The Texas Public Health Action Plan

Improving the Future Performance of the Public Health System

2017 - 2021

November 2016
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**Message from the Commissioner**

Our own personal health and the health of those we love are very dear to us. I view public health as the means by which the state works to bring about optimal health for all persons in our beloved Texas. Public health professionals work to make this vision a reality in many ways. In some instances, it is through the direct provision of public health services, in others, public health professionals and agencies serve as leaders who convene and coordinate the work of others. This report will describe how this is accomplished and suggest future direction for public health in our state.

Every day, public health professionals throughout the state work to preserve the health and well-being of Texans. This dedicated work often goes unnoticed, and yet the impact to Texans is profound. In many ways, the quiet nature of public health work is evidence of this effective system—a system that prevents disease outbreaks from spreading to vulnerable Texans, that collaborates with others to break the cycle of chronic disease by educating Texans on healthy living, and that maintains readiness for response to even the most severe natural and manmade disasters. However, as high-profile situations like the Zika and Ebola viruses illustrate, it is imperative that the public health system continuously pursue improvement, never resting in the endeavor to provide Texans with the most seamless and dependable public health protections.

The public health system in Texas goes far beyond the Texas Department of State Health Services, and beyond any other single group or organization. This complex system includes numerous players from multiple state agencies, from every level of government, and from every sector of business and life. These players depend on each other, learn from each other, and also impact each other through their independent actions and decisions.

To add to this complexity, the health of individual Texans is influenced by a multitude of environmental and social factors, such as safe communities, education, and access to healthy foods. The challenging nature of our work in public health points to one clear fact: in order to tangibly improve the health of individual Texans and their communities, Texas must have a clear and cohesive public health system that strategically addresses well-defined goals.

The Texas Public Health Action Plan is a first step in the improvement of Texas’s multi-faceted public health system. This document will lead to the development and execution of an implementation plan. In order to achieve success in this effort, consensus among the system’s players is essential. The Department’s unique role in this endeavor is to provide a guiding framework for the system, to serve as a resource for data and expertise, and to provide leadership in convening partners to find achievable solutions to public health challenges.

I look forward to the task ahead, and am confident that this process will not just lead to a better functioning system—it will lead to improved health for Texans and Texas communities.

John Hellerstedt, M.D.
Commissioner, Department of State Health Services
Executive Summary

Public health may be defined as promoting and protecting the health of people and the communities where they live, learn, work, and play. In Texas, public health is the responsibility of a complex and diverse system, composed of a wide array of traditional and non-traditional public health partners that include both public and private sector entities.

The Department of State Health Services (DSHS) mission is to improve the health, safety, and well-being of Texans through stewardship of public resources and a focus on core public health functions. The DSHS mission places the agency at the lead of this complex public health system, which is driven by an increasing need for traditional public health services amidst the growing threat of emerging infectious diseases, natural and man-made disasters, and epidemic levels of chronic disease. At the same time, the DSHS leadership role is challenged because the majority of public health system participants – including local public health entities – are independent entities organizationally and politically autonomous from DSHS. Increasingly, DSHS must act as the convener, bringing together these diverse partners to achieve consensus on actionable strategies to address pressing public health objectives.

Given these complexities, DSHS has developed a framework by which to move the Texas public health system forward. This vision prioritizes:

- Clear system-wide health objectives
- Engaged leadership
- Partnerships and open communication
- Data and resource sharing

Using this framework, the agency will work with its partners on development and implementation of actionable strategies to address each of the priorities identified by a steering committee and DSHS during the development of the Texas Public Health Action Plan. The identified priorities fall within six functional categories, and are as follows:

- **Communicable Disease Prevention and Control**
  - Using a systems approach, coordinate the availability of subject matter experts to support infectious disease issues for state, regional, and local health entities.
  - Strengthen internal and external communication among public health organizations and public health/health stakeholders.
  - Ensure capacity and capability of the public health system to prepare for emerging and re-emerging infectious disease outbreaks as well as historically-significant infectious diseases.

- **Chronic Disease, Tobacco, and Injury Prevention and Control**
  - Improve capacity and capability of state and locally-based chronic disease and injury prevention programs according to prevalence, and disease burden.
  - Establish a statewide professional chronic disease and injury prevention network or group to provide leadership, inform decision making, coordinate efforts, and promote innovation in practice.
• **Maternal and Child Health**
  o Assure healthy mothers and babies by reducing disparities in maternal child health populations, facilitating access to maternal and child health services, and increasing the use of evidence-based policy, system, and environmental changes to address obesity across the lifespan.

• **Environmental Health**
  o Improve coordination and impact of environmental health surveillance by strengthening internal and external communication among environmental health organizations and partners.
  o Increase capacity and capability of the environmental public health workforce.

• **Mental Health and Substance Abuse**
  o Develop and emphasize strategies that accommodate the interdependencies of behavioral health and public health.
  o Diversify capacity and capability of surveillance and epidemiological systems to better incorporate behavioral health.

• **Clinical Preventive and Primary Care**
  o Integrate community level efforts with existing clinically-based preventive and primary care service delivery to better meet the health needs of at-risk populations.

For each identified priority, the steering committee advised DSHS on the creation of goals and strategies, which may be carried out on a regional basis. These goals and strategies are found on pages 14 – 26.

This document will lead to the development of an implementation plan to carry out identified strategies over a five-year period. This will include identification of timelines and defined metrics by which to measure progress. DSHS will undertake the implementation plan process in the coming months, including solicitation of feedback from the Legislature, stakeholders, and public health partners.

Significantly, this report does not address interventions for specific diseases. Rather, the report focuses on how the public health system itself may be improved. System improvement is a needed first step to carrying out meaningful public health initiatives that will have the greatest impact throughout the state and throughout Texas subpopulations.
Introduction

In July 2015, the Sunset Advisory Commission concluded that the Texas public health system would benefit from better definition of local and state public health roles and responsibilities and from the development of a long-term plan for Texas public health. Thus, the Legislature charged DSHS with creating a Texas Public Health Action Plan (PHAP). This requirement may be found in the 2016-17 General Appropriations Act, House Bill 1, 84th Texas Legislature, Regular Session, 2015; Article II, Department of State Health Services, Rider 81 (Rider 81). Rider 81 charges DSHS to collaborate with the Public Health Funding and Policy Committee and other stakeholders to:

- Develop a comprehensive inventory of the roles, responsibilities, and capacity relating to public health services delivered by DSHS and local health entities and authorities.
- Establish statewide priorities for improving the state's public health system and to create a public health action plan, with regional goals and strategies, to effectively use state funds to achieve these priorities.

DSHS has published the Public Health System Inventory report, which provides additional background and context for this plan.

The PHAP also acts as a complement to DSHS portion of the five-year Health and Human Services System Strategic Plan 2017 - 2021, which more narrowly focuses on agency programmatic activities. The PHAP provides a broad strategic framework for improving the state’s public health system, and focuses on public health system needs rather than current strengths. Improving the system’s health is an essential first step to improving overall public health in Texas. Successful public health may only be accomplished within the structure of a healthy system. For this reason, ongoing efforts to improve the system are just as vital as continuous work to ensure programmatic activities lead to positive measurable outcomes. The PHAP will serve as a foundation to build on future efforts to advance the efficiency and effectiveness of public health programs and service delivery across the public health system.

Background

In March 2016, DSHS convened a statewide steering committee to develop statewide priorities for the PHAP. Seven subject matter expert workgroups assisted in this process.1 Stakeholder participation was drawn from across the spectrum of traditional and non-traditional public health sectors and included representation from:

- Local public health entities
- Health-related organizations
- Professional associations
- Academia

1 For a description of the processes and activities accomplished to develop the plan, see Appendix A. For a listing of all committee and workgroup members, see Appendices B, C, and D.
The workgroups used state and national data sources to develop statewide priorities for the PHAP, relative to specific functional public health categories:

- Communicable Disease Prevention and Control
- Chronic Disease, Tobacco, and Injury Prevention and Control
- Maternal and Child Health
- Environmental Health

Additionally, the steering committee and workgroups considered the following categories, which are not under the sole purview of public health, but are strongly interlinked with public health outcomes:

- Mental Health and Substance Abuse
- Clinical Preventive and Primary Care Services

Other public health functions, such as preparedness and response or public health laboratories, are also essential to the system, and are incorporated within the categories above.

In order to further develop the goals and strategies required by Rider 81, additional subject matter expert workgroups were formed. All recommendations developed by the workgroups were presented to the PHAP steering committee for consideration. The priorities, goals, and strategies outlined in this document are a result of their collective work.

The PHAP report includes: background on the current public health system, a description of the vision for improving those elements that make up a well-functioning public health system, as well as the state priorities and regional goals and strategies based on the recommendations of the PHAP steering committee.

**Current Texas Public Health System**

The Texas public health system is comprised of both private and public entities with varying expertise and mission focus. At the same time, other state agencies like the Health and Human Services Commission (HHSC) and the Texas Department of Emergency Management (TDEM) play a significant part in certain aspects of public health. Non-traditional public health partners with a role in the system include:

- Hospital systems, physician practices, and health clinics
- Universities and school districts
- Professional associations
- Public and private insurance providers
- Non-profit and community-based organizations
- Public safety entities

Each entity has a role in addressing public health objectives for the state, although public health may not be a focal point of its activities. As the state public health agency, DSHS’s appropriate role is to harness cooperation among these partners to amplify the activities of traditional governmental public health entities.
Traditional governmental public health entities within the state include the state public health agency, local health entities, and local health authorities. The scope and jurisdiction of each entity is defined by Texas statute and by decisions made at the local level.

**Local Health Entities**

Local health entities are established according to the Texas Health and Safety Code as local health departments, public health districts, or local health units. They vary in size, resources, and capacity. As a home rule state, individual local jurisdictions decide what public health programs and services to offer. This results in a variation of service availability across the state and among communities. Currently, 61 of the 159 local health entities in Texas provide a fuller array of public health programs and services. The remaining 98 provide a limited range of services, usually with an environmental program focus.

**Local Health Authorities**

A health authority is a physician appointed to administer state and local laws relating to public health within an appointing body’s jurisdiction. Under Section 121.024 of the Texas Health and Safety Code, a health authority is a state officer when performing duties prescribed by state law. Duties and responsibilities may vary depending on the characteristics of the jurisdiction, but typically include aiding the state with quarantines; enforcing sanitation and public health laws; reporting of notifiable conditions; and collecting vital statistics.

A municipality or county without an organized health department may, but is not required to, appoint a health authority. At a minimum, every county in Texas should have a designated health authority. In counties where there is no locally-appointed health authority, DSHS regional medical directors (RMDs) perform the duties of the health authority.

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2 Texas Health and Safety Code, Title 2, Subtitle F, Chapter 121, Sections 121.031, 121.041 and 121.004.
3 Texas Health and Safety Code, Title 2, Subtitle F, Chapter 121, Sections 121.007.
As the state health agency, DSHS administers legislatively-directed public health programming, including operations from eight health service regions (HSRs). Each DSHS region partners with local health entities to support local control over public health issues, emergencies, and statewide availability of public health services. These services include “protecting, promoting and improving the health and wellness of communities and populations by encouraging healthy behaviors; detecting, monitoring, preventing and controlling the spread of infectious and chronic diseases; analyzing and reporting disease trends; promoting injury prevention; identifying, treating, managing, preventing and reducing health problems related to environmental hazards; and coordinating emergency response and preparedness activities.”4 In counties where there is no

local public health entity, DSHS regional offices serve as the local health entity and provide basic services.

While DSHS is the state public health agency for the state, other agencies play vital roles in the implementation of public health objectives. Chief among these partners are the Health and Human Service system agencies. In addition, other state agencies with either direct or indirect public health roles include, but are not limited to:

- TDEM
- Texas Education Agency
- Texas Animal Health Commission
- Texas Department of Agriculture
- Texas Commission for Environmental Quality.

DSHS regularly coordinates with these agencies. During the PHAP implementation process, DSHS will focus on bringing together other state agencies, as applicable, to ensure amplification of the public health system's efforts.

**Figure 3. Local and Regional Public Health Coverage**
Vision for a Well-Functioning Public Health System in Texas

The future success of the Texas public health system is contingent upon the system operating in a cohesive and coordinated fashion. This coordination is a necessity to accomplish priority improvements in the health and well-being of Texans and Texas communities. The overarching vision for a well-functioning public health system that integrates state and local health entities and other public health partners is:

The public health system in Texas will increase its capacity and capability to improve measurable health outcomes of individuals and communities in Texas. This will be accomplished through:

- Clear system-wide health objectives
- Engaged leadership
- Partnerships and open communication
- Data and resource sharing

This vision will serve as a framework during the PHAP implementation process, and is consistent with elements described in the Sunset Commission final staff report. Working with public health leadership throughout the state, DSHS will identify clear, data-driven objectives that will be implemented through partnerships, with defined metrics by which to measure progress. This effort will occur in coming months, and DSHS will begin by gathering feedback from the Legislature, stakeholders, and partners.

Ultimately, improving the public health system will require a disciplined commitment – clearly defined by leadership at the level of state policy – to ensure that the system moves in an increasingly coordinated fashion. Adherence to the framing vision above will support the statewide priorities and regional goals and strategies identified with the advice of the PHAP steering committee.

Clear System-wide Health Objectives

Clearly-stated objectives to improve public health system capacity and capabilities are vital to achieving commitment and coordination by partners throughout the system. Mutual commitment among partners is indispensable to achieve significant improvements in Texas health outcomes. Development of clear system-wide objectives has the potential to spur the following:

- Definition of clear roles and points of coordination among the system’s various partners
- Identification of opportunities for system efficiencies
- Mitigation of potential overlap or duplication of services

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Engaged Leadership

Incumbent on public health leaders throughout the state is a shared commitment to working with each other to amplify the limited resources that support the system. In its capacity as the state public health agency, DSHS has a significant role in this element of a well-functioning public system. DSHS has the opportunity to continuously grow its capacity to bring public health leadership – traditional and non-traditional – together to improve the health outcomes for Texans and Texas communities. This convergence of leadership creates possibilities not achievable by traditional public health alone:

- More widespread ability to influence health-related behaviors
- Better understanding and consideration of the social determinants of health, those factors that impact health like socioeconomic status and environment
- Greater ability to work across various sectors

Partnerships and Open Communication

Engaged leadership working towards clear system-wide objectives facilitates another hallmark of the vision for a well-functioning public health system: partnership and open communication. Successful accomplishment of improved health outcomes calls for strong partnerships in which each partner recognizes its part in the public health system and its responsibility toward shared objectives.

While engaged leadership can help establish system-wide objectives and convene partners from diverse backgrounds and expertise groups, non-traditional partnerships are needed to roll out interventions and programs, and open communication is needed to track outcomes and effectiveness of initiatives. Partnerships and open communications allow:

- Broader coverage of public health efforts throughout communities
- Amplification of public health messaging through non-public health services and programming
- More innovative solutions by incorporating expertise from outside traditional public health
- Better identification and sharing of best practices and positive outcomes
- Quicker recognition of interventions that are less effective

Data and Resource Sharing

Limited resources necessitate the most effective use of available resources, including health data, funding, and human assets. The Public Health Inventory completed under Rider 81 provides a base of information on which to build further conversations among public health system partners on this topic.

While each public health system partner independently allocates its own resources, collaboration within the system has led to increasing coordination in response to disease outbreaks and data trends. A concentrated effort has the potential to allow for more systematic coordination of resources:
• Shared health information to provide situational awareness about emerging trends, target evidence-based interventions and actionable data
• Shared data to identify improvements in system operations
• Seamless integration of local and state resources to collectively respond to heightened public health issues of concern
• Communication to ensure activities among partners complement each other rather than compete with each other

**Public Health Action Plan – Statewide Priorities**

The PHAP steering committee advised DSHS on public health service delivery improvements that are feasible given current resources, capabilities, and mission focus. The focus of the priorities, goals, and strategies is aimed at improving public health in Texas over the next five years.

Throughout the PHAP process, DSHS and the steering committee have assumed the following:

・ Identified improvements should be achievable within the structure and resource constraints of the current public health system.
・ Suggested improvements should concentrate on foundational public health functions.
・ Generally, identified improvements should be achievable within a five-year time frame.

The following list summarizes, by functional category, statewide priorities for the Texas Public Health Action Plan. These categories are not presented in priority order, but rather represent key aspects of health that directly or indirectly interface with the public health mission. Within its scope, public health is charged to help improve outcomes in each of these categories.

**Communicable Disease Prevention and Control**

・ Using a systems approach, coordinate the availability of subject matter experts to support infectious disease issues for state, regional, and local health entities.
・ Strengthen internal and external communication among public health organizations and public health/health stakeholders.
・ Ensure capacity and capability of the public health system to prepare for emerging and re-emerging infectious disease outbreaks as well as historically-significant infectious diseases.

**Chronic Disease, Tobacco, and Injury Prevention and Control**

・ Improve capacity and capability of state and locally-based chronic disease and injury prevention programs according to prevalence and disease burden.
・ Establish a statewide professional chronic disease and injury prevention network or group to provide leadership, inform decision making, coordinate efforts, and promote innovation in practice.
Maternal and Child Health

- Assure healthy mothers and babies by reducing disparities in maternal child health populations, facilitating access to maternal and child health services, and increasing the use of evidence-based policy and system and environmental changes to address obesity across the lifespan.

Environmental Health

- Improve coordination and impact of environmental health surveillance by strengthening internal and external communication among environmental health organizations and partners.
- Increase capacity and capability of the environmental public health workforce.

The following two categories, Mental Health and Substance Abuse and Clinical Preventive and Primary Care, are not directly public health related, but are integral to the public health outcomes. Mental illnesses affect people's ability to engage in healthy behaviors and lifestyles. Illnesses such as depression have long been tied to substance abuse, impacting overall health of communities. Primary preventive care services are critical to the health of populations across Texas. A shortage of healthcare providers limits access to basic preventive healthcare services in some areas of the state.

Mental Health and Substance Abuse

- Develop and emphasize strategies that accommodate the interdependencies of behavioral health and public health.
- Diversify capacity and capability of surveillance and epidemiological systems to better incorporate behavioral health.

Clinical Preventive and Primary Care

- Integrate community level efforts with existing clinically-based preventive and primary care service delivery to better meet the health needs of at-risk populations.

Public Health Action Plan – Regional Goals and Strategies

No community in Texas is entirely free from the issues and problems public health must address. However, the prevalence of any given public health concern will vary from community to community, and region to region throughout the state. Thus, while the initiatives needed to address a particular public health concern may be relatively standardized, each community and region in the state must define which of these are of greatest priority for them.

In order to facilitate local and regional prioritization, DSHS acts as a source of data and expertise for communities. As DSHS moves into the implementation process, it will initiate local and regional conversations to delve deeper into these issues to ensure that PHAP implementation activities not only reflect statewide priorities, but also complement local and regional priority objectives.
The PHAP steering committee similarly advised DSHS on the creation of the following list of the goals and strategies developed to achieve the statewide priorities. Rider 81 states that the Plan include “regional goals and strategies” for achieving the statewide priorities. The term “regional” used within this plan refers to the geographic regions designated as DSHS Health Service Regions.

Each functional category includes a table of goals and strategies based on the identified statewide priorities. Also included for each functional category is a series of representative supportive data with regional detail, which may serve as a starting point to identify potential prioritization of activities on a regional basis.

While the PHAP only includes a representative sample of data for regions, additional regional health data may be found at the interactive DSHS Texas Health Data website.
Communicable Disease Prevention and Control

The Texas Public Health Inventory report indicated that the majority of local health departments provide services to prevent, test and/or treat HIV/AIDS, sexually transmitted diseases (STDs), and tuberculosis (TB). They also generally immunize children and adults against vaccine-preventable diseases.

Prevention and control of infectious or communicable diseases is foundational public health work. The challenge of addressing traditional communicable diseases such as TB and STDs may be compromised as the incidence of emerging and/or high consequence infectious diseases (HCID) like Ebola and Zika increases and diverts resources and subject matter expertise at the state and local level. The threat could be further heightened during disaster situations.

For this category, improvements to the public health system would result in the following outcomes:

- Enhance response success
- Meet provider and local health department needs
- Improve the level of ongoing infectious disease surveillance, prevention, and control
- Increase the pool of experts available to respond to infectious disease outbreaks

<table>
<thead>
<tr>
<th>Representative Sample of Supporting Data</th>
<th>Regional Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tuberculosis</strong></td>
<td>Highest rate: 9.8*</td>
</tr>
<tr>
<td>In 2015, Texas ranked fourth highest among the 50 states for tuberculosis incidence, with a rate of 4.6 per 100,000 persons.</td>
<td><strong>Region 11</strong></td>
</tr>
<tr>
<td>Texas reported 13.5% of all 2014 cases in the U.S. with a TB infection rate of 4.7 cases per 100,000 population.</td>
<td>Lowest rates: 2.7-3.5*</td>
</tr>
<tr>
<td></td>
<td><strong>Region 1</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Region 7</strong></td>
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<tr>
<td></td>
<td><strong>Region 4/5N</strong></td>
</tr>
<tr>
<td>* Cases per 100,000</td>
<td></td>
</tr>
</tbody>
</table>

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9 Ibid.
**HIV/STD**

From 2008 to 2015, chlamydia, gonorrhea, and syphilis rates have steadily increased, with Central Texas in particular having high rates.\(^{10}\)

The Houston metropolitan area accounted for a third of persons living with HIV and the Dallas metropolitan area accounted for about a quarter of persons living with HIV.\(^{11}\)

<table>
<thead>
<tr>
<th>Highest rates: 64.7-346.7(^*)</th>
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</thead>
<tbody>
<tr>
<td>• Region 4/5N</td>
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<tr>
<td>• Region 6/5S</td>
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<table>
<thead>
<tr>
<th>Lowest rates of newly-diagnosed HIV: 0.0-2.7(^*)</th>
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<tbody>
<tr>
<td>• Region 1</td>
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<tr>
<td>• Region 2/3 (eastern portion)</td>
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<tr>
<td>• Region 9/10 (western portion)</td>
</tr>
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</table>

\(^*\) Incident rate per 100,000

**Zika**

Texas has over 200 travel-related reported cases of Zika virus disease, with most cases in North Central Texas and the Gulf Coast.\(^{12}\)

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<th>Highest rate: 64 cases(^{13})</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Region 6/5S – Harris County</td>
</tr>
</tbody>
</table>

| Lowest rate is widespread across counties in the state at 0 – 1 case. |

**Priority A:**

Using a systems approach, coordinate the availability of subject matter experts to support infectious disease response needs for state, regional and local health entities.

| Goal 1 | Define and identify subject matter experts (SME) to provide response support, as needed, to jurisdictions experiencing an infectious disease event/outbreak. |

**Strategies:**

1. Define criteria (education, experience, training etc.) required to serve as a SME on infectious disease issues and identify public health professionals with those credentials using the Texas Disaster Volunteer Registry.

2. Identify and establish effective protocols for activation (e.g. supplementing and not supplanting local responsibility) of subject matter experts.

3. Offer training and exercise opportunities to cultivate trusted relationships between subject matter experts and public health stakeholders.

**Priority B:**

Strengthen communication among public health organizations and public health/health stakeholders to enhance preparedness and response capabilities.

| Goal 1 | Enhance and ensure situational awareness that promotes a timely and effective public health and laboratory response to infectious diseases. |

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\(^{13}\) Ibid.
Strategies:

1. Implement a situational awareness and communications platform that integrates existing public health communications systems with enhanced technological solutions.

2. Create an automated tiered distribution list that allows for accessible and open dissemination of information.

3. Streamline the approval process for electronic laboratory messaging and guidance in order to more quickly provide partners critical information.

4. In collaboration with educational institutions, develop a global disease situational awareness initiative and encourage public health mapping and disease reporting within those systems.

Priority C:
Ensure capacity and capability of the public health system to prepare for emerging and re-emerging infectious disease outbreaks as well as historically-significant infectious diseases.

Goal 1: Use evidence-based and scientific best practices to maintain and enhance laboratories, epidemiological capacity, access to treatment and an integrated surveillance system for effective infectious disease preparedness and response.

Strategies:

1. Develop and make available to stakeholders a repository for evidence-based scientific best practices literature on topics of laboratories, epidemiological capacity, access to treatment, integrated surveillance systems, and crisis standards of care.

2. Enhance the training for Medical Reserve Corps personnel, community health workers, and other health-related professionals to expand and improve access to treatment and response capacity and capability.

Goal 2: Ensure that more effective processes are in place to address existing communicable diseases in order to better prepare and respond to emerging and re-emerging HCID.

Strategies:

1. Increase training to improve expertise in the early detection, assessment, and response to vaccine preventable and other communicable diseases.

2. Assess reporting among healthcare partners and compare regionally and to other states.

3. Engage with healthcare leadership to encourage more comprehensive disease reporting from healthcare partners.

Goal 3: Implement standardized training for public health laboratory operations in order to better support communicable disease identification.
Strategies:

1. Evaluate workforce needs and identify opportunities for needed training and education.

2. Develop a focused training program for public health laboratorians that includes a train the trainer program for external partners.

3. Host an annual meeting of laboratorians in order to promote information sharing and best practices.
The Texas Public Health Inventory report identified gaps in state and locally-based services to address the impact and disease burden on Texans due to preventable chronic disease, tobacco use, and unintentional injuries. Poor outcomes for these three issues may generally be prevented by similar interventions, and so chronic disease, tobacco, and unintentional injuries are placed in the same category.

For this category, improvements to the public health system would result in the following outcomes:

- Identify resource needs and the potential for better administration of current resources
- Provide opportunities for broader sharing of the latest public health science
- Result in improvements to existing programs, impacting program outcomes for the better

### Representative Sample of Supporting Data

#### Obesity

Obesity is a key risk factor for type 2 diabetes, hypertension, and is associated with coronary artery disease and some cancers. In 2015, an estimated 32.4 percent of adults in Texas were obese.

- **Highest rates:** 36.7% - 37.9%
  - Region 4/5N
  - Region 11
- **Lowest rates:** 30.2% - 31.0%
  - Region 2/3
  - Region 6/5S
  - Region 7

#### Tobacco

Tobacco use is the leading preventable cause of death in Texas, with 24,500 annual deaths. The percentage of adults who smoke in Texas has declined from 23.1 in 1995 to 15.2 percent in 2015. Smoking remains a serious public health problem accounting for $12.2 billion in excess medical care.

- **Highest rates:** 19.6% – 20.4%
  - Region 4/5N
  - Region 9/10
- **Lowest rates:** 13.7% - 14.0%
  - Region 2/3
  - Region 6/5S
  - Region 8

#### Deaths due to unintentional injuries

Highest rates: 42.1-52.5*

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15 Texas Department of State Health Services, 2015 Texas Behavioral Risk Factor Surveillance System, Center for Health Statistics

16 Ibid.


19 Ibid.

20 Texas Department of State Health Services, 2015 Texas Behavioral Risk Factor Surveillance System, Center for Health Statistics

21 Ibid.
Unintentional injury is the fifth leading cause of death in Texas and the leading cause of death among individuals aged 1 to 44 years for 2014.\textsuperscript{22,23}

| Region 1 |
| Region 4/5N |
| Region 9/10 \textsuperscript{24} |

Lowest rates: 31.0-35.2\textsuperscript{*}
- Region 11
- Region 2/3
- Region 6/5S \textsuperscript{25}

\textsuperscript{*}Age adjusted rates (deaths per 100,000 population)

**Priority A:** Improve capacity and capability of state and locally-based chronic disease, tobacco, and injury prevention programs according to prevalence and disease burden.

**Goal 1**
Assess and document the prevalence and disease burden of chronic disease, tobacco, and injuries in Texas as well as the corresponding capacity of the public health system to address these costs.

**Strategies:**
1. Convene expert staff and gather data to document the statewide prevalence and disease burden of chronic disease, tobacco, and injury into one report.
2. Identify the workforce capacity and capability to adequately address the disease burden of chronic disease, tobacco, and injury in each area of the state.
3. Identify resource needs based on the gap between disease burden and public health capacity available to address that burden.

**Goal 2**
Develop and implement a plan to address the assessment findings.

**Strategies:**
1. Collaborate with stakeholders for input on development of plan.
2. Develop the plan.
3. Partner with stakeholders to implement the plan.

**Priority B:** Establish a statewide professional chronic disease and injury prevention network to provide leadership, inform decision-making, coordinate efforts, and promote innovation in practice.

**Goal 1**
Develop a network of chronic disease and injury prevention public health professionals to inform program decision-making.

**Strategies:**
1. Identify an organization/methodology to provide operational guidance and oversight for the network.

\textsuperscript{24} Texas Department of State Health Services, Texas Health Data, Center for Health Statistics, 2014 Finalized Death Certificate Data among Texas Residents
\textsuperscript{25} Ibid.
2. Identify the network membership for chronic disease and injury prevention at local, regional, and state levels.

3. Convene the first local, regional, and state public health chronic disease representatives meeting.

4. Develop and implement processes for the network to make recommendations to public health leadership.
Maternal and Child Health

The Texas Public Health Inventory report showed that the majority of local health departments in Texas do not provide maternal and child health services. Maternal and child health services, including safety net services, are more likely to be performed through other state, local, private, and non-profit entities.

For this category, improvements to the public health system would result in the following outcomes:

- Help reduce pre-pregnancy and prenatal risk factors like hypertension, obesity and diabetes
- Help decrease the number of maternal and infant deaths and infants born with low birth weight

Representative Sample of Supporting Data

<table>
<thead>
<tr>
<th>On-Time Prenatal Care</th>
<th>Regional Impact</th>
</tr>
</thead>
</table>
| On-time prenatal care access (women receiving prenatal care in the first trimester) has increased in Texas since 2008. However, Texas rates are below the Healthy People 2020 target of 77.9%, with only 61.5% of women having their first visits within the first trimester. | Lowest on-time prenatal care rates 50.3% - 53.6%  
- Region 1  
- Region 4/5N |
| Highest on-time prenatal care rates: 59.7% - 62.9% |  
- Region 6/5S  
- Region 7  
- Region 9/10 |

Maternal Mortality Risk Factors 2005-2014

- Pre-pregnancy obesity has increased 24.6%  
- Diabetes has increased 44.6%  
- Hypertension has increased 23.6%

Maternal Mortality Disparities 2011-2012

Black women’s risk of maternal death was 2.51 times higher than that of other racial/ethnic groups.

<table>
<thead>
<tr>
<th>Maternal Mortality Risk Factors 2005-2014</th>
<th>Regional Impact</th>
</tr>
</thead>
</table>
| - Pre-pregnancy obesity has increased 24.6%  
- Diabetes has increased 44.6%  
- Hypertension has increased 23.6% | Highest maternal mortality rates: 0.30-0.38  
- Region 4/5N  
- Region 1  
- Region 6/5S |

<table>
<thead>
<tr>
<th>Maternal Mortality Disparities 2011-2012</th>
<th>Regional Impact</th>
</tr>
</thead>
</table>
| Black women’s risk of maternal death was 2.51 times higher than that of other racial/ethnic groups. | Lowest maternal mortality rate*: 0.18  
- Region 11 |

* Per 1,000 births. Maternal Deaths are reported as the number of deaths due to pregnancy, childbirth, the puerperium up to six weeks post-delivery, and any obstetric cause from 42 days to a year post-delivery and its sequelae (ICD-10 codes O00 - O99). Data from 2005 through 2014 were grouped to have enough cases for reliable comparison by Health Service Region.

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26 Mandell, D.J., & Kormondy, M. 2015 Healthy Texas Babies: Data Book. Austin, TX: Division for Family and Community Health Services, Texas Department of State Health Services, 2015.
27 Texas Department of State Health Services, Texas Health Data, Center for Health Statistics, 2014 Finalized Live Birth Certificate Data among Texas Residents
28 Ibid.
29 Texas Department of State Health Services, Texas Health Data, Center for Health Statistics, 2005-2014 Finalized Live Birth and Death Certificate Data among Texas Residents
30 Ibid.
**Priority A:**
Assure healthy mothers and healthy babies by reducing disparities in maternal child health populations; facilitating access to maternal and child health services; and increasing the use of evidence-based policy, system, and environmental changes to address obesity over the lifespan.

<table>
<thead>
<tr>
<th>Goal 1</th>
<th>Facilitate access to maternal and child health preventive and treatment services.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategies:</strong></td>
<td>1. Facilitate access to existing options for care through innovative community partnerships and evidence-based practices.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 2</th>
<th>Decrease maternal mortality and morbidity.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategies:</strong></td>
<td>1. Build on efforts through the Texas Maternal Mortality and Morbidity Task Force to review existing data and research on reducing maternal mortality and morbidity.</td>
</tr>
<tr>
<td></td>
<td>2. Identify and implement focused public health interventions that target highest risk populations.</td>
</tr>
<tr>
<td></td>
<td>3. Coordinate with other state agencies and with healthcare providers to ensure public health efforts are complementary to already-existing services in other sectors.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 3</th>
<th>Decrease the rate of infant mortality and low birth weight in economic, racial/ethnic, and geographically disparate populations.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategies:</strong></td>
<td>1. Develop partnerships with public and private community entities to make available evidence-based prevention, cessation, and referral services for alcohol, tobacco, and other drugs in all maternal visits.</td>
</tr>
<tr>
<td></td>
<td>2. Promote evidence-based education and services from pre-conception through the first year of life.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 4</th>
<th>Decrease the rate of obesity and other chronic disease risk factors among children and women of childbearing age.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategies:</strong></td>
<td>1. Develop partnerships with public and private community entities to promote and implement evidence-based healthy eating and active lifestyles, interventions, and programs, with a focus on pregnant women and women of childbearing age.</td>
</tr>
<tr>
<td></td>
<td>2. Increase the use of evidence-based policy, system, and environmental changes to address obesity and other chronic disease risk factors over the lifespan.</td>
</tr>
<tr>
<td></td>
<td>3. Promote evidence-based breastfeeding improvement practices.</td>
</tr>
</tbody>
</table>
Environmental Health

The Texas Public Health Inventory report indicated that approximately half of all local health entities in Texas provide environmental food safety-related services. This includes licensing and enforcement of early age/child care facilities, restaurants, and schools.

For this category, improvements to the public health system would result in the following outcomes:
- Provide a more responsive public health system to health threats in the environment
- Help reduce the incidence of foodborne illnesses in the state

<table>
<thead>
<tr>
<th>Representative Sample of Supporting Data</th>
<th>Regional Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Salmonellosis</strong>&lt;br&gt; In 2014, 5,145 cases of salmonellosis were reported in Texas.</td>
<td>Highest rate: 50 - 100*&lt;br&gt; - Region 1&lt;br&gt; - Region 2/3&lt;br&gt; - Region 8 (eastern portion)**&lt;br&gt; Lowest rate: 0.1 – 25*&lt;br&gt; - Region 4/5N&lt;br&gt; - Region 6/5S</td>
</tr>
<tr>
<td><strong>Shiga-toxin producing Escherichia (E. coli)</strong>&lt;br&gt; Between 2011 and 2015, the average number of cases caused by Shiga-toxin producing E. coli reported in Texas has been 563 cases per year (ranging from 486 to 612).</td>
<td>Highest rate: 10.1 - 20*&lt;br&gt; - Region 1&lt;br&gt; - Region 9/10&lt;br&gt; - Region 2/3 (western portion)**&lt;br&gt; Lowest rate: 1 – 5*&lt;br&gt; - Region 4/5N&lt;br&gt; - Region 6/5S&lt;br&gt; - Region 8&lt;br&gt; - Region 11</td>
</tr>
</tbody>
</table>

*incidence rate per 100,000.

Priority A:<br> Improve coordination of environmental health surveillance and strengthen communication among environmental health organizations and partners.

Goal 1 | Improve impact of environmental health surveillance through access to additional data sources and subject matter expertise.

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31 Texas Department of State Health Services, Infectious Disease Control, Salmonellosis Data, [https://www.dshs.texas.gov/IDCU/disease/salmonellosis/Data/](https://www.dshs.texas.gov/IDCU/disease/salmonellosis/Data/), accessed October 27, 2016.

32 Ibid.

33 Texas Department of State Health Services, Infectious Disease Control, E. Coli Data, [https://www.dshs.texas.gov/IDCU/disease/e-coli/data/](https://www.dshs.texas.gov/IDCU/disease/e-coli/data/), accessed October 27, 2016.
**Strategies:**
1. Develop a data delivery system that fosters communication among local and state partners and expands the breadth of information collection from public health and non-public health sources.

2. Develop accurate educational information for health-related organizations and partners regarding environmental health risks that promote and reinforce the role of public health within each local jurisdiction served.

**Priority B:**
Increase capacity and capability of the environmental public health workforce.

**Goal 1**
Improve expertise and retention of environmental health workforce.

**Strategies:**
1. Develop policies that support workforce retention.

2. Develop a cross-training system to increase capacity based upon environmental health threats.

**Goal 2**
Seek collaborative opportunities to capitalize on local, regional, and state resources for better protection against environmental health threats.

**Strategies:**
1. Develop and share resource information among local, regional, and state collaborators.

2. Establish public health partnerships that address roles and responsibilities for collaboration within each jurisdiction.

3. Engage academic institutions, health organizations, and other stakeholders to create opportunities for environmental health workforce development.
Mental Health and Substance Abuse

Mental illnesses affect people’s ability to engage in healthy behaviors and lifestyles. Individuals with severe mental illness die of tobacco-related chronic diseases, including cardiovascular disease and cancer, on average 25 years earlier than those without mental illness. The signs of mental health and substance abuse often go unseen or undiagnosed, not only by the public but also those in health professions. The Public Health Inventory report indicated a need to increase coordination and referral between public health and mental health providers.

For this category, improvements to the public health system would result in the following outcomes:
- Promote early identification and entry of individuals into the behavioral health support system
- Increase behavioral health outcomes for those individuals who otherwise may not have been referred to care

### Representative Sample of Supporting Data

<table>
<thead>
<tr>
<th>Depressive Disorders</th>
<th>Regional Impact</th>
</tr>
</thead>
</table>
| In 2015, an estimated 16.1 percent of persons reported ever having a potential diagnosis of depressive disorder, including depression, major depression, dysthymia or minor depression. | Highest rate: 19.7%  
- Region 1 |
| Lowest rate: 12.2%  
- Region 11 |

<table>
<thead>
<tr>
<th>Suicide Mortality Rates</th>
<th>Regional Impact</th>
</tr>
</thead>
</table>
| In 2014, Texas had an age adjusted suicide death rate of 12.1 per 100,000. | Highest rate 2014: 17.1  
- Region 4/5N |
| Lowest rate 2014: 8.3  
Region 11 |

### Priority A:
Develop and emphasize strategies that accommodate the interdependencies of behavioral health and public health.

**Goal 1**
Develop a behavioral health training plan for the public health workforce in order to aid in identification of mental health problems and early referral for services.

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34 Lawrence, et al., BMC Public Health, 2009; 9:285; CDC, MMWR; 62; Feb 5, 2013 Lasser et al., JAMA 2000; 284:2606, As presented at the Tobacco Use and Special Populations: Mental Health Disparities – Texas Tobacco Summit, June 2014, by Jan Blalock, PhD, Department of Behavioral Science, University of Texas, MD Anderson Cancer Center.
35 Texas Department of State Health Services, 2015 Texas Behavioral Risk Factor Surveillance System, Center for Health Statistics.
36 Ibid.
37 Ibid.
38 Texas Department of State Health Services, Texas Health Data, Center for Health Statistics, 2014 Finalized Death Certificate Data among Texas Residents
39 Ibid.
40 Ibid.
**Strategies:**
1. Increase the number of public health staff trained in evidence-based behavioral health curricula appropriate for their position and function.
2. Promote the use of screening, brief intervention, referral to treatment (SBIRT) in clinical settings.

**Priority B:**
Diversify capacity and capability of surveillance and epidemiological systems to better incorporate behavioral health data into the public health system for early intervention.

<table>
<thead>
<tr>
<th>Goal 1</th>
<th>Incorporate mental health and substance abuse data points into all existing epidemiological and surveillance systems.</th>
</tr>
</thead>
</table>

**Strategies:**
1. Examine the current surveillance and epidemiological systems for opportunities to incorporate behavioral health data points.
2. Educate providers on reporting of data points, including, but not limited to suicide, depression, and substance abuse data.
### Clinical Preventive and Primary Care Services

Primary preventive care services are critical to the populations across Texas, and the state supports programs to address the shortage of healthcare providers and access to treatment for the underserved populations. Indicators point to continued healthcare workforce shortages as a challenge for Texas.

For this category, the steering committee identified goals and strategies intended to:

- Encourage low-cost delivery of specific high-value preventive services to low income, minority, or other underserved populations
- Expand primary healthcare education for underserved and hard-to-reach populations

#### Representative Sample of Supporting Data

<table>
<thead>
<tr>
<th>Primary Care Physicians</th>
<th>Regional Impact</th>
</tr>
</thead>
</table>
| In 2015, Texas had about 72 primary care physicians per 100,000 population. The total number of primary care physicians increased by 3 percent between 2014 and 2015. The increase is not sufficient to keep up with the demands of a growing population. | Lowest coverage: 0 Physicians (30 counties)  
- Regions 1 (portions)  
- Region 2/3 (western portions)  
- Region 4/5 (portions)  
- Region 9/10 (portions)  
- Region 8 (western portions)  
- Region 11 (portions)  

Highest coverage: 12% - 14.6%  
- Regions 1 (southern portion)  
- Region 2/3 (western portion)  
- Region 8 (central portion)  

The small clusters represent metropolitan areas in these regions. |

#### Regional Impact

| Priority A: Integrate community-level efforts with existing clinically-based preventive and primary care service delivery to better meet the health needs of at-risk populations. |
| Goal 1 Increase utilization of community health workers and outreach staff to integrate community-level efforts and link individuals to care. |
| Strategies:  
1. Educate healthcare providers about the opportunities to use community health workers to link individuals to needed services, including placement in clinical settings under appropriate supervision. |

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42 Ibid.
Conclusion

The Public Health Action Plan’s recommendations provide an actionable starting point to improve the future performance of the public health system. The identified priorities include:

- Improved coordination of public health assets
- Development of skilled public health workforce
- Innovations in communications, data gathering, and sharing
- Use of academic and professional association partnerships
- Enhanced community collaborations

In the coming months, DSHS will seek guidance and recommendations from the Legislature, stakeholders, fellow state agencies, and public health partners on next steps to implementing the PHAP. For regional goals and strategies in particular, participation and agreement by local entities will be key to implementation. The implementation plan will include a timeline for completion, and metrics by which to benchmark progress. DSHS will complete the implementation plan by December 1, 2017, in order to begin implementation in January 2018.

This plan points out a visionary framework to serve as a standard when addressing each of the above priorities – leadership, communication, data, and partnerships will all be key elements in the planning and implementation process. As the state public health agency, DSHS will work to take a lead role in being a statewide convener, goal setter, and source of data for the benefit of the public health system in Texas, while simultaneously respecting local sovereignty and individual community priorities.

While progress on the priorities outlined in the PHAP can be made within the five-year scope of the plan, some priorities will take longer to address. A key to the successful evolution of the public health system will be sustaining steady progress towards achievement of the stated current priorities, and remaining adaptable to the changing health status, conditions, and emerging health threats in the state.
Appendix A: Development of the Public Health Action Plan

The Department of State Health Services (DSHS) collaboratively developed the components of the Public Health Action Plan (PHAP) from March to August 2016, using a statewide steering committee and workgroup structure. Throughout the process, DSHS emphasized to stakeholders the need to establish a plan with public health system improvements that are feasible within the state’s current public health infrastructure.

In March 2016, DSHS established a steering committee responsible for reviewing statewide priorities, goals, and strategies developed by the multidisciplinary workgroups for consideration and inclusion into the PHAP. All members fulfilled their duties of reviewing workgroup products (statewide priorities, regional goals, and strategies) in a timely manner, actively participating in meetings and reaching consensus as a group.

Members of the steering committee were obtained through a statewide nomination process and represent the following stakeholder groups. For a complete listing of committee members and the organizations they represented, see Appendix B.

- Local health departments/public health districts (6)
- Health authorities (1)
- Local health entities with an environmental health focus (1)
- State schools of public health (1)
- Public health/health-related organizations and professional associations (2)
- DSHS Health Service Regions (3)
- DSHS Central Office (2)
- Member at Large (1)

In April 2016, seven workgroups were formed and tasked with drafting statewide priorities relative to their group’s public health service category and four crossover categories (Figure 1). Workgroup members were recommended to serve or volunteered through a statewide recruitment process and were assigned to one of the seven workgroups based on their subject matter expertise and interests. Similar to the steering committee, priority workgroup members represented local health entities, health related organizations, professional associations, academia, and DSHS. For a complete listing of all priority workgroup members see Appendix C.
Workgroup members participated in an initial orientation during which DSHS explained the Rider 81 requirements and provided guidance to the workgroup to complete development of statewide priorities to improve the public health system. Workgroup members were also expected to participate in at least three additional meetings between April 20 and June 23, 2016, in-person or remotely by conference phone line and webinar. In preparation of these meetings, and to encourage relevant discussion around system-improvement priorities, DSHS shared data and information from the Public Health Inventory report as well as other state and national sources with workgroup members, including but not limited to the following:

- Texas Behavioral Risk Factor Surveillance System reports and tables for HIV, STD, tuberculosis, tobacco use, obesity, and diabetes
- County Health Rankings Health Gaps Report 2015
- Institute of Medicine Report – The Future of the Public’s Health in the 21st Century
- Scorecard on State Health System Performance 2015
- DSHS Texas Primary Care Needs Assessment 2016
- Health Resources and Services Administration (HRSA) Texas Title V State Snapshot

Each of the workgroups reviewed available data, thoroughly discussed priority options, and developed up to three priorities for improving the state’s public health system relative to their public health topic area for consideration by the steering committee.

Goals and Strategies Workgroup

In July 2016, DSHS formed a workgroup to develop regional goals and strategies to achieve the intent of the statewide priorities. Members were recommended to serve or volunteered through a statewide recruitment process of public health management and senior-level staff from local health entities and DSHS. Workgroup members were expected to participate in an initial orientation on July 29, 2016. Workgroup members were also expected to participate in an all-
day workshop on August 2, 2016, and one additional meeting on August 15, 2016. For a complete list of all workgroup members see Appendix D.

In preparation for the all-day workshop, DSHS provided each member a list of the statewide priorities, information from the Public Health Inventory report, and instructions to consider the following when developing goals and strategies.

- Recommendations should be achievable within the current system’s frameworks and resources.
- Priorities should have one to two goals.
- Goals should reflect a five-year timeframe.
- Goals should have two to three strategies.

On the day of the workshop, members were divided into smaller groups to develop goals and strategies. Common to each workgroup, goals and strategies were developed to account for the numerous circumstances, which may limit the opportunities of vulnerable populations to access services and improve their health. A draft set of goals and strategies was developed and eventually finalized from additional feedback from members through email and a meeting held on August 15, 2016. The draft was presented to the steering committee and approved for consideration for inclusion into the plan on August 19, 2016.

In the development of this report the priorities, goals, and strategies from the laboratory workgroup were combined into other functional categories.
Appendix B: Steering Committee for the Public Health Action Plan

Members of the steering committee for the Public Health Action Plan were obtained through a statewide nomination process and represent the following stakeholder groups:

- **Local Health Departments/Public Health Districts**
  - Lou Kreidler, RN, BSN, Director of Health, Wichita Falls-Wichita County Health Public Health District
  - Anil T. Mangla, MS, PhD, MPH, FRIPH, Assistant Director, San Antonio Metropolitan Health District
  - George Roberts, J.R., Chief Executive Officer, Northeast Texas Public Health District
  - Johnnie Roberts, Administrative Director, Jefferson County Public Health Department
  - Rocaille Roberts, MPH, Harris County Public Health & Environmental Services
  - Veerinder "Vinny" Taneja, MBBS, MPH, Director, Tarrant County Public Health Department

- **Health Authorities**
  - Hector I. Ocaranza, MD, MPH, FAAP, Health Authority City/County of El Paso

- **Local Health Entity with an Environmental Focus**
  - Rachel C. Patterson, REHS/RS, Director for Environmental Health and Sustainability, City of Plano

- **State School of Public Health, Coalitions**
  - Jennifer M. Griffith, DrPH, MPH, Associate Dean, School of Public Health at Texas A&M Health Science Center

- **Health-related organizations and professional associations**
  - Texas Public Health Coalition
    - Cindy Zolnierek, PhD, RN, Executive Director, Texas Nurses Association
  - Texas Public Health Association
    - Melissa Oden, DHEd, LMSW-IPR, MPH, CHES, President, Texas Public Health Association

- **DSHS**
  - Health Service Regions
    - Mary Anderson, MD, MPH, FACPM, Regional Medical Director, DSHS HSR 9/10
    - Julie Graves, MD, MPH, PhD, Regional Medical Director, DSHS HSR 6/5S
    - Sharon K. Melville, MD, MPH, Regional Medical Director, DSHS HSR 7
  - Central Office
    - Jennifer Sims, Deputy Commissioner, DSHS
    - David Gruber, Associate Commissioner, DSHS Division for Regional and Local Health (Committee Chair)

- **Member At-Large**
  - Edward J. Sherwood, MD, FACP, Texas A&M Health Science Center College of Medicine (Round Rock)
Appendix C: Statewide Priority Workgroups

The following is a list of the members of the statewide priorities workgroup with the organization they represented and their public health service category workgroup assignment. Some names repeat if they served on multiple workgroups.

- **Chronic Disease, Tobacco, and Injury Prevention and Control Workgroup**
  - Amy Bailey, DSHS Division for Family and Community Health (FCH)
  - Kim Beam, DSHS HSR 6/5 South
  - Vince Fonseca, Texas Medical Association
  - Karin Hopkins, DSHS Division for Disease Control and Prevention (DCP)
  - Philip Huang, Austin/Travis County Health and Human Services Department
  - Evelyn Interis, DSHS FCH
  - Taiya Jones, DSHS HSR 1
  - Lou Kreidler, Wichita Falls-Wichita County Public Health District
  - Clifford Lindell, DSHS Health Emergency Preparedness and Response Section (HEPRS)
  - Sara Mendez, Brazos County Health District
  - Lisette Osborne, DSHS HEPRS
  - Saroj Rai, DSHS Health Policy
  - Ankhit Sanghavi, Texas Health Institute
  - Jennifer Smith, Texas Association for County and City Health Officials (TACCHO)
  - Katherine Velasquez, DSHS HSR 8
  - Erin Wu, DSHS DCP
  - Audrey Young, DSHS Health Policy

- **Communicable Disease Prevention and Control Workgroup**
  - Lori Woznicki, DSHS Division for Regulatory (REG)
  - Julie Anderson, Brazos County Health District
  - Wendy Chung, Dallas County Health and Human Services Department
  - Laurel Churchman, Waco-McClennan County Public Health District
  - Tishara Coleman, DSHS REG
  - Lisa Cornelius, DSHS DCP
  - Paul Grunenwald, DSHS HSR 6/5 South
  - Steven Hinojosa, Hidalgo County Health and Human Services
  - Terry LaFon, DSHS HSR 2/3
  - Elvia Ledezma, DSHS HSR 8
  - Melanie Lee, DSHS HSR 1
  - Diana Martinez, Harris County Health Department
  - Leticia Nogueira, DSHS DCP
  - Nanci Otts, DSHS HSR 9/10
  - Karen Polvado, Texas Nurses Association
  - Saroj Rai, DSHS Health Policy
  - Lewis Ressler, DSHS REG
  - Juan Rodriguez, Denton County Health Department
  - Alison Romano, DSHS HEPRS
  - Rachel Samsel, DSHS Health Policy
  - Kirstin Short, City of Houston Health Department

33
- **Environmental Health Workgroup**
  - Becky Coonrad, DSHS 6/5 South
  - Cindy Corley, City of Garland Health Department
  - Annabelle Dillard, DSHS Regulatory
  - Jim Dingman, City of Plano
  - David Litke, Waco-McLennan County Public Health District
  - George McKirahan, DSHS HSR 7 Meat Safety Assurance
  - Ken Ofunrein, DSHS Regulatory
  - Emilie Prot, DSHS Office of Academic Affairs (Residency Program)
  - Alison Romano, DSHS HEPRS
  - Terry Sheppard, DSHS HSR 7 Public Sanitation and Retail Food Safety
  - Sandra Villarreal, San Angelo Health Department
  - Stevan Walker, City of Lubbock Health Department
  - Audrey Young, DSHS Health Policy

- **Maternal and Child Health Workgroup**
  - Melanie Dossey, Consortium of Certified Nurse Midwives
  - Lana-Amy Giles, Allen Birthing Center
  - Holly Groom, Caring for Women
  - Evelyn Interis, DSHS FCH
  - Remeka Jones, DSHS HSR 6/5 South
  - Zahra Koopaei, Houston Health Department
  - Ramah Leith, DSHS FCH
  - Decrecia Limbrick, Houston Health Department
  - Clifford Lindell, DSHS HEPRS
  - Monica Molina, DSHS FCH
  - Peter Norton, Taylor County Public Health District
  - Lisette Osborne, DSHS HEPRS
  - Martha Payne, DSHS HSR 7 Community Health Nursing
  - Saroj Rai, DSHS Health Policy
  - Mauro Ruiz, DSHS HSR 11
  - Linda Russell, Waco-McLennan County Public Health District
  - Rachel Samsel, DSHS Health Policy
  - Julie Stagg, DSHS FCH
  - Jeff Swanson, DSHS Center for Health Statistics
  - Dinah Waranch, Lovers Lane Birth Center
• **Laboratory Workgroup**
  o Grace Kubin, DSHS DCP
  o Kevin McClaran, DSHS HSR 1
  o Alison Romano, DSHS HEPRS
  o Rachel Samsel, DSHS Health Policy
  o Larry Seigler, Houston Health Department
  o Christopher Olivas, City of El Paso, Department of Public Health
  o Amanda Garner, Brazos County Health Department
  o Angela Flores, Corpus Christi/Nueces County Health Department
  o Celestino "Sal" Garcia, City of Midland Health & Senior Services
  o Jessica DeNigro, Abilene-Taylor County Health Department
  o Edward R. Bannister, Dallas County Health and Human Services
  o Gretchen Vinson, UT Health Science Center at Tyler
  o Guy Dixon, Tarrant County Public Health Department
  o Jennifer Chewens, Wichita Falls-Wichita County Health Department
  o Julia V. Perales, City of Laredo Health Department
  o K (Kim) Keys, Northeast Texas Public Health District
  o Kim Swacina, City of Lubbock Health Department
  o Laurel Churchman, Waco-McLennan County Public Health District
  o L. Hobbs-Fewell, Northeast Texas Public Health District
  o Lloyd Haggard, Port Arthur City Health Department
  o Aurora Martinez, DSHS
  o Harvey Ware, Sweetwater-Nolan County Health Department
  o Mark Wade, San Antonio Metropolitan Health District
  o Cynthia Galvan, DSHS DCP

• **Mental Health and Substance Abuse Workgroup**
  o James Baker, Texas Medical Association
  o Carson Easley, Texas Nurses Association/The Harris Center for Mental Health and IDD
  o Diane Foucher-Moy, Texas Nurses Association
  o Natalie A. Furdek, DSHS FCH
  o Dee Harrison, Health and Human Services Commission (HHSC) Mental Health and Substance Abuse (MHSA)
  o Judy Lara, DSHS HSR 1
  o Clifford Lindell, DSHS HEPRS
  o Riaz Malik, HHSC MSHA
  o Betty Richardson, Texas Nurses Association
  o Rachel Samsel, DSHS Health Policy
  o Lesli San Jose, HHSC MHSA
  o William Tharp, HHSC MHSA
  o Christina Wei, Alamo Elite Wellness

• **Clinical Preventive and Primary Care Workgroup**
  o Raquel Flores  DSHS FCH
  o Celestino "Sal" Garcia, City of Midland Health & Senior Services
  o Linda Harrington, Texas Nurses Association
- Carol Harvey, DSHS FCH
- Ramah Leith, DSHS FCH
- Liang Liu, DSHS FCH
- Deb McCullough, Andrews County Health Dept.
- Edtrina Moss, Texas Nurses Association
- Raafia Muhammad, HHSC MHSA
- Nicole Murray, DSHS FCH
- Lisette Osborne, DSHS HEPRS
- Diane Rhodes, Texas Dental Association
- Alison Romano, DSHS HEPRS
- Andrea Serrano, DSHS HSR 1
- Sharon Shaw, Angelina County and Cities Health District
- Audrey Young, DSHS Health Policy
Appendix D: Members of the Goals and Strategies Workgroup

The following is a list of members of the regional goals and strategy workgroup. Included with their name is the organization they represented and their small group assignment for the all-day workshop on August 2, 2016.

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Workgroup Assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kathy Barroso</td>
<td>Galveston County Health District</td>
<td>Chronic/Clinical Preventive and Primary Care (CPPC)</td>
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<tr>
<td>Amy Fagan</td>
<td>Wichita Falls - Wichita County PHD</td>
<td>Chronic/CPPC</td>
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<td>Esmeralda Guajardo</td>
<td>Cameron County Health Department</td>
<td>Chronic/CPPC</td>
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<td>Philip Huang</td>
<td>Austin/Travis County HHS</td>
<td>Chronic/CPPC</td>
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<tr>
<td>Caleb Rackley</td>
<td>DSHS HSR 4/5</td>
<td>Chronic/CPPC</td>
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<tr>
<td>Ann Salyer-Caldwell</td>
<td>Tarrant County PH Department</td>
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<tr>
<td>Brett Spencer</td>
<td>DSHS Health Promotion &amp; Chronic Disease Prevention Section</td>
<td>Chronic/CPPC</td>
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<tr>
<td>Christopher Taylor</td>
<td>Cherokee County Health Department</td>
<td>Chronic/CPPC</td>
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<tr>
<td>Tricia Vowels</td>
<td>DSHS HSR 1</td>
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<tr>
<td>Gwen Campbell</td>
<td>City of Amarillo Health Department</td>
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<td>Laurel Churchman</td>
<td>Waco-McClennan Co. PH Dept</td>
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<td>Kenneth Coleman</td>
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<td>Russell Hopkins</td>
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<td>Eduardo Olivarez</td>
<td>Hidalgo County Health Department</td>
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<td>Matt Richardson</td>
<td>Denton County Health Department</td>
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<td>Debra Seamans</td>
<td>DSHS HSR 7</td>
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<td>Roman Abeyta</td>
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<td>Miguel Cervantex</td>
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<tr>
<td>Kitten Holloway</td>
<td>DSHS Environmental Epidemiology and Disease Registries Section</td>
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<td>Keith Johnson</td>
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<td>Name</td>
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<td>Specialization</td>
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<td>Gwen Mills</td>
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<td>Kevin Veal</td>
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<td>Clifford Lindell</td>
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<td>Vincent Nathan</td>
<td>San Antonio Metro Health District</td>
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<td>Robert Resendes</td>
<td>City of El Paso Health Department</td>
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<td>Amy Schlabach</td>
<td>DSHS Austin Laboratory</td>
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<td>Kim Smith</td>
<td>Marshall-Harrison County Health District</td>
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<td>Terry La Fon</td>
<td>DSHS HSR 2/3</td>
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<tr>
<td>Deb McCullough</td>
<td>Andrews City-County Health Department</td>
<td>Maternal and Child Health (MCH)/Mental Health and Substance Abuse (MHSA)</td>
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<td>Sarah Mendez</td>
<td>Brazos County Health Department</td>
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<td>Monica Molina</td>
<td>DSHS FCH</td>
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<td>Nanci Otts</td>
<td>DSHS HSR 9/10</td>
<td>MCH/MHSA</td>
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<td>Kaye Reynolds</td>
<td>Fort Bend Health Department</td>
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<td>Annette Rodriguez</td>
<td>Corpus Christi - Nueces County Health Department</td>
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<td>Mauro Ruiz</td>
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<td>Mary Sowder</td>
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<td>Katherine Velasquez</td>
<td>DSHS HSR 8</td>
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<tr>
<td>Melissa A. Davis</td>
<td>DSHS HSR 11</td>
<td>MCH/MHSA</td>
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Appendix E: Categorization of Local Health Departments

The Sunset Advisory Commission’s July 2015 Staff Report with Final Results put forth three recommendations. The first two were formalized as Rider 81 and complement the non-statutory management action that directed DSHS to develop a system to categorize different types of local health departments based on the services they currently provide. As stated in the report, “the purpose in having these categories would be to show how the responsibility for providing these public health services is currently shared between the state and local jurisdictions and inform what improvement may be needed.”

With input from the Public Health Funding and Policy Committee (PHFPC), local health entities, the Texas Association of City and County Health Officials, schools of public health, and health-related organizations and professional associations, DSHS will develop a system to categorize local health entities based on a comparison between services currently provided against a standard set of core services. Progress towards completion of the development of a categorization system for local health departments includes the following past activities:

- 08/31/2015 – Developed a list of the major categories of public health services from which core services could be identified.
- 12/30/2015 – Identified a comprehensive set of public health services for each major service category possibly provided by local health entities, and/or DSHS Health Service Regions, and/or DSHS Central Office, and placed in survey format.
- 3/31/2016 - Completed a survey of public health services currently delivered by local health entities, DSHS Health Service Regions, and DSHS Central Office.
- 10/12/2016 – In collaboration with PHFPC, identified which services from the Public Health Inventory report should be defined as “core” based on indicators like:
  - Public health efficacy
  - Scientific support in disease/health risk reduction
  - Local demand and/or need
  - Current availability of the service, per the Public Health Inventory report
- 10/31/2016 - Identified a standard set of core public health services for Texas.

Timeline for completion of the categorization system:
- 11/30/16 - Align inventory of services data collected from local health entities with standard set of core public health services.
- 12/31/2016 - Determine categories of public health entities based on the results of the comparison.
- 1/15/2017 - Categorize public health entities based on response to the Public Health Inventory report.
- 1/31/2017 - Submit report on categorization system and results.

43 Texas Sunset Advisory Commission, Department of State Health Services Staff Report with Final Results, July 2013, pg. 69.