The Public Health Funding and Policy Committee 2017 Annual Report

As Required by

Texas Health and Safety Code

Section 117.103

With Support from the Department

of State Health Services

December 2017

TEXAS
Health and Human Services

Texas Department of State Health Services

Table of Contents

1. Public Health Overview

Public health "promotes and protects the health of people and the communities where they live, learn, work, and play".[1] While a physician treats people who are sick, public health workers try to prevent people from getting sick or injured in the first place; and promote wellness by encouraging healthy behaviors.[1]

"From conducting scientific research to educating about health, people in the field of public health work to assure the conditions in which people can be healthy. That can mean vaccinating children and adults to prevent the spread of disease or educating people about the risks of alcohol and tobacco. Public health sets safety standards to protect workers and develops school nutrition programs to ensure kids have access to healthy food.

Public health works to track disease outbreaks, prevent injuries and shed light on why some are more likely to suffer from poor health than others. The many facets of public health include speaking out for laws that promote smoke-free indoor air and seatbelts, spreading the word about ways to stay healthy and giving science-based solutions to problems."[1]

The state government is responsible and accountable to ensure basic public health services to its residents. In Texas, the primary providers of public health are the Texas Department of State Health Services (DSHS) and local health departments (LHDs). The types and categories of public health services vary across the state, and depend on community conditions, population, needs, funding, and state and local politics and culture.

Since its inception, the Public Health Funding and Policy Committee (PHFPC) collaborated with DSHS and the Texas Association of City and County Health Officials (TACCHO) to define and categorize public health in Texas. TACCHO

---

[1] American Public Health Association (APHA), 2017. What is Public Health? Retrieved from https://www.apha.org/what-is-public-health. Accessed on November 3, 2017.

represents local public health in Texas. Although the activities are ongoing, during 2017, the PHFPC finalized the ten core public health services in Texas (refer to Appendix A). The areas encompass:

1. Chronic Disease Prevention and Control
2. Communicable Disease Prevention and Control
3. Environmental/Regulatory Services
4. Maternal/Child Health
5. Injury Prevention and Control
6. Infrastructure/Foundational Capabilities
7. Laboratory
8. Access and Linkage to Care
9. Surveillance and Epidemiology
10. Preparedness, Response, and Recovery

In the Texas Public Health Action Plan 2017-2021[2], DSHS identified the need to improve capacity and capability in six priority functional areas:

1. Chronic Disease, Tobacco, and Injury Prevention and Control
2. Communicable Disease Prevention and Control
3. Maternal and Child Health
4. Environmental Health
5. Mental Health and Substance Abuse
6. Clinical Preventive and Primary Care

After reviewing multiple public health reports and discussing current public health issues in Texas, the PHFPC presented 15 recommendations to DSHS. The recommendations originate from discussions about core functions, roles and responsibilities of the LHDs and Public Health Regions (PHR), data sharing, need for insurance category for public health, infectious disease, workforce development, and technology. The recommendations are detailed in this document.

---

[2] Texas Department of State Health Services, 2016. The Texas Public Health Action Plan 2017-2021. Retrieved from https://webcache.googleusercontent.com/search?q=cache:oLVxpXQE5X0J:https://www.dshs.texas.gov/legislative/2016-Reports/Rider81TexasPublicHealthActionPlan.pdf+&cd=1&hl=en&ct=clnk&gl=us. Accessed November 6, 2017.

2. Texas State of Health

Texas is the second largest state in the country with a large and diverse population. It is comprised of 254 counties and each county falls into one of the 11 Public Health Regions. Three of the country's ten largest cities are in Texas: Houston (fourth largest); San Antonio (seventh largest); and Dallas (ninth largest). Of the 254 counties, only one-fifth have their own city or county health department. Geographically, Texas is primarily rural with hubs of concentrated population numbers in larger urban areas.

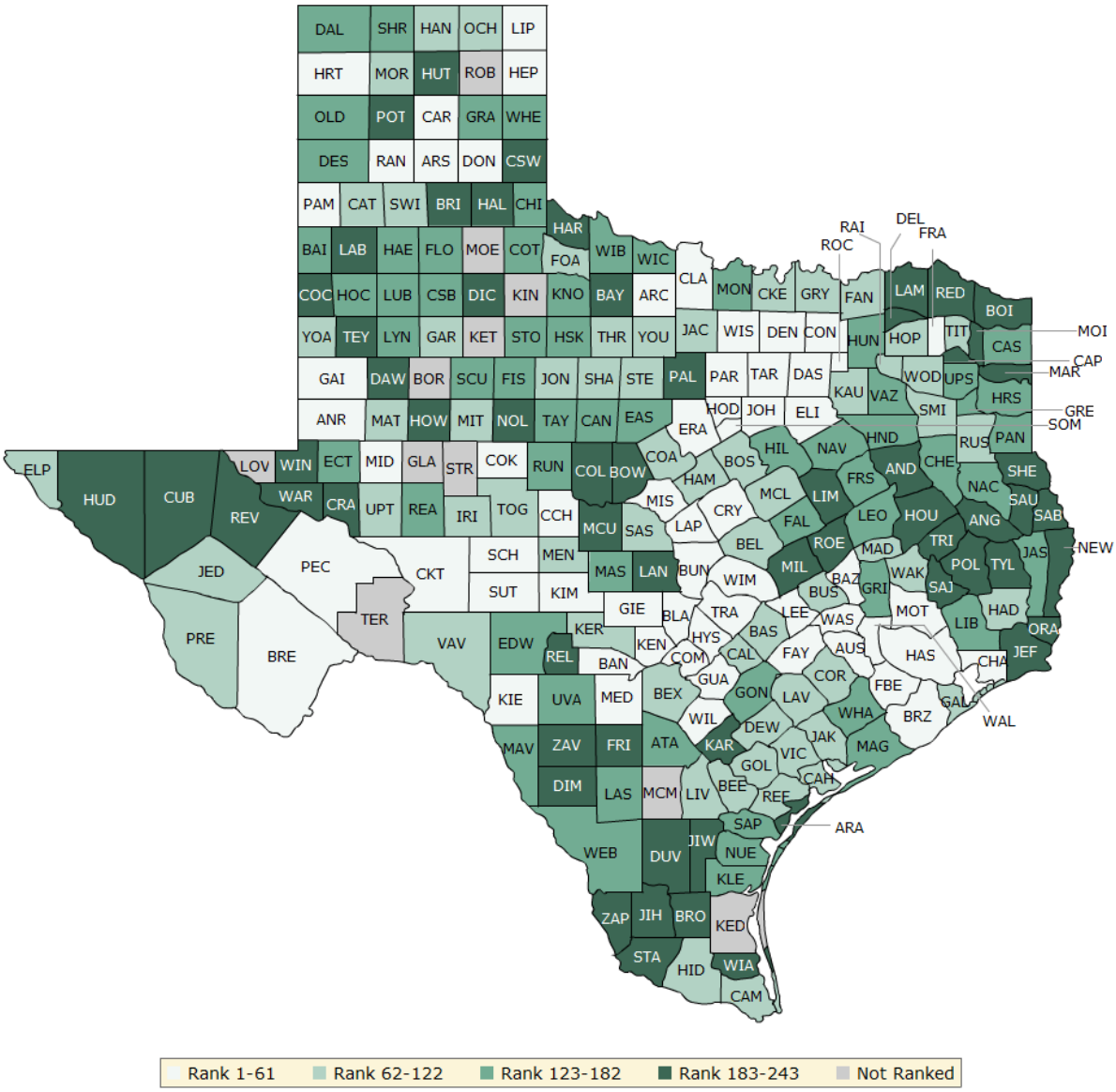
Over the past century, the public health field made great strides to improve living conditions. The greatest contributions include access to safe food, safe water, and immunizations for many vaccine preventable diseases. Following this morbidity and mortality patterns shifted from infectious and communicable diseases to chronic diseases.

The following figures provide an overview of the current health of Texas. Figure 1 and Figure 2 provide County Health Rankings data[3]; the darker colors indicate Texas counties with poorer health data. Figure 1, ranks the counties based on how long residents live (length of life) and how healthy they feel while alive (quality of life). Figure 2 ranks the counties based on four factors: health behaviors, clinical care, social and economic, and physical environment factors.

[3] University of Wisconsin Population Health Institute, 2017. County Health Rankings & Roadmaps, Texas 2017. Retrieved from http://www.countyhealthrankings.org/app/texas/2017/overview. Accessed on November 8, 2017.

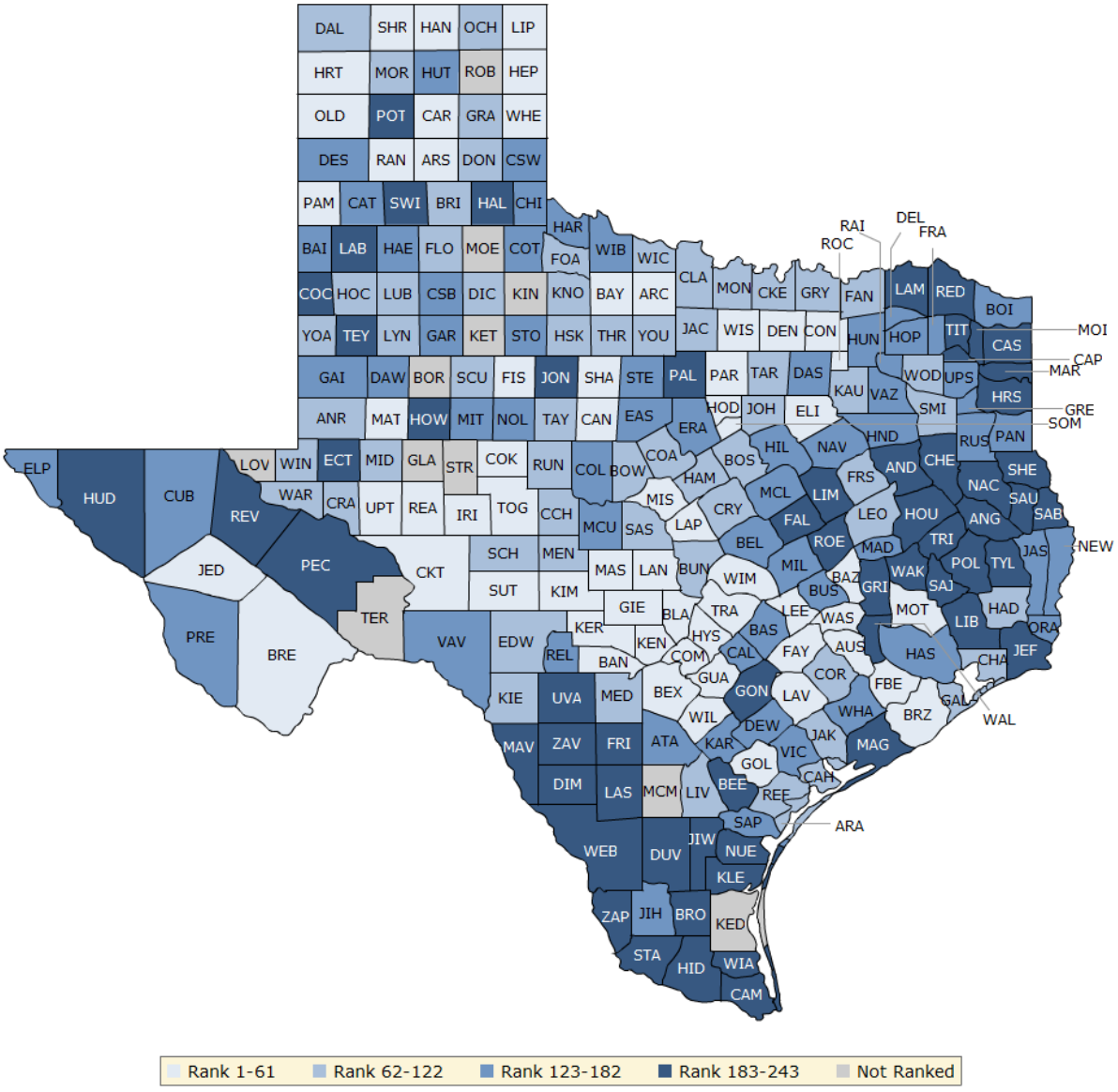
Health Outcomes and Health Factors in Texas

Figure 1. Texas Health Outcomes Map from the 2017 County Health Rankings



Darker shaded counties have a lower length and quality of life expectancy.

Figure 2. Texas Health Factors Map from the 2017 County Health Rankings



The top five leading causes of death in Texas have remained the same since 1979.[4] Figure 3: Top 10 Causes of Mortality in Texas provides a list. Chronic diseases such as heart disease, cancer, stroke, diabetes, chronic lower respiratory disease, and Alzheimer's disease remain the top causes of morbidity and mortality.[5] Refer to Figure 4: Diseases of the Heart and Figure 5: Stroke Prevalence for county details. Changes to modifiable risk factors such as, tobacco use, physical inactivity, and poor nutrition will decrease chronic disease burden.[5]

[4] Texas Health and Human Service, Texas Department of State Health Services, 2008 Mortality. Retrieved from https://www.dshs.texas.gov/CHS/VSTAT/latest/nmortal.shtm. Accessed on November 7, 2017.

[5] Texas Department of State Health Services, 2017. Center for Health Statistics Texas Health Data, Data Visualization Dashboard. Retrieved from http://healthdata.dshs.texas.gov/VitalStatistics/Death. Accessed on November 8, 2017.

Leading Causes of Death in Texas

Figure 3. Top 10 Causes of Mortality in Texas

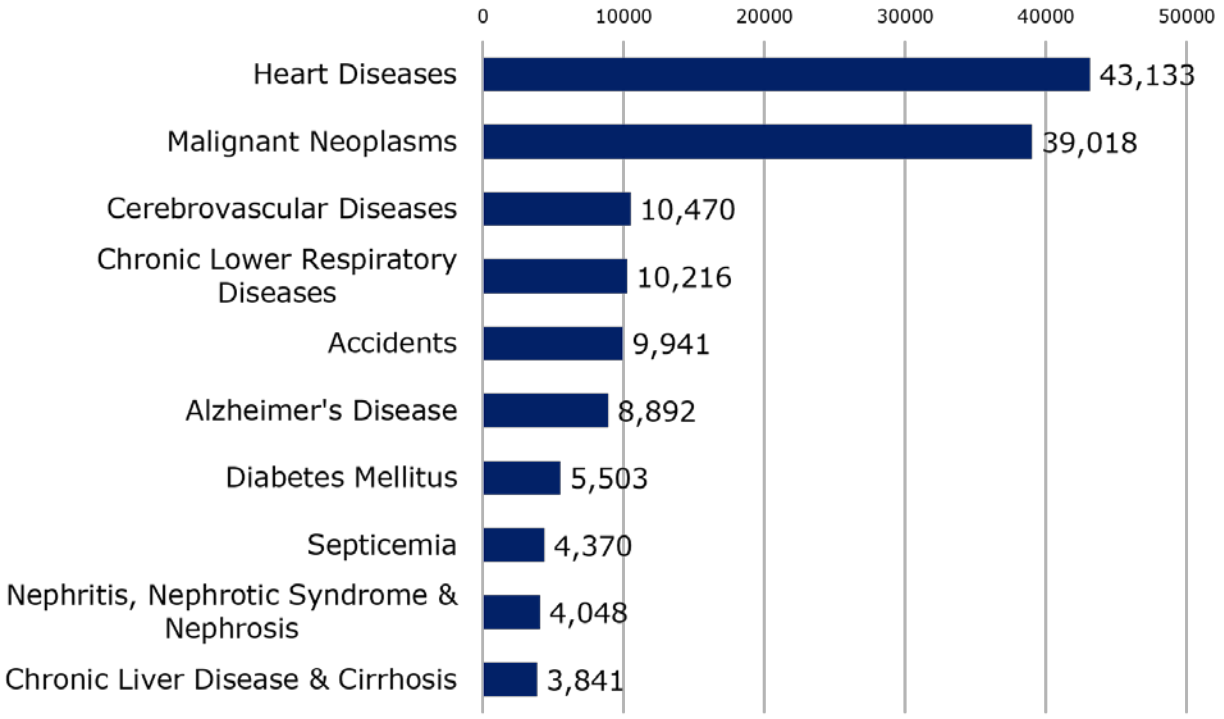


Figure 4. Heart Disease Prevalence in Texas by Public Health Region

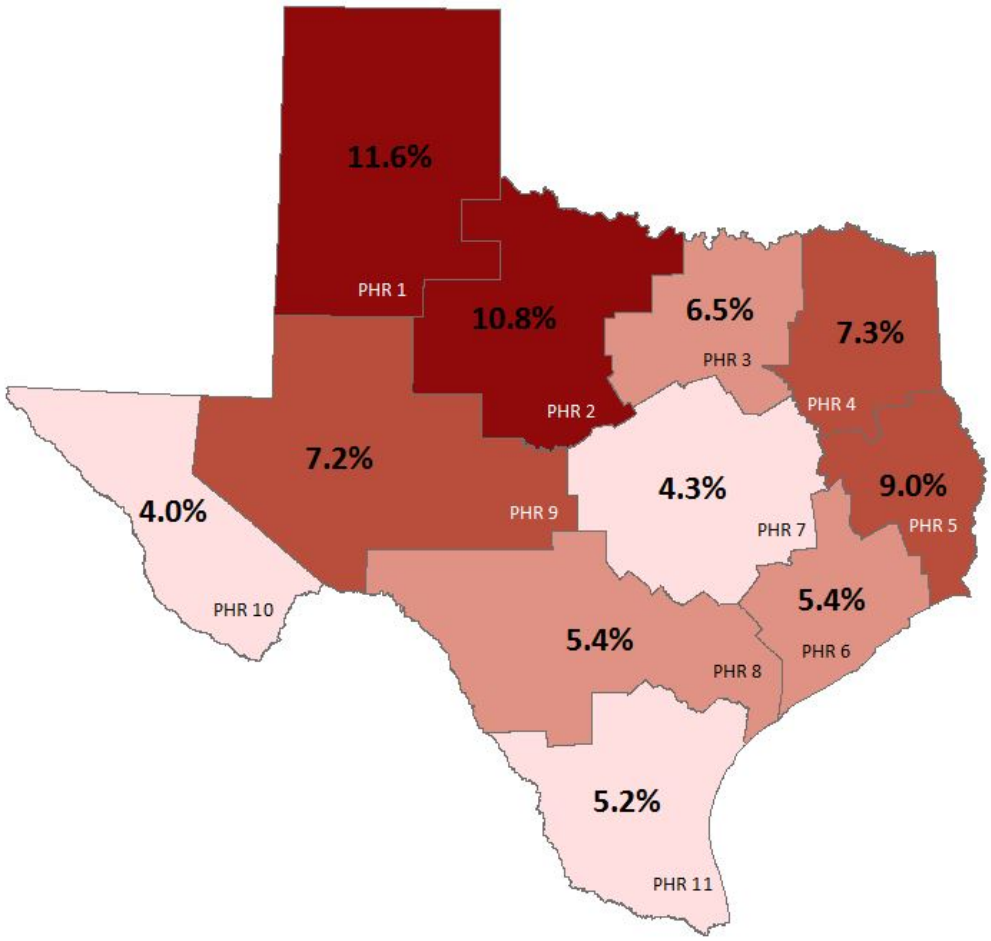
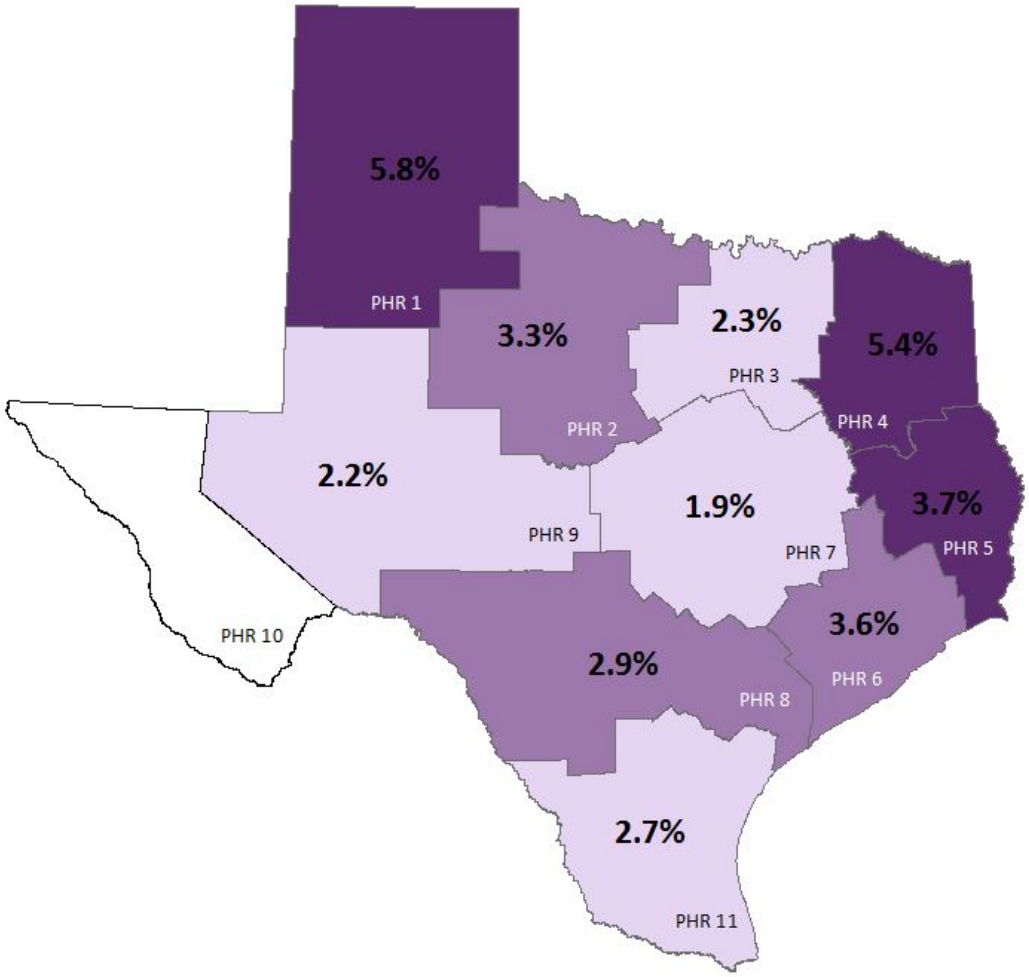


Figure 5. Stroke Prevalence in Texas by Public Health Region



In Figure 4 and Figure 5, the darker areas in the maps indicate a higher prevalence of heart disease and stroke. Public Health Region 10 (white area) was excluded because of insufficient data to determine the prevalence rate.

Other chronic conditions affecting the health of Texans include lung diseases, such as chronic obstructive pulmonary disorder, emphysema, and bronchitis. The prevalence of diabetes is on the rise, as well as the conditions associated with uncontrolled diabetes.

Figure 6. Lung Disease Prevalence (Chronic Obstructive Pulmonary Disease, Emphysema, Bronchitis) in Texas by Public Health Region

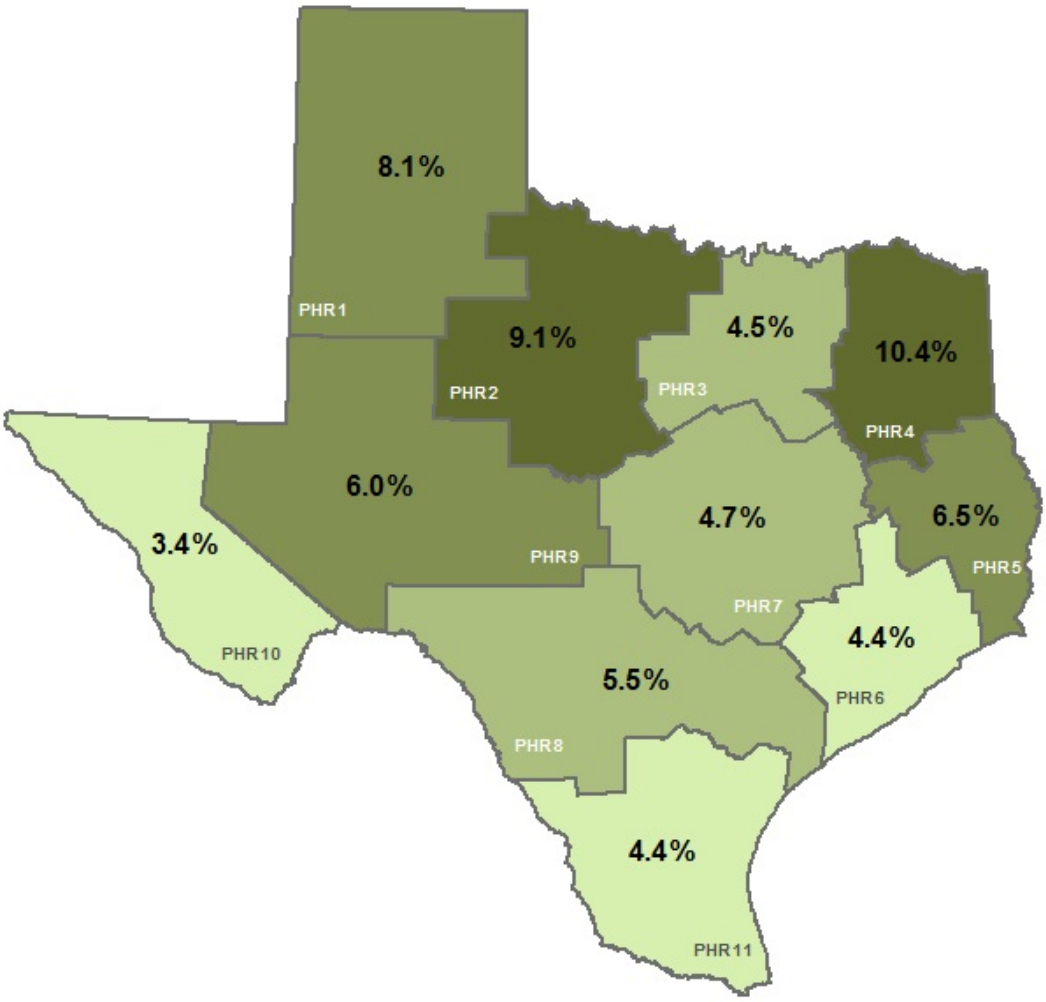
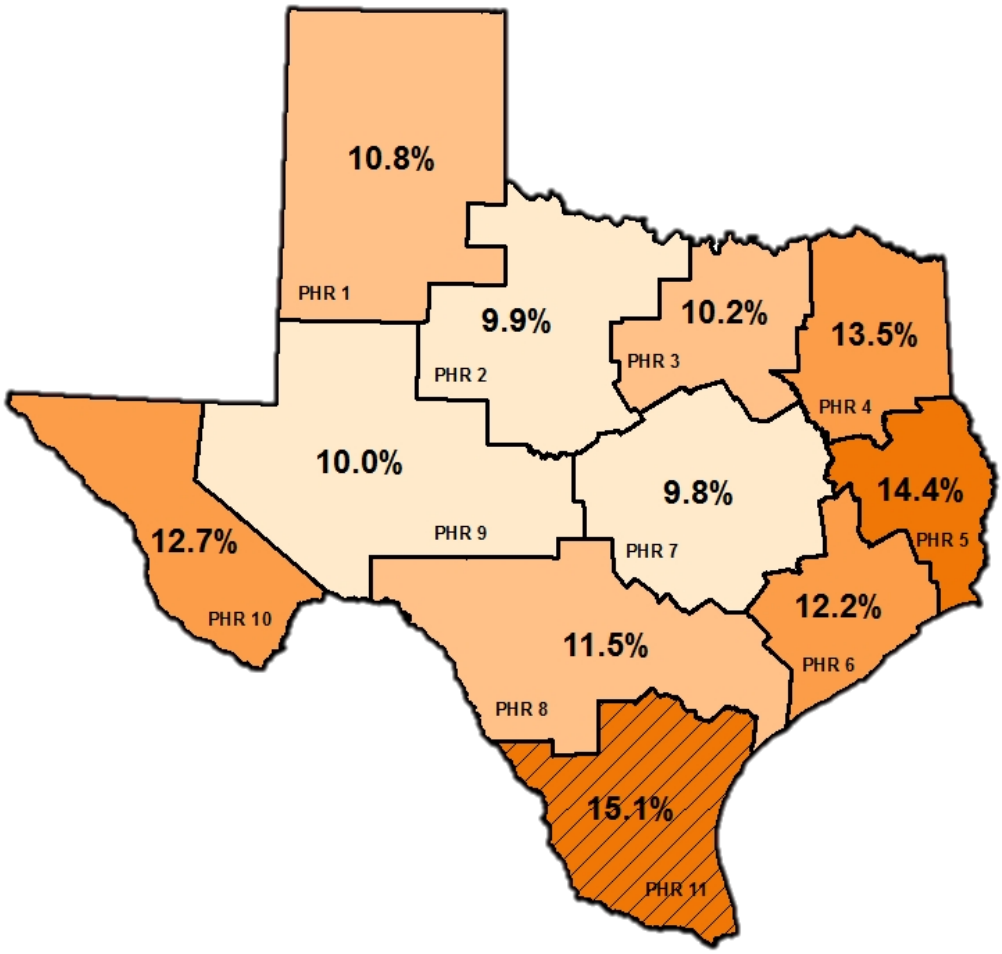


Figure 6. Diabetes Prevalence in Texas by Public Health Region



In addition to the chronic diseases described above, maternal and infant health, vaccine preventable disease, and emerging diseases remain public health challenges for Texans.

3. 2017 PHFPC Recommendations

The PHFPC meets every two months. Based on multiple reports and discussions of current public health issues, the PHFPC made 15 recommendations to DSHS from 7 functional areas. Listed below are the recommendations, followed by a discussion and goal.

Core Functions

Recommendations:

A. The PHFPC recommends that DSHS adopt core services as listed in the "Defining Core Public Health Services" document as the Texas standard. ***See Appendix A.***

Discussion: The first charge of the PHFPC under Chapter 117, Health and Safety Code is to define the core public health services a local health entity should provide in a county or municipality. Since its inception, the PHFPC collaborated with DSHS and TACCHO to complete this charge. In 2015, DSHS assembled a Core Services Workgroup comprised of public health stakeholders, including LHD representatives, PHR representatives, and DSHS staff members. The Workgroup purpose was to identify a standard set of core public health services. The PHFPC addressed progress toward defining core public health services and continually revised the "Defining Core Public Health Services" document from June 2015 to June 2017. On June 7, 2017, the PHFPC made a final edit and voted to approve the "Defining Core Public Health Services" (refer to Appendix A) as the final document. The document was derived from years of work, discussions, and contributions from public health stakeholders throughout the state; therefore, the PHFPC believes it should be adopted as the standard for the state.

B. The PHFPC recommends that DSHS define core public health as written in the DSHS report titled Public Health Service Delivery in Texas: A System for Categorizing Local Health Entities, but change the criteria to "assure in the local jurisdiction" not directly provided by LHDs.

Discussion: DSHS conducted multiple activities to achieve the Sunset Advisory Commission directive to develop an LHD categorization system based on public health services provided. DSHS provided the PHFPC with the results of the Public Health System Inventory Survey. The survey resulted in detailed information about public health services provided in Texas. To determine what services to define as core, DSHS sought feedback from multiple stakeholders including DSHS, PHR, and LHD staff via multiple telephone meetings. Using the feedback, DSHS determined 14 functional areas for public health in Texas.

DSHS used the 14 functional areas to define the level of public health services each LHD provides within its jurisdiction. The three levels of categorization are targeted, core, and enhanced services. The core services include 8 of the 14 functional areas: food safety; water and septic systems; environmental health hazards; vector-borne and zoonotic disease prevention; communicable disease prevention and control; surveillance and epidemiology; preparedness, response, and recovery; and chronic disease prevention and control. Enhanced services include 6 of the 14 areas: access and linkage to care; maternal and child health; mental health and substance abuse; public health infrastructure improvements; injury prevention and control; and laboratory. In the targeted services category, the LHD provides services in 1 or more of the 14 functional areas but not all 8 listed in the core services category.

The final DSHS 14 functional areas and categorization system did not reflect the categories and criteria discussed with the PHFPC. DSHS presented the *Public Health Service Delivery in Texas: A System for Categorizing Local Health Entities* report to the PHFPC after submitting it to meet the Sunset directive. A survey of 45 LHDs, using the categories and requirements listed in the document, revealed only 6 (13 percent) directly provide the listed core functions. The remaining 39 (87 percent) LHDs directly provided some of the core services, but not all. For example, DSHS directly provides zoonotic disease prevention for multiple LHDs, consequently the LHD does not directly provide the service.

The national Public Health Accreditation Board determined LHDs must “assure” residents receive the core services, but does not require LHDs to directly provide the services. In other words, if an LHD does not perform the services in-house, but contracts with another entity (public or private) to provide the service on its behalf, the LHD should get credit for providing the service. The PHFPC requests the language reflect national accreditation criteria and require the LHD to assure services are provided, not directly provide the service.

C. The PHFPC recommends that DSHS conduct facilitated meetings in each DSHS PHR with the LHDs and PHR staff to: 1) discuss/determine core functions expected for all residents in Texas, 2) identify the assets in the region/LHD to provide the core services, 3) identify gaps/barriers in the Region/LHDs, 4) prioritize gaps, 5) discuss possible solutions, and 6) determine cost-effective and efficient methods in each region to ensure core services.

Discussion: Because of the unique demographics, population, and public health needs in each region of the state, the PHFPC believes DSHS should conduct one meeting in each PHR. The meeting should include staff from the PHR and all LHDs within the region to identify and assess regional needs and concerns.

The meeting should result in an open dialogue between all public health entities within the PHR. The purpose of the meeting is to collectively identify the current state of the region and reach consensus regarding the core functions, assets, and gaps in the PHRs. This discussion should reveal the capacity of each entity within the PHR and of the PHR in its entirety. Once the PHR's current capacity is recognized, the LHDs, PHR, and DSHS can work together to prioritize the gaps, and develop solutions. The goal is to close the gaps that hinder the region's ability to provide all the core functions in an efficient manner.

The PHFPC recommends DSHS conduct one regional meeting with all the regional stakeholders at the table to establish a baseline in every PHR, and create one cohesive picture clearly reflecting the gaps and overlaps in services. Several meetings with different stakeholders at each meeting would result in a fragmented picture of the region's current capacity.

The PHFPC conducted a similar type of assessment in 2012. The PHFPC met in every PHR of the state and invited all the public health entities in the PHR to present on the conditions and concerns in their area. The experience was quite telling, we discovered major differences in priorities and gaps from PHR to PHR, but all PHRs had the same goal; to provide the most efficient public health services to the clients they serve.

Goal: To ensure LHDs and PHRs provide core services in Texas, identify the interdependency of LHDs and PHRs, and acknowledge the independence of jurisdictions to choose which services they will provide.

Local and Regional Health Services Departments Roles

Recommendations:

A. The PHFPC recommends that DSHS evaluate local and state roles in each region; promote independence and create surge capacity at DSHS PHR offices; and define DSHS PHR and LHD functions. To clearly define public health roles, create Memorandums of Understanding (MOUs) describing the DSHS PHR and local responsibilities in each jurisdiction, with or without funding attached.

Discussion: DSHS should consider multiple models for health department roles specific to the geographic needs. One example worth considering is the Centers for Disease Control and Prevention (CDC) model. The CDC operates by providing leadership and guidance and developing policy while recognizing state health departments are in a better position to evaluate the needs of their community. CDC provides funds to help the states carry out these responsibilities. The CDC allows state health departments to operate independently, within certain parameters. CDC experts are available to assist when state/local resources do not meet the immediate needs, e.g., epidemiological investigations. To integrate this model in Texas, DSHS would function at the state-wide level, providing leadership in the core public health functions of assessment, policy development, and assurance. The state would maintain responsibility for setting funding priorities, allocating resources, providing guidance and technical assistance to LHDs, and facilitating discussions with federal agencies, statewide stakeholders, and international/border organizations.

B. The PHFPC recommends that DSHS revisit having a cooperative agreement between DSHS and LHDs. Describe roles and responsibilities resulting in partnership versus contract.

Discussion: DSHS currently issues contracts to award LHD funding for programs. The PHFPC believes DSHS should consider issuing cooperative agreements for multiple reasons. Cooperative agreements: 1) provide a more flexible contracting instrument requiring substantial involvement between the parties; 2) support flexibility in the scope of work, budget, and other changes; 3) establish a partnership between DSHS and LHDs; and 4) grant LHDs more autonomy in carrying out the services under the agreement.

C. PHFPC recommends that DSHS increase public health capacity at the PHR level in the areas of routine public health functions and the ability for surge capacity in the areas of epidemiologists, disease intervention specialists, nurses and sanitarians.

Discussion: DSHS should embed state employees in LHDs. This provides specialized personnel (epidemiologists, nurses, sanitarians, etc.) to LHDs either on a permanent or temporary basis to meet long and/or short-term needs. DSHS could maintain a cadre of trained public health professionals to support PHRs and LHDs as needed. By providing surge capacity, the state assures the essential public health service of disease investigation and control is carried out in all parts of Texas, regardless of LHD.

Goal: To identify, define, and develop a systemic and integrated approach to planning and filling service gaps.

Data Sharing

Recommendation:

A. The PHFPC recommends DSHS continue to work with the TACCHO workgroup to determine how LHDs can obtain public health data maintained by DSHS. Look at options: 1) evaluate the possibility of governmental transfer of information, 2) identify the statutes creating barriers, and review the language, and 3) review and identify legislative barriers and define the interdependent relationship between LHDs and DSHS removing barriers to data sharing.

Discussion: PHFPC is working with DSHS to resolve barriers to data sharing. Key issues include: 1) Recognition that LHDs have the same public health authority and rights to obtain access to public health data as DSHS. The Health Insurance Portability and Accountability Act (HIPAA) allows providers to disclose protected health information (PHI) to health departments without patient authorization for public health activities, such as communicable disease reporting, or to a public health authority to prevent or control disease, injury, or disability under the public health exemption [45 C.F.R. § 164.512(b) (2013)]; 2) Clarification regarding ownership of data – some of the data is collected by LHDs and provided to DSHS. LHDs should have equal claim of ownership over the data for local public health purposes; 3) Recognition that many activities using public health data are part of

local public health practice as opposed to research, and should therefore not be subject to the standard review process by the DSHS Internal Review Board; 4) Recognition that some of the barriers identified may relate to existing statutes and require changes to state statutes or interpretation in the administrative code.

Goal: To resolve barriers to data sharing, including those relating to statutes.

Insurance Category for Public Health

Recommendations:

A. The PHFPC recommends that DSHS request the Health and Human Services Commission (HHSC) to sponsor a meeting between HHSC, Medicaid, LHD, and PHR representatives to develop solutions and strategies to eliminate the credentialing and contracting barriers that currently exist for LHDs and PHRs seeking contracts with public and private insurance companies.

B. The PHFPC recommends that DSHS identify potential legislation and policies to reduce barriers and challenges LHDs and PHRs experience when credentialing and contracting with Medicaid and other third-party reimbursement for services provided to eligible clients.

C. The PHFPC recommends that DSHS central office programs, PHRs, and LHDs collectively work with HHSC to support incorporation of community-based public health services into value-based payment/reimbursement models. Examples include community health workers/disease management, lead abatement/asthma trigger removal in the home, etc.

Discussion: LHDs serve as a safety net for individuals who lack access to primary care, whether they have a source of payment or not. For example, some LHDs offer limited primary care services. This service varies from area to area. It is more prominent in inner city and rural areas experiencing a primary care provider shortage or providers willing to serve the health needs of uninsured, Medicaid, and Children's Health Insurance Program (CHIP) clients. The safety net role is important in maintaining and promoting the health of a community. Another example is in frontier counties without providers, DSHS or LHDs provide immunizations to uninsured children and adults, but the insured population may have to drive 50+ miles to receive vaccinations.

Because of the great difficulties LHDs have contracting and credentialing with insurance providers, previous PHFPC reports contained recommendations requesting the Commissioner to support and promote simplified credentialing for LHDs with CHIP, Medicaid, and private insurance companies. The problem continues and LHDs need assistance from the state to resolve.

Goal: To decrease the time burden on LHDs and PHRs associated with credentialing and negotiating contracts with public or private insurance, create a public health insurance category instead of forcing us to mimic traditional providers.

Infectious Disease

Recommendations:

A. The PHFPC recommends that DSHS develop and implement a plan to enhance communication and operational processes to ensure the fidelity and efficiency for the local health authority role in responding to disease outbreaks.

Discussion: Response to infectious diseases varies with the severity and communicability of the disease. LHDs, healthcare providers, emergency responders, and government routinely work together and are in the best position to exact immediate action for both small and large-scale community events. The appointed local health authority brings medical expertise combined with local knowledge and insight to assure appropriate communicable disease control measures are in place in their jurisdiction in accordance with Chapter 81 of the Texas Health and Safety Code.

Working toward enhancing communication and operational processes requires a solid understanding of the roles and responsibilities at local and state level. Infectious disease events and outbreaks occur locally, consequently the response to infectious diseases consider local context, capacity, and capabilities. State-level decisions in-turn must consider and respect local control and local health authority.

B. The PHFPC recommends that DSHS invest in the development and maintenance of a robust, multidisciplinary approach, such as One Health, to infectious disease prevention and response.

Discussion: Assuring robust and timely infectious disease response is challenging for DSHS and LHDs. The challenges range from limited funding to variable capacities. Some of the contributing factors constraining a robust and timely response include: 1) lack of personnel to complete surveillance activities; 2) redundant and time-consuming paper work; 3) categorical and inflexible funding streams for response personnel such as epidemiologists; and 4) funds restricting activities to human factors (e.g., human surveillance/lab testing, etc.) without taking into consideration the agents (e.g., mosquitos) and/or the role of the natural or built environment.

"**One Health** recognizes the health of people is connected to the health of animals and the environment. The goal of One Health is to encourage the collaborative efforts of multiple disciplines-working locally, nationally, and globally - to achieve the **best health for people, animals, and our environment**.[6] Implementing the One Health framework could advance a robust and cross-disciplinary infectious disease response at the local and state level.

Goal: To maximize the use of local assets and reinforce collaborative roles between a LHD and DSHS.

Workforce Development

Recommendation:

A. The PHFPC recommends that DSHS collaborate with academic partners and LHDs to develop role-specific classes and create a general employee public health training class for non-professional and professional staff. The classes should be available electronically (on-line classes/webinars) and some face-to-face options.

---

[6] Centers for Disease Control and Prevention (CDC), 2017. One Health. Retrieved from https://www.cdc.gov/onehealth/index.html. Accessed on November 6, 2017

Discussion: Since 2008, LHDs across the nation have eliminated over 50,000 jobs due, in part, to layoffs and attrition related to budget cuts and hiring freezes.[7] Although 2014 saw the fewest numbers of jobs lost, lingering is the negative impact of the reduced governmental public health workforce. The trend to reduce budgets and workforce resulted in fewer employees to provide more services, which requires the existing employees to have broad skill sets to protect the public's health.

The de Beaumont Foundation's Report, *Building Skills for More Strategic Public Health Workforce: A Call to Action,* echoes the need to re-envision the governmental public health workforce. Over the past several decades, education focused on specialization and knowledge in core public health disciplines. However, to be effective in governmental public health's changing landscape the workforce must bolster strategic skills. These include: systems thinking, change management, persuasive communication, data analytics, problem solving, diversity and inclusion, resources management, and policy engagement.[8]

The 2016 Accreditation Criteria from the Association of Schools and Programs of Public Health reflect the transition from discipline-based content to a more cross-cutting and practice-based skills approach.[9] Public health schools and programs are a natural ally in developing tomorrow's workforce and training the current workforce. To prepare a future workforce savvy in traditional disciplines and strategic skills as outlined in the de Beaumont report will require academic institutions partner to assure curriculum for bachelors, masters, and doctoral trained public health professionals aligns with governmental public health needs.

---

[7] National Association of County and City Health Officials, 2015. The Changing Public Health Landscape, Findings from the 2015 Forces of Change Survey. Retrieved from http://nacchoprofilestudy.org/wp-content/uploads/2017/10/2015-Forces-of-Change-Slidedoc-Final1.pdf. Accessed on November 8, 2017.

[8] De Beaumont Foundation. *Building Skills for More Strategic Public Health Workforce: A Call to Action.* Retrieved from http://www.debeaumont.org/wordpress/wp-content/uploads/Building-Skills-for-a-More-Strategic-Public-Health-Workforce.pdf. Accessed on November 8, 2017.

[9] Council on Education for Public Health (CEPH), 2016. Accreditation Criteria, *Schools of Public Health &Public Health programs*. Retrieved from https://ceph.org/assets/2016.Criteria.pdf. Accessed on November 8, 2017.

Student internships and practicum placements allow the student to apply academic knowledge in the professional setting and gain practical experience.

For the existing governmental workforce, the most immediate need is creating role-specific training and resources to integrate strategic skills with existing core discipline knowledge. Academic partners can provide trainings, through multiple modalities including in-person workshops and online modules. Academia could conduct continuing education and workforce development activities with LHDs, PHRs, and at annual meetings across the state. Many public health employees have no formal public health training; therefore, it is imperative that the state develop Public Health 101 training. This training would provide a general overview of public health's role in Texas and allow employees to see how their contributions impact the health of Texans.

Goal: To ensure the public health workforce is sufficiently and specifically trained in public health so services will be efficiently provided to the clients throughout the state.

Technology

Recommendations:

A. The PHFPC recommends that DSHS create one centralized disease reporting system for the state. Upgrade DSHS technology to HL7 format so LHD's can electronically send reports to the DSHS database.

Discussion: Technology access, availability, and expertise varies among LHDs. Many LHDs have electronic disease reporting and investigation systems, but cannot electronically transfer the data to DSHS. For example, one LHD electronic system gives local providers access to disease reporting via the web. The provider's nurse logs into the system and reports a chlamydia case including treatment, diagnoses, etc. The reporting system sends an email to public health employees engaged in epidemiology activities. The LHD employee accesses the information and initiates a disease investigation. The investigation is completed and documented in the system, but the employee must print and fax the chlamydia report to DSHS.

Technology can improve efficiencies in the public health system. If the LHD in the previous example could send the report electronically it would decrease staff time associated with disease reporting. The PHFPC does not wish to limit the formats

used to interface with LHDs, but requests DSHS look at options and ways to improve efficiencies using technology. Also, if DSHS needs multiple reporting systems, then look for options to make them electronically compatible with LHD systems.

B. The PHFPC recommends that DSHS create a workgroup to evaluate efficiencies and identify areas where technology solutions can improve the public health system.

The Health Information Technology for Economic and Clinical Health (HITECH) ACT of 2009, made adopting Electronic Health Record (EHR) technology a national priority. EHR implementation in the public health arena falls far behind the private sector. Survey data collected by the National Association of County and City and Health Officials (NACCHO) between 2011 and 2013 indicated only a 2.7 percent increase in EHR adoption rates by LHDs compared to a 35 percent increase for acute care hospitals during the same period. To promote interoperability and keep pace with adoption and use rates in other health system areas, public health providers including LHDs and DSHS PHRs need to accelerate EHR adoption. Electronic health information exchange between PHRs, LHDs, Health Information Exchanges (HIE), laboratories, private health care providers, and other community partners is needed. The information exchange will improve the efficiency of disease reporting, coordinate provision of client services (such as TB treatment and contact tracing), improve documentation to facilitate accurate coding and billing for patient services, and advance the ability to monitor the community's health. Electronic health information exchange is extremely valuable in times of disaster and public health emergencies. The recent hurricanes demonstrated the importance when shelters accessed evacuee health records for prescriptions, immunizations, and health histories.

In addition, EHRs increase the quality of patient care provided through enhanced decision support, clinical alerts, reminders, and medical information. Many LHDs have, or are moving to, electronic health records while the DSHS PHRs continue to use paper records. To have an efficient public health system in Texas, all partners in the system need the ability to exchange electronic health information.

The PHFPC suggests DSHS create a workgroup of LHD, PHR, and DSHS central office program personnel to discuss existing technology, how to use technology to improve efficiency and potentially decrease costs, identify needed technology, etc.

The workgroup would report assets, issues, gaps, and possible solutions to the PHFPC for future recommendations.

Goal: To utilize technology to improve efficiencies in the public health system.

4. Future Considerations

In the next year, the PHFPC intends to consider the issues of chronic disease and social determinants of health while investigating the link between the two as well as the steps public health should take to effectively address these issues. Chronic disease prevention and control is a fundamental public health concern. Chronic diseases are the leading cause of death and disability in the United States, and account for 86 percent of the nation's health care costs.

The PHFPC will review the most efficient way DSHS can provide personnel support on an as needed basis to LHDs and PHRs, as discussed in the Local and Regional Health Services Roles Recommendations section of the report. It is imperative that with the development of a statewide public health system surge capacity is built in and available to every jurisdiction across the state.

5. Conclusion

The PHFPC continues to be committed to carrying out its duties as outlined by state statute and appreciates the opportunity to be a part of the planning and development of a statewide public health system. The PHFPC is eager to work with DSHS to accomplish the goals outlined in this report and develop goals regarding the future considerations. Upon the completion of every report the PHFPC believes it closer to accomplishing this overall goal.

Appendix A. Defining Core Public Health Services Public Health Funding and Policy Committee 6/7/2017

Chronic Disease Prevention and Control

Nutrition

Physical Activity

Tobacco

Chronic Disease Detection and Management (Heart Disease, Cancer, Stroke, Diabetes)

Communicable Disease Prevention and Control

HIV/Sexually Transmitted Diseases/Viral Hepatitis

Tuberculosis

Emerging/High-Consequence Infectious Disease

Immunizations

Food Borne

Zoonotic Diseases (Vector)

Healthcare Acquired Infections

Environmental/Regulatory Services

Food Safety

Water Safety

Air Safety

Environmental Health Hazards

Rodent and Vector Control

Maternal/Child Health

Prenatal Care

Family Planning

Health Screening and Child Development

Infant Mortality

Breastfeeding/Nutrition

Injury Prevention and Control

Intentional

Unintentional

Infrastructure/Foundational Capabilities

Workforce Development

Technology

Business Efficiencies

Fund Development

Accreditation

Operations/Finance

Advocacy

Laboratory

Environmental

Human

Zoonotic/Vector

Access and Linkage to Care

Definition

Behavioral Health

Surveillance/Epidemiology

Disease/Condition Reporting and Surveillance

Data Collection and Reporting

Epi Investigation and Study

Syndromic Surveillance

Data Sharing and Exchange

Preparedness, Response and Recovery

Community Preparedness/Mitigation

Community Response

Community Recovery

Resilience