



Texas Council on Cardiovascular Disease and Stroke
Annual Legislative Report
January - December 2006



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

Message from the Chair

Message from the Chair of the Texas Council on Cardiovascular Disease and Stroke

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 (council) in 1999. In 2005, the 79th Texas Legislature amended Chapter 93 of the Health and Safety code, by changing the 11-member council to a 15-member council consisting of 11 Governor-appointed, Senate-approved voting members and four state-agency appointed non-voting members. The amendment also included the designation of certain classifications of council members; allowing the council to seek and receive funds; setting up a Heart Disease and Stroke Resource Fund; and giving the council the authority to create, comment on and advocate for appropriate legislation. The council's dedicated members come from varied backgrounds using their combined skills to address chronic diseases of the heart and brain. These council members are outstanding leaders in their respective fields, and provide this expertise at their own expense to improve the overall health of Texans.

In May 2002, the council outlined a plan of action in the first Texas Plan to Reduce Cardiovascular Disease and Stroke, and in May 2005 created a second edition of the plan. Many of the goals and

objectives in the plan have been achieved and were reported in the May 2005 plan.

Some of the notable achievements of the council during the past few years include:

- The development of awards and recognition programs such as the Texas Cardiovascular Health Promotion Awards, the Texas Cardiovascular Quality and Patient Safety Initiative, and the Heart and Stroke Healthy City Recognition Program.
- The maintenance of a Cardiovascular Disease and Stroke Surveillance Database. Mortality, risk factor, hospital discharge and HEDIS information is made available on the council Web site in a presentation format. This allows the public access to information on the status of heart disease and stroke and can be used for educational purposes.
- Support for other heart and brain health initiatives in Texas, such as the American Heart Association's Get With The Guidelines supported by the Texas Medical Association, GETAC Statewide Stroke Transport plan and stroke center designations, ALLHAT (Anti-hypertension and Lipid-Lowering Treatment to Prevent Heart Attack Trial) Dissemination Project, and preparing presentations for national, state and local meetings.
- Development of Key Legislative Priorities



Contents

Message From the Chair.....	2
Council Charges, Membership and Meeting Dates	4
Current Burden of CVD in Texas and the US.....	6
Charge 1 - Develop a State Plan	8
Description of Council Activities by Strategy.....	12
Charge 2 - Database of Clinical Resources.....	19
Charge 3 - Data Collection.....	20
2007 Council Legislative Priorities.....	21
Future Activities of the Council.....	22
Appendix 1 - Health and Safety Code - Chapter 93.	23
Appendix 2 - Texas Council on Cardiovascular Disease and Stroke.....	30

for the next Legislative Session. Members of the council met in November to begin the process of developing a list of key legislative priorities in order to better inform the legislature and other agencies on key issues within cardiovascular disease and stroke. This has been communicated to the Governor’s office, the Texas Department of State Health Services (DSHS), and other councils and agencies as well as interested organizations, such as the American Heart Association.

- 2006 CVD and Stroke Summit on the Assessment of the Heart Disease and Stroke Public Health Infrastructure in Texas. This was led by Jennifer Smith with active participation by several council members resulting in a comprehensive assessment of the heart disease and stroke public health infrastructure in Texas with key opportunities identified.

Although we have achieved many of our goals during the first six years, much remains to be done.

Future plans of the council include more intensive surveillance combined with awareness campaigns and intervention activities conducted at both the clinical and public health levels. These activities will help impact 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, including Jennifer Smith, Dr. Philip Huang, Casey Blass, Janna Zumbrun, Barbara Keir, Brett Spencer, Lois Grant, Weihua Li and Reuben Parrish. Their tireless work has been an inspiration to the council. I would also like to thank the former Commissioner of DSHS, Eduardo Sanchez, M.D., M.PH., for his continued support of the council and look forward to working with Commissioner David Lakey, M.D., on 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 two 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.
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, authorized by House Bill 2085 during the 76th Legislature, was charged with three main duties:

- 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 2006.

Council Membership and DSHS Support

House Bill 2344, passed during the 79th Legislative Session, 2005, increased the number of council members from 11 to 15, including 11 appointed public voting members and four state-agency appointed nonvoting members.

Voting Members

The governor, with approval by the senate, is

responsible for appointing the 11 public voting members. House Bill 2344 also specified categories of council representation. 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 or a caregiver. 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

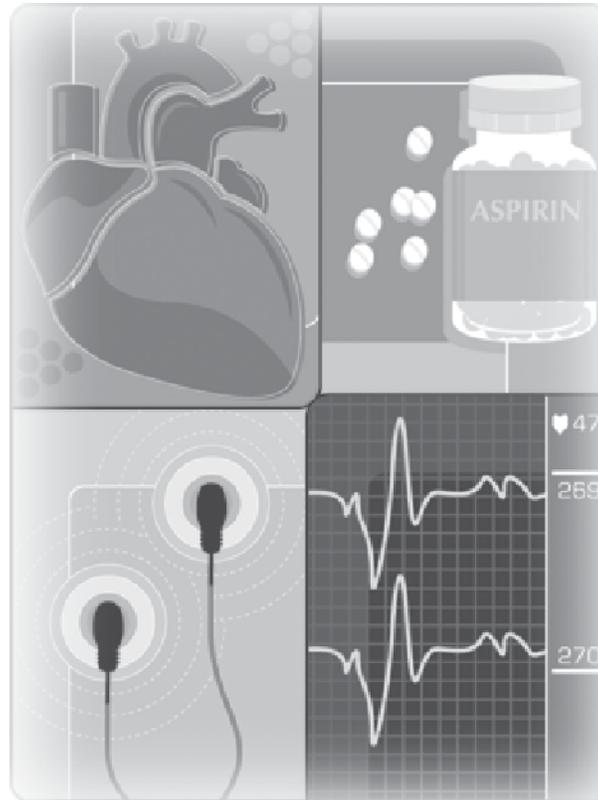
Four nonvoting members represent state agencies that oversee services for health, aging and disabilities, education, and assistive and rehabilitative. The state agency commissioners are responsible for designating these representatives.

Donated Hours

Council members donate between 30 and 125 hours per year on council business.

Administrative Support

The council is attached to the Texas Department of State Health Services. State funding is not appropriated for the council, however DSHS



provides support for the council through state and federally funded positions and services. A program manager oversees the arrangement of council meetings and corresponding business activities. Epidemiological support is also provided. Additional staff support is provided through the occasional use of other managers, program specialists, medical consultants and statisticians from other programs within the department.

Council Members

Term Expiration Dates and Attendance for 2006 Council Representation

2006 Council Meetings: February 28, June 3, August 5, November 3

Appointed Voting Members

Walter F. Buell, M.D.
02/01/09; Feb. 28, June 3, Aug. 5, Nov 3
Consumer

Kate Darnell, M.S.
02/01/07; June 3, Aug. 5, Nov. 3
General Public

Michael M. Hawkins, M.D. (Chair)
02/01/07; Feb. 28, June 3, Aug 5, Nov 3
Consumer

Melbert C. (Bob) Hillert, Jr., M.D.
02/01/09; Feb 28, Aug 5, Nov 3
Cardiologist

Deanna Hoelscher, Ph.D., R.D.
02/01/11; Feb 28, June 3, Aug 5, Nov.3
Registered Dietitian

Carolyn Hutchison, R.N., B.S.N.
02/01/09; June 3, Aug. 5
Registered Nurse

J. Neal Rutledge, M.D.
02/01/11; Feb. 28, June 3, Aug. 5, Nov 3
Neurointerventionist

Martha Simien, M.Ed.
02/01/07; Feb. 28, June 3, Nov. 3
Public Health Member

Erica Swegler, M.D.
02/01/11; Feb. 28, June 3, Nov 9
Primary Care

Sheila Tello, R.N.
02/01/11; Aug. 5
Consumer

Thomas Tenner, Jr., Ph.D.
02/01/09; Feb. 28, June 3, Aug. 5, Nov. 3
Public Health Member

State Agency Non-Voting Members

Barbara Keir, Feb. 28, June 3, Aug. 5, Nov. 3
Health Services

Marissa Rathbone, Feb. 28, Aug. 5, Nov. 3
Education

Michael Wilson, Feb. 28, June 3,
Aging and Disabilities Services

Grace Elinsway, Feb. 28, Aug. 5, Nov. 3
Assistive and Rehabilitative Services
Council Charges, Membership and Meeting
Dates

The Current Burden of CVD in Texas and the United States

Cardiovascular disease (CVD) is the leading cause of death in Texas and has been since 1940. CVD accounts for 2 out of every 5 deaths in Texas, and in 2005 more than 1,422,000 Texas adults reported having had a diagnosed heart attack, a stroke, angina or coronary heart disease. In 2002, the Cardiovascular Health and Wellness Program at the Texas Department of State Health Services created the Texas Cardiovascular Disease Surveillance System and Report to monitor specific trends and 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 2002* (updated 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 and environmental issues including 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-2005 Update*, the American Heart Association (AHA) reported that 70,100,000 Americans (34.2 percent of the United States population) 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. Additionally, about 4.9 million Americans live with the debilitating effects of congestive heart failure, which is the single most frequent cause of hospitalization of Americans age 65 and older.

The AHA has estimated that CVD cost Americans \$393.5

billion in medical expenses and lost productivity in 2005.

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, December 2006* include:

- 1) Cardiovascular disease accounted for 35 percent of all deaths in Texas for the five-year period of 1999 to 2003.
- 2) Total hospitalization charges for CVD and stroke in 2004 were more than \$9.8 billion.

3) Total hospitalization charges for CVD and stroke have risen 62 percent from 1999 to 2004.

In 2003, 51,940 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, December 2006*, developed by the DSHS Cardiovascular Health and Wellness program, data shows that mortality rates due to IHD are declining, patterns of disease still show that Texas males 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 (201 deaths/100,000 population) than whites (154/100,000), Hispanics (148/100,000) and other racial/ethnic groups (70/100,000).

Risk Factors

There are several factors that increase the risk of heart disease and stroke. The major non-modifiable risk factors are *heredity, male sex, 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

State Plan to Reduce Cardiovascular Disease and Stroke - First Edition May 2002 and Second Edition May 2005

The council, in partnership with public and private entities, has coordinated the implementation of activities noted in the May 2002 state plan. The plan was reviewed and updated in 2005. Both plans are available on the council Web site. The May 2005 Update provides a list of accomplishments during the years 2002-2005 and identifies 22 short and long-term action steps for the years 2005-2010.

Four key strategies were adopted by the council to develop action steps for approaching the awareness, detection, prevention, treatment and control of heart disease and stroke in Texas.

They include:

- 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 created four workgroups around these four strategies to create a framework to address the legislated responsibilities of the council located in Appendix 1. The council focuses its planning efforts during quarterly meetings that are open to the public and allow participation in the process through the four workgroups.

During 2005 and 2006, over 390 partners have implemented state plan activities. These partners include the American Heart Association; American Cancer Society; Texas Action for Healthy Kids Coalition; Texas Legislature; cities of Dallas, Fort Worth, Houston, Austin, San Antonio, and El Paso; Paso del Norte Health Foundation; TemBel Health and Wellness Coalition; DSHS programs that focus on school health, nutrition, physical activity and obesity prevention, diabetes prevention, tobacco prevention and control, women's health and elimination of

health disparities; 267 churches, and 105 work sites. The state plan activities implemented during this time include the *Search Your Heart* Program, *Go Red Sunday*, The Heart of Texas Women Initiative, The Cardiovascular Health Promotion Awards, encouraging adoption of smoking ordinances, and promotion of coordinated school health programs.

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

On November 1-3, 2006, the council cosponsored the Fourth CVD and Stroke Summit with the American Heart Association, Texas Affiliate, the Texas Public Health Association, Texas Association of Local Health Officials, and the DSHS.

- 97 individuals participated in the conference;
- 51 organizations were represented at the conference; and
- Conference participants came from 25 cities across Texas.

This assessment represents a significant first step by public health partners across Texas to improve upon, or begin development of, 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/nphpsp/.) The HDSSPHS is defined as all public, private and voluntary organizations in Texas that contribute to the public's health and the well being in regards to heart disease and stroke. This system collectively, rather than the DSHS, was the focus of the assessment summit. The assessment tools and process were patterned after the Texas State Public Health System Assessment (TSPHSA) held in July 2006.

The following describes the assessment process, results and recommendations:

Assessment Process

HDSSPHSA assessed the 10 essential public health services (ES) for heart disease and stroke:

1. **Monitor** health status to identify and solve community health problems.
2. **Diagnose** and investigate health problems and health hazards in the community.
3. Inform, **educate**, and empower people about health issues.
4. Mobilize community **partnerships** and action to identify and solve health problems.
5. Develop **policies** and plans that support individual and community health efforts.
6. **Enforce** laws and regulations that protect health and ensure safety.
7. **Link** people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care **workforce**.
9. **Evaluate** effectiveness, accessibility, and quality of personal and population-based health services.
10. **Research** for new insights and innovative solutions to health problems.

Each ES was assessed based on four indicators:

1. Planning and Implementation
2. State-Local Relations
3. Performance Management & Quality Con-

trol

4. Public Health Capacity and Resources

Three to five assessment questions were associated with each indicator, and each assessment question was assigned one of the five values below. The value assigned to the assessment question was based on assessment group consensus.

- Optimal (means 76-100 percent of the optimal standards are met);
- High Partial (means 51-75 percent of the optimal standards are met);
- Low Partial (means 26-50 percent of the optimal standards are met);
- Minimal (means 1-25 percent of the optimal standards are met); and
- No Activity (means 0 percent of the optimal standards are met).



Each of the four indicators were also assigned a value for the following two questions:

1. “How much of this Model Standard/indicator (e.g., Planning and Implementation) is achieved by the HDSSPHS collectively?”
2. “How much of this Model Standard/indicator (e.g., Planning and Implementation) is achieved through the direct contribution of the state public health agency (DSHS)?”

For the HDSSPHS collectively, participants judged 12 of the 40 model standards performance as minimal (1-25 percent), 24 as low partial (26-50 percent) and 4 as high partial (51-75 percent). None of the standards were judged as either zero or optimal performance (76-100 per-

cent). Across the essential services, system performance was rated highest for ES2 (Diagnose/ Investigate) and lowest for ES3 (Inform/Educate), ES4 (Mobilize Partnerships) and ES9 (Evaluate). Across the model standards, scores were lowest for performance management and quality control.

DSHS' contribution to system performance was assessed as minimal (1-25%) for 26 model standards, low partial (26-50%) for 12 model standards, high partial (51-75%) for 2 standards. No standard received a score of zero or optimal. Across the essential services, DSHS' contribution was highest for ES10 (Research) and lowest for ES 3 (Inform), ES8 (Workforce), and ES9 (Evaluate). Across the model standards, DSHS contribution was lowest for state-local relationships and performance management-control and highest for public health capacity.

Summary and Recommendations

This assessment collected information relevant to the performance of the Texas HDSSPHS by means of a statewide summit convened in November of 2006. The conference was attended by 97 individuals representing more than 51 organizations from 25 cities around the state. A limitation of the summit was that it was not well attended by more stakeholders, who may have been able to provide a more complete assessment of HDSSPHS. With this caveat, most participants felt that the assessment provided an

opportunity for exchanging information and expert opinion among important system partners in the HDSSPHS.

The summit also produced numerical estimates of collective system performance and the contribution of DSHS to that performance. The sys-

tem's collective performance was judged to be less than optimal on most of the model standards contained in the assessment instrument. It is noteworthy that the assessment instrument used by participants was a revised field test version, which has not yet been validated, and this may have affected the results. Furthermore, judgments about system performance ultimately reflect the qualitative and quantitative perceptions of those who participated in the assessment process. Verification of these perceptions was beyond the scope of this undertaking. When summit participants identified gaps in model standard performance it was unclear whether this should be attributed



to the status of the system or to the participants' level of awareness about the system. Despite this ambiguity, performance gaps identified during the assessment summit provide a starting point for future efforts to improve system functioning.

In addition, the summit itself served as an important tool to improve the public health system by inviting a broad group of stakeholders together and have them reflect about their roles as system partners.

As this process moves beyond the system assessment phase into the system improvement planning, phase the Steering Committee and summit organizers offer four recommendations:

1. Maintain Communication with System Partners Identified Through this Assessment.

If the diverse set of organizations involved in providing essential public health services for heart disease and stroke awareness, detection, treatment and control in Texas is to function as an integrated, collaborative system, they must see themselves as part of a community of common interest. The governor-appointed Texas Council on Cardiovascular Disease and Stroke is positioned to build and maintain that sense of identity. The HDSSPHS Assessment Conference was an initial step in the process. Assessment findings and “next steps” should be communicated as widely as possible to meeting participants and other interested stakeholders.

2. Determine Priorities for System Improvement. The assessment conference revealed many areas of less than optimal performance which might be addressed in an improvement plan. System partners should be

reconvened over the next few months to participate in a priority-setting process. This process might identify a limited number of “high priority” essential services upon which to focus and result in an early round of action planning.

3. Develop Strategies for Performance Improvement.

As part of this process, the system partners will set collaborative goals as well as develop individual organizational goals that are aligned with the overall system goals. It is particularly essential that state agencies who impact determinants of health are continually included in these planning efforts. The health of Texans are a joint responsibility, not just one of a single agency or organization.

4. Convene Partners around Priorities. To coordinate how the system advances towards meeting “high-priority goals,” partners will meet on a regular basis to report on activities.

In conclusion, it is recommended that performance assessment and improvement efforts take place at all levels of the public health system: state, regional and local.

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:** re-viewing trend data.
- **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 at the city level.
- **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.

Medicaid Data: reviewing actual costs to the state of Texas for the provision of services for heart disease and stroke.

Key Strategy: Health Education and Outreach

The council collaborated with state and national partners in many health education, public awareness, and community outreach activities in 2006.



Faith Based Outreach

Search Your Heart and Go Red Sunday

- In collaboration with the DSHS Cardiovascular Health and Wellness Program, who provided funding from the Centers for Disease Control and Prevention (CDC), the council worked with the AHA to promote the *Search Your Heart* and the *Go Red Sunday* programs. *Search Your Heart* uses tested, culturally appropriate strategies and materials to motivate African Americans

to adopt healthy lifestyles and develop heart-healthy habits. *Search Your Heart* is designed for use in churches and other faith-based organizations, and includes six modules covering nutrition, physical activity, stress reduction and other risk factors. *Go Red Sunday* promotes awareness of heart disease and stroke in women and encourages environmental support for prevention of heart disease and stroke.

Results:

Eighteen *Search Your Heart* Train the Trainer classes were conducted, resulting in 342 Trainers being trained. These trainers recruited 74 African American Churches and other faith based organizations in 15 Texas communities. A total of 4,332 individuals participated in one or more of the *Search Your Heart* program components.

Search Your Heart seemed to be most successful in more metropolitan areas, where more resources were available. Complete implementation was a little more challenging in rural areas. Nine Faith-based African American organizations in rural East Texas, where heart disease and stroke deaths are higher than the state rate, received training and committed to implementing the *Search Your Heart* program in their churches. Of these nine, three of the churches were able to implement the program.

Go Red Sunday was conducted through partnership with the American Heart Association resulting in 193 churches recruited and trained. Forty-two communities were targeted/impacted and 32,350 people reached. Each participant received the following *Go Red Sunday* materials: *Go Red for Women* Brochure in either Spanish or English, *Everyday Choices* Brochure, *Just Move Physical Activity* Brochure, a *Search Your Heart* Book Mark and a *Red Dress* pin.

Risk Factor Awareness

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

Physical Activity - The council supports the Texas Round-Up, the Governor's statewide physical activity program.

Women and Heart Disease - The council, in conjunction with DSHS, planned and promoted the second annual Heart of Texas Women campaign held in February 2006.

The Cardiovascular Health and Wellness (CHW) Program at DSHS contacted local health departments, state agencies, universities, psychiatric centers, family health care vendors, consortiums, hospitals, city offices, and not-for-profit community service organizations to participate in ongoing

work site and community health education efforts supported by the council. One hundred and five organizations agreed to provide educational materials and information on heart disease and stroke to women through events held at their site using a kit developed with resources identified by the DSHS CHW program. Eleven community resource/ health centers, seven hospitals, 10 local health departments, 25 state agencies, 47 schools, and 5 universities participated in the program. Three thousand-thirty five women and men were reached at actual events and an estimated more than 48,500 people were potentially impacted with the materials/information from the kit. Evaluation forms were completed by the organizations describing the events held and the type of policy and/or environmental change that was implemented at their site.

Results:

Fourteen organizations plan to implement a smoking policy, along with nineteen planning to permanently post educational materials on risk factors of CVD, 10 planning on installing AED machines, 10 adding or offering more CPR classes and 10 designated safe and accessible areas for physical activity.

High Blood Pressure Awareness - The council, in collaboration with DSHS conducted a month-long campaign to increase awareness of the risks of high blood pressure and the importance of finding and treating people with high blood pressure.

The Cardiovascular Health and Wellness Program at DSHS offered free *High Blood Pressure Awareness* Starter Kits to local health departments, state agencies, universities, healthcare providers, faith-based groups and nonprofit organizations. Kits contained *My Blood Pressure* Wallet Cards, *High Blood Pressure* Slide Guides, *DASH Diets*, *Know Stroke* Wallet Cards, downloadable Web materials and resources, awareness posters and incentives on healthy eating, high blood pressure and stroke. These items

facilitated the organization of awareness events throughout the state during High Blood Pressure Month in May.

Results:

Fifty-one organizations registered to implement the program, consisting of ten community resource/ health centers, four hospitals, ten local health departments, seven state agencies, nineteen schools, and one community college, with the potential to reach over 25,000 people. The events provided avenues to employees on prevention of heart disease through detection and control of high blood pressure, and the benefits that a lifestyle change can have on their overall health. Six out of 51 partners returned their evaluation resulting in more than 3,450 people potentially reached and 385 people reached through specific one on one interventions. Three of the six entities implemented an environmental change that will provide a lasting support system to prevention and control of high blood pressure. It was reported that participants have made life-changing decisions due to the promotion of High Blood Pressure Awareness Month using the promotional kit.

Key Strategy: Community Policy and Environmental Change

Texas Cardiovascular Health Promotion Awards

The Texas Cardiovascular Health Promotion Awards program has been held since 2002. These awards identify and recognize entities in the categories of healthcare, school, work site, 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.

2006 Cardiovascular Health Promotion Award Winners

These awards are presented at the Texas Public Health Association Annual Conference held in the Spring of each year.

Outstanding Program Recognition:

Community: Get Fit El Paso - El Paso
TemBel Wellness Coalition - We .Can! - Temple
Brain and Spine Center - Austin

Healthcare: The SCI Fitness Center - Brain and Spine Center - Austin

Honorable Mention Program Recognition:

Community: Vestido Rojo - City of Fort Worth Public Health Department

Healthcare: Ask Me About Smoke Free - Parker College of Chiropractic

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.

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 brought together through the DSHS Cardiovascular Health and Wellness 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 2006, 10 mid size cities (population size of 100,000 - 499,999) were assessed on whether the indicators were in place and 20 small size cities (population size of 0 - 99,999) are in the process of being assessed. The 10 mid size 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 1,521,072 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 setting in general, 2) school and 3) healthcare.**

Community Overall:

Mass media campaigns for CVD and Stroke - All 10 communities promoted American Heart Association's *Go Red for Women* and Heart Disease, Heart Walk, and other Heart Association materials throughout the year. Beaumont inserted fliers on heart disease and stroke in monthly water bills.

Physical Activity Areas - Programs for youth, adults, and seniors were identified in 9 cities.

Healthy Food Options – Only three cities developed a local coalition to promote healthy eating messages. A dining guide promoting nutrition and healthy dining was not identified in any of the cities.

Smoking Ordinances - Two cities passed 100 percent Smoke Free Ordinances, Beaumont and Laredo.

CPR Classes - Classes were identified as being

provided in all 10 cities by private entities and health sites.

Health Disparities Plan - Two communities, Lubbock and Waco, were identified as having a plan in place to reduce disparities in CVD and stroke with an active community coalition.

Healthcare Setting:

Defibrillators - Four cities were identified as having defibrillators widely available in the community (e.g., convention centers, airports, sports arena, high schools, state/city/county buildings).

Stroke Response - The 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 eight cities the healthcare sites promoted primary and secondary prevention of CVD and stroke. Over 50 percent of the ten cities implemented a quality improvement program in health sites (example: Get With The Guidelines (GWTG)-Stroke, Coronary Artery Disease, or Heart Failure). No primary stroke centers were identified in those cities.

Schools:

Two hundred and twelve elementary public schools (grades K- 6) were assessed within the ten mid size cities, and of these, 161 schools (76 percent) implemented a coordinated school health program approved by the Texas Education Agency. Over 50 percent of the schools were in the process of developing a school health advisory council with monthly meetings planned.

2005 Award Presentations:

Cities in the metro size category that had been assessed in 2005 were recognized in 2006 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

El Paso is the first city to be recognized at the Gold Level, the highest level available. El Paso met all of the 10 indicators. By having a smoke-free city ordinance in place, El Paso was able to move ahead of the other cities. Tom Tenner, Ph.D., presented the award at the June 13, 2006, El Paso City Council Meeting.

Silver Level

Houston

Bronze Level

Austin received its award from Michael Hawkins, M.D., during the August 24, 2006, Austin City Council meeting.

Fort Worth

San Antonio received its award from Michael Hawkins, M.D., during the August 31, 2006, San Antonio City Council meeting.

Honorable Mention

Dallas

Key Strategy: Clinical Prevention and Treatment Services

Stroke in Texas

The council's responsibilities include collaborating with the Governor's EMS and Trauma Advisory Council (GETAC) and others 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. Senate Bill 330 enacted by the 79th Legislature created the Texas Stroke Act which required the establishment of a stroke committee within the GETAC who would look at development of a stroke emergency transport plan and plans for stroke prevention and community education regarding stroke and stroke emergency transport. Two members of the council, Dr. Neal Rutledge and Dr. Walter Buell are members of the GETAC Stroke Committee and have provided oversight and advice on the development of those plans.

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 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 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. Through a competitive Request For Application (RFA) process in 2005, DSHS entered into a contract with Quality Implementation Systems, Inc. (QISI), a private entity located in San Antonio. Highlights from the final project period report follow:

With rates of heart disease and stroke-related deaths exceeding the federal goal level by 50 percent, physicians treating Medicaid patients in the San Antonio and Lower Rio Grande Valley are challenged every day to effectively manage care and help their patients reduce their risk of disability and death. To be effective, physicians must assess their delivery of care, but often they lack the resources to do so. To overcome this barrier and identify successful treatment approaches that can be promoted to all physicians in Texas, a project was launched in January of 2006 that partners the DSHS Cardiovascular Health and Wellness Program with QISI, a physician-focused quality improvement organization.

For the HDSP project, QISI's goal was to recruit a minimum of four Texas physicians or physician groups (maximum of six physicians per site, up to a total of 24 physicians) in the San Antonio and Rio Grande Valley areas who provide care

to Medicaid clients and then assess the care provided to a sample of CVD/stroke patients by these physicians.

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.

Measure:	Required % of Patient Sample
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%

To assess their performance on the HSRP measures, individual physicians or medical groups use a spreadsheet to collect data for a sample of their patients who have cardiovascular disease or who have suffered a stroke. The data are evaluated against the program measure performance thresholds, which were set based on performance by physicians and physician groups participating in a pilot of the program. Physicians and groups who meet or exceed these thresholds are recognized and receive visibility through a Web listing that identifies recognized physicians by city and state. Many health plans recognize physicians in online and print directories they provide to their members and physicians often promote their recognition in marketing materials and advertising.

Plans and payers support the HSRP because in a similar recognition program, the American Diabetes Association/NCQA Diabetes Physician Recognition Program, physicians who are recognized have shown treatment rates that far exceed national averages in all measures of diabetes care. As a result of this level of performance, pa-

tients of physicians recognized for diabetes care are more likely to receive treatment that helps them manage their health and improve their quality of life. Patients with better outcomes also help health plans by demonstrating quality to their customers and assuring payors that they are receiving value for their health care expenditures. During the first year of the project, QISI was able to successfully:

- Assess cardiovascular and stroke care and outcomes for a total of 240 patients who received care from eight physicians at five practice sites in San Antonio and the Valley, exceeding the project goal to assess care for four physicians at four practice sites.
- Determine that six of the eight physicians

participating in the project meet evidence-based, national standards for cardiovascular and stroke care, as set by the American Heart Association and American Stroke Association.

- Identify barriers preventing physicians from evaluating their own care delivery, including lack of staff time and interest, use of external billing services which impedes access to their own data, use of paper medical records which can make abstraction of data time-consuming, and when electronic medical records are used, lack of understanding of the system and inability to generate data using their system.

- Use findings from the first year of the project to make recommendations for future quality improvement projects, including partnering with health plans to utilize the plan's physician data, meeting with office staff of target practices prior to start of a project to get their buy-in and understand their needs, utilizing local project staff to enable in-office visits for communication and relationship building, and designating a physician liaison to continue a collegial dialogue with physicians about performance measurement and quality improvement.

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: The Initiative continues to identify nationally recognized best practices for the achievement of quality improvement standards. The American Heart Association/American College of Cardiology guidelines for secondary prevention of CVD and stroke as those best suited for promotion in the

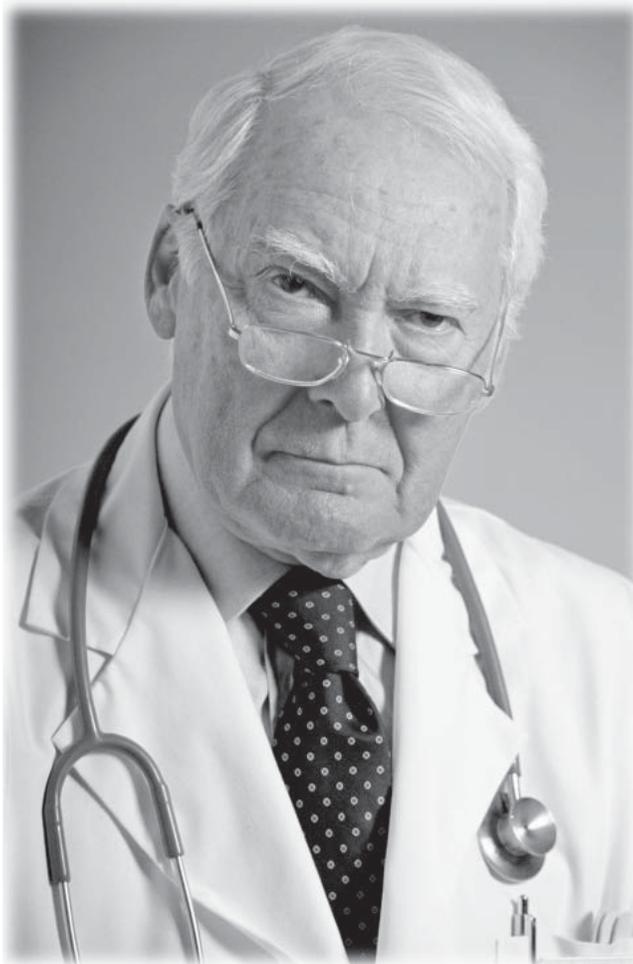
state. The **Physician Tool Kit**, which consists of

Patient Tracking Forms and **Prescription Pads** to promote primary and secondary prevention methods was developed by initiative partners, and is available to health care providers.

Activity 2: The initiative continues to support the **Texas CV Quality Recognition Program**.

The recognition program has listed hospitals and health care providers meeting the program requirements for their participation in nationally recognized registries for CVD or stroke or their participation in a nationally recognized evidence-based quality improvement program for CVD or stroke. The council recently changed the requirements so that

only health providers who have received recognition for meeting required standards will be listed on the council Web site located at www.texascvd-council.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 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*, December 2006 to report data using 2005 BRFFS data, 2001-2004 Mortality and Hospital discharge data, 2005 Medicaid data, and 2003 EMS/Trauma registry data. The Executive Summary highlights the following:

Highlights

- Cardiovascular disease 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.
- 34 percent of all deaths in Texas in 2003 were due to heart disease and stroke, more than any other cause.
- In Texas and the U.S., during the period from 1999-2003, age-adjusted mortality rates for CVD have steadily declined.
- Age-adjusted mortality rates for ischemic heart disease declined from 202.4 per 100,000 in 1999 to 165.8 per 100,000 in 2003.
- Age-adjusted mortality rates for stroke declined from 66.3 per 100,000 in 1999 to 59.7 per 100,000 in 2003.
- In 2005, about 1.4 million Texas adults aged 18 years and older reported that they have CVD or stroke.
- Overall, hospitalizations for CVD and

stroke cost Texas over \$9.8 billion dollars in 2004. Ischemic heart disease alone accounted for 59.4 percent of this cost.

- In 2005, 19 percent of Texans aged 18 years and older with CVD or stroke stated they did not have any type of health care coverage, 24 percent cannot see a doctor due to the cost, and 21 percent did not have a routine checkup within the past year.
- In 2005, only 13.5 percent of Texas adults could correctly identify all heart attack signs and symptoms, 21 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 have been diagnosed with high blood pressure and 34 percent with high blood cholesterol.
- People in Texas are increasingly overweight and obese. From 1995 to 2005, the percentage of overweight and obese adults increased from 51.4 percent to 61.3 percent.
- The prevalence of diabetes, a major risk factor for CVD, has increased over the past decade in Texas (from 1995 to 2005).
- 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).”

Council 2007 Legislative Priorities

Council 2007 Legislative Priorities

During the June 3, 2006 council meeting, legislative priorities were identified for the upcoming session. The following recommendations were made:

Issue: Council must conduct health education, public awareness and community outreach activities on cardiovascular disease and stroke.

The council recommends that the Legislature appropriate funds to conduct health education, public awareness and community outreach activities on cardiovascular disease and stroke to support the following council programs: 1) Heart and Stroke Healthy City Program, 2) Heart Attack and Stroke Signs and Symptoms, 3) Heart of Texas Women Initiative, and 4) Health Disparities Programs for African Americans and Hispanics

POSITION: The Texas Council on CVD and Stroke is required by legislation to conduct health education, public awareness and community outreach activities on cardiovascular disease and stroke, yet dedicated funds are not appropriated for such activities. The council has worked with the DSHS to develop several educational and awareness programs that have been provided on a limited basis to communities in Texas. Funds are more specifically needed to support a broad statewide dissemination of the Heart and Stroke Healthy City programs and the Heart of Texas Women educational initiative and a targeted local initiative to reduce health disparities for CVD and stroke in African Americans and Hispanics.

Issue: Statewide dissemination of evidence-based programs that promote heart and stroke health through reduction of smoking, physical inactivity and obesity.

The council recommends that the Legislature appropriate funding that will disseminate proven risk-reduction programs as demonstrated in Tex-

as for the prevention of heart disease and stroke. Tobacco use and obesity are major risk factors for heart disease and stroke. Tobacco causes 400,000 deaths annually in the U.S., while obesity and physical inactivity cause 300,000 deaths annually in the U.S.

POSITION: The council recommends that the Legislature appropriate:

- \$3 per capita for a statewide comprehensive tobacco prevention and cessation program to include: media, enforcement, provider reminder systems and telephone quitline.
- \$2 per capita for a statewide comprehensive obesity prevention and nutrition and physical activity program to include: media, comprehensive school-based health programs, and adult and community intervention programs.

Issue: Provide incentives for businesses and individuals to engage in healthier actions to prevent heart disease and stroke.

Employers are becoming more aware that overweight and obesity, lack of physical activity, and tobacco use adversely affect the health and productivity of their employees, and ultimately, the businesses' bottom line. By changing their lifestyles, employees could improve their personal health status and ultimately the corporate landscape.

POSITION: The council supports legislation that offers tax breaks for businesses for that implement work site wellness or health promotion programs. Comprehensive work site wellness programs focused on changing lifestyle behavior have been shown to yield a \$3 - \$6 return on investment for each dollar invested.

Future Activities of the Council

Strategies and Action Steps from the Second Edition, 2005 State Plan

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

Conduct the women's heart health promotion program, "The Heart of Texas Women" during February 2007 in collaboration with local health departments, state agencies, breast and cervical cancer control services contractors, primary health care sites, schools and other community organizations.

Implement the Cardiovascular Health Promotion Awards.

Coordinate with various associations to infuse chronic disease education programs at educational conferences in 2007.

Disseminate the Heart Disease and Stroke Awareness, Prevention and Control Promotion program with an implementation guide for public sector work sites.

Implement a Hypertension Awareness Campaign in May 2007 for work sites, schools, health care providers and communities.

Community Policy and Environmental Change

Continue the *Heart and Stroke Healthy City* Recognition program by reassessing the metro-size cities.

Disseminate the *Heart and Stroke Healthy City* Implementation Guide for cities to utilize when setting goals to meet Heart and Stroke Healthy Indicators.

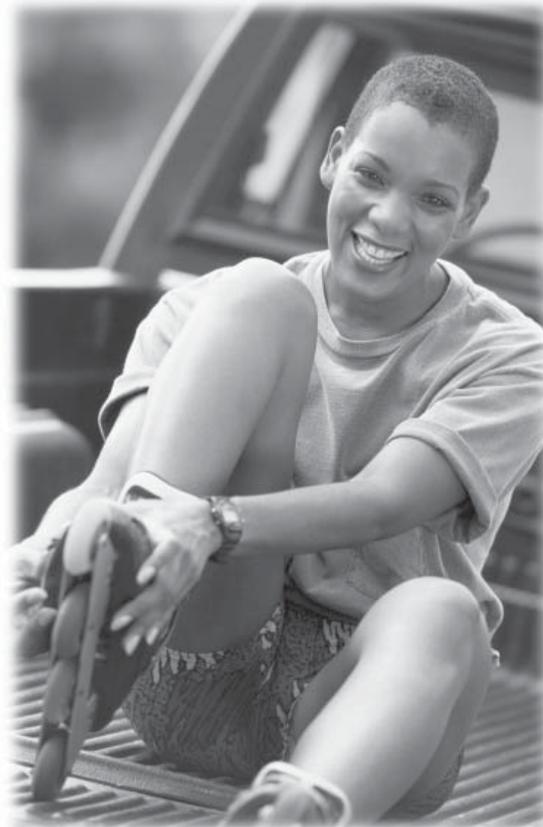
Collaborate with the American Heart Association-Texas Affiliate to develop task forces in communities that have been assessed, and assist cities in meeting the Heart and Stroke Healthy Indicators.

Clinical Prevention and Treatment Services

Implement the Heart Disease and Stroke Prevention Program Pilot Project to reach Medicaid clients with heart disease or stroke.

Continue dissemination of the Physician Tool Kit for patients and health care providers.

Implement the Texas Quality Improvement Recognition Program for health care providers.



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.

Appendix 2

Texas Council on Cardiovascular Disease and Stroke

Roster – December 2006

Walter F. Buell, M.D., P.A.

P.O. Box 5088
Austin, Texas 78763
512-407-8251
512-306-1975 FAX
wbuell@Austin.rr.com
Term Expires - 2009

Kate Darnell, M.S.

2200 Indian Trail
Salado, Texas 76571
254-947-5038
254-718-9854 FAX
kdarnell@vvm.com
Term Expires - 2007

Michael M. Hawkins, M.D.

11137 Amesite Trail
Austin, Texas 78726 -2422
512-996-9142
414--615-4434 FAX
michael_m_Hawkins@uhc.com
Term Expires - 2007

Bob C. Hillert, M.D., F.A.C.C., F.A.C.P., F.A.H.A.

1130 Beachview, Suite 100
Dallas, Texas 75218
214-321-6951
214-324-3187 FAX
hillert@aol.com
Term Expires - 2009

Deanna Hoelscher, PhD., R.D., L.D., C.N.S.

1200 Herman Pressler
RAS W-942

Houston, Texas 77030
713-500-9335
713-500-9329
Deanna.M.Hoelscher@uth.tmc.edu
Term Expires - 2011

Carolyn Hutchinson, R.N., B.S.N.

5914 Country Lane
Harlingen, Texas 78552
956-536-3840
e_hutchinson@sbcglobal.net
Term Expires - 2009

J. Neal Rutledge, M.D.

4401 Green Cliffs Road
Austin, Texas 78746
512-328-6262
512-446-1661 FAX
nrutledge@austin.rr.com
Term Expires - 2011

Martha Simien, M.Ed.

5745 Springdale Ln
Beaumont, TX 77708
409-983-8848 work
409-892-8407 fax
msimien@portarthur.net
Term Expires - 2007

Erica W. Swegler, M.D.

North Hills Family Medicine
816 Keller Parkway, #102
Keller, Texas 76248
817-431-3800
817-337-0270 FAX
erica@nhfp.net
Term Expires - 2011

Sheila Tello, R.N.

Save Health Care Inc.

4639 Corona Dr. Ste 34
Corpus Christi, Texas 78411
361-9393
361-855-9392 FAX
sheilatello@yahoo.com
Term Expires - 2007

Thomas E. Tenner, Jr, Ph.D.
TTUHSC
3601 4th Street
Lubbock, Texas 79430-6592
806-743-3010 ext.255
tom.tenner@ttuhsc.edu
Term Expires - 2009

Agency Representatives:

Health Services

Barbara Keir

Manager
Chronic Disease Branch
Texas Department of State Health Services
1100 West 49th Street
Austin, Texas 78756
512-458-7200
512-458-7618 FAX
Barbara.Keir@dshs.state.tx.us

Education

Marissa L. Rathbone

Director of Health & Physical Education
Division of Curriculum
Texas Education Agency
1701 North Congress Avenue
Austin, TX 78701-1494
512 - 463-9581
512 - 463-8057 FAX
Marissa.Rathbone@tea.state.tx.us

Assistive and Rehabilitative Services **Grace Elinsway, M.Ed.**

Program Specialist - Physical Disabilities
DARS
Division for Rehabilitation Services
4900 North Lamar Blvd.
Austin, TX 78759-2399
Phone: (512) 424-4175
Fax: (512) 424-4669
grace.elinsway@dars.state.tx.us

Aging and Disability Services

Michael P. Wilson, Ph.D.

Aging Texas Well Coordinator
Center for Policy and Innovation
701 W. 51st St.
Austin, Texas 78756
512-438-5471
Michael.Wilson@dads.state.tx.us