program

The Heart and Stroke Healthy City Recognition Program was developed in August 2003 by a group of public and private organizations dedicated to reducing the burden of heart disease and stroke on Texans. This planning group was convened by the DSHS CHW program and included representatives from health, business, and school settings. The group identified the top 10 community-based indicators that are vital to reducing the burden of heart disease and stroke. Members of the group also identified criteria for each community-based indicator to determine the level at which the indicator is considered met, partially met or not met. The CHW program contacts each city and uses an assessment tool to collect information on all criteria. The council reviews this information and determines if the indicator is met, partially met, or not met in each city. The 10 indicators are:

Heart and Stroke Healthy City Indicators

1. CVD and stroke media campaigns are provided in the community.
2. Physical activity areas are designated, safe, accessible, and promoted.
3. Healthy food options are accessible and promoted.
4. Public schools (grades K-8) comply with all legislated components of a coordinated school health program and daily physical activity.
5. Moderate to strong city smoking ordinances are in place.
6. CPR classes are available.
7. A plan is in place to reduce disparities in CVD and stroke.
8. Defibrillators (manual and/or automated external) are available.
9. Stroke is treated as a medical emergency in the community and appropriate acute stroke treatment protocols are in place.
10. Health sites in the community promote primary and secondary prevention of CVD and Stroke.

Recognition Criteria Level:

Gold Level - Score of 40 with all indicators met

Silver Level - Score of 35 or greater and no “No Indicators Met” with no more than two partially met indicators

Bronze Level - Score of 30 or greater and no “No Indicators Met” with no more than five partially met indicators

Honorable Mention - Score of 30 or greater and only one “No Indicator Met”

City Assessment and Recognition Results:

During 2007, small cities (0-100,000 population) were assessed on whether the indicators were in place and metropolitan areas (500,000+ population) were in the process of being assessed. The small cities that have been assessed identified gaps in their services and are beginning to implement appropriate evidence-based programs, policies and environmental changes to eliminate those gaps. More than 900,000 people have been potentially impacted by the policy and environmental changes being implemented in those cities.

Information was retrieved from three specific settings within communities: **1) community overall, 2) healthcare and 3) school.**

Community Overall:

The program has been in effect for more than four years. The small cities have been assessed twice within those years. The most recent assessment of the fourteen small cities showed improvements and changes in many of the indicators used in the assessment.

One positive change observed in this round of assessments is the major contribution of CVD and stroke awareness campaigns through the American Heart Association.

In the area of healthy food options, all cities do not have a dining guide that promotes nutrition and healthy dining. There was an increase in nutrition classes through local hospitals and community organizations that included tips on choosing healthier options when eating out.

One indicator showed ten (71 percent) of the fourteen cities had a weak smoking ordinance, meaning that they had no coverage to limited restrictions on where smoking is allowed. The City of Victoria was the only small city at the time of the assessment to be 100 percent smoke free.

Cardiopulmonary resuscitation classes and first aid classes were available in all cities with an increase in the number of people trained in only a few cities.

As for addressing the health disparities in CVD and stroke in high risk populations, only a few cities had organizations or groups that had a specific plan in place or included it as an activity in an overall city plan addressing health concerns.

Healthcare Setting:

Stroke Response - The emergency response time in cities varied from 5 - 8 minutes or longer. A stroke protocol was in place within the Emergency Medical Systems in four cities.

In seven cities the healthcare sites promoted primary and secondary prevention of CVD and stroke. Over 28 percent of the fourteen cities implemented a quality improvement program in health sites (example - Get With the Guidelines (GWTG)-Stroke, Coronary Artery Disease, or Heart Failure). Two primary stroke centers were identified in those cities.

Schools:

Sixteen elementary public schools (grades K- 6) were assessed within the small size cities, and of these, eleven schools (79 percent) implemented a coordinated school health program approved by the Texas Education Agency. Over 28 percent of the schools were in the process of developing a school health advisory council with monthly meetings planned.

2007 Award Presentations:

Small cities that had been assessed in 2007 were recognized for their levels of achievement. Council members presented awards during city council meetings in these cities. As stated by Tom Tenner, Ph.D., council member who oversees the Community Policy and Environmental Change Workgroup, "This program helps bring into focus those cities that implement quality activities to raise the bar in cardiovascular health. The following cities were found to be the best prepared, based on an assessment of implementation of recognized best practices in policies and environmental changes. We hope to add more to the list of Gold Level award winners, using El Paso as a model city, as we encourage greater participation in existing programs and new initiatives for the prevention and treatment of CVD and stroke in the years ahead."

Gold Level – no awardees

Silver Level – no awardees

Bronze Level – no awardees

Honorable Mention

City of Bryan, City of Galveston, City of Temple, City of Tyler

Key Strategy: Clinical Prevention and Treatment Services

Texas Cardiovascular (CV) Quality Initiative

The Texas CV Quality Initiative was created to develop a consensus on high priority actions to improve treatment, prevention and public awareness of CVD and stroke. The initiative identified nationally recognized guidelines for treatment and prevention of CVD and stroke, and specific actions to promote the guidelines and increase physician participation in quality improvement programs.

Guidance on evidence-based primary and secondary guidelines for the prevention and treatment of CVD and stroke is promoted on the council Web site at: **www.texascvdcouncil.org**.

Reaching Uninsured and Underinsured Populations

Secondary Prevention of Heart Disease in the Medicaid Population

The council continued working with the Texas Health and Human Services Commission - Medicaid Program to implement the Heart Disease and Stroke Prevention Project (HDSPP) to address heart disease and stroke prevention and treatment in Medicaid clients who have heart disease and/or stroke. Funding in the amount of \$250,000 per year for two years was made available as a value added program arrangement, with the DSHS acting as the fiscal agent and representative for the council. In agreement with Bristol Myers Squibb/Sanofi-Aventis, the Phase I pilot project began targeting the San Antonio and Rio Grande Valley area where a high number of Medicaid clients with CVD and stroke was identified. The Phase I project ended in October 2006 and a new Phase II project was identified to assess the level of care provided to underinsured and uninsured patients being seen in community health centers and ensure that the care provided meets nationally recognized standards of care.

The most widely accepted set of CVD and stroke measures are those established by the American Heart Association/American Stroke Association/National Committee for Quality Assurance (NCQA) Heart/Stroke Recognition Program (HSRP), which are based on American Heart Association/American Stroke Association clinical guidelines and are listed below.

<u>Measure:</u>	<u>Required % of Patient Sample</u>
1. Blood pressure control <140/90 mm Hg	75 %
2. Complete lipid panel	80 %
3. LDL control <100 mg/dl	50 %
4. Use of aspirin or another antithrombotic	80 %
5. Smoking status and cessation advice and treatment	80 %

A contract was developed with the Texas Association of Community Health Centers (TACHC) in collaboration with the DSHS Diabetes Program. Five community health centers were identified to participate in the cardiovascular disease (CVD) project, agreeing to collect baseline and monthly clinical measure data on their patients with CVD. The clinics are also participating in a system improvement collaborative called Access/Redesign. The purpose of the collaborative is to improve the access to the clinic by patients through reduced appointment and wait times. Through better access, patients can receive improved timely and quality care from their physician.

The five sites are located in Austin, Houston, Midland, San Antonio and Waco. The clinic staff participates in on-site, email and web-based learning sessions on clinical processes and heart disease, stroke and diabetes. Staff will input their clinical and office process information into a web-based data collection system that will provide more immediate feedback to the clinics on the progress of their system development and clinical measures. The project started in June 2007 and will continue until August 2008. Additional funds should be identified to continue the project and extend the time to conduct a more thorough evaluation.

High Blood Pressure Control in Hispanics Project

The council submitted an application to the Novartis Pharmaceutical Corporation and received \$100,000 in funding to conduct a project to determine barriers and challenges for controlling high blood pressure (HBP) in the Hispanic population in Texas. Though the Hispanic population has a low reported HBP prevalence, those Hispanics with HBP are less likely to be in control of their blood pressure.

The project is working with the DSHS Diabetes Program to contract with the Gateway Community Health Center (Gateway) in Laredo, Texas. The project, named the Awareness, Control and Treatment (ACT) on High Blood Pressure, is focusing on creating awareness of HBP in two sites, clinics and worksites. Gateway is providing their clinic clients with more intensive information on HBP and access to education and support groups. They are also working with two of the largest employers in Laredo, the Laredo and United Independent School Districts. Gateway is providing onsite screening to the school employees, as well as developing the capacity for the schools to adopt onsite worksite wellness programs by training the school nurses. Employees also have the option of using many of the Gateway clinical and educational services. This project runs from September 2007 through August 2008.

Charge 2 - Database of Clinical Resources

The council and CHW program supported the development of the Texas Cardiovascular Quality and Patient Safety Initiative to increase the quality of care for people with CVD or affected by stroke.

The initiative identified three priorities:

- Promotion of consensus guidelines for the secondary prevention of CVD and stroke.
- Development of a recognition program for health care providers engaged in quality improvement practices.
- Identification of incentives to promote use of the secondary prevention guidelines.

Activity 1: Nationally recognized best practices for the achievement of quality improvement standards are identified on a continual basis. The American Heart Association/American College of Cardiology guidelines for secondary prevention of CVD and stroke continue to be those best suited for promotion in the state. The **Physician Tool Kit**, which consists of **Patient Tracking Forms** and **Prescription Pads** to promote primary and secondary prevention methods, is available to health care providers on the council Web site at www.texascvdcouncil.org.

Activity 2: Healthcare providers are recognized for meeting quality of care performance measurements. The **Texas CV Quality Recognition Program** lists hospitals and health care providers meeting the program requirements for their achievement in reaching nationally recognized evidence-based quality improvement program standards of care for CVD or stroke. The list is available for view on the council Web site located at www.texascvdcouncil.org.

Charge 3 - Data Collection

The council collaborates with the various agencies and organizations currently engaged in collecting, monitoring, and evaluating CVD and stroke health data. The DSHS Cardiovascular Health and Wellness Program (CHW) is funded by the Centers for Disease Control and Prevention, Division of Heart Disease and Stroke, to develop a statewide heart disease and stroke prevention program. An important responsibility of the program is to collect, analyze, and report on the burden of heart disease and stroke in the state. The CHW program created *The Burden Report: Cardiovascular Disease in Texas*, November 2007, to report data using 2005 or 2006 BRFFS data, 2001-2004 Mortality, 2005 Hospital discharge data, 2005 Medicaid data, and 2003 and 2004 EMS/Trauma registry data. The Executive Summary of this Burden Report provides the following highlights:

Highlights

- Cardiovascular disease (CVD) and stroke are serious and costly diseases.
- Heart disease is the leading cause of death in Texas.
- Stroke is the third leading cause of death in Texas.
- 33 percent of all deaths in Texas in 2004 were due to heart disease and stroke, more than any other cause.
- In Texas and the U.S., during the period from 1999-2004, age-adjusted mortality rates for CVD steadily declined.
- Age-adjusted mortality rates for ischemic heart disease declined from 202.4 per 100,000 in 1999 to 153.5 per 100,000 in 2004.
- Age-adjusted mortality rates for stroke declined from 66.3 per 100,000 in 1999 to 55.9 per 100,000 in 2004.
- In 2006, about 1.4 million Texas adults aged 18 years and older reported that they have CVD or stroke.
- Overall, hospitalization charges for CVD and stroke in Texas were over \$10 billion dollars in 2005.
- In 2006, 18 percent of Texans aged 18 years and older with CVD or stroke stated they did not have any type of health care coverage, 23 percent could not see a doctor due to the cost, and 22 percent did not have a routine checkup within the past year.
- In 2005, only 9 percent of Texas adults could correctly identify all heart attack signs and symptoms, 17 percent could correctly identify all stroke signs and symptoms, and 85 percent could recognize 911 as the first emergency response option for heart attack and stroke.
- High blood pressure and cholesterol are important health concerns for people in Texas. In 2005, more than 24 percent of Texas adults were

diagnosed with high blood pressure and 34 percent with high blood cholesterol.

- People in Texas are increasingly overweight and obese. From 1995 to 2006, the percentage of overweight and obese adults increased from 51.4 percent to 62.3 percent.
- The prevalence of diabetes, a major risk factor for CVD, has increased over the past decade in Texas.
- Significant disparities exist among Texans with CVD or stroke and their risk factors.
- Generally, persons that are older, poorer, have a lower education and are African American have a higher CVD prevalence, more risk factors, and are at higher risk of death from cardiovascular disease in Texas.
- The average Emergency Medical Services (EMS) response time for a suspected cardiac event was approximately 8 minutes from "Call Received Time to Time EMS Arrived on the Scene" and nearly 40 minutes from "Call Received Time to Time EMS Arrived at Destination (Hospital)."

2008 Council Activities

During 2008, the council, in collaboration with partners, will work on the development of a new State Plan that will describe the four key strategies and priority action steps to reduce heart disease and stroke in Texas. At a minimum, the following specific activities of the council will include:

Strategies and Action Steps

Surveillance, Data and Outcome Management

- Disseminate the updated Heart Disease and Stroke Burden Report.
- Continue reviewing the available data to identify the trends in the burden of heart disease and stroke in Texas and the populations that suffer a disproportionate share of the burden.
- Based upon trends, make recommendations on actions to address noted disparities.

Health Education and Outreach

- Implement the Cardiovascular Health Promotion Awards.
- Coordinate with various associations to infuse chronic disease education programs at educational conferences in 2008.
- Develop plans to educate the public on heart disease and stroke.

Community Policy and Environmental Change

- Continue the Heart and Stroke Healthy City Recognition program.
- Disseminate the *Heart and Stroke Healthy City Implementation Guide* for cities to utilize when setting goals to meet Heart and Stroke Healthy Indicators.
- Collaborate with the American Heart Association-Texas Affiliate to develop task forces in communities that have been assessed, and assist cities in meeting the Heart and Stroke Healthy Indicators.

Clinical Prevention and Treatment Services

- Implement and evaluate the Secondary Prevention of Cardiovascular Disease in Medicaid clients with heart disease or stroke and the ACT on High Blood Pressure in Hispanics pilot projects.
- Continue dissemination of the Physician Tool Kit for patients and health care providers.
- Implement the Texas Quality Improvement Recognition Program for health care providers.
 - Develop the Quality Improvement Recognition Scoring Sheet.
 - Update the Quality Improvement Recognition Application.
 - Identify physicians and hospitals that have been recognized for meeting quality indicators and provide state recognition for achieving those performance measures promoted by the council.
 - Update the Texas Quality Improvement Recognition Program Web site.

Appendix 1

HEALTH & SAFETY CODE CHAPTER 93. PREVENTION OF CARDIOVASCULAR DISEASE AND STROKE

HEALTH & SAFETY CODE

CHAPTER 93. PREVENTION OF CARDIOVASCULAR DISEASE AND STROKE

SUBCHAPTER A. GENERAL PROVISIONS

§ 93.001. DEFINITIONS. In this chapter:

(1) "Cardiovascular disease" means the group of diseases that target the heart and blood vessels and that are the result of complex interactions between multiple inherited traits and environmental factors.

(2) "Council" means the Council on Cardiovascular Disease and Stroke.

Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999.

§ 93.002. APPOINTMENT OF COUNCIL; TERMS OF MEMBERS. (a)

The Council on Cardiovascular Disease and Stroke is composed of:

(1) 11 public members appointed by the governor, with the advice and consent of the senate, as follows:

(A) a licensed physician with a specialization in cardiology;

(B) a licensed physician with a specialization in neurology to treat stroke;

(C) a licensed physician employed in a primary care setting;

(D) a registered nurse with a specialization in quality improvement practices for cardiovascular disease and stroke;

(E) a registered and licensed dietitian;

(F) two persons with experience and training in public health policy, research, or practice;

(G) two consumer members, with special consideration given to persons actively participating in the Texas affiliates of the American Heart Association or American Stroke Association, managed care, or hospital or rehabilitation settings; and

(H) two members from the general public that have or care for persons with cardiovascular disease or stroke; and

(2) one nonvoting member representing each of the state agencies that oversee:

(A) health services;

(B) education;

(C) assistive and rehabilitative services; and

(D) aging and disability services.

(b) In appointing public members under Subsection (a)(1), the governor shall attempt to appoint female members and members of different minority groups, including African Americans, Hispanic Americans, Native Americans, and Asian Americans.

(c) The head of each agency overseeing services listed in Subsection (a)(2) shall appoint the agency's representative nonvoting member.

(d) Public members of the council serve staggered six-year terms, with the terms of three or four of the public members expiring February 1 of each odd-numbered year. A nonvoting member representing a state agency serves at the will of the appointing agency.

Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999. Amended by Acts 2003, 78th Leg., ch. 1170, § 6.01, eff. Sept. 1, 2003; Acts 2005, 79th Leg., ch. 732, § 1, eff. Sept. 1, 2005.

§ 93.003. REIMBURSEMENT. (a) Except as provided by Subsection (b), a member of the council may be reimbursed for travel expenses incurred while conducting the business of the council at the same rate provided for state employees in the General Appropriations Act, provided funds are appropriated to the department for this purpose.

(b) If funds are not appropriated to support reimbursement of travel expenses, the commissioner may authorize reimbursement of the travel expenses incurred by a member while conducting the business of the council, as provided in the General Appropriations Act, if the commissioner finds on application of the member that travel for council business imposes a financial hardship on the member.

Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999. Amended by Acts 2005, 79th Leg., ch. 732, § 2, eff. Sept. 1, 2005.

§ 93.004. DUTIES OF DEPARTMENT; FUNDS. The department shall accept funds appropriated for the purposes of this chapter and shall allocate those funds. The council shall make recommendations to the department concerning the allocation of funds.

Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999.

§ 93.005. CONSULTANTS; ADVISORY COMMITTEE. To advise and assist the council with respect to the council's duties under this chapter, the council may appoint one or more:

- (1) consultants to the council; or
- (2) advisory committees under Chapter 2110,

Government Code.

Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999.

§ 93.006. REPORT TO LEGISLATURE. (a) Repealed by Acts 2005, 79th Leg., ch. 732, § 7.

(b) Not later than January 15 of each year, the council shall report to the governor, the lieutenant governor, and the speaker of the house of representatives on the activities of the council, accounting for all funds received and disbursed by or for the council during the preceding fiscal year.

Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999. Amended by Acts 2005, 79th Leg., ch. 732, § 3, 4, 7, eff. Sept. 1, 2005.

§ 93.007. RESTRICTIONS ON COUNCIL APPOINTMENT, MEMBERSHIP, OR EMPLOYMENT. (a) A person is not eligible to serve as a public member if the person or the person's spouse:

(1) is employed by or participates in the management of a business entity or other organization receiving funds at the council's direction;

(2) owns or controls directly or indirectly more than a 10 percent interest in a business entity or other organization receiving funds at the council's direction; or

(3) uses or receives a substantial amount of tangible goods, services, or funds from the department at the council's direction, other than compensation or reimbursement authorized by law for council membership, attendance, or expenses.

(b) A person who is required to register as a lobbyist under Chapter 305, Government Code, may not serve as a member of the council or act as the general counsel of the council.

(c) An officer, employee, or paid consultant of a trade association in the field of health care may not be a member or employee of the council. A person who is the spouse of an officer, employee, or paid consultant of a trade association in the field of health care may not be a member of the council and may not be an employee, including an employee exempt from the state's position classification plan, who is compensated at or above the amount prescribed by the General Appropriations Act for step 1, salary group A17, of the position classification salary schedule.

(d) For purposes of Subsection (c), a trade association is a nonprofit, cooperative, and voluntary association of business or professional competitors designed to assist its members and its industry or profession in dealing with mutual business or professional problems and in promoting their common interests.

Added by Acts 2005, 79th Leg., ch. 732, § 5, eff. Sept. 1, 2005.

§ 93.008. REMOVAL OF COUNCIL MEMBER. (a) It is a ground for removal from the council if a member:

(1) is not eligible for appointment to the council at the time of appointment as provided by Section 93.007(a);

(2) is not eligible to serve on the council as provided

by Section 93.007(a);

(3) violates a prohibition established by Section 93.007(b) or (c);

(4) cannot discharge the member's duties for a substantial part of the term for which the member is appointed because of illness or disability; or

(5) is absent from more than half of the regularly scheduled council meetings that the member is eligible to attend during each calendar year, unless the absence is excused by a majority vote of the council.

(b) The validity of an action of the council is not affected by the fact that it is taken when a ground for removal of a member of the council exists.

(c) If the presiding officer of the council knows that a potential ground for removal exists, the presiding officer shall notify the governor of its existence.

(d) The council shall inform its members as often as necessary of:

(1) the qualifications for office prescribed by this chapter; and

(2) the responsibilities under applicable laws relating to standards of conduct for state officers or employees.

Added by Acts 2005, 79th Leg., ch. 732, § 5, eff. Sept. 1, 2005.

§ 93.009. PRESIDING OFFICER. The governor shall designate a member of the council as the presiding officer of the council to serve in that capacity at the will of the governor.

Added by Acts 2005, 79th Leg., ch. 732, § 5, eff. Sept. 1, 2005.

§ 93.010. STAFF SUPPORT. Each agency represented on the council:

(1) shall provide the council with staff support of specialists as needed; and

(2) may provide staff support to an advisory committee.

Added by Acts 2005, 79th Leg., ch. 732, § 5, eff. Sept. 1, 2005.

§ 93.011. DIVISION OF POLICY AND MANAGEMENT RESPONSIBILITIES. The council shall develop and implement policies that clearly separate the policy-making responsibilities of the council and the management responsibilities of the commissioner and staff of the department.

Added by Acts 2005, 79th Leg., ch. 732, § 5, eff. Sept. 1, 2005.

§ 93.012. MEETINGS. (a) The council shall meet at least quarterly and shall adopt rules for the conduct of its meetings.

(b) An action taken by the council must be approved by a majority of the voting members present.

Added by Acts 2005, 79th Leg., ch. 732, § 5, eff. Sept. 1, 2005.

§ 93.013. GIFTS AND GRANTS. (a) The council may receive gifts and grants from any public or private source to perform its duties under this chapter. The department shall accept the gifts on behalf of the council and shall deposit any funds accepted under this section to the credit of a special account in the general revenue fund as required by Section 93.014.

(b) The department may retain five percent of any monetary gifts accepted on behalf of the council to cover its costs in administering this section.

Added by Acts 2005, 79th Leg., ch. 732, § 5, eff. Sept. 1, 2005.

§ 93.014. HEART DISEASE AND STROKE RESOURCE FUND. (a) The heart disease and stroke resource fund is an account of the general revenue fund.

(b) The legislature may appropriate money deposited to the credit of the heart disease and stroke resource fund only to the council for:

- (1) heart disease and stroke prevention, research, and medical care for heart attack and stroke victims; and
- (2) grants to nonprofit heart disease and stroke organizations.

(c) The council shall develop a policy governing the award of funds for clinical research that follows scientific peer review guidelines for primary and secondary prevention of heart disease or stroke or that follows other review procedures that are designed to distribute those funds on the basis of scientific merit.

(d) Interest earned from the investment of the heart disease and stroke resource fund shall be deposited to the credit of the fund.

Added by Acts 2005, 79th Leg., ch. 732, § 5, eff. Sept. 1, 2005.

SUBCHAPTER B. POWERS AND DUTIES OF COUNCIL

§ 93.051. CARDIOVASCULAR DISEASE AND STROKE PREVENTION PLAN; DUTIES OF COUNCIL. (a) The council shall develop an effective and resource-efficient plan to reduce the morbidity, mortality, and economic burden of cardiovascular disease and stroke in this state. The council shall:

(1) conduct health education, public awareness, and community outreach activities that relate to primary and secondary prevention of cardiovascular disease and stroke;

(2) promote, enhance, and coordinate health education, public awareness, and community outreach activities that relate to primary and secondary prevention of cardiovascular disease and stroke and that are provided by private and other public organizations;

(3) coordinate activities with other entities that are concerned with medical conditions that are similar to cardiovascular disease and stroke or that have similar risk

factors;

(4) identify to health care providers, employers, schools, community health centers, and other groups the benefits of encouraging treatment, primary and secondary prevention, and public awareness of cardiovascular disease and stroke and recognize innovative and effective programs that achieve the objectives of improved treatment, prevention, and public awareness;

(5) provide guidance regarding the roles and responsibilities of government agencies, health care providers, employers, third-party payers, patients, and families of patients in the treatment, primary and secondary prevention, and public awareness of cardiovascular disease and stroke;

(6) improve access to treatment for and primary and secondary prevention of cardiovascular disease and stroke through public awareness programs, including access for uninsured individuals and individuals living in rural or underserved areas;

(7) assist communities to develop comprehensive local cardiovascular disease and stroke prevention programs;

(8) assist the Texas Education Agency and local school districts to promote a public school curriculum that includes physical, nutritional, and health education relating to cardiovascular disease and stroke prevention;

(9) establish appropriate forums, programs, or initiatives designed to educate the public regarding the impact of heart disease and stroke on women's health, with an emphasis on preventive health and healthy lifestyles; and

(10) evaluate and enhance the implementation and effectiveness of the program developed under this chapter.

(b) The council shall make written recommendations for performing its duties under this chapter to the department and the legislature.

(c) The council shall advise the legislature on legislation that is needed to develop further and maintain a statewide system of quality education services for all persons with cardiovascular disease or stroke. The council may develop and submit legislation to the legislature or comment on pending legislation that affects persons with cardiovascular disease and stroke.

(d) The council shall collaborate with the Governor's EMS and Trauma Advisory Council, the American Stroke Association, and other stroke experts to make recommendations to the department for rules on the recognition and rapid transportation of stroke patients to health care facilities capable of treating strokes 24 hours a day and recording stroke patient outcomes.

Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999. Amended by Acts 2005, 79th Leg., ch. 732, § 6, eff. Sept. 1, 2005.

§ 93.052. DATABASE OF CLINICAL RESOURCES. The council shall review available clinical resources and shall develop a database of recommendations for appropriate care and treatment of patients with cardiovascular disease or who have suffered from or are at risk for stroke. The council shall make the database accessible to the public.

Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999.

§ 93.053. CARDIOVASCULAR DISEASE AND STROKE DATABASE. (a) The council shall collect and analyze information related to cardiovascular disease and stroke at the state and regional level and, to the extent feasible, at the local level. The council shall obtain the information from federal and state agencies and from private and public organizations. The council shall maintain a database of this information.

(b) The database may include:

- (1) information related to behavioral risk factors identified for cardiovascular disease and stroke;
- (2) morbidity and mortality rates for cardiovascular disease and stroke; and
- (3) community indicators relevant to cardiovascular disease and stroke.

(c) In compiling the database, the council may use information available from other sources, such as the Behavioral Risk Factor Surveillance System established by the Centers for Disease Control and Prevention, reports of hospital discharge data, and information included in death certificates.

Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999.

§ 93.054. INFORMATION RECEIVED FROM ANOTHER STATE AGENCY; CONFIDENTIALITY. (a) To perform its duties under this chapter, the council may request and receive information in the possession of any state agency. In addition to the restriction imposed by Subsection (b), information provided to the council under this subsection is subject to any restriction on disclosure or use of the information that is imposed by law on the agency from which the council obtained the information.

(b) Information in the possession of the council that identifies a patient or that is otherwise confidential under law is confidential, is excepted from required public disclosure under Chapter 552, Government Code, and may not be disclosed for any purpose.

Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999.



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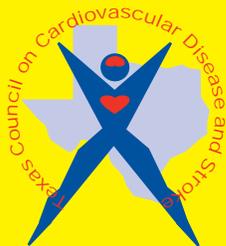
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