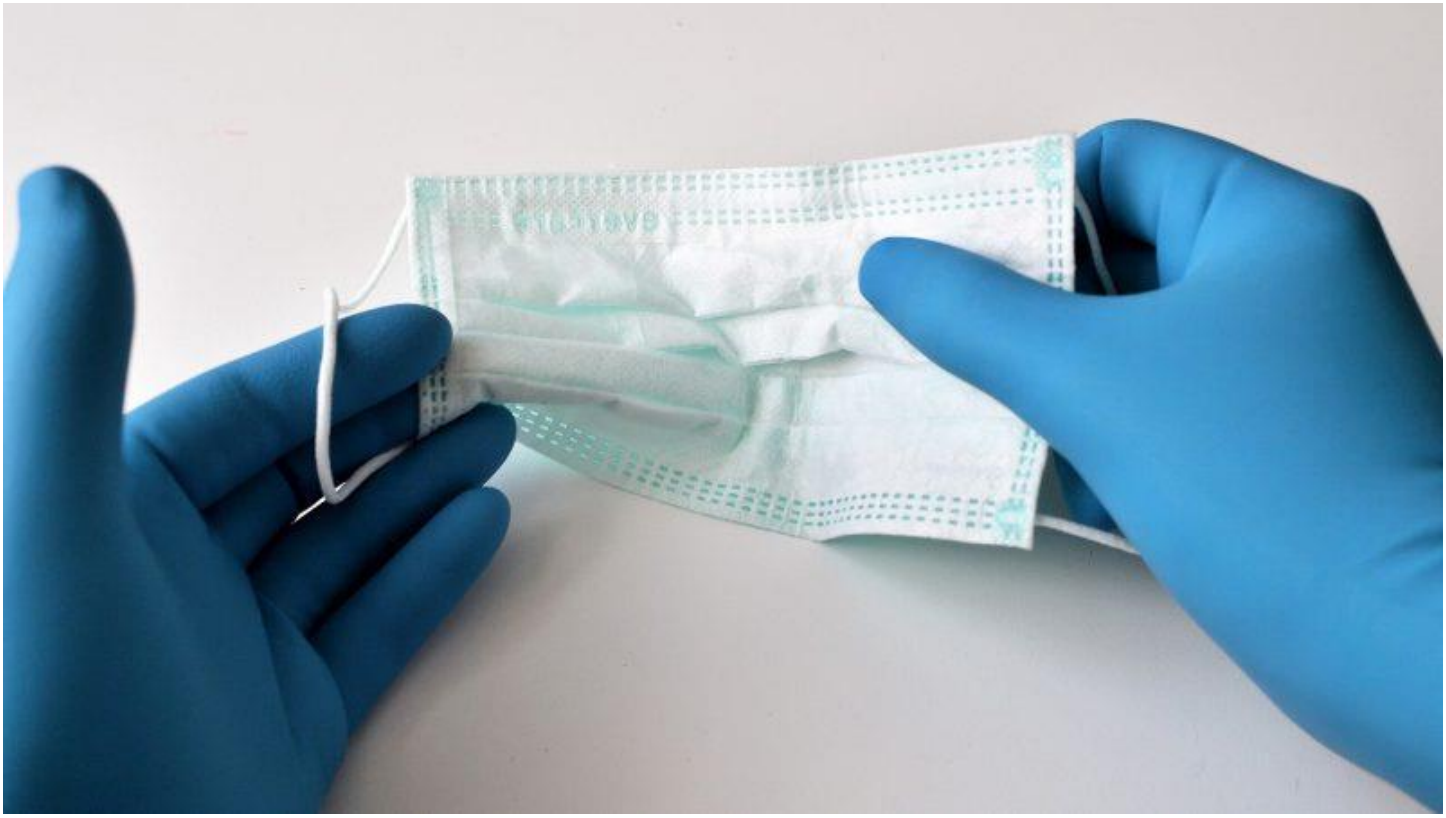

HHSC: Public Health Funding and Policy Committee
August 11, 2021

Public Health Funding & Policy Committee shall:

(1) define the core public health services a local health entity should provide in a county or municipality;

(2) evaluate public health in this state and identify initiatives for areas that need improvement;

(3) identify all funding sources available for use by local health entities to perform core public health functions;

(4) establish public health policy priorities for this state; and

(5) at least annually, make formal recommendations to the department regarding:

(A) the use and allocation of funds available exclusively to local health entities to perform core public health functions;

(B) ways to improve the overall public health of citizens in this state;

(C) methods for transitioning from a contractual relationship between the department and the local health entities to a cooperative-agreement relationship between the department and the local health entities; and

(D) methods for fostering a continuous collaborative relationship between the department and the local health entities.

Recommendations made under Subsection (a)(5)(A) must be in accordance with:

(1) prevailing epidemiological evidence, variations in geographic and population needs, best practices, and evidence-based interventions related to the populations to be served;

(2) state and federal law; and

(3) federal funding requirements.

Call to Order/Welcome. The meeting was called to order by the Chair, John Williams.

June 9, 2021, Meeting Minutes. The minutes were approved with only minor, nonsubstantive changes.

Update on Vaccine Allocation Distribution Planning

Moderna COVID-19 Vaccine Booster Dose & Delta Variant

Six months durability data

- In final analysis of Phase 3 COVE study data, the Moderna COVID-19 Vaccine showed 93% efficacy, with the efficacy remaining durable through six months after administration of the second dose.COVID-19 Vaccine mRNA-1273: Final blinded analysis of Phase 3 COVE study shows 93% efficacy; Efficacy remains durable through six months after second dose.

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Addressing Variants of Concern

- In a Phase 2 study, vaccination with 50 µg of three different Moderna mRNA booster candidates induced robust antibody responses against the wildtype D614G COVID-19 strain and against important variants of concern including Gamma (P.1); Beta (B.1.351); and Delta (B.1.617.2).
- The booster candidates included mRNA-1273, investigational mRNA-1273.351, and investigational mRNA-1273.211. Neutralizing antibody levels following the boost approached those observed after primary vaccination with two doses of 100 µg of mRNA-1273. These data have been submitted to a peer-reviewed journal for publication.

Pfizer COVID-19 Vaccine Booster Dose & Delta Variant

July 8, 2021: the company announced that a booster dose given 6 months after the second dose elicited high neutralizing titers against the Beta variant.

- The immune sera obtained after dose 2 of the primary two-dose series of the current vaccine had strong neutralization titers
- The company has stated "….based on the totality of the data we have to date, that a third dose may be needed within 6 to 12 months after full vaccination. While protection against severe disease remained high across the full 6 months, a decline in efficacy against symptomatic disease over time and the continued emergence of variants are expected. Based on the totality of the data they have to date, Pfizer and BioNTech believe that a third dose may be beneficial to maintain the highest levels of protection."

Development of an updated version of the current vaccine specifically targeting the Delta variant is in progress. Clinical studies are anticipated to begin in August.

The FDA has accepted Pfizer's COVID-19 vaccine full licensure application with a response date by January 2022.

COVID-19 Vaccine Boosters FDA & CDC

At this point, the CDC is not recommending a booster dose for any of the three currently authorized COVID-29 vaccines in the U.S. The last two ACIP meetings have discussed booster doses in immunocompromised individuals

Booster doses

- Are booster doses needed for all persons or only in specific populations?
- What is the optimal timing of booster doses after primary series? • Can these be given as a 'mixed dose' or do they need to be matched to a primary series?

June 23, 2021: Overview of data to inform recommendations for booster doses of COVID-19 vaccines (cdc.gov)

July 22, 2021 : https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2021- 07/07-COVID-Oliver-508.pd

Pfizer COVID-19 Vaccine Children Under 12 Years of Age

The Phase 1/2/3 dose-escalation study in healthy children 6 months old to 11 years on a two-dose schedule (approximately 21 days apart) in three age groups:

- Children ages 5 to 11 years
- 2 to 5 years
- And 6 months to 2 years (Children younger than 6 months of age may subsequently be evaluated, once an acceptable safety profile has been established).

If safety and immunogenicity is confirmed, and pending authorization or approval from regulators, target to submit the vaccine for potential Emergency Use Authorization (EUA) to the FDA sometime in the Sept-Oct for children 5 to 11, and soon after for 6 months to 5.

July 26, 2021: the FDA has requested to expand the number of participants in the clinical studies designed to detect rate adverse effects.

Studies in Additional Populations | pfpfizeruscom

Moderna COVID-19 Vaccine

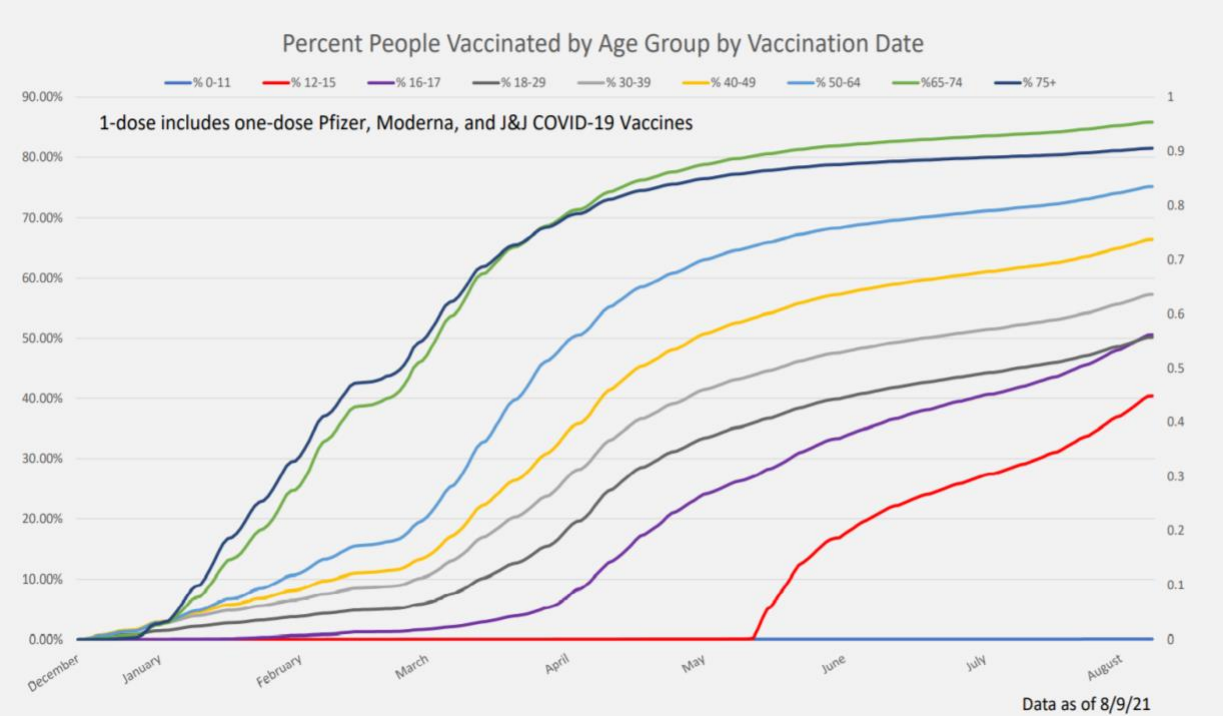
Filed a 'rolling submission' for a full approval to the FDA. The company stated completing their submission this month.

No decision from the FDA on its application for expanding the current EUA to include ages 12 years and older.

Ongoing pediatric studies in ages 6 months to 11 years of age.

- No target filing dates with the FDA yet
- The FDA asked to expand number of participants in the ongoing pediatric studies, similar to Pfizer pediatric studies.

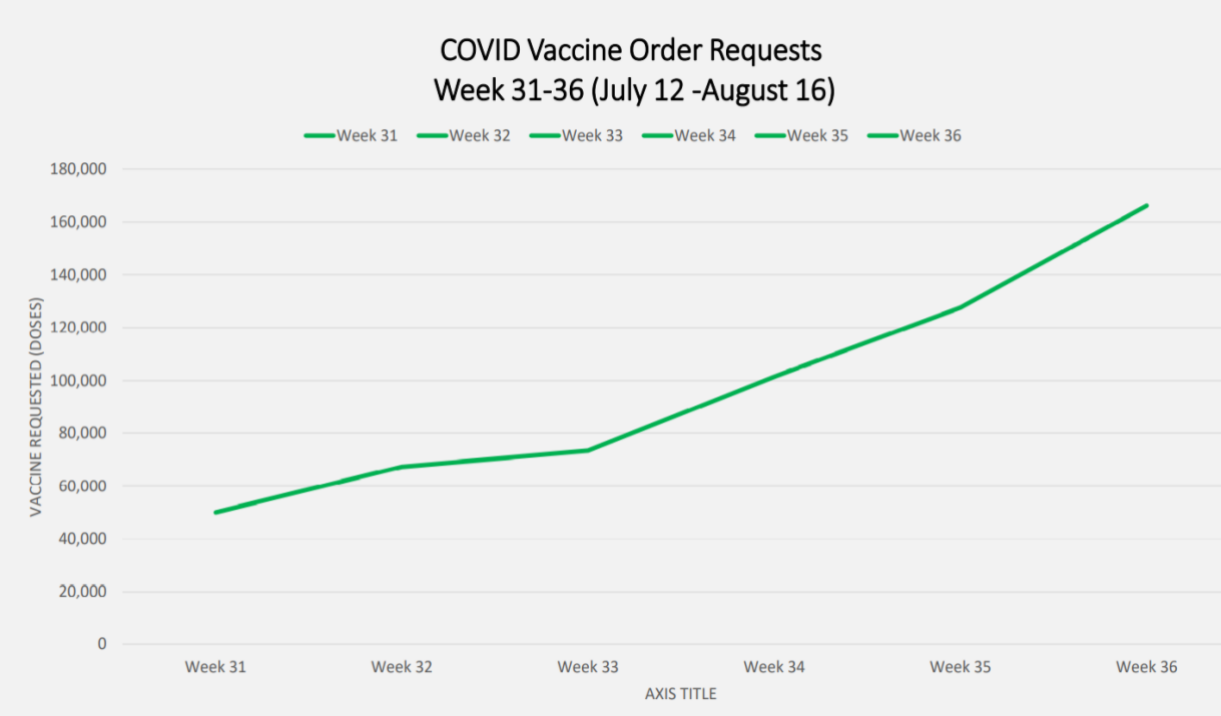
Update on COVID-19 Trends



	Population Estimates	People Vaccinated	Fully Vaccinated
Texas Total	28,995,881	15,346,852	12,889,294
% Total		53%	44%
>=12 y.o.	24,101,113	15,342,142	12,887,928
% >=12 y.o.		64%	53%
>=18 y.o.	21,596,071	14,246,545	12,134,908
% >=18 y.o.		66%	56%
>=65 y.o.	3,734,229	3,140,955	2,815,988
% >=65 y.o.		84%	75%

People Vaccinated includes first doses of Moderna and Pfizer and single doses of Janssen.
Fully Vaccinated includes second doses of Moderna and Pfizer and single doses of Janssen.

Data as of 8/9/21



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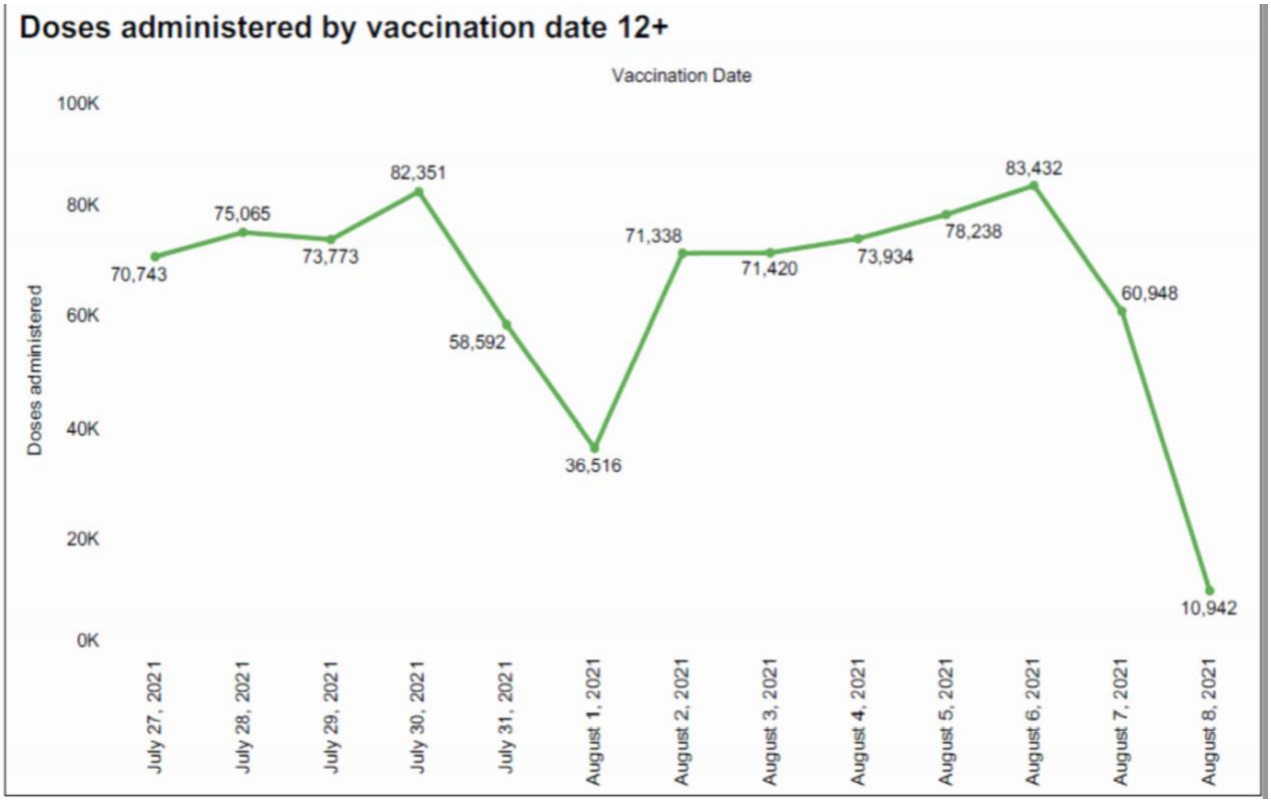
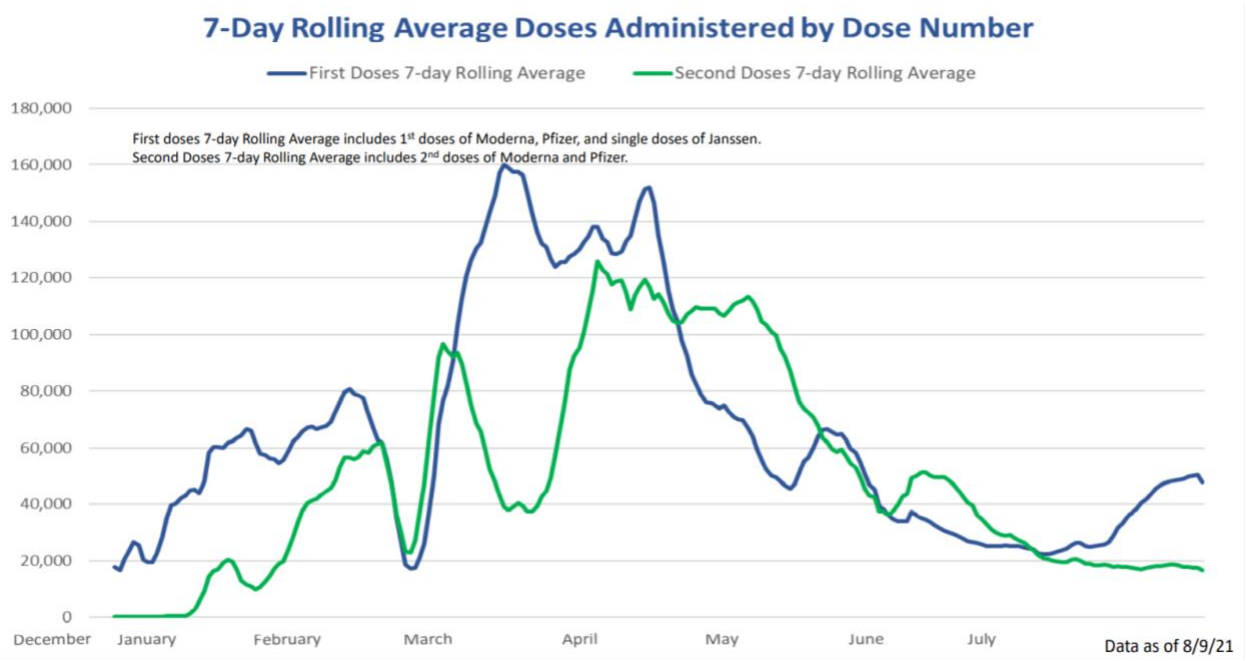
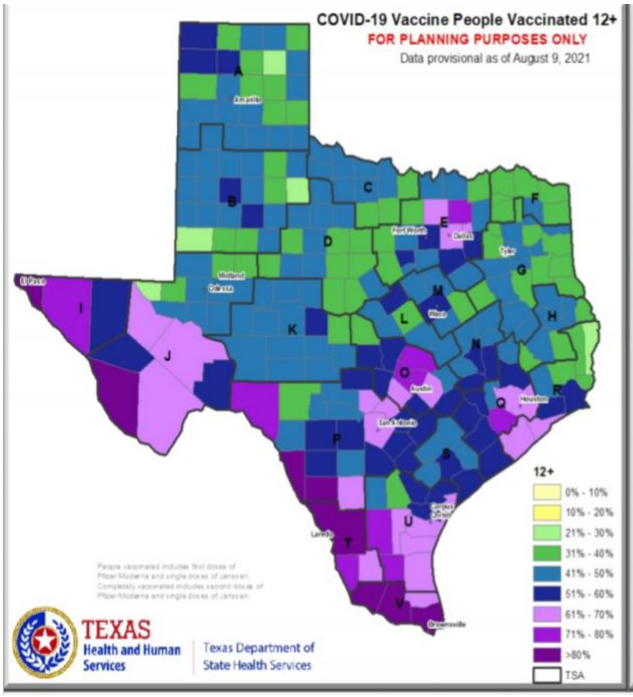
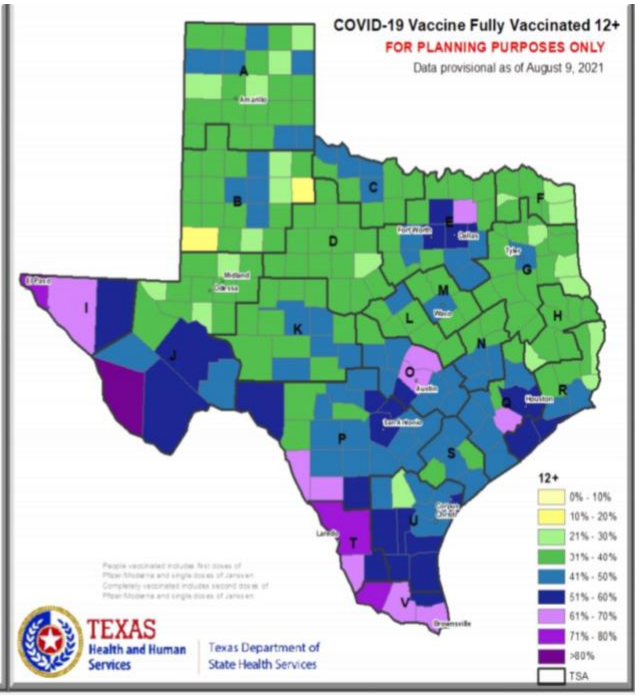
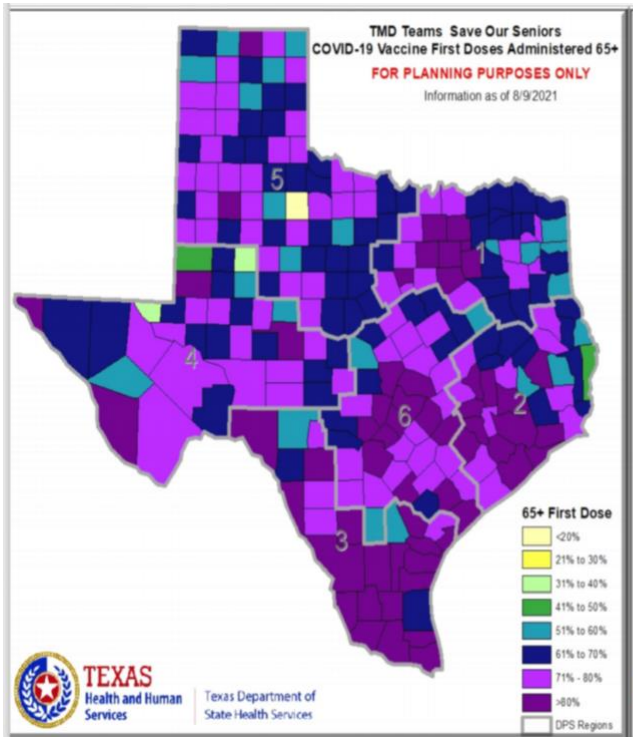
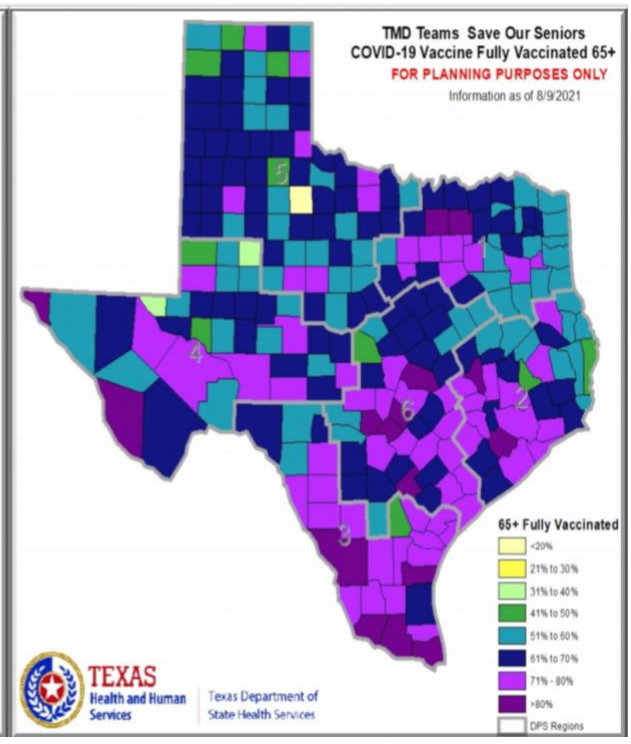

Doses administered by vaccination date 12+
Vaccination Date
Doses administered
100K
80K
60K
40K
20K
0K
70,743
75,065
73,773
82,351
58,592
36,516
71,338
71,420
73,934
78,238
83,432
60,948
10,942
July 27, 2021
July 28, 2021
July 29, 2021
July 30, 2021
July 31, 2021
August 1, 2021
August 2, 2021
August 3, 2021
August 4, 2021
August 5, 2021
August 6, 2021
August 7, 2021
August 8, 2021


7-Day Rolling Average Doses Administered by Dose Number
First Doses 7-day Rolling Average
Second Doses 7-day Rolling Average
First doses 7-day Rolling Average includes 1st doses of Moderna, Pfizer, and single doses of Janssen.
Second Doses 7-day Rolling Average includes 2nd doses of Moderna and Pfizer.
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
December
January
February
March
April
May
June
July
Data as of 8/9/21









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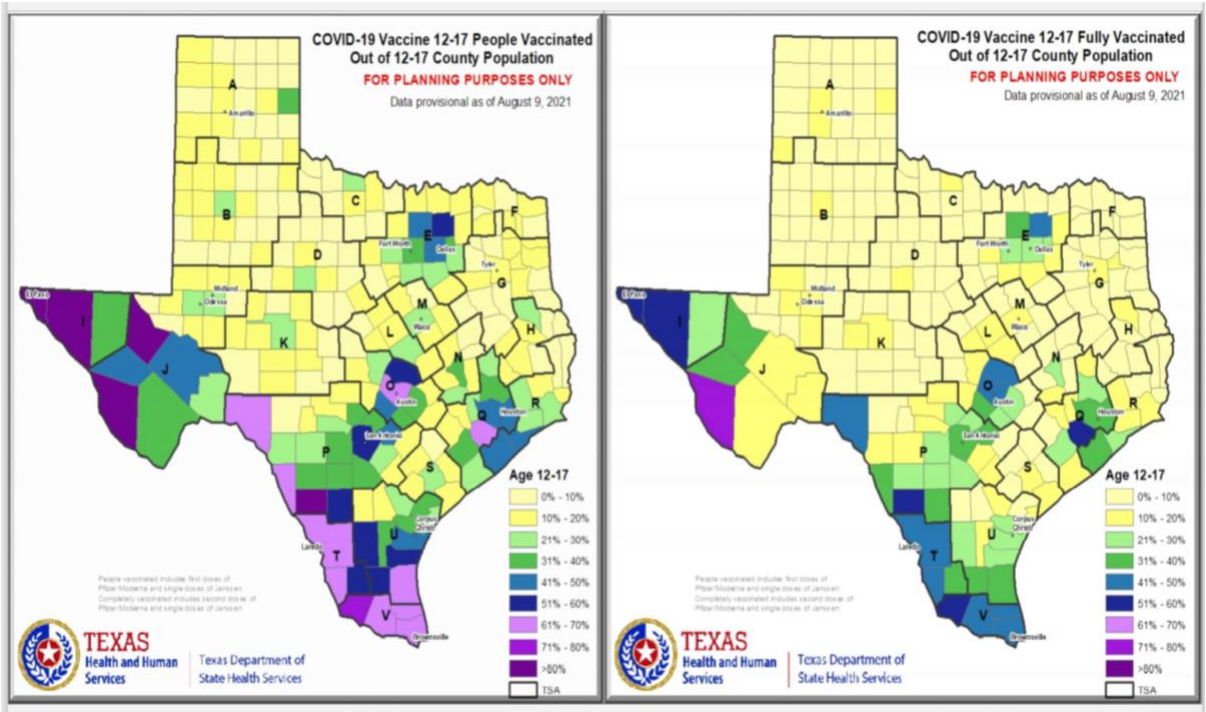


The information presented today is based on CDC's recent guidance and MAY change

Update on Public Health Workforce Grant Opportunity

Performance Period: July 1, 2021 – June 30, 2023

- Semi-annual reporting of workforce metrics

Texas Application due to CDC: September 1, 2021

Goal of funds: To establish, expand, train, and sustain the public health workforce to support COVID-19 prevention, preparedness, response, and recovery initiatives.

Allowable Workforce Costs: COVID Response

Wages, benefits, and other costs related to recruiting, hiring, and training of individuals to serve as:

- Administrative support staff
- Clinical or professional staff
- Disease investigation staff
- School health staff
- Program management staff

Purchase of equipment and supplies necessary to support the expanded workforce including personal protective equipment, equipment needed to perform the duties of the position, computers, cell phones, internet costs, cybersecurity software, and other costs associated with support of the expanded workforce

Administrative support services necessary to implement and manage activities funded under this section, including travel and training

Public Health (PH) Workforce Co-Ag Milestones

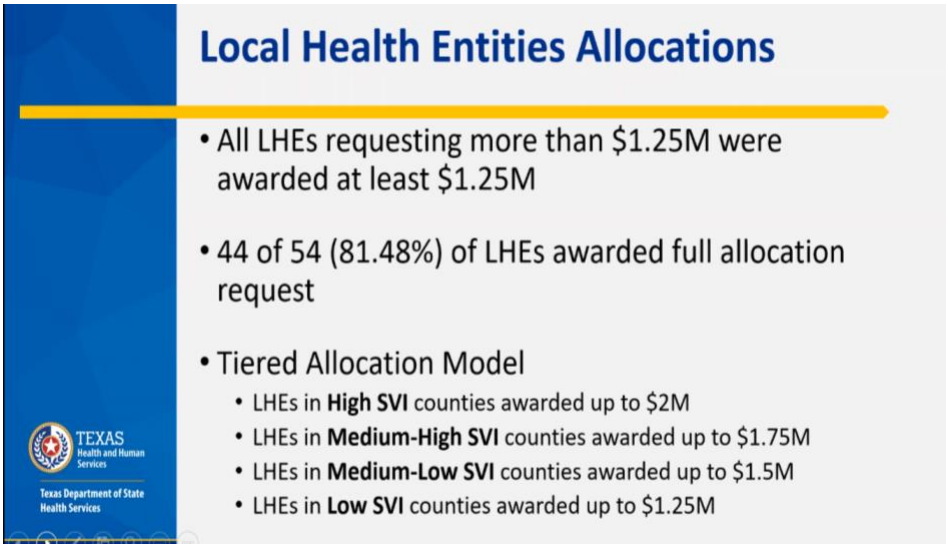
Milestones	Date
Announcement of PH Workforce Co-Ag	Tuesday, June 8th
Intent to Apply Deadline	Friday, June 11th
Notification of Allocations and Request for Workplan & Budget Development	Monday, June 21st
Final Public Health Funding Policy Committee (PHFPC) Feedback	Friday, June 18th
PH Workforce Co-Ag Kickoff Meeting	Wednesday, June 23rd
Technical Assistance Calls held	Tuesday, July 6th & July 13th
Budgets and Work Plans Due to DSHS	Wednesday, July 14th
DSHS Reviews Budgets & Workplans - obtains corrections	July 15th – 23rd
DSHS begins Agency Application Review/Approval	Monday, August 2nd

Available Funds

Allocation Groups	CDC Guidance	Final Alloc*
Schools	$ 39.3 M	$ 39.3 M
Local Health Entities	$ 47.1 M	$ 54.4 M
DSHS (includes PHRs)	$ 70.6 M	$ 63.3 M
Grand Total	**$ 157 M**	**$ 157 M**

*Final Allocation includes State of Texas indirect cost amount

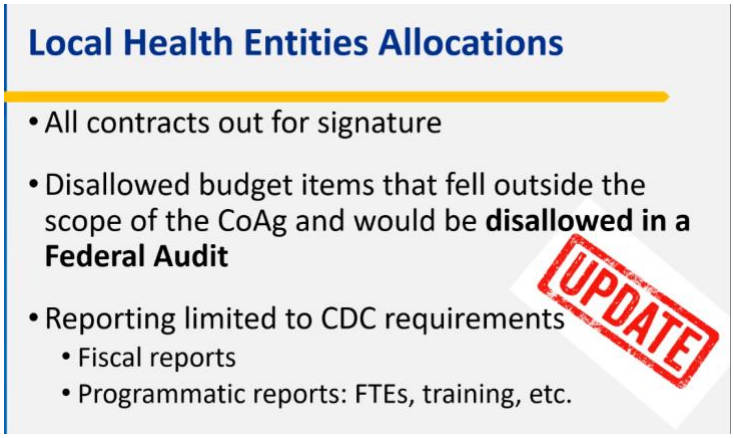

Local Health Entities Allocations
•$54,423,921 allocated to LHEs
•53* LHE applicants
WORKFORCE
•Used Social Vulnerability Index (SVI) to tier counties/entities and award funding
TEXAS
Health and Human Services
Texas Department of State Health Services
* 54 applications submitted; a city and county requests were combined into one allocation


Local Health Entities Allocations
• All LHEs requesting more than $1.25M were awarded at least $1.25M
• 44 of 54 (81.48%) of LHEs awarded full allocation request
• Tiered Allocation Model
• LHEs in High SVI counties awarded up to $2M
• LHEs in Medium-High SVI counties awarded up to $1.75M
• LHEs in Medium-Low SVI counties awarded up to $1.5M
• LHEs in Low SVI counties awarded up to $1.25M
TEXAS
Health and Human Services
Texas Department of State Health Services

SVI and LHE Allocations

SVI Category	Allocation	# of Applicants	# Fully Funded	# Allocated a Reduced Amount	Total Allocation
High SVI	$2M per LHE	12	10 (83.33%)	2 (16.66%)	$12.795M
Medium-High SVI	$1.75M per LHE	18	15 (83.33%)	3 (16.66%)	$17.979M
Medium Low SVI	$1.5M per LHE	12	10 (83.33%)	2 (16.66%)	$12.724M
Low SVI	$1.25M per LHE	12	9 (75.00%)	3 (25.00%)	$11.072M

DSHS used the county level for the SVI data.



When items were disallowed it was because they felt out of the scope of the cooperative agreement.

<u>Update on DSHS' COVID-19 Health Disparities Funded Activities</u>. The seven largest jurisdictions are receiving direct funding from the grant.

DSHS will administer **$45.2M** in CDC funds to **engage** targeted communities disproportionately impacted by COVID-19 and **build sustainable relationships** in those targeted communities leading to improved health among vulnerable populations.

- $6.3M: Epidemiology and Laboratory Capacity (ELC) funds [6/1/21 – 7/31/23]
- $38.9M: National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities (CDC-RFA-OT21-2103) [6/1/21 – 5/31/23]

Grant Goals:

1. **Infrastructure:** Describe existing human infrastructure or proposed human infrastructure
2. **Community Engagement:** Identify communities most impacted by COVID-19
3. **COVID-19 Vaccinations:** Implement steps to maximize COVID-19 vaccination rates in impacted communities
4. **Partnership Directory:** Document engaged community partners & build sustainable cross sectoral partnerships
5. **Health Disparity Improvement Initiative:** Design interventions aimed at addressing an identified community need
6. **Information Sharing & Learning:** Describe efforts to learn & share information on addressing COVID-19 health disparities among vulnerable populations

Implementation Mechanisms

1. **Community engagement**
    - Establishing rapport & developing relationships
    - Spending time in the community & building trust
    - Listening to community needs
        - ✓ Town halls, listening sessions, interviews, focus groups
    - Staying engaged with community when funding dissipates
2. **Building sustainable relationships**
    - Engaging community partners
        - ✓ Hospitals, clinics, FQHCs, community-based organizations, faith-based organizations, social service agencies
    - Cross sectoral partnerships
        - ✓ Public health – healthcare – social services
3. $19,550,000 was available for 54 local health departments (LHDs) to support **community engagement** in targeted communities disproportionately impacted by COVID-19 and to **build sustainable relationships** in those targeted communities.

46 LHDs requested $16,977,708 (87%) of the available $19,550,000.

<u>The following 7 LHDs are not eligible to receive COVID-19 Health Disparity Funding from DSHS because they will receive direct funding from CDC</u>:

• Austin Public Health

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• City of El Paso Department of Public Health

• Dallas County Health and Human Services

• Harris County Public Health

• Houston Health Department

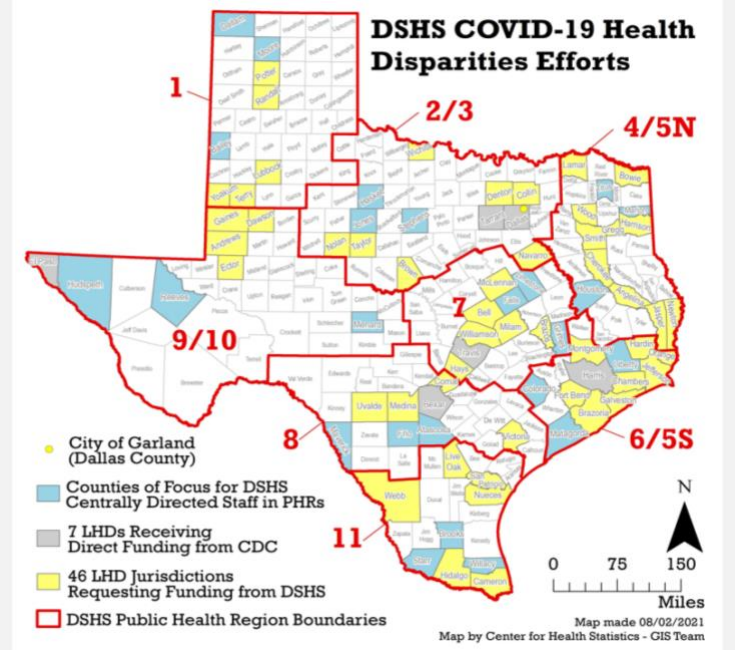
• San Antonio Metropolitan Health District

• Tarrant County Public Health

8 DSHS PHRs Eligible for DSHS COVID-19 Health Disparity Funding

$3,325,000 will be available for 7 DSHS administrative Public Health Regions (PHRs) to support **community engagement** in targeted communities, without an LHD, disproportionately impacted by COVID-19 and the **building of sustainable relationships** in those targeted communities.

Each of the 7 DSHS PHRs eligible to receive up to $475,000.



Texas Public Health Fellowship

What is the Texas Public Health Fellowship?

- A paid training program for up to 16 fellows with the goal to expand diversity in the public health workforce & to address health disparities among underserved and higher risk populations

Who's Eligible?

- Recent graduates from community and technical colleges, non-four-year academic institutions, historically black colleges and universities, or graduates from public health programs with diverse backgrounds and experiences
- 54 eligible local health departments

How will this work?

- DSHS will match host sites with Fellows who will work on public health, COVID response, and/or health disparity initiatives
- Fellows will be matched based on geography, subject matter interest, and relevant skills
- DSHS and host sites will provide a mentorship component to all Fellows to supplement their experience

Additional State Partners

- Texas A&M AgriLife Extension – Hire 8 AgriLife Health Disparity Specialists; existing expertise, community partners, and infrastructure across TX
- Area Health Education Centers (AHECs) - Investment in the public health workforce (e.g., community health workers)
- Texas Parks and Wildlife Department - Hire Community Health and Nature Liaison to improve access to nature and outdoor programs for vulnerable populations across LHDs and PHRs
- State Office of Rural Health - Pilot Community Paramedicine Program to improve primary care services to rural communities

The chair asked will the Agrilife folks be going through training. Trainings will be provided in Austin for all new staff.

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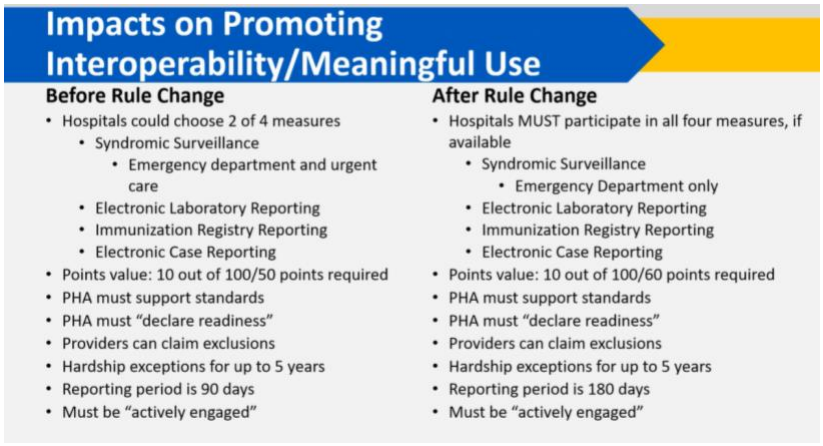
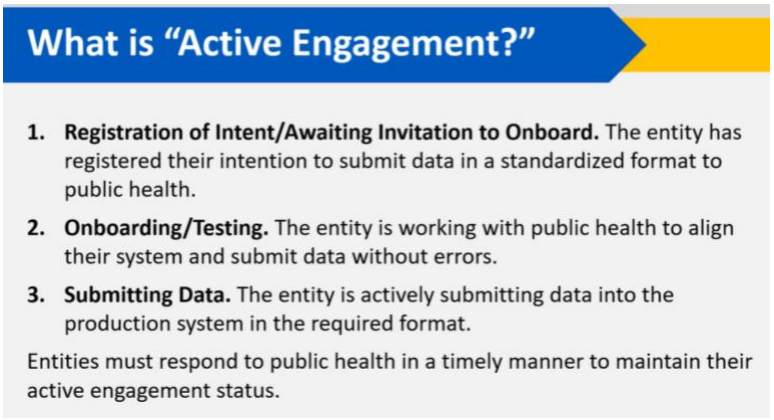
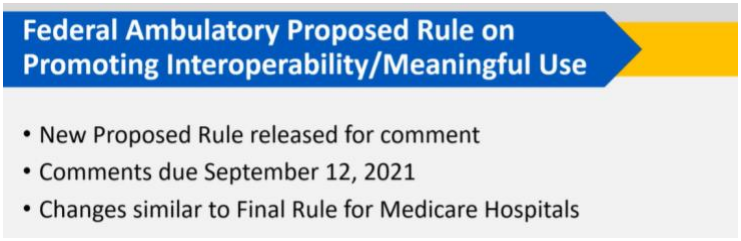
Update on Public Health Information Systems and Interoperability with Local Health Departments

There has been activity at the federal level. The inpatient perspectives rule has been finalized. It provides meaningful use rules as well by hospitals. Before the rule change hospitals could choose among four different measures







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Impacts on Promoting Interoperability/Meaningful Use

Before Rule Change

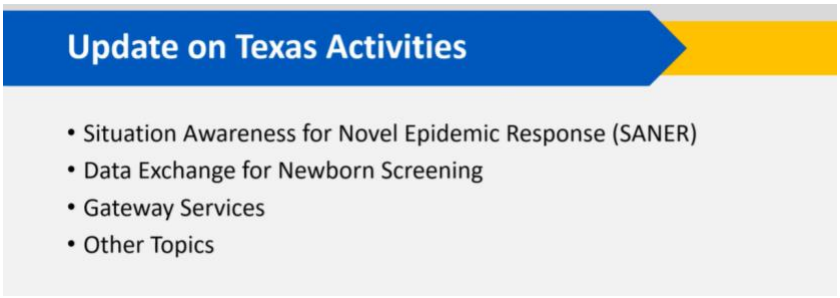
- Providers could choose 2 from menu set of 5
  - Syndromic surveillance
  - Immunization registry reporting
  - Clinical data registry
  - Electronic case reporting
  - Public health registry
- PHA must support standards
- PHA must "declare readiness"
- Providers can claim exclusions
- Hardship exceptions for up to 5 years
- Reporting period is 90 days
- Must be "actively engaged"

After Rule Change

- Providers MUST participate in
  - Immunization registry reporting
  - Electronic case reporting
- Providers get 5 bonus points for clinical data registry submission, syndromic surveillance submission, or public health registry submission
- PHA must support standards
- PHA must "declare readiness"
- Providers can claim exclusions
- Hardship exceptions for up to 5 years
- Reporting period is 180 days
- Must be "actively engaged"

Tracking and Awareness of National Activities

- Standards Development
  - HL7
    - Public health workgroup
    - Community-based workgroup
    - FHIR
  - USCDI (Office of the National Coordinator)
    - Core data standards for incorporation of data into EHRs and other platforms
  - US@ address standards
- Entities/Projects
  - Health Information Technology Advisory Committee and Task Forces
  - Trusted Exchange Framework and Common Agreement
  - United States Digital Service



Questions/Answers/Comments

The Chair inquired about case reporting. The overall goal is to avoid manually submitting data but to allow the public health systems used by hospitals to submit data directly (AIMS platform) and provide information exchange. We have to gain consensus of the data that has to be reported across all jurisdictions.

Is there an opt in option? Does it use the AIMS bundles. DSHS stated that this is not new but uses the AIM bundles and hospitals who participate in Medicare. It will be available to all hospitals. Readiness could be phased in and is not constrained to hospital bed counts

We will begin with COVID data and then move to other areas.

The Chair asked about timelines. DSHS said they are being developed. The challenge is looking at completeness over time.

Discussion of the 2021 PHFPC Annual Report

The following recommendations have been developed and edits have been incorporated.

Recommendation on Medicaid Billing:

The PHFPC recommends that DSHS become the leading agency in the implementation of SB73 to ensure that Local Health Departments (LHDs) can expand their participation in Texas Medicaid and continue forward momentum regarding LHD Managed Care Organization contract execution. As the lead agency, DSHS should obtain monthly updates from Health and Human Services Commission (HHSC), coordinate with a member of HHSC executive leadership to participate in regular implementation planning, request a timeline of implementation and ensure technical assistance for LHD provider type enrollment.

Recommendation on Public Health Data and Information Systems:
The PHFPC recommends that DSHS lead a collaborative effort to establish a collective vision that includes a modern and efficient public health data and information system. This includes developing a plan, strategies and timeline to accomplish goals.

Recommendation on PHP-Charity Care Program:
The PHFPC recommends that DSHS become a leading agency in the 1115 Waiver transition and advocate for the PHP-Charity Care Program. This should include provision of assistance with the allocation of a proportionate share of the funds available for LHD and Mental Health programs, advocacy for comprehensive inclusion of core public health services within the PHP- Charity Care Program, and provision of technical assistance regarding cost-reporting and charity care policy development.

MOTION: Include the recommendations in the annual report prevailed.

Public Comment. No public comment was offered.

Timelines, Next Steps, Announcements, and Future Meetings.

- October 13th is the next meeting
- Nominations for membership are open
- The virtual meeting option declaration from the Governor will be expiring. It is possible that virtual meetings can be continued after the pandemic. There was agreement that this be an option.

Adjourn. There being no further business, the meeting was adjourned.

***

This summary contains supplemental information from third-party sources where that information provides clarity to the issues being discussed. Not every comment or statement from the speakers in these summaries is an exact transcription. For the purpose of brevity, their statements are often paraphrased. These documents should not be viewed as a word-for-word account of every meeting or hearing, but a summary. Every effort has been made to ensure the accuracy of these summaries. The information contained in this publication is the property of Texas Insight and is considered confidential and may contain proprietary information. It is meant solely for the intended recipient. Access to this published information by anyone else is unauthorized unless Texas Insight grants permission. If you are not the intended recipient, any disclosure, copying, distribution or any action taken or omitted in reliance on this is prohibited. The views expressed in this publication are, unless otherwise stated, those of the author and not those of Texas Insight or its management.