HHSC: Public Health Funding and Policy Committee

December 8, 2021

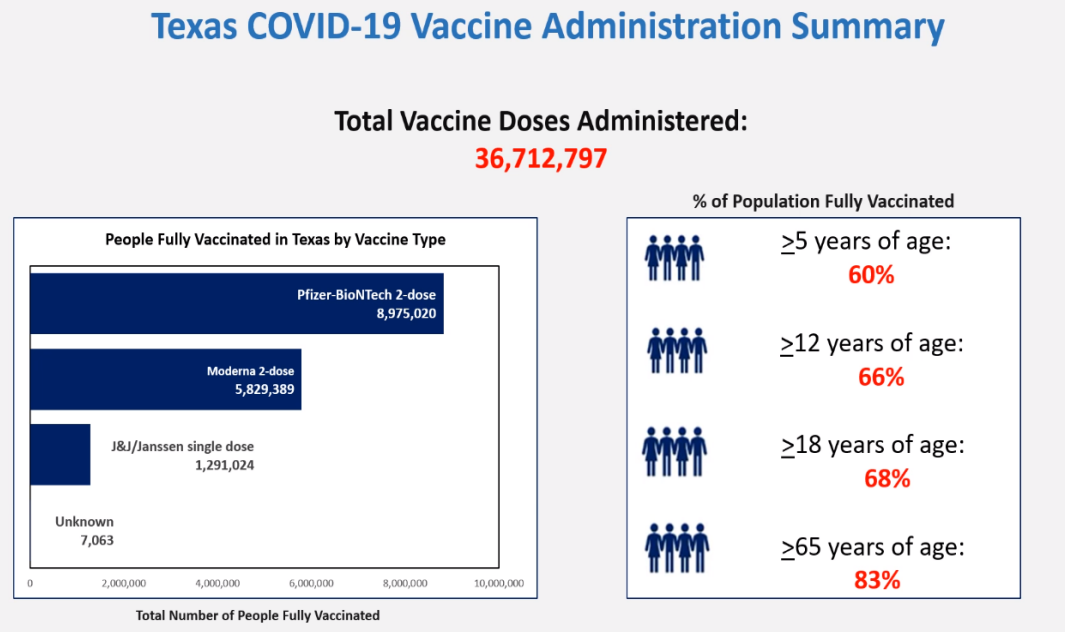
Public Health Funding and Policy Committee defines core public health services a local health entity should provide in a county or municipality; evaluates public health in the state and identifies initiatives for areas that need improvement; identifies funding sources available to local health entities; and establishes public health policy priorities.

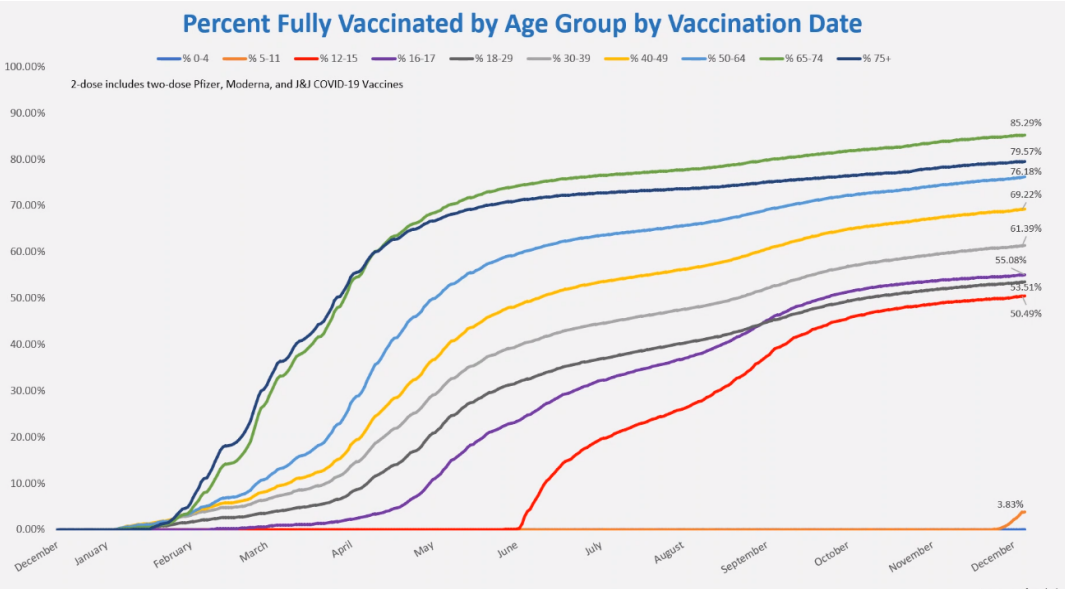
Sharon K. Melville, MD, MPH Regional Medical Director, Public Health Region 7, Temple Department of State Health Services Phone: 254/778-6744 Email: Sharon.Melville@dshs.state.tx.us Term expires February 1, 2023 Lou Kreidler, RN, BSN Director of the Wichita Falls-Wichita County Public Health District Phone: 940/761-7800 Email: lou.kreidler@wichitafallstx.gov Term Expires: February 1, 2021 Julie St. John, DrPH Assistant Dean, Graduate School of Biomedical Sciences Associate Chair, Julia Jones Matthews Department of Public Health Abilene Campus, Texas Tech University Health Sciences Center Phone: 325/696-0473 Email: julie.st-john@ttuhsc.edu Term Expires: February 1, 2025 Jennifer Griffith, DrPH, MPH Associate Dean for Public Health Practice/Public Health Professor Texas A & M Health Science Center School of Public Health Phone: 979-436-9426 email: jgriffith@tamhsc.edu Term expires: February 1, 2021	Lisa Dick, R.D.N., L.D. Health Administrator, Brown County Health Department Phone: 325-646-0554 Email: Lisad@BrownwoodTexas.gov Term expires February 1, 2027 Todd Bell, M.D. Health Authority, City of Amarillo Health Department Phone: 806-414-9800 Email: todd.bell@ttuhsc.edu Term expires February 1, 2027 Stephen Williams, M.Ed., M.P.A. Director of the Houston Public Health Phone: 832/393-5001 Email: stephen.williams@houstontx.gov Term Expires: February 1, 2025 Philip Huang, MD, MPH Director, Dallas County Health and Human Services phone: 214-819-2000 email: philip.huang@dallascounty.org Term expires: February 1, 2023 Emilie Prot, DO, MPH Regional Medical Director, Public Health Region 11, Harlingen Department of State Health Services Phone: 956-423-0130 Email: Emilie.Prot@dshs.texas.gov Term Expires: February 1, 2025

Call to Order/Welcome. The meeting was convened by the Chair, Stephen Williams.

October 13, 2021, Meeting Minutes . The minutes were approved as written

Update on COVID-19 Vaccine Administration All tables are as of December 6 unless otherwise noted.





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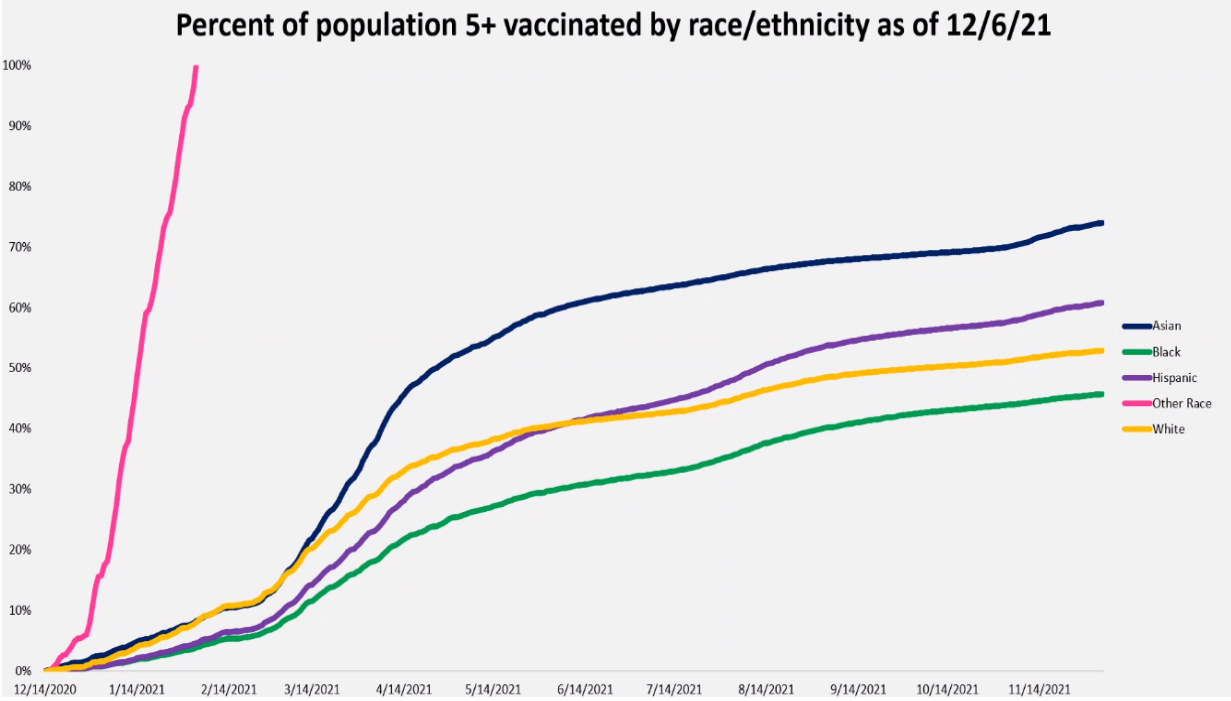
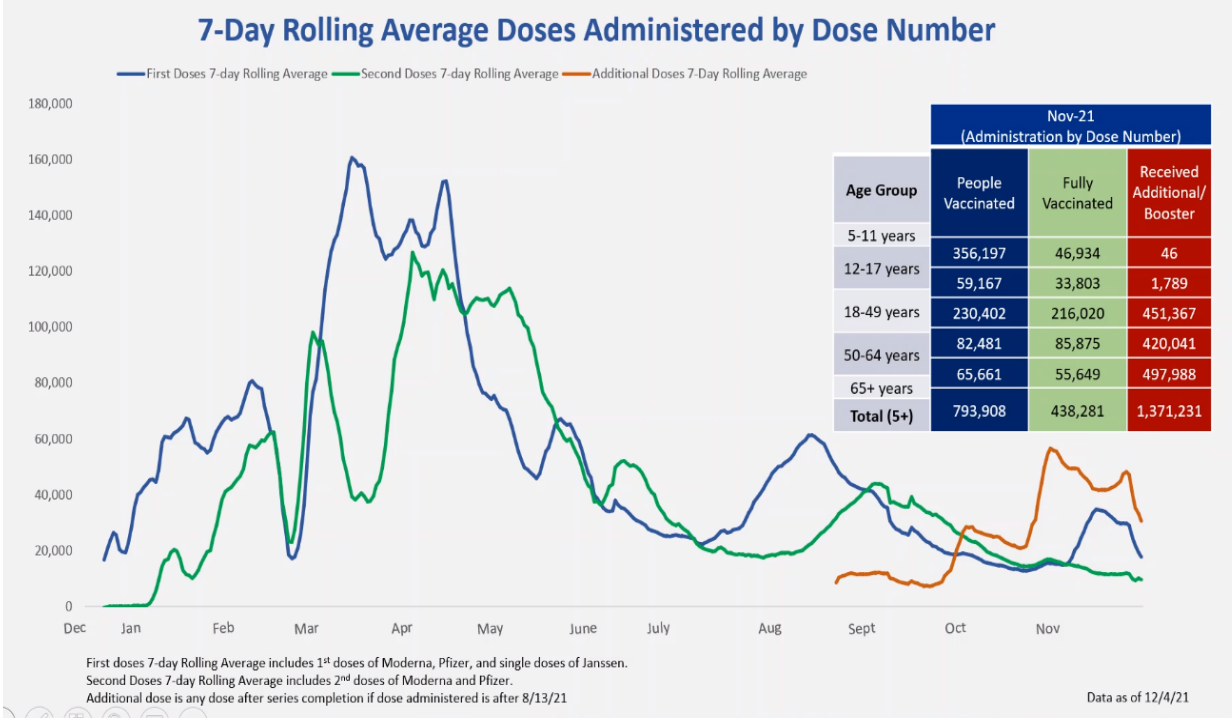
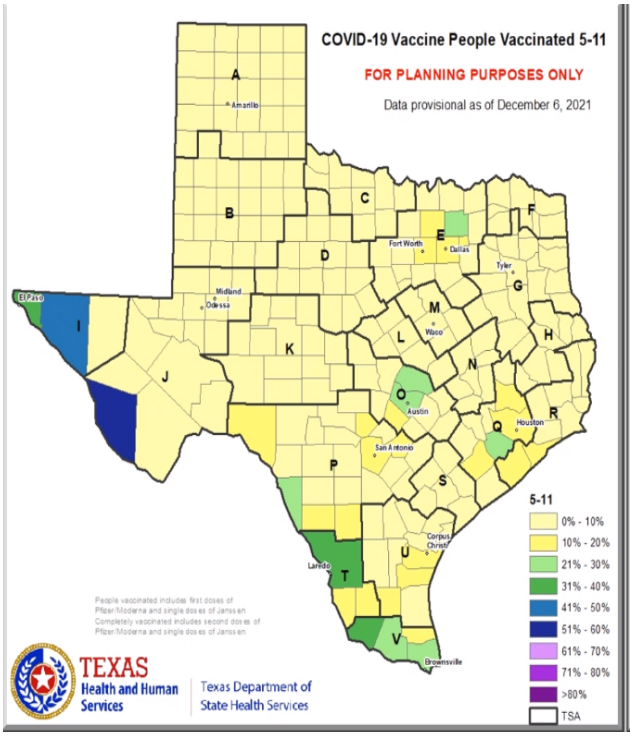
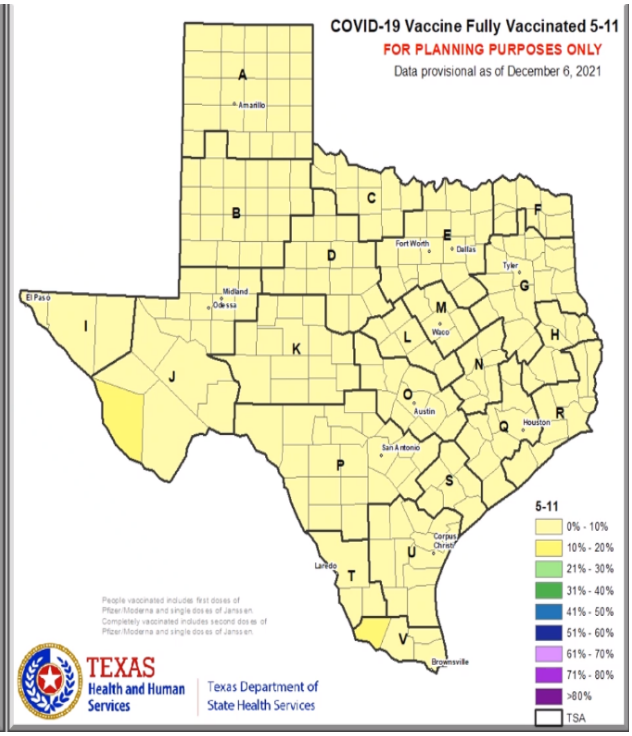




Nov-21 (Administration by Dose Number)			
Age Group	People Vaccinated	Fully Vaccinated	Received Additional/ Booster
5-11 years	356,197	46,934	46
12-17 years	59,167	33,803	1,789
18-49 years	230,402	216,020	451,367
50-64 years	82,481	85,875	420,041
65+ years	65,661	55,649	497,988
Total (5+)	793,908	438,281	1,371,231


COVID-19 Vaccine People Vaccinated 5-11
FOR PLANNING PURPOSES ONLY
Data provisional as of December 6, 2021
5-11
0% - 10%
10% - 20%
21% - 30%
31% - 40%
41% - 50%
51% - 60%
61% - 70%
71% - 80%
>80%
TSA
TEXAS Health and Human Services
Texas Department of State Health Services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5-11
0% - 10%
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>80%
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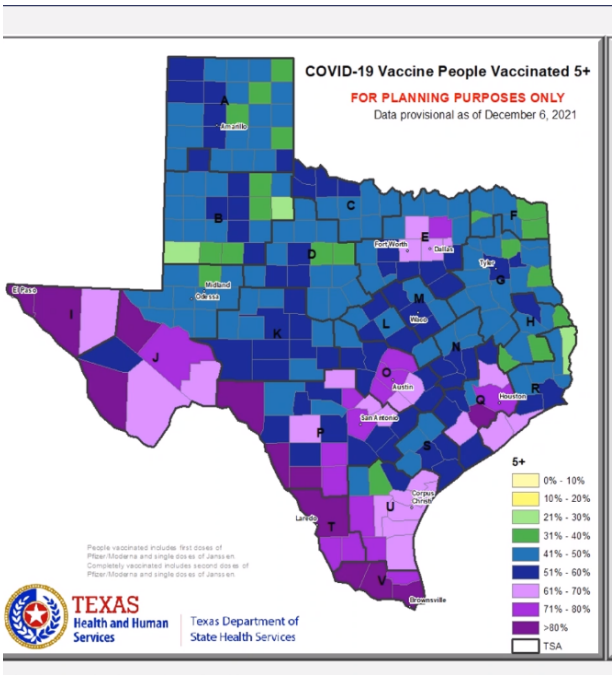
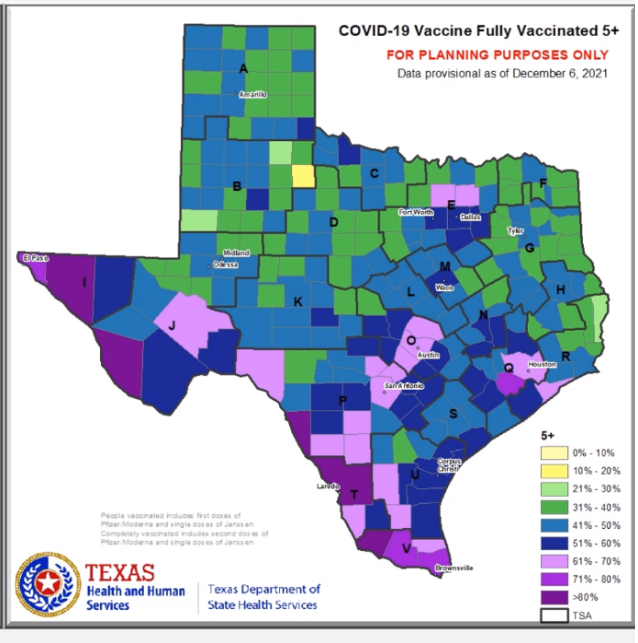

COVID-19 Vaccine People Vaccinated 5+
FOR PLANNING PURPOSES ONLY
Data provisional as of December 6, 2021
5+
0% - 10%
10% - 20%
21% - 30%
31% - 40%
41% - 50%
51% - 60%
61% - 70%
71% - 80%
>80%
TSA
TEXAS Health and Human Services
Texas Department of State Health Services


COVID-19 Vaccine Fully Vaccinated 5+
FOR PLANNING PURPOSES ONLY
Data provisional as of December 6, 2021
5+
0% - 10%
10% - 20%
21% - 30%
31% - 40%
41% - 50%
51% - 60%
61% - 70%
71% - 80%
>80%
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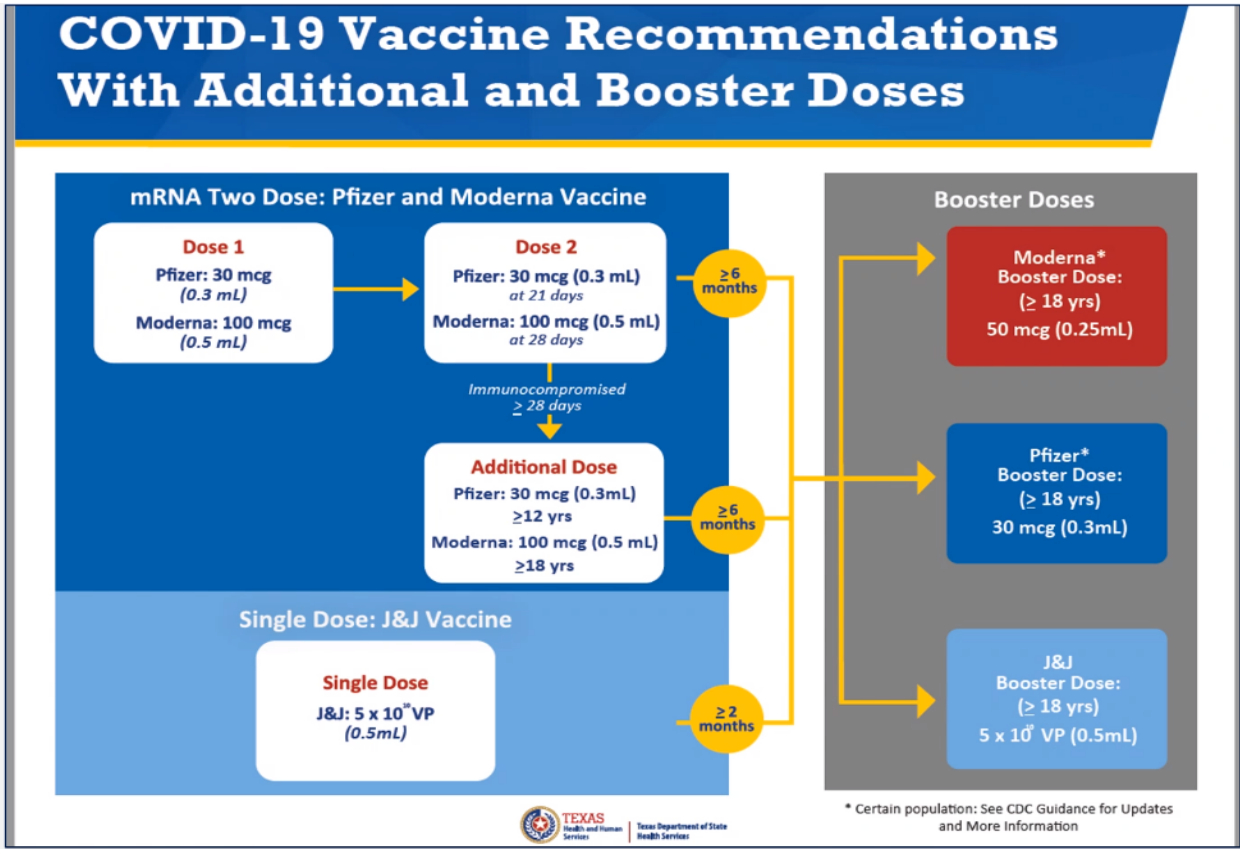
Texas Department of State Health Services

Booster update



Individuals Eligible for Booster by Month – All Vaccines

Month Eligible Individuals Due Booster Dose (All COVID-19 Vaccines)	Individuals ≥ 18 yrs (Total)	Individuals ≥ 65 yrs
21-Dec	8,600,836	1,402,416
22-Jan	481,962	40,238
22-Feb	725,503	61,248
22-Mar	793,367	64,705
22-Apr	419,720	52,275
22-May	253,534	39,232
22-Jun	38,983	5,377
Total	11,313,905	1,665,491

6-month projection based on FDA guidance - People fully vaccinated with Pfizer or Moderna in December, January, February & March projected due in September, people fully vaccinated with Pfizer or Moderna in April projected due in October, etc. Individuals who received an additional dose between 8/13/21 and 12/1/21 are not included in the projection.

Data as

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Fully Vaccinated Individuals Eligible for Booster – All Vaccines

Age Group	2019 Texas Population	Total Eligible Individuals as of December Remaining Due for Booster*	Eligible Individuals Received an Additional/Booster Dose
Age ≥18 yrs	21,596,071	8,600,836	3,276,242 (28%)
Age ≥ 65 yrs	3,734,229	1,402,416	1,411,683 (50%)

People (≥65 yrs) Boosters Details for Selected Counties

Client County	2019 Population Estimate (65+ Years)	Total Eligible People (≥ 65 yrs) as of December Remaining Due for Booster	Eligible Individuals (≥ 65 yrs) Received a Booster
Bexar	247,843	81,359	107,105 (57%)
Collin	116,575	44,862	50,793 (53%)
Dallas	292,117	104,595	110,686 (51%)
Denton	93,499	34,923	42,467 (55%)
El Paso	105,175	49,778	41,170 (45%)
Harris	514,167	194,987	196,803 (50%)
Tarrant	244,511	88,886	99,812 (53%)
Travis	129,553	44,255	60,389 (58%)
Williamson	73,202	29,050	32,734 (53%)

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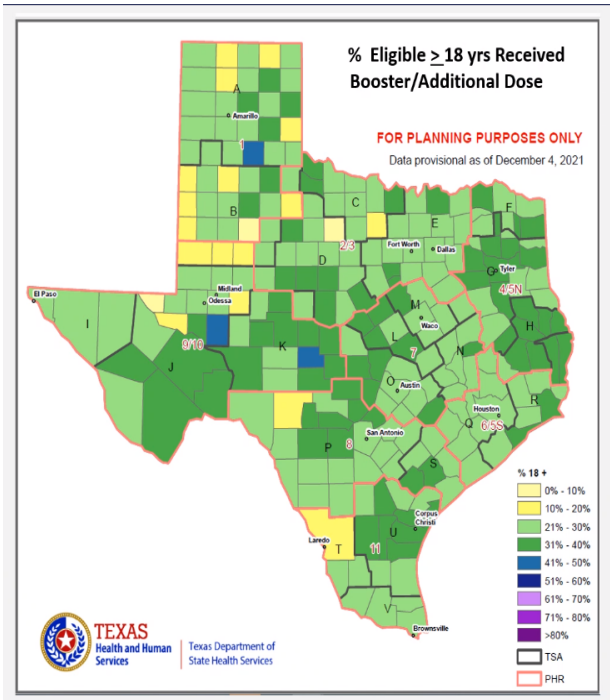

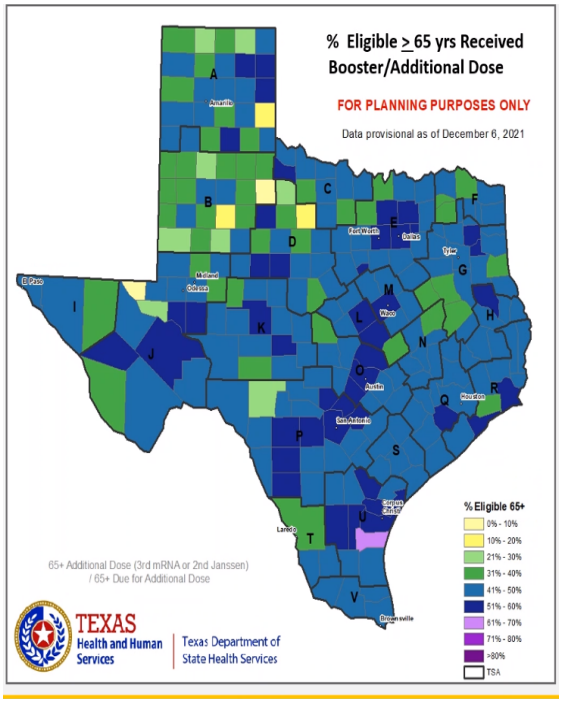

COVID-19 Vaccine

Areas of Focus

1. Continued emphasis on vaccinating the unvaccinated ages 5 years and older
   - 9.52 Million eligible Texans are completely unvaccinated
2. Emphasis on boosters for eligible population
3. Transition to a new Pfizer COVID-19 vaccine formulation for ≥12 yrs
4. Planning for pediatric (2-4 years) vaccination

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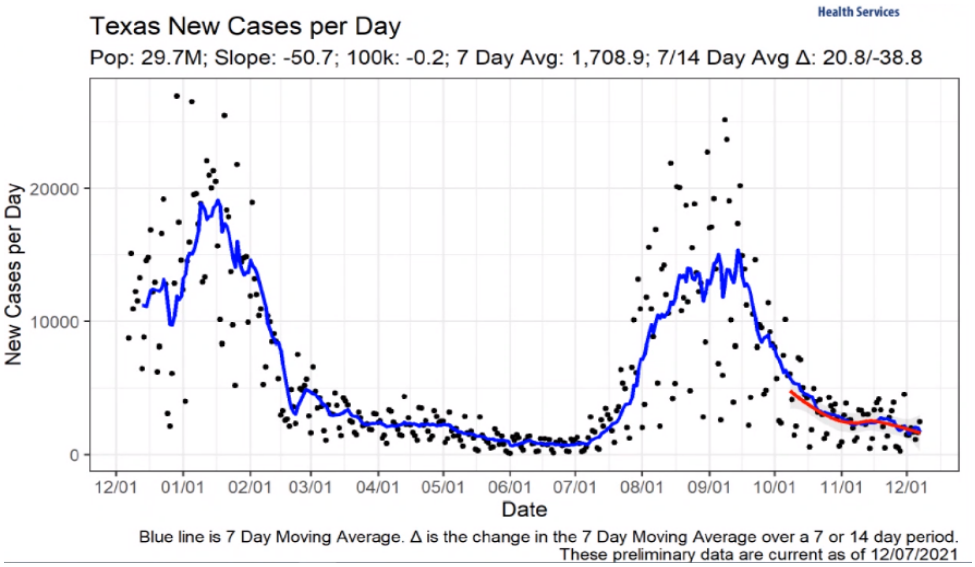
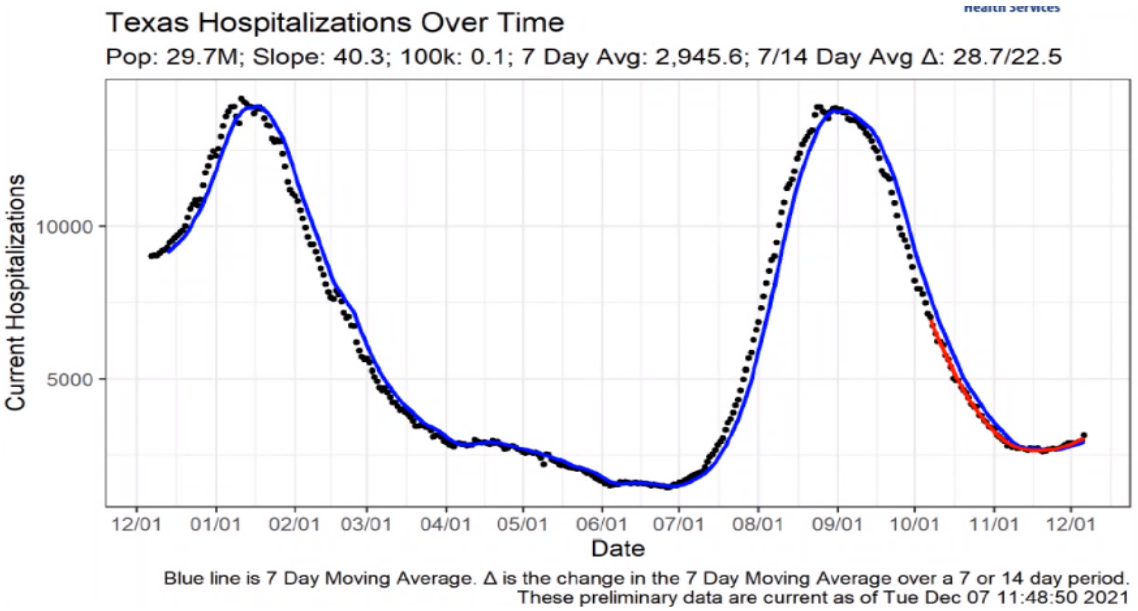
Pfizer COVID-19 Vaccine Formulations

Pfizer COVID-19 Vaccine	Pediatric Formulation[1] (100 doses/pack)	Adolescent/Adult Formulation[1] (300 dose/pack)	Adolescent/Adult Formulation[1] (1,170 dose/pack)
Age Group	5 to 11 years	12 years and older	12 years and older
Vial Cap Color	ORANGE 	GRAY 	PURPLE 
Dilution Needed	YES	NO	YES
Dose	0.2 mL after dilution (10 mcg)	0.3 mL (30 mcg)	0.3 mL after dilution (30 mcg)
Total Doses per Vial	10 doses per vial (after dilution)	6 doses Per Vial	6 doses per vial (after dilution)
Storage Options			
Thermal Shipper	X	X	30 Days[2]
Ultra-Low Temperature Freezer	6 months	6 months	9 months
Freezer	X	X	2 weeks
Refrigerator	10 weeks	10 Weeks	1 month
Room Temperature	12 hours prior to first puncture	12 hours prior to first puncture	2 hours prior to dilution
After First Puncture	Discard after 12 hours	Discard after 12 hours	Discard after 6 hours

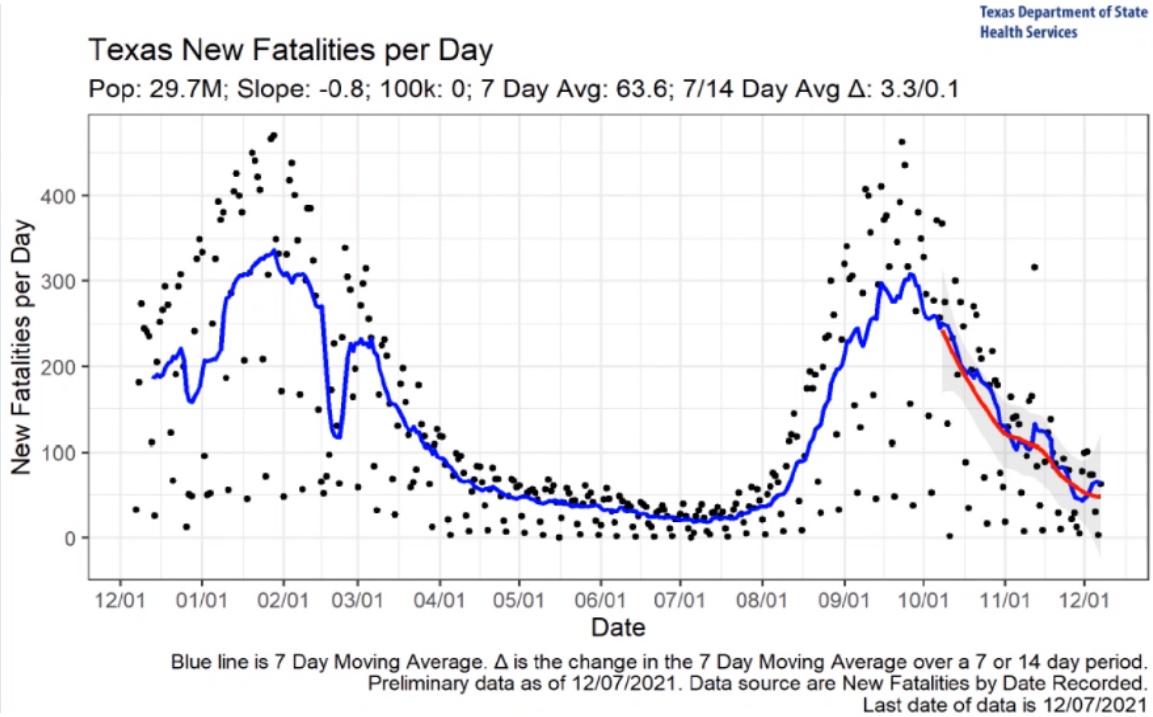
1. Orange cap vial cannot be used in individuals 12 years of age and older. Purple cap and Gray Cap vials cannot be used for children younger than 12 years.
2. Dry ice replenishment every 5 days

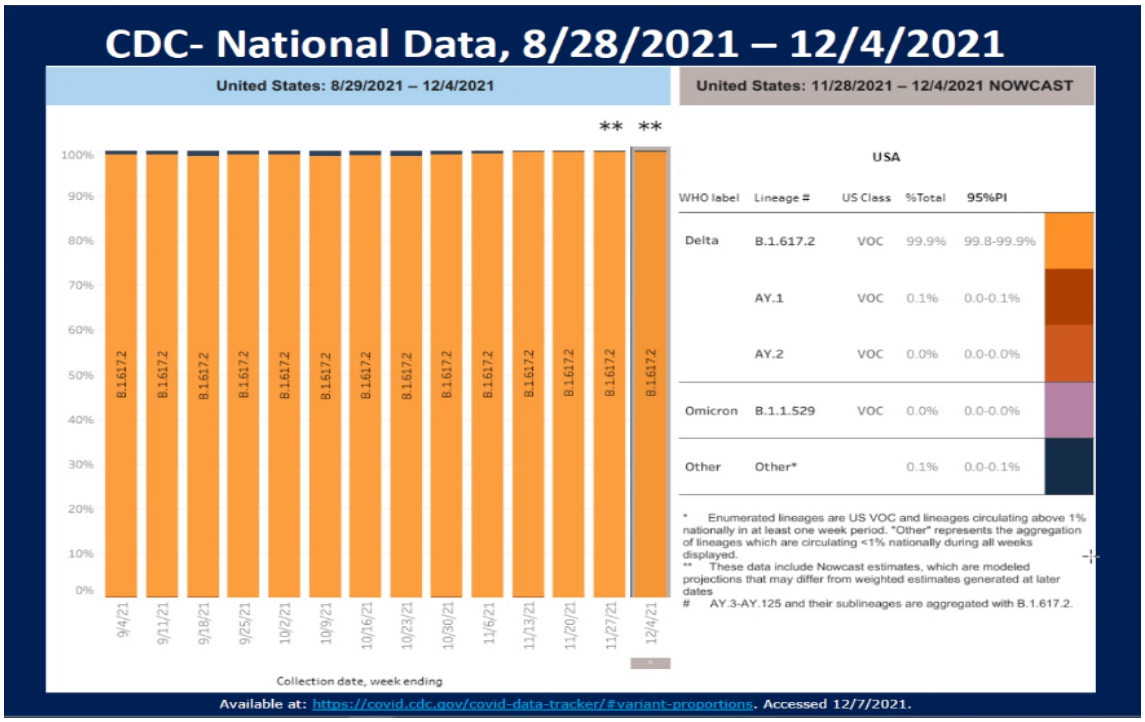
Update on COVID-19 Epidemiology Trends



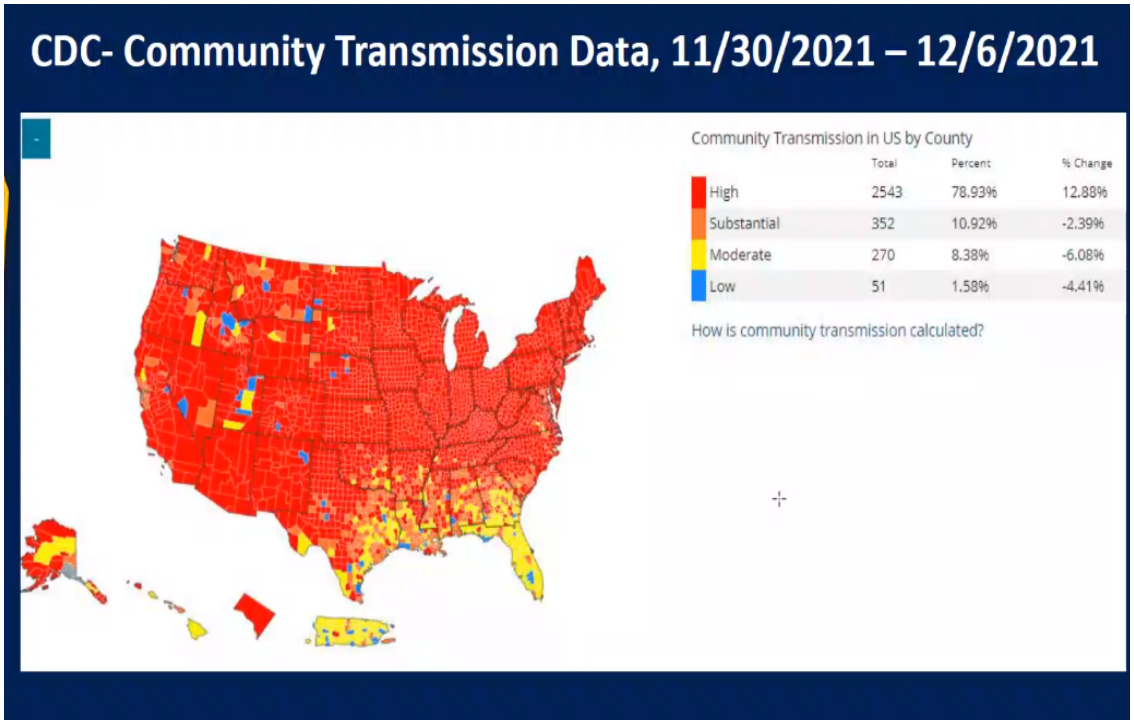


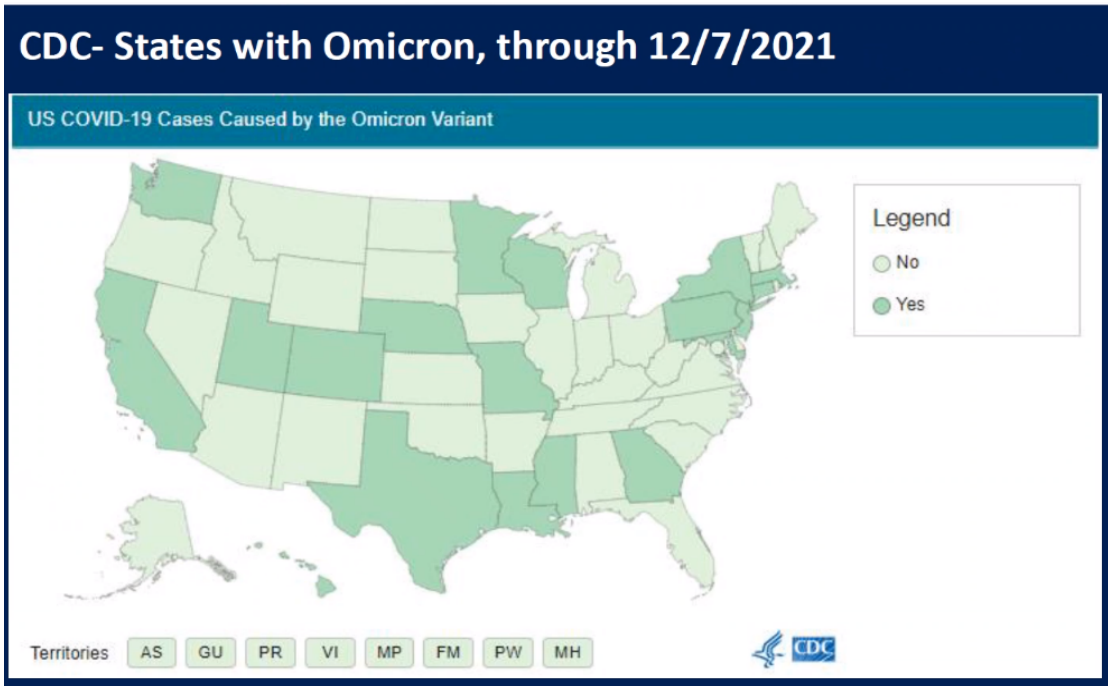
Hospitalizations Snap Shot
Total General and ICU Hospitalizations by TSA showing proportion of lab-confirmed COVID-19 occupancy out of total occupancy and number of beds available on:


Texas Department of State Health Services
Texas New Fatalities per Day
Pop: 29.7M; Slope: -0.8; 100k: 0; 7 Day Avg: 63.6; 7/14 Day Avg Δ: 3.3/0.1
New Fatalities per Day
400
300
200
100
0
12/01
01/01
02/01
03/01
04/01
05/01
06/01
07/01
08/01
09/01
10/01
11/01
12/01
Date
Blue line is 7 Day Moving Average. Δ is the change in the 7 Day Moving Average over a 7 or 14 day period.
Preliminary data as of 12/07/2021. Data source are New Fatalities by Date Recorded.
Last date of data is 12/07/2021


CDC- National Data, 8/28/2021 – 12/4/2021
United States: 8/29/2021 – 12/4/2021
United States: 11/28/2021 – 12/4/2021 NOWCAST
** **
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
B.1.617.2
9/4/21
9/11/21
9/18/21
9/25/21
10/2/21
10/9/21
10/16/21
10/23/21
10/30/21
11/6/21
11/13/21
11/20/21
11/27/21
12/4/21
Collection date, week ending
USA
WHO label
Lineage #
US Class
%Total
95%PI
Delta
B.1.617.2
VOC
99.9%
99.8-99.9%
AY.1
VOC
0.1%
0.0-0.1%
AY.2
VOC
0.0%
0.0-0.0%
Omicron
B.1.1.529
VOC
0.0%
0.0-0.0%
Other
Other*
0.1%
0.0-0.1%
* Enumerated lineages are US VOC and lineages circulating above 1% nationally in at least one week period. "Other" represents the aggregation of lineages which are circulating <1% nationally during all weeks displayed.
** These data include Nowcast estimates, which are modeled projections that may differ from weighted estimates generated at later dates
# AY.3-AY.125 and their sublineages are aggregated with B.1.617.2.
Available at: https://covid.cdc.gov/covid-data-tracker/#variant-proportions. Accessed 12/7/2021.

The CDC labs are showing the same concentration pattern of almost entirely Delta variant with Omicron presently barely showing an impact.





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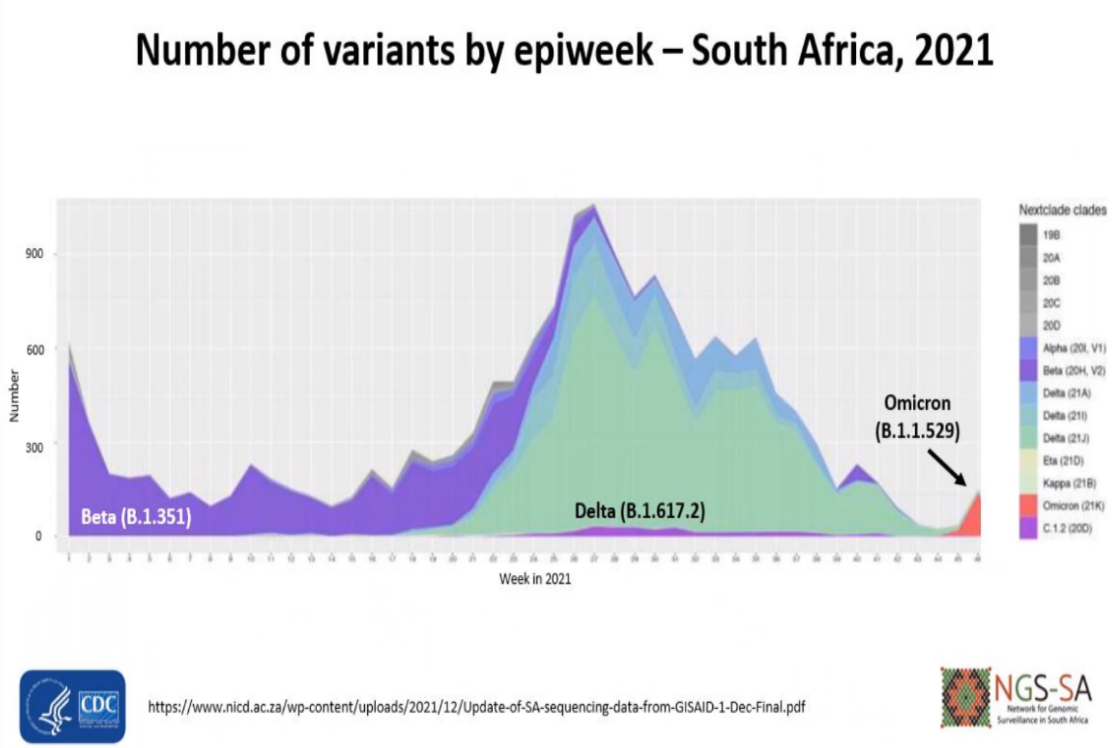
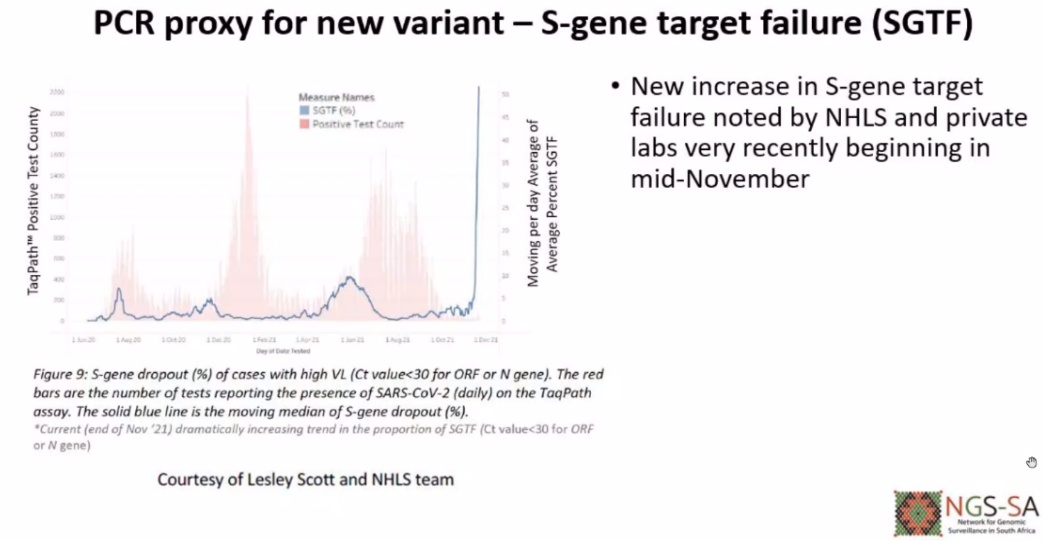
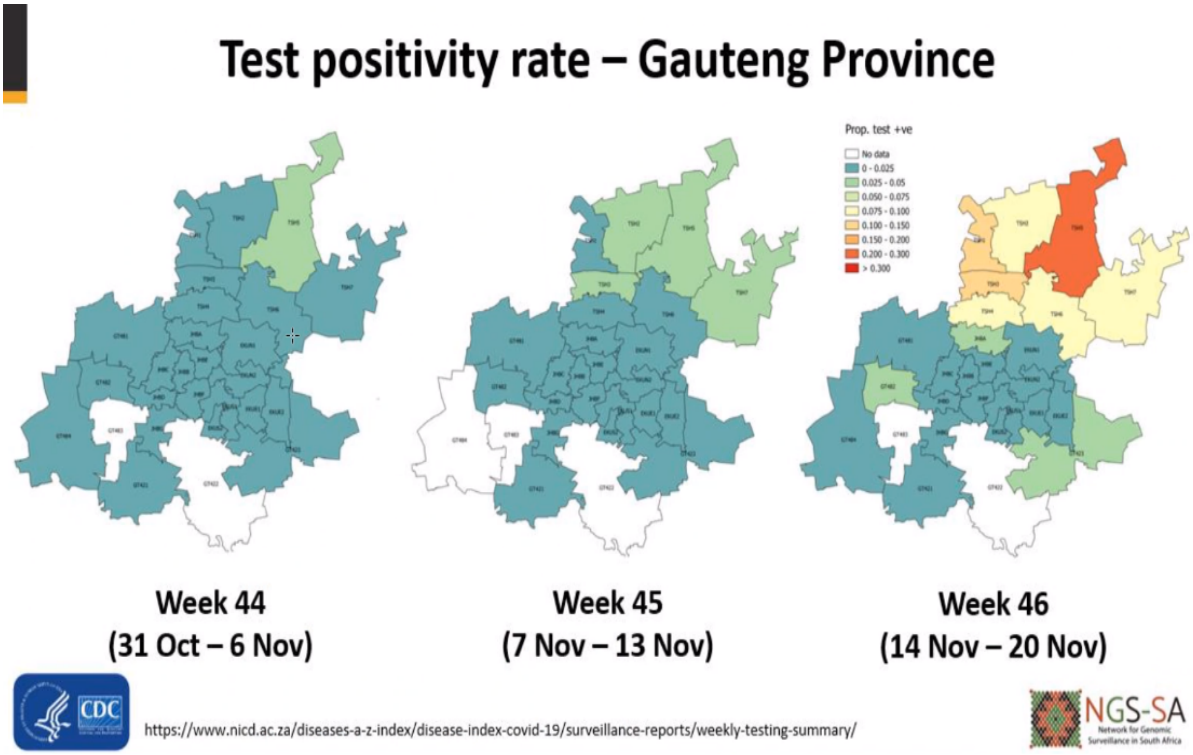
Due to lag time the data is about a week old

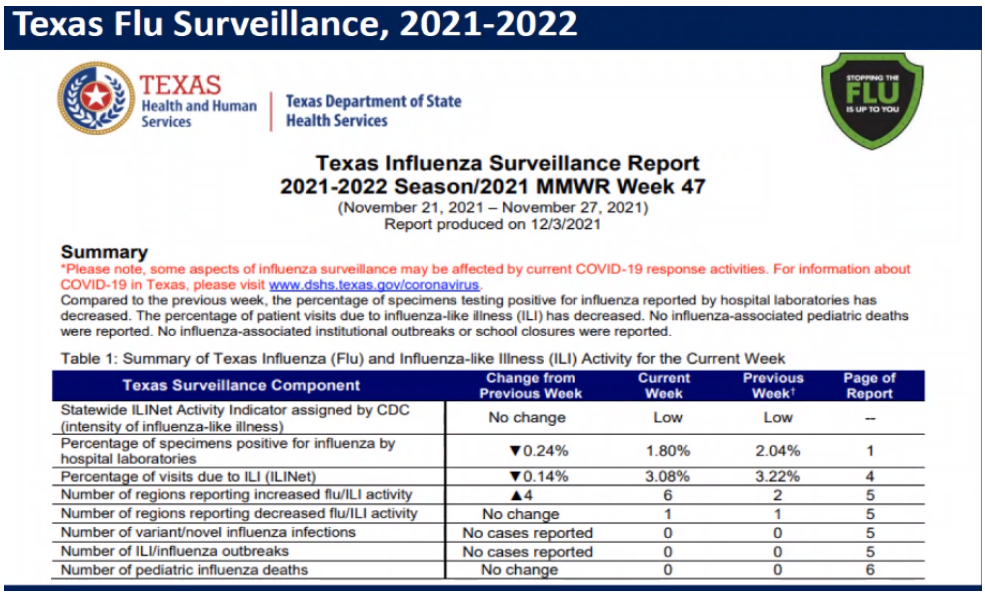






We cannot extrapolate that our experience will be the same as south Africa (younger population, different strain exposure)

Influenza Update



Texas Flu Surveillance, 2021-2022

TEXAS Health and Human Services | Texas Department of State Health Services

STOPPING THE FLU IS UP TO YOU

Texas Influenza Surveillance Report
2021-2022 Season/2021 MMWR Week 47
(November 21, 2021 – November 27, 2021)
Report produced on 12/3/2021

Summary

*Please note, some aspects of influenza surveillance may be affected by current COVID-19 response activities. For information about COVID-19 in Texas, please visit www.dshs.texas.gov/coronavirus.

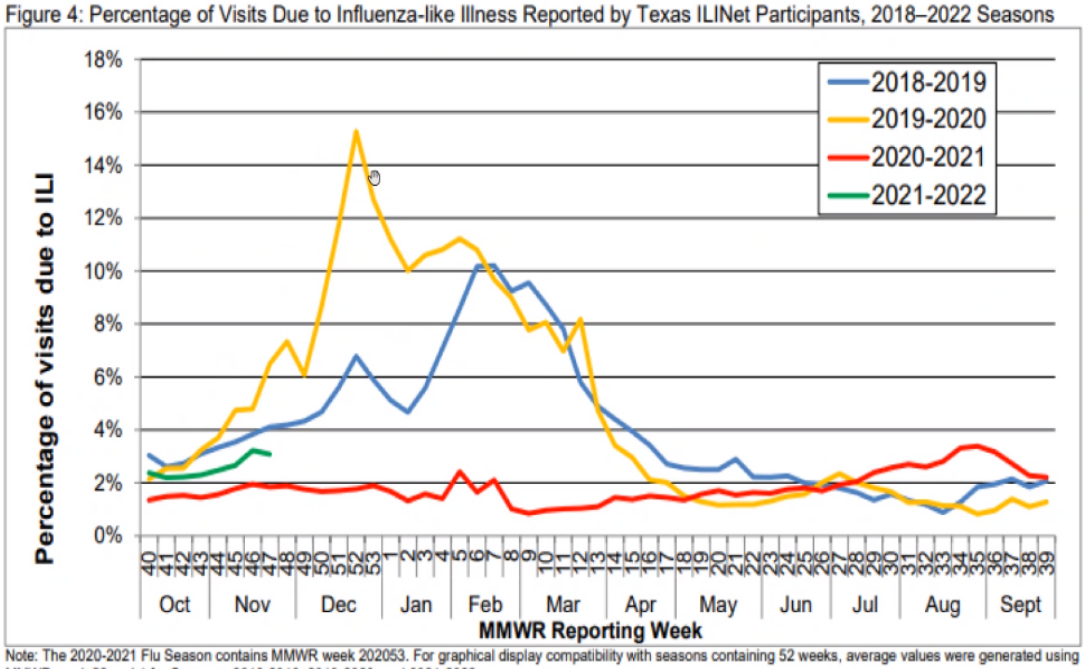
Compared to the previous week, the percentage of specimens testing positive for influenza reported by hospital laboratories has decreased. The percentage of patient visits due to influenza-like illness (ILI) has decreased. No influenza-associated pediatric deaths were reported. No influenza-associated institutional outbreaks or school closures were reported.

Table 1: Summary of Texas Influenza (Flu) and Influenza-like Illness (ILI) Activity for the Current Week

Texas Surveillance Component	Change from Previous Week	Current Week	Previous Week†	Page of Report
Statewide ILINet Activity Indicator assigned by CDC (intensity of influenza-like illness)	No change	Low	Low	--
Percentage of specimens positive for influenza by hospital laboratories	▼0.24%	1.80%	2.04%	1
Percentage of visits due to ILI (ILINet)	▼0.14%	3.08%	3.22%	4
Number of regions reporting increased flu/ILI activity	▲4	6	2	5
Number of regions reporting decreased flu/ILI activity	No change	1	1	5
Number of variant/novel influenza infections	No cases reported	0	0	5
Number of ILI/influenza outbreaks	No cases reported	0	0	5
Number of pediatric influenza deaths	No change	0	0	6

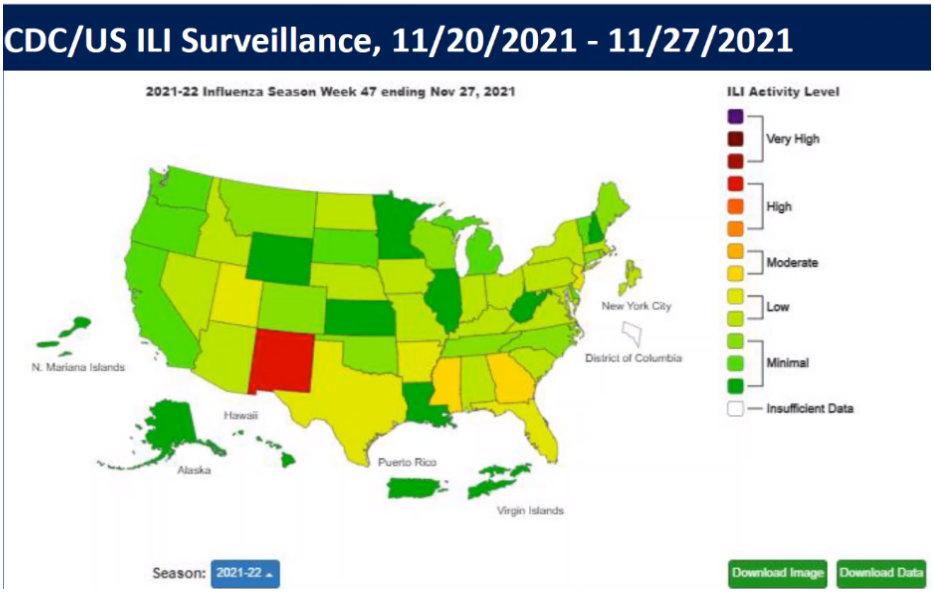
Texas Influenza-like Illness Surveillance, 2018-2022

Figure 4: Percentage of Visits Due to Influenza-like Illness Reported by Texas ILINet Participants, 2018–2022 Seasons



Note: The 2020-2021 Flu Season contains MMWR week 202053. For graphical display compatibility with seasons containing 52 weeks, average values were generated using MMWR week 52 and 1 for Seasons: 2018-2019, 2019-2020, and 2021-2022.

CDC/US ILI Surveillance, 11/20/2021 - 11/27/2021



Increasing Seasonal Influenza A (H3N2) Activity, Especially Among Young Adults and in College and University Settings, During SARS-CoV-2 Co-Circulation

HAN HEALTH ALERT NETWORK

This is an official CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
November 24, 2021, 11:00 AM ET
CDCHAN-00458

Summary

The Centers for Disease Control and Prevention (CDC) is issuing this Health Alert Network (HAN) Health Advisory about increased influenza A(H3N2) activity that could mark the beginning of the 2021-2022 influenza season. The purpose of this HAN Health Advisory is to

1. Remind public health practitioners and clinicians to recommend and offer the current seasonal influenza vaccine to all eligible persons aged six months and older (Flu vaccine and COVID-19 vaccine can be given at the same visit).
2. Remind clinicians to consider testing for both influenza virus and SARS-CoV-2 in patients with influenza-like illness (ILI).
3. Advise clinicians that antiviral treatment is recommended as early as possible for any patient with confirmed or suspected influenza who is: a) hospitalized; b) at higher risk for influenza complications; or c) developing progressive illness. In patients with suspected influenza, decisions about starting antiviral treatment should not wait for laboratory confirmation of influenza, however COVID-19 should be excluded if a rapid assay is available.
4. Remind public health practitioners and clinicians to consider mitigation measures including antiviral post-exposure prophylaxis during influenza outbreaks in institutions (e.g., long-term care facilities, university dormitories) in the setting of co-circulation of SARS-CoV-2.
5. Remind the public to use non-pharmaceutical interventions (NPI) or everyday preventive actions, in addition to getting a flu vaccine. Everyday preventive actions include staying home when sick, covering coughs and sneezes, and washing hands often.

Update on DSHS' COVID-19 Health Disparities Funded Activities

The grant addressing health disparities runs through May of 2023 and addresses communities' unique needs, such as documenting through listening sessions and Identifying partnerships There are 46 local health departments and other state agencies. Internally, DSHS has been staffing up the teams and half of the 21 positions have been staffed. Some local Health departments have begun doing outreach efforts. A partnership directory is being developed and there are 135 partners identified so far.

Monthly sharing sessions have begun with the focus to increase cross coordination. It has been identified that people are experiencing pandemic fatigue. The grant provides skill building and training sessions will be held in the future, Some LHDs are not experienced in addressing pandemics.

Update on COVID-19 School Testing Grant

$803 million grant to the state of Texas to promote testing and enable students to safely return to schools. The grant has had mixed reactions. Some schools did not take advantage of the opportunity.

- 940 school districts out of 1200 have signed up
- 239 private schools out of 1200 have signed up.
- Those actually receiving tests and services total 306 ISDs
- 69 private schools have received tests.
- 122 ISDs have conducted testing.

Contractors/Vendors provide the tests and are contacted directly by the ISD, and payment is made from DSHS. There were originally 4-5 vendors, but some dropped out and some new vendors were added to a total of 6.

It is a one year program. The state is waiting to hear about extensions. Millions of dollars would be returned if it is not extended.

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

- Situational awareness project expediting data reporting through HIEs. Working on a proof of concept with a few hospitals
- Streamlining reporting so data requests are reduced to one request as opposed to numerous
- Expanding electronic case reporting engaging providers and LHDs for pilots
- Texas Health Services Authority on PULSE. Provides remote access to electronic health records for continuous care during disasters. It can be used to address investigations as well.

Update on the 2021 PHFPC Annual Report/Recommendations

The reports have been filed and the recommendations and DSHS formal responses appear below. .

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Medicaid Billing Recommendation

PHFPC recommends that DSHS become the leading agency in the implementation of SB73 to ensure that Local Health Entities (LHEs) can expand their participation in Texas Medicaid and continue forward momentum regarding LHE Managed Care Organization contract execution. As the lead agency, DSHS will obtain monthly updates from the 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 LHE provider type enrollment.

DSHS Response to Medicaid Billing Recommendation

Senate Bill 73, 87th Texas Legislature, 2021 addresses contracting challenges often faced by LHEs regarding reimbursement from managed care organizations (MCO) for services provided and funded through Medicaid. The bill directs HHSC to establish a separate provider type for a local public health entity. "Local public health entity" means a local health unit, a local health department, and/or a public health district. HHSC does not yet have a finalized implementation plan for SB 73. The DSHS Center for Public Health Policy and Practice is the agency's point of coordination with HHSC Medicaid, in collaboration with the Division for Regional and Local Health Operations and will serve as a point of coordination between LHEs and HHSC Medicaid regarding the implementation of the bill.

Public Health Data and Information Systems Recommendations

The PHFPC recommends that DSHS lead a collaborative effort, including but not limited to the potential representation of LHEs, hospital groups, and the healthcare provider community, to establish a collective vision that includes modern and efficient public health data and information system. This includes developing a plan, strategies, and timeline to accomplish goals.

DSHS Response to Public Health Data and Information Systems Recommendation

The COVID-19 pandemic has demonstrated the need for an effective and efficient public health system. Coordination between federal, state, and local health entities (LHEs) is critical in ensuring that needs are properly identified and that available resources are distributed in a manner that addresses those needs. Timely, accurate, and complete information is vital in identifying needs and tracking progress in addressing health concerns. A DSHS-led collaboration of LHEs, health care providers, and other stakeholders can develop a shared, statewide vision, strategic and operating plans, and timelines. The focus of this collaborative effort should be to improve Texas' health information framework and include appropriate data access controls and services to ensure individuals' privacy is respected.

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This statewide structure should support the timely, standards-based, secure access and/or exchange of health data. Any statewide plan needs to address what technology services are required by each stakeholder group and how to best implement those services within resource constraints. It should also identify when independent, separate systems should be implemented; when services should be offered on a shared platform; and what standards should be used for exchanging data. Commitments from each stakeholder group, including both participation in planning and implementing necessary technologies, will enable long-term data access and system stability, helping Texas prepare for, and respond to, future disasters.

Collaboration between state and local entities is critical in designing and implementing policy approaches and technology solutions that are cost-effective and can meet the needs of a diverse set of users, such as DSHS, LHEs, health care providers, and other stakeholders.

Building upon the consolidation of DSHS and HHSC and supported with one-time funding from Centers for Disease Control and Prevention, DSHS has begun contractor-supported work focused on public health data sharing. This helps enhance the state's capacity and capabilities to securely exchange data with health care providers and to transform that data into actionable information by policy makers at all levels of government as well as enhancements to better serve health care providers.

DSHS is currently coordinating efforts with HHSC in the development of the Medicaid health information technology plan, as well as working with HHSC to advance an interoperability center of excellence. This center is intended to provide coordinated services for data submission and retrieval, leveraging health information exchange networks. DSHS is also engaged in developing clear information about data governance, providing additional detail about the data DSHS has and how, with whom, and in what circumstances that data may be shared.

Several large LHEs are investing significant resources in developing local data systems to meet local needs. DSHS and these LHES are collaborating in advancing electronic case reporting (eCR), an automated method for informing public health of a reportable condition, such as tuberculosis.

DSHS and the LHEs can build their collaborative activities around eCR, the work DSHS is doing with HHSC, and the experience developed by DSHS through work with other partners. This helps produce a statewide informatics plan that can be used across the state, serving as a guide for improving services and a resource to be referenced in applying for funding to advance the plan's goals. DSHS can lead this effort at the request of the LHEs and PHFPC.

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Public Health Provider-Charity Care Program Recommendation
The PHFPC recommends that DSHS become a leading agency in the 1115 Waiver transition and advocate for the Public Health Provider-Charity Care Program (PHPCCP). This should include the provision of assistance with the allocation of a proportionate share of the funds available for local health entities and mental health programs, advocacy for a comprehensive inclusion of core public health services within the PHP-CCP, and provision of technical assistance regarding costreporting and charity care policy development.

DSHS Response to Public Health Provider-Charity Care Program Recommendation
The DSHS Center for Public Health Policy and Practice, which is the agency's point of coordination with HHSC Medicaid, will serve in collaboration with the Division for Regional and Local Health Operations as a point of coordination between local health entities (LHEs) and the PHP-CCP. The Center currently attends HHSC internal and external stakeholder meetings regarding the PHP-CCP and is available to help assist LHEs as they apply for support via the PHP-CCP from HHSC. The Center will continue to work with HHSC to ensure that LHEs are considered throughout this process, for example, in determining the services included for reimbursement in future fiscal years.

Public Comment. No public comment was offered.

Timelines, Next Steps, Announcements, and Future Meetings.
Updates on current topics
Next meeting is proposed on February 9th

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

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