SUBJECT: Health extension service pilot for biosecurity and emergency response

COMMITTEE: Public Health — favorable, without amendment

VOTE: 6 ayes — Kolkhorst, Naishtat, J. Davis, Gonzales, Hopson, S. King

0 nays

5 absent — Coleman, Laubenberg, McReynolds, Truitt, Zerwas

WITNESSES: For — (*Registered, but did not testify:* Greg Herzog, Texas Medical Association)

Against — None

On — Scott Lillibridge, Texas A&M Health Science Center; Eduardo Olivarez, Hidalgo County Health and Human Services; Raymond Swienton, University of Texas Southwestern; (*Registered, but did not testify:* Greg Herzog, Texas Medical Association; Richard Bays, Department of State Health Services)

BACKGROUND: The Department of State Health Services (DSHS) has regional staff that assure the provision of essential public health services in eleven health services regions. Health Service Region 11 serves a 19-county area in the Rio Grande Valley.

DIGEST: HB 1948 would require DSHS to establish a public health extension service pilot program in Health Service Region 11 to support local public health and medical infrastructure and promote:

- disease control and medical preparedness; and
- biosecurity, pathology services, detection of dangerous biologic agents, and management of hazardous materials.

The pilot program would evaluate the effectiveness of a public health extension service for regions of the state that could be particularly vulnerable to biosecurity threats, disaster, and other emergencies.

DSHS could contract with the Texas A&M University System, University of Texas System, or both systems to implement the pilot. DSHS would implement projects and systems to support the program and could:

- provide support for medical assistance and tactical medical operations teams;
- establish a disaster training and exercise program; and
- establish and equip caches of medical supplies and equipment.

DSHS also could establish regionally based systems to manage emergency medical logistics and to provide technical assistance for disaster mitigation and recovery.

By December 1, 2010, DSHS would report on the program to the governor, the lieutenant governor, and the speaker of the House, including recommendations for continuation of the program and expansion to other regions of the state that could be vulnerable to biosecurity threats, disaster, and other emergencies.

The bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2009. The pilot program would be abolished September 2, 2011.

SUPPORTERS SAY:

HB 1948 would establish a pilot public health extension service in Health Services Region 11 that could lead to the establishment of a model program for providing technical assistance, hands-on training, and capacity-building to local health authorities for response to biosecurity threats, disasters, and other emergencies. The bill would evaluate the benefits of an ongoing, rather than episodic, focus on medical infrastructure development. The pilot extension service could help the state establish a uniform approach to managing the logistics of emergency response and to enhancing surveillance of pathogens. An established planning process would involve more local medical and service providers in emergency response for their areas. DSHS does a good job of emergency response given its limited resources, yet DSHS must contract with staffing agencies to mobilize an emergency response workforce that is less familiar with an affected community than local health establishments.

Region 11 would be appropriate for the pilot because it lacks the health infrastructure to deal with the spectrum of biosecurity threats and natural disasters it could face. The region has confronted hurricanes, and some areas have inadequate water, sewage, and other infrastructure that could lead to infectious-disease outbreaks. Region 11 also hosts many transient populations and serves as the gateway for goods and people crossing the border or entering through major ports. These circumstances not only place the border population at risk, but potentially the full Texas population if the risks are not addressed.

The university systems that would implement the pilot would be well-qualified to do so, because they have studied emergency response efforts for years, have disaster-management experts who have responded directly to emergencies, and have provided similar training programs in the past. The Texas A&M University System has established other extension service programs and could apply that model to public health. The universities could work with Region 11 communities and would be supported by DSHS in their efforts to bring together local resources.

Contracting with universities to establish the pilot would be preferable to health authorities running the pilot, because local health authorities are not experienced in establishing and conducting the sort of broad-based, regional training approach that would be required by this bill. CSHB 1948 would not replace the control local health authorities have over formal emergency response efforts, but instead would train and coordinate local resources in advance of an incident and establish better monitoring of infectious diseases that could flow across the border.

OPPONENTS SAY:

While the objectives of this bill would be beneficial, HB 1948 would be more effective if resources were invested in an effort led by local health authorities with support from the university systems for tasks such as establishment of emergency-related databases. Local health authorities are the entities that conduct emergency preparedness and surveillance activities on a day-to-day basis. With more resources, local health authorities could apply the direct experience they have in responding to emergencies and tracking infectious diseases to develop the model approaches and health infrastructure this bill aims to establish.

University-designed trainings and strategies would be biased toward a more academic than experience-based approach to responding to emergencies. The input universities received from people experienced

with disasters likely would be limited to those who had spent time in disaster management headquarters but who were unfamiliar with the front-line responses that local health authorities are responsible for making. The universities also would lack the relationships necessary to gain buy-in from local governing bodies, such as city councils and county commissioners courts, that would be responsible for setting local health response policy.

This bill could do more harm than good if this pilot or any extension of the program in subsequent sessions was supported with existing DSHS preparedness appropriations. Without new funding, support for preparedness efforts by local health authorities would diminish.

NOTES:

The fiscal note indicates a general-revenue cost of $2,373,743 through the end of fiscal 2010-11 to develop and implement aspects of HB 1948, including training and exercise programs, management of a supply and equipment cache, and contracting, staffing, and travel costs.

The House-passed budget proposal includes a contingency rider for consideration in Article 11 that would appropriate $3 million for HB 1948.