



# Texas Council on Cardiovascular Disease and Stroke

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## Annual Legislative Report



*Michael M. Hawkins, M.D.  
Chair, Texas Council  
on Cardiovascular Disease  
and Stroke*

# Message from the Chair

Heart disease and stroke, commonly referred to as cardiovascular disease, are the number one and three causes of death among Texans. In response to ensuing costs at both the individual and public health levels, the 76th Texas Legislature established the Texas Council on Cardiovascular Disease and Stroke in 1999. The fifteen-member council consists of eleven Governor-appointed, Senate-approved voting members and four state-agency appointed non-voting members. The council continues to discharge its duty through the development and implementation of a state plan to reduce heart disease and stroke in Texas, and it does so by working with partners throughout the state. The council's dedicated members combine their skills to address chronic diseases of the heart and brain. These council members are outstanding leaders in their respective fields, and provide their expertise to improve the overall health of Texans.

This could not be accomplished without the direct support of staff from the Texas Department of State Health Services (DSHS), including staff from the Cardiovascular Health and Wellness (CHW) Program, Health Promotion and Chronic Disease Prevention Section, and the Division of Prevention and Preparedness Services. Their tireless work has been an inspiration to

the council. It has been a privilege and honor to serve as chair of the council for the past four years. The council members join me in the continued commitment to reduce the morbidity and mortality caused by Texas' greatest health burdens, cardiovascular disease and stroke.



Michael M. Hawkins, M.D.  
*Chair, Texas Council on Cardiovascular Disease and Stroke*

# Executive Summary

The Texas Council on Cardiovascular Disease and Stroke consists of 15 members including 11 appointed public voting members and four state-agency appointed non-voting members. It is administratively supported by the Texas Department of State Health Services.

The mission of the council is to “educate, inform, and facilitate action among Texans to reduce the human and financial toll of cardiovascular disease and stroke.”

Heart disease and stroke are not only the number one and number three killers in the nation and Texas, but together they are the number one drain on healthcare resources:

- Cardiovascular disease (CVD) accounted for 32 percent of all deaths in Texas in 2005.
- Total hospitalization charges for CVD and stroke in 2007 were more than \$10 billion.
- The Texas Medicaid Program paid over \$200 million in medical claims for CVD in 2007.

In 2005, 49,338 deaths were attributed to heart disease and stroke. Of these deaths, 81 percent were due to ischemic heart disease (IHD) and 19 percent were due to stroke.

Some of the notable achievements of the council during the past year include:

- Participation in the Texas Heart Disease and Stroke Prevention Partnership and development of the new *Texas Plan to Reduce Heart Disease and Stroke - 2008*.
- Implementation of the Secondary Prevention of Heart Disease in the Medicaid Population Project.
- Implementation of the Awareness, Control, and

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Treatment of High Blood Pressure in Hispanics Project.

- Expansion of the Heart and Stroke Healthy City Recognition Program.
- Co-sponsorship of a worksite wellness training on value-based benefit design to reduce heart disease and stroke.

The council, in collaboration with its partners, has identified two priority issues that require immediate attention during the 2010-2011 biennium. These are: 1) data collection to monitor the quality of care provided to heart disease and stroke patients, and 2) implementation of evidence-based primary and secondary prevention interventions in communities, worksites, and healthcare settings.

# Council Duties

The Texas Council on Cardiovascular Disease and Stroke (council), authorized by House Bill 2085 during the 76th Legislature, is charged with three main duties (Appendix 1):

- 1) Development of an effective and resource-efficient plan to reduce the morbidity, mortality, and economic burden of cardiovascular disease (CVD) and stroke in Texas,
- 2) Review available clinical resources and develop a database of recommendations for appropriate care and treatment of patients with CVD or who have suffered from or are at risk for stroke, and
- 3) Collect and analyze information related to CVD and stroke at the state and regional level and, to the extent feasible, at the local level, and maintain a database of this information.

## Reimbursement for Services

The council does not receive state appropriations, so members do not receive reimbursement for their travel costs or time. The council conducts four meetings a year, with an additional one to two special called meetings. The average yearly financial contribution per voting council member ranges from \$2,000 to \$31,000, including the direct costs of travel, per diem, incidentals, and the indirect expenses including loss of income and after-hours work on council projects. Council members spend between 30 and 125 hours per year on council business.

## Administrative Support

The council is administratively supported by the Texas Department of State Health Services (DSHS). DSHS does not receive appropriated funds for this purpose; however, it provides support for the council through other state and federally funded positions and services. The manager of the Adult Health and Chronic Disease Branch, which includes the Cardiovascular Health and Wellness (CHW) Program, serves as the executive director

of the council, overseeing council meetings, communicating with stakeholders, and conducting the business activities of the council. Staff from the CHW Program, Health Promotion and Chronic Disease Prevention Section, as well as other programs within DSHS, including program specialists, medical consultants, epidemiologists, and statisticians provide support during the council meetings, help implement council programs, and work with stakeholders to ensure coordination of programs that work to reduce heart disease and stroke in Texas.

## Council Membership

The council consists of 15 members including 11 appointed public voting members and four state-agency appointed non-voting members.

### Voting Members

The governor, with approval by the senate, is responsible for appointing the 11 public voting members that consist of the following: three medical doctors with backgrounds in cardiology, neurology, and primary care; a registered nurse with a background in quality improvement processes; a registered dietitian; two consumers with backgrounds in either volunteer heart and stroke organizations or work in hospital or managed care administration; two persons with experience in public health research, practice, or policy; and two members from the general public that represent persons with CVD or stroke and their caregivers. Members come from a variety of communities, locales, and demographic groups providing sufficient representation of the overall burden of CVD and stroke in Texas. Appendix 1 provides a list of members and their contact information.

### Non-Voting Members

Four non-voting members represent state agencies that oversee services for health, aging and disabilities, education, and assistive and rehabilitative services. The state agency commissioners are responsible for designating these representatives.

# Council Priorities for the 81st Legislative Session

## Legislative Priorities for the 2010-2011 Biennium

Heart disease and stroke continue to rank as the first and third leading causes of deaths in the U.S. and Texas. In 2005, 49,338 Texans died from heart disease or stroke. In 2007, an estimated 1.5 million Texans ages 18 years and older had cardiovascular disease or a stroke. Hospital charges in Texas in 2005 for these conditions were over \$10 billion and the state of Texas paid over \$200 million in Medicaid claims.

In 1999, the 76th Legislature passed House Bill 2085 which created Chapter 93 of the Health and Safety Code (HSC) and the Texas Council on Cardiovascular Disease and Stroke. The council's charge is to create a state plan to reduce the burden of cardiovascular disease and stroke in the state. In 2005, the 79th Legislature passed Senate Bill 330, creating the Texas Stroke Act, and House Bill 2344, amending Chapter 93 of HSC, authorizing the council to make written recommendations for performing its duties and to advise the Legislature on legislation that is needed to develop further and maintain a statewide system of quality education services for all persons with cardiovascular disease or stroke. Funding has never been appropriated to the council to discharge its duties.

The council, in collaboration with partners, has identified several priority issues that require immediate attention during the 2010-2011 biennium. These priority issues include actions to collect data. The council will use this data to identify best practices and gaps in services and to inform decision makers at the state and local level on the availability and effectiveness of evidence-based policies and education programs to reduce heart disease and stroke in Texas. By investing in the implementation of heart disease and stroke prevention programs that reduce

heart attacks and strokes and their associated costs, Texas will help ensure a healthier, more productive workforce.

## Priority Issues

### Objective:

All Texas cities will offer a heart and stroke healthy environment for persons to work, live, and play.

### Strategies:

- 1) Provide grants to cities to help them meet the criteria of a Heart and Stroke Healthy City.
- 2) Improve Texans' ability to recognize signs and symptoms of heart attacks and strokes, and initiate the Chain of Survival System.
- 3) Monitor the illness and deaths caused by heart attacks and strokes and the quality of care provided by healthcare facilities for heart attacks and strokes.
- 4) Improve the quality of care for prevention, detection, and treatment of heart disease and stroke at community health centers.

## Heart and Stroke Healthy City means Texans:

- Receive regular messages about the risk factors of heart disease and stroke, and what they can do to reduce their risk.
- Live in cities that promote physical activity and healthful eating, and that ban tobacco.
- Can access cardiopulmonary resuscitation (CPR) classes and automated external defibrillators within the community.

- Are transported safely and quickly by emergency medical services (EMS) to heart attack and stroke-ready hospitals.
- Have access to quality, cost-effective clinical preventive services for heart disease and stroke by public and private healthcare providers.

implement obesity reduction and worksite-wellness programs, and budgetary requests related to chronic diseases supported by groups such as the Partnership for a Healthy Texas and the Texas Public Health Coalition.

## Supporting Issues

The council finds that policies and programs to reduce risky behaviors that negatively affect health can also reduce development of chronic conditions and the eventual costs for treating or controlling those conditions.

According to the 2008 American Heart Association Heart Disease and Stroke Statistics report, “it is estimated that more than 90 percent of coronary heart disease events will occur in individuals with at least one elevated risk factor and approximately 8 percent will occur in people with only borderline levels of multiple risk factors.”

Tobacco use remains the number one preventable cause of death and disease in Texas, yet we know that we can reduce tobacco use by implementing evidence-based comprehensive tobacco prevention and control programs. Texas has demonstrated significant reductions in youth and adult tobacco use in areas of Southeast Texas that implemented a comprehensive tobacco prevention and control program funded at \$3 per person per year. Between 2000 and 2004, 6th - 12th grade tobacco use was reduced 37 percent and adult tobacco use dropped 27 percent.

The council recommends:

- 1) Enactment of legislation for a smoke-free Texas.
- 2) Appropriation of funding at \$3 per person to implement a statewide comprehensive tobacco prevention program.
- 3) Appropriation of adequate funding to

# The Burden of CVD in Texas and the United States

Cardiovascular disease is the leading cause of death in Texas and has been since 1940. As noted in *The Burden Report: Cardiovascular Disease & Stroke in Texas, 2008*, it accounts for two out of every five deaths in Texas, and in 2007 approximately 1.5 million adult Texans reported that they had been diagnosed as having had a heart attack, myocardial infarction, angina, coronary heart disease, or stroke. In 2002, the DSHS CHW Program created the Texas Cardiovascular Disease Surveillance System and Report to monitor specific trends in risk factors related to CVD and stroke. The program continually collects and provides CVD and stroke data, and makes these data available to the council and the public. These data serve as a benchmark and determinant of progress toward goals and objectives as outlined in the council's *Texas State Plan to Reduce Cardiovascular Disease and Stroke - 2008*. The data are available on the council's website at [www.texascvdcouncil.org](http://www.texascvdcouncil.org).

## Definition

Cardiovascular disease refers to a group of diseases that target the heart and blood

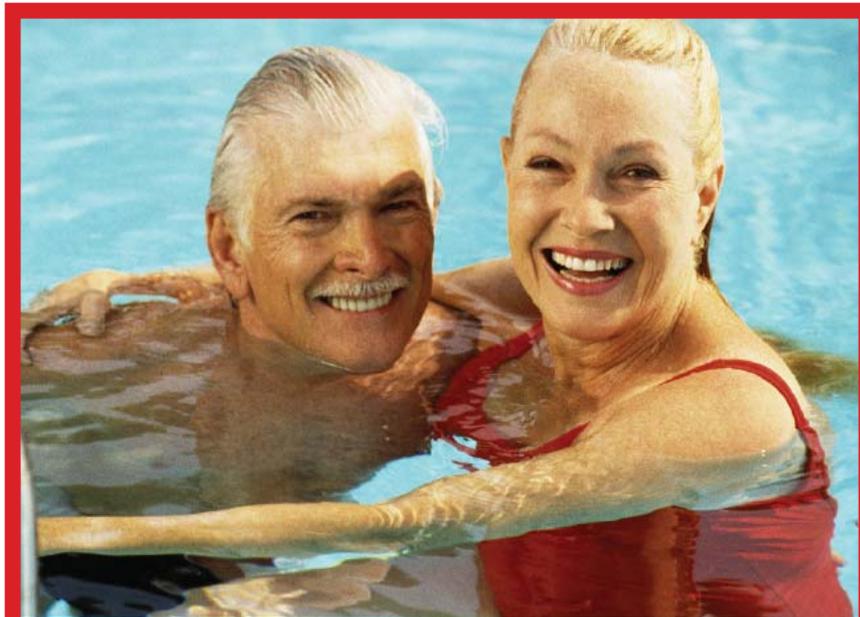
vessels. It is the result of complex interactions between multiple inherited traits, behaviors, and environmental issues that impact cholesterol, body weight, blood pressure, and lifestyle habits. Common forms include heart disease, stroke, and congestive heart failure.

A major cause of CVD is atherosclerosis, a general term for the thickening and hardening of the arteries. It is characterized by deposits of fatty substances,

cholesterol, and cellular debris in the inner lining of an artery. The resulting buildup is called plaque, which can partially or completely occlude a vessel and may lead to heart attack or stroke.

## National Figures

In its *Heart Disease and Stroke Statistics - 2008 Update*, the American Heart Association (AHA) reported that 80.7 million Americans are estimated to have one or more forms of cardiovascular disease. The most prevalent forms of heart disease and stroke in which narrowed or blocked arteries result in decreased blood supply to the heart or brain are referred to as ischemic heart disease (IHD) and ischemic stroke. If all forms of major CVD were eliminated, life expectancy would rise



*Cholesterol, body weight, blood pressure, and lifestyle habits may increase the risk of CVD and stroke.*

by almost seven years. The estimated direct and indirect cost of CVD in the United States in 2008 was \$444.8 billion.

## State Figures

Heart disease and stroke are not only the number one and number three killers in the nation and Texas, but together they are the number one drain on healthcare resources.

Highlights of the *Burden Report: Cardiovascular Disease & Stroke in Texas, 2008*, include:

- 1) Cardiovascular disease accounted for 32

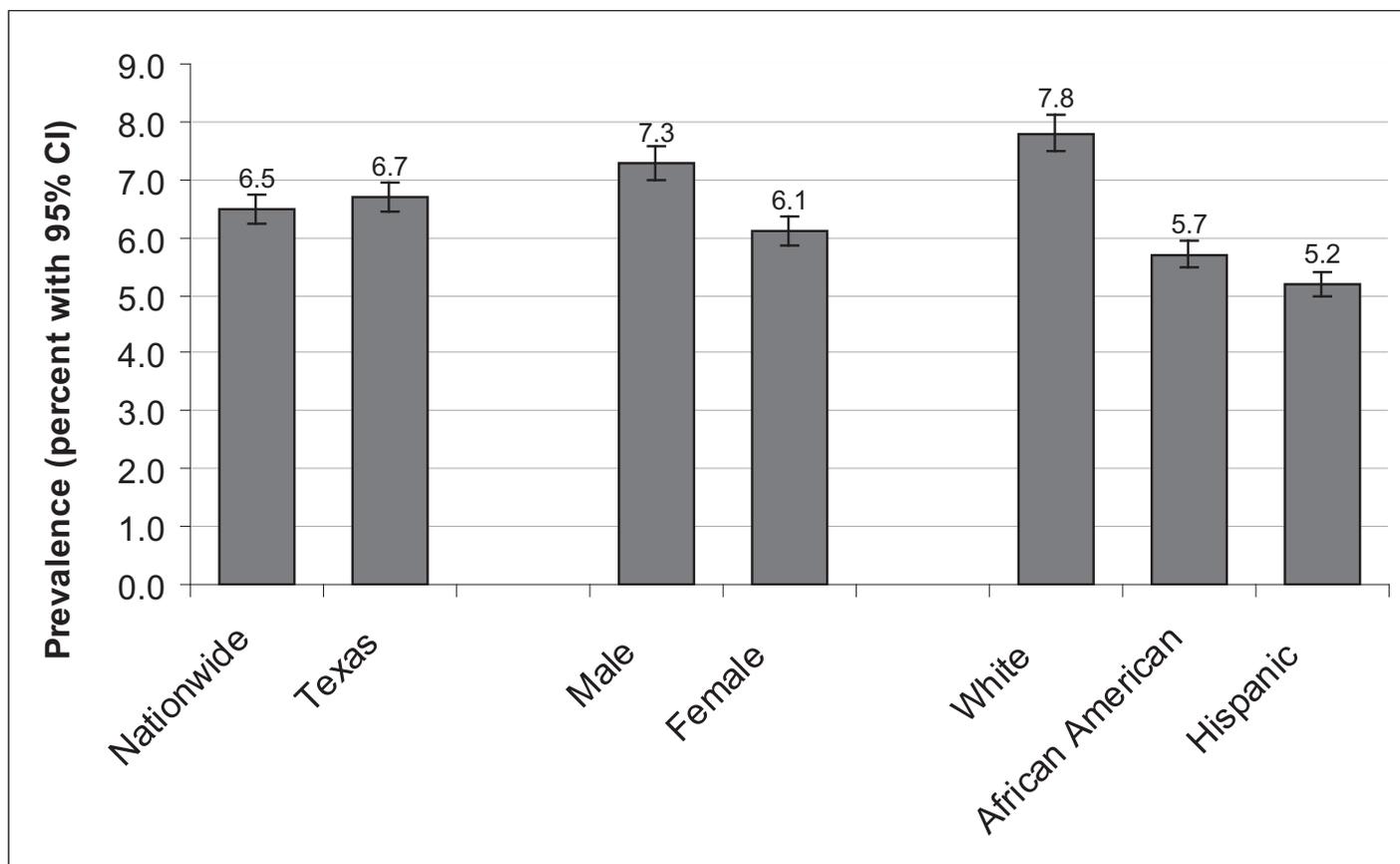
percent of all deaths in Texas in 2005.

- 2) Total hospitalization charges for CVD and stroke in 2007 were more than \$10 billion.

- 3) The Texas Medicaid Program paid over \$200 million dollars in medical claims for CVD in 2007.

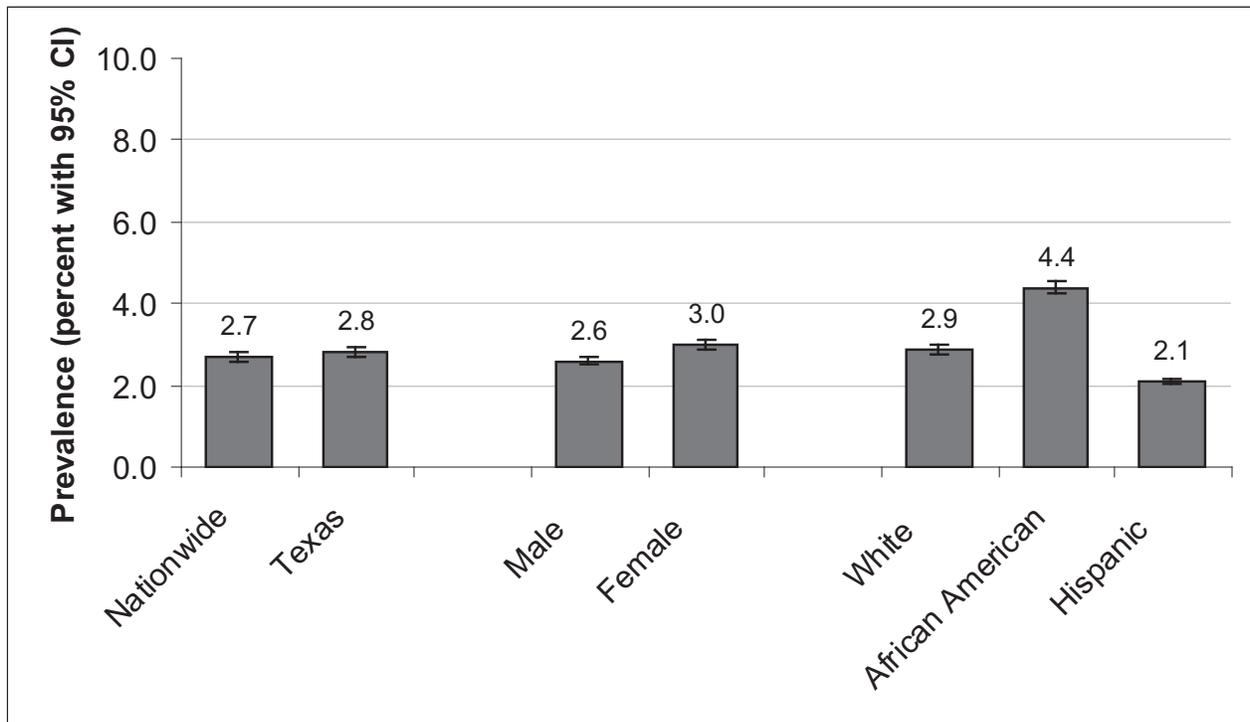
In 2005, 49,338 deaths were attributed to heart disease and stroke as the leading cause of death. Among these deaths, 81 percent were due to ischemic heart disease (IHD) and 19 percent were due to stroke.

**Figure 1. Prevalence of Heart Disease by Gender and Race, Adults (18 years and older), Texas, 2007**



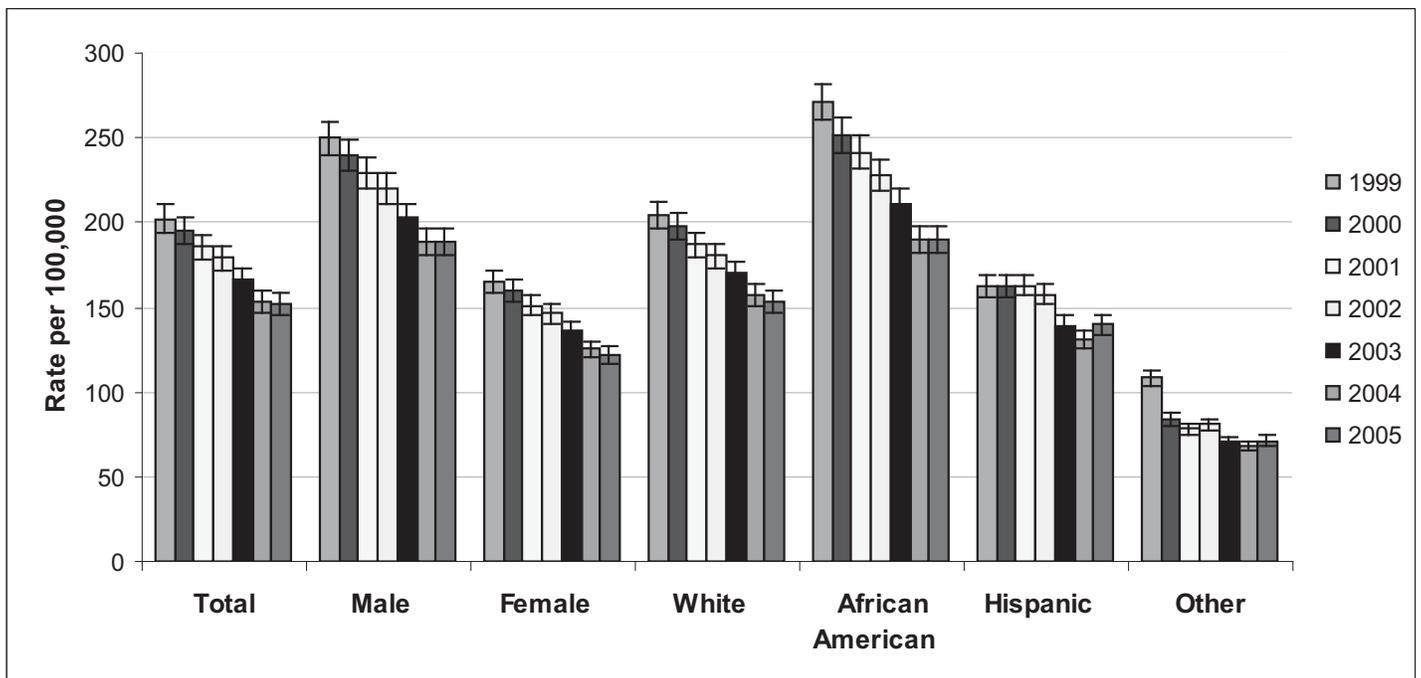
Data source: Texas Behavioral Risk Factor Surveillance System, Center for Health Statistics, Texas Department of State Health Services, 2007

**Figure 2. Prevalence of Stroke by Gender and Race, Adults (18 years and older), Texas, 2007**



Data source: Texas Behavioral Risk Factor Surveillance System, Center for Health Statistics, Texas Department of State Health Services, 2007

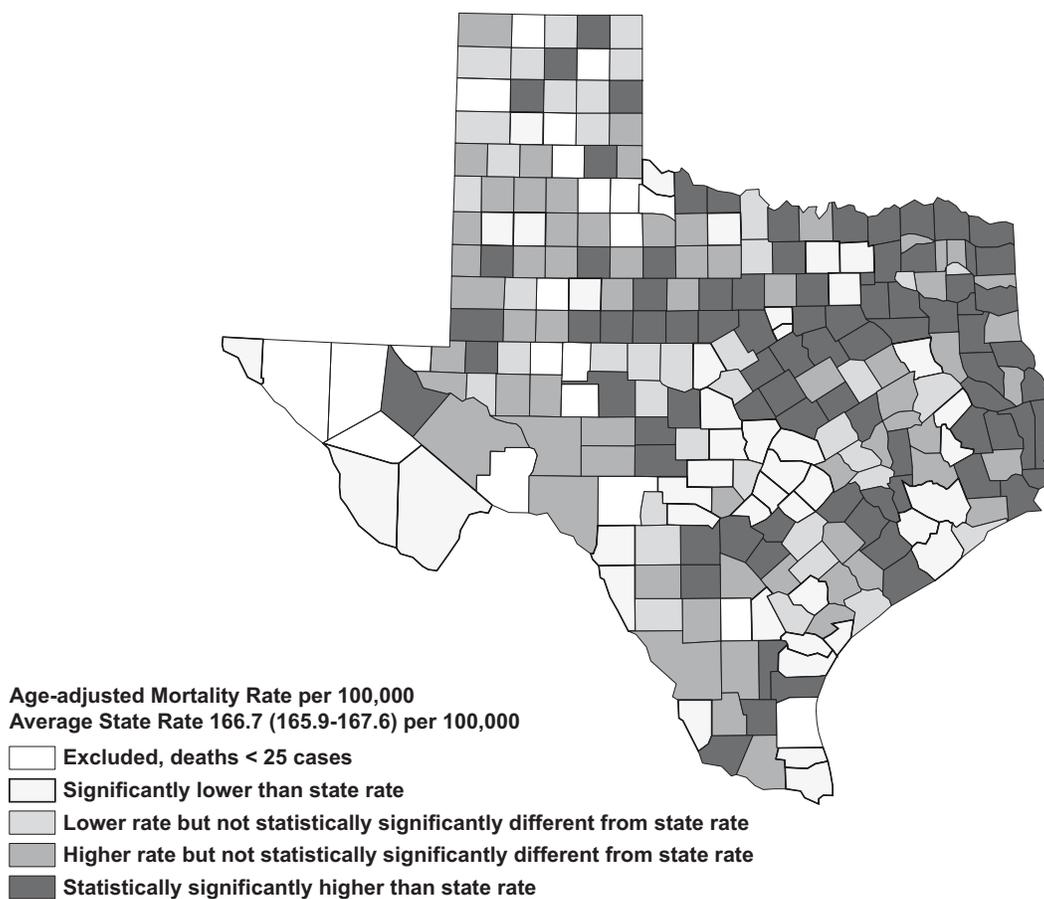
**Figure 3. Age-adjusted Mortality Rates for Ischemic Heart Disease, Texas, 1999-2005**



Data source: Texas Vital Statistical Unit, Texas Department of State Health Services, 1999-2005

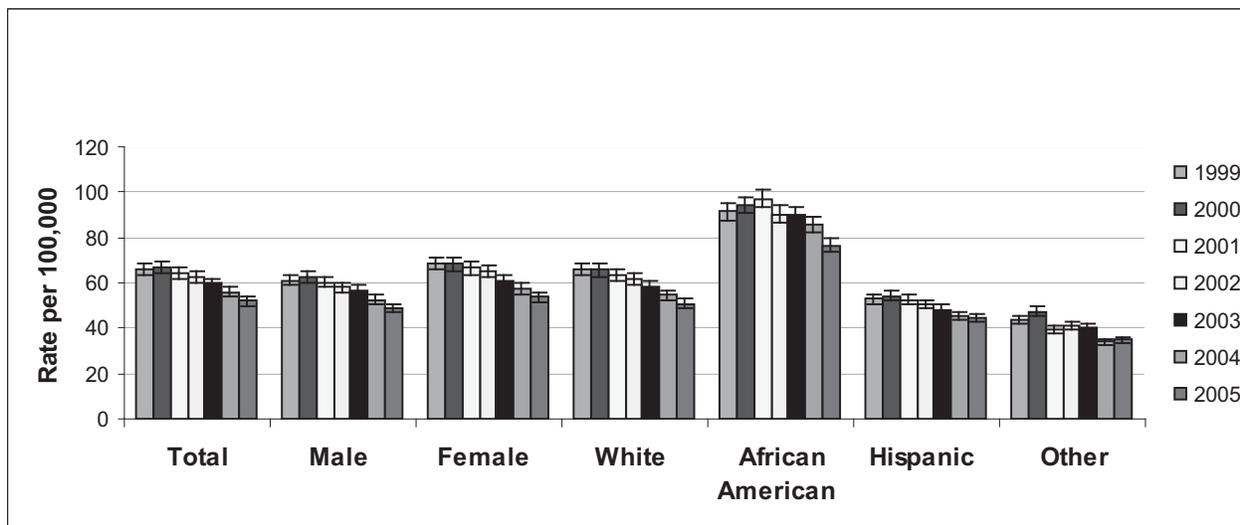
### Figure 4. Ischemic Heart Disease (ICD 10 I20-I25)

5 year Average Age-adjusted Mortality Rates for Ischemic Heart Disease, Texas, 2001-2005



Data source: Texas Vital Statistical Unit, Texas Department of State Health Services, 2001-2005

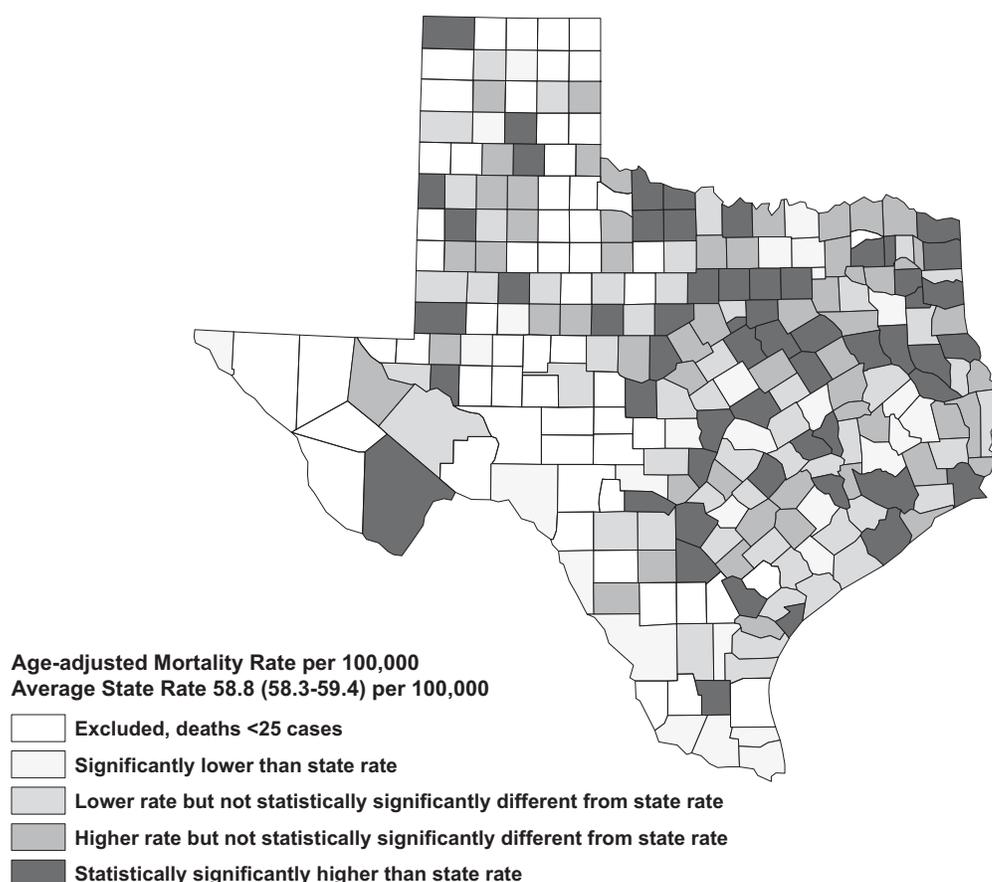
### Figure 5. Age-adjusted Mortality Rates for Stroke, Texas, 1999-2005



Data source: Texas Vital Statistical Unit, Texas Department of State Health Services, 1999-2005

## Figure 6. Stroke (ICD 10 I60-I69)

5-year Average Age-adjusted Mortality Rates Per 100,000, Texas, 2001-2005



Data source: Texas Vital Statistical Unit, Texas Department of State Health Services, 2001-2005

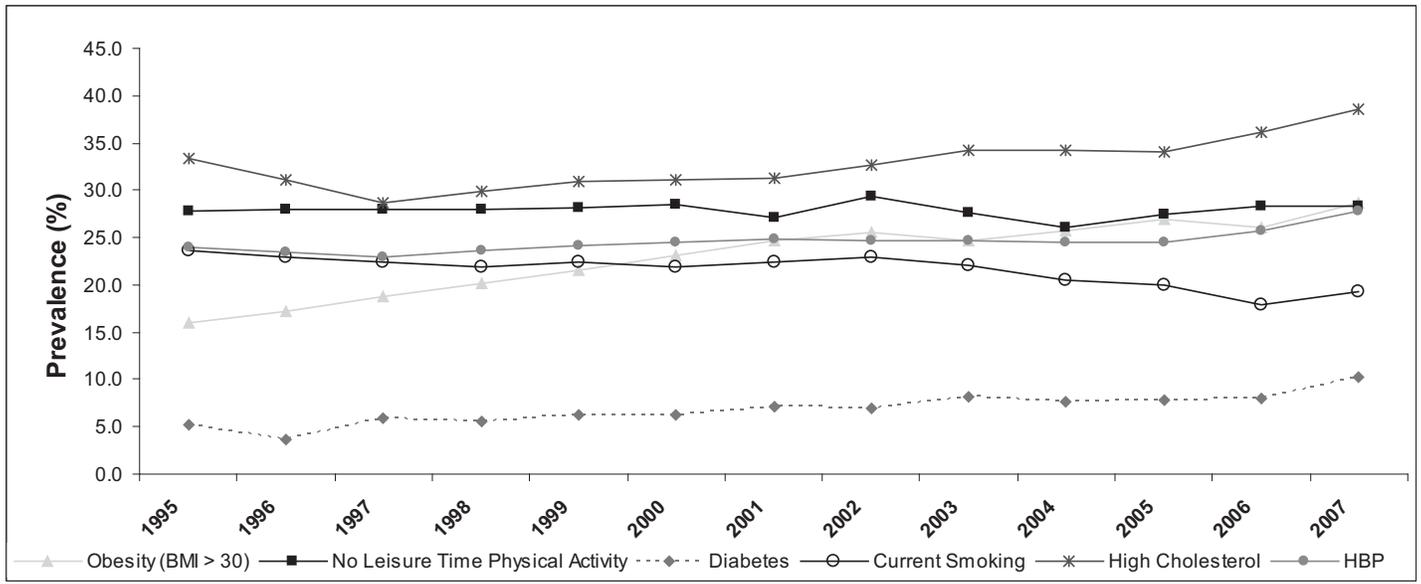
CVD mortality rates have been declining over the past 40 years. Factors affecting this decline may include more effective disease management, more emphasis on reducing controllable risk factors, and better treatment for heart attack and stroke patients. In *The Burden Report: Cardiovascular Disease & Stroke in Texas, 2008*, data show that while mortality rates due to IHD are declining, males still have a significantly higher risk of dying from IHD than females. CVD continues to be the major cause of death among Texas' minority populations. In 2005, African Americans had a higher risk of dying from IHD (190.2 deaths/100,000 population) than whites (153.3/100,000), Hispanics (139.8/100,000), and other racial/ethnic groups (71.3/100,000).

## Risk Factors

There are several factors that increase the risk of heart disease and stroke. The major non-modifiable risk factors are heredity, male gender, and increasing age. The modifiable risk factors are smoking, high cholesterol, high blood pressure, overweight and obesity, and physical inactivity. Another major risk factor for CVD is diabetes mellitus.

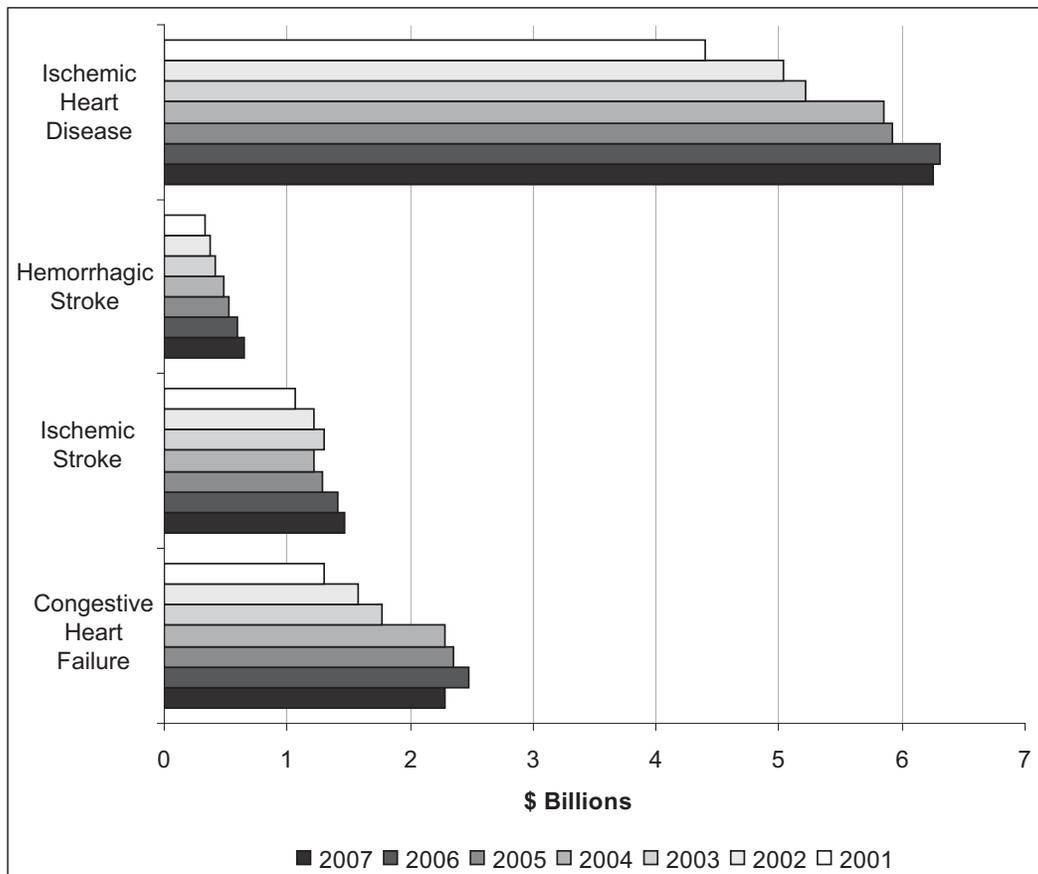
The prevention and control of the major modifiable risk factors for heart disease and stroke are critical to achieving a heart-healthy and stroke-free Texas. The council, DSHS, and collaborating partners are working to reduce these risk factors, eliminate disparities in health, and promote policy and environmental change in Texas communities.

**Figure 7. Prevalence of Risk Factors for CVD and Stroke, Texas, 1995-2007**



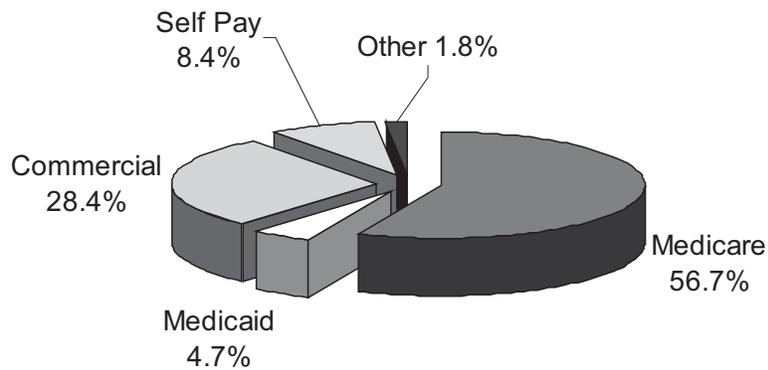
Data source: Texas Behavioral Risk Factor Surveillance System, Center for Health Statistics, Texas Department of State Health Services, 1995-2007

**Figure 8. Total Hospital Charges for Selected CVD Diagnoses, Texas, 2001-2007**



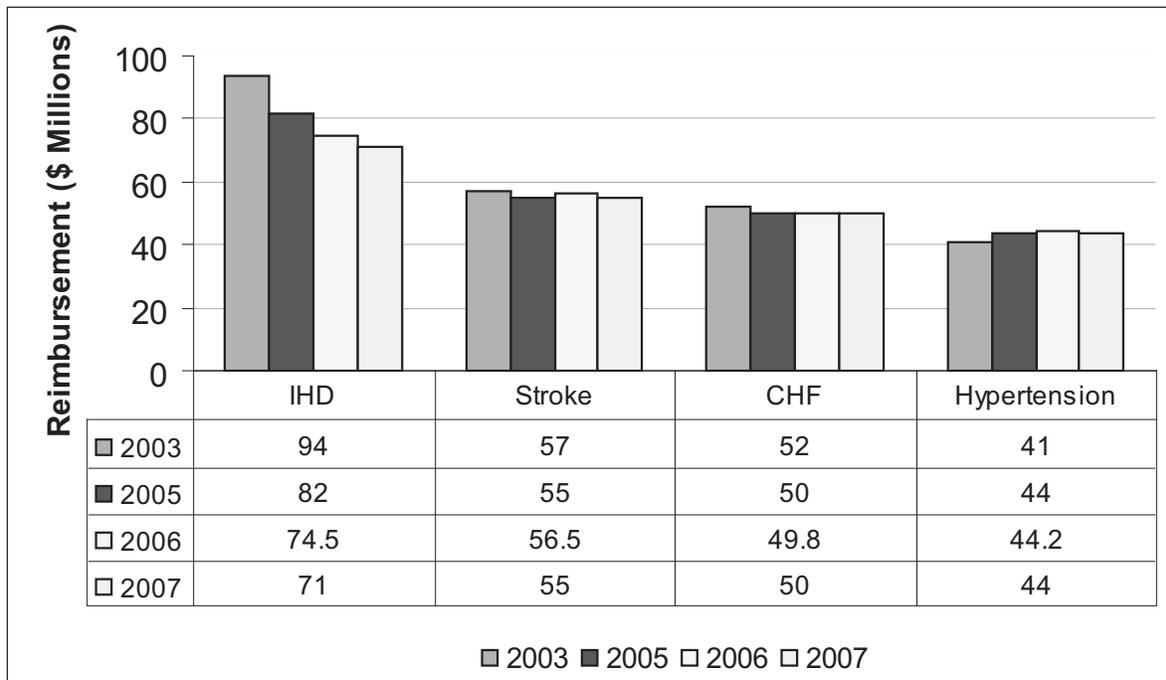
Data source: Texas Healthcare Information Collection, Texas Department of State Health Services, 2001-2007

**Figure 9. Sources of Primary Payment for Cardiovascular Disease in Texas, 2007 Hospital Discharge**



Data source: Texas Healthcare Information Collection, Texas Department of State Health Services, 2007

**Figure 10. Trends in Texas Medicaid Reimbursement for CVD, 2003, 2005, 2006, 2007**



Data source: Fee for Service and Patient Care Management clients, Texas Health and Human Services Commission, 2003, 2005, 2006, 2007

# Duty 1: Develop a State Plan

## *Texas Plan to Reduce Cardiovascular Disease and Stroke - 2008*

The council, in partnership with public and private entities, developed the first state plan in May 2002, and subsequently updated the plan in May 2005. Both plans are available on the council's website. A new state plan was completed in June 2008 with input from a wide and diverse collection of partners called the Texas Heart Disease and Stroke Prevention Partnership. The plan was released in December 2008.

The council promotes the use of four key strategies which have been included in the framework of the state plan:

- 1) Surveillance, Data, and Outcome Management
- 2) Health Education and Outreach
- 3) Community Policy and Environmental Change
- 4) Clinical Prevention and Treatment Services

Along with the four key strategies, the new state plan presents five goals that establish a framework of care across the spectrum of heart disease and stroke from primary prevention to tertiary care. The goals are stated as follows - Texans will experience improved cardiovascular health and quality of life through the:

- 1) Prevention of Risk Factors
- 2) Early Detection and Treatment of Risk Factors
- 3) Early Detection and Treatment of Heart Attacks and Stroke
- 4) Prevention of Recurrent Events

- 5) Improved State and Local Capacity to Address Heart Disease, Stroke, and Related Risk Factors

Each goal is supported by a list of measurable objectives identified from the national Healthy People 2010. The plan consists of 31 objectives and 121 strategies that can be adopted and acted upon by an individual or organization.

### **Goal I. Prevention of Risk Factors**

Goal I consists of seven objectives and 21 strategies related to increasing the number of Texans that engage in regular physical activity, eating fruits and vegetables, and reducing tobacco use.

The Texas Heart Disease and Stroke Prevention Partnership has chosen the following objective to focus on in 2009: Objective 1. Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.

### **Goal II. Detection and Treatment of Risk Factors**

Goal II consists of 10 objectives and 31 strategies intended to increase the number of Texans who are aware of their high blood pressure, high blood cholesterol, diabetes, weight status, and who learn steps to control those risk factors.

The Texas Heart Disease and Stroke Prevention Partnership has chosen the following objective to focus on in 2009: Objective 3. Increase the proportion of adults who report having had CVD, including stroke, have high blood pressure, and who are taking at least two actions (for example, losing weight, increasing physical activity, or reducing sodium intake) to help control their blood pressure.



*The State Plan calls for Texans to reduce their risk of heart attack and stroke by engaging in regular physical activity, eating fruits and vegetables, and reducing tobacco use.*

### **Goal III. Early Detection and Treatment of Heart Attacks and Stroke**

Goal III consists of six objectives and 22 strategies intended to increase the number of persons who can recognize the signs and symptoms of a heart attack or stroke and understand the importance of contacting the emergency response system in a timely manner. Strategies also focus on improving the healthcare facilities' ability to respond in timely manner with artery-opening therapies that can reduce death and long-term disability.

The Texas Heart Disease and Stroke Prevention Partnership has chosen the following objective to focus on in 2009: Objective 3. Increase the proportion of adults who are aware of the early warning signs and symptoms of heart attack, stroke, and the importance of calling 911 if a heart attack or stroke is suspected.

### **Goal IV. Preventing Recurrent Events**

Goal IV consists of four objectives and 20 strategies intended to increase the availability and awareness of therapeutic interventions

that can be used to treat persons with heart attacks or stroke and subsequently prevent second events.

The Texas Heart Disease and Stroke Prevention Partnership has chosen the following objective to work on in 2009: Objective 1. Increase utilization of appropriate therapeutic interventions and application of clinical practice guidelines for treating patients with CVD and stroke.

### **Goal V. Improved Local Capacity to Address Heart Disease, Stroke, and Related Risk Factors**

Goal V consists of four objectives and 19 strategies intended to develop stronger systems of support to monitor the burden of disease, increase the availability of resources to address heart disease and stroke prevention, and to increase communication and collaboration between the system partners and Texas communities.

The Texas Heart Disease and Stroke Prevention Partnership is committed to working on all four objectives and strategies. Infrastructure support at the state, regional, and local level is crucial to successfully implement the 2008 plan.

# Council Workgroup Activities to Implement the State Plan

## *Surveillance, Data, and Outcome Management Workgroup*

The council workgroup reviews the following data that describe the impact of CVD and stroke on the Texas population including, but not limited to:

- Mortality Data: trends in deaths per year by age, sex, race, and geographical location.
- Medicaid Data: costs paid for in-hospital, out-of-hospital, and physician services.
- Behavioral Risk Factor Surveillance System Review (BRFSS): trends in behaviors that place adults in Texas at risk for CVD and stroke.
- Heart and Stroke Healthy City Assessments: baseline measures are set and progress is reviewed on a city's actions towards the initiation of policy and environmental supports within a community, worksite, school, or healthcare site.
- Programmatic: evaluation of individual program activities to determine effectiveness and outcomes.
- Texas Healthcare Information Collection: trends in hospital discharge data for ischemic heart disease, congestive heart failure, ischemic stroke, and hemorrhagic stroke.
- Youth Risk Behavioral Survey (YRBS): behavioral trends among youth in grades nine through 12 that put them at risk for CVD and stroke.
- Texas Association of Community Health

Centers: aggregate health outcome data from participating community health centers collected through the Secondary Prevention of Heart Disease and Stroke project registry.

This workgroup provides input to the DSHS CHW Program in the development of the yearly fact sheets, burden document, and powerpoint presentations available on the DSHS and council website. The workgroup also makes recommendations to DSHS and stakeholders about programs that should be considered for implementation or target populations upon which more intense interventions should be focused.

## *Health Education and Outreach Workgroup*

The council collaborated with partners to promote health education, public awareness, and community outreach activities. A key program activity supported by the council is the Texas Cardiovascular Health Promotion Awards.

### **Texas Cardiovascular Health Promotion Awards**

These awards have been given annually since 2002. They identify and recognize entities in the categories of healthcare, school, worksite, and community that have implemented innovative and effective programs to improve treatment, prevention, and public awareness of heart disease and stroke. Entities competing for the awards must demonstrate not only their efforts to help targeted audiences recognize the impact of the risk factors for heart disease and stroke, but they must also demonstrate a reduction in those risk factors or improvement in the care for persons with heart

disease or stroke.

## 2008 Award Winners

The following organizations were recognized at the Texas Public Health Association Annual Conference held in March 2008.

### Outstanding Program Recognition:

GET FIT Lubbock – Texas Tech University, Garrison Institute on Aging

Bringing Patient to Care – Living Without Limits! Learning to Manage Cardiovascular Diseases and Diabetes – Midland Community Healthcare Services (MCHS)

Conozca Su Corazón – American Heart Association, Pharr

Eddy Scurlock Stroke Center – The Methodist Hospital, Houston

CVD/Stroke Community Center – Brain and Spine at Brackenridge a member of the Seton Family of Hospitals, Austin

### Honorable Mention Program Recognition:

Don't Smoke Your Life Away – Julie Rogers "Gift of Life" Program, Beaumont

Diabetes Community Action Plan – CHRISTUS Spohn Health System, Corpus Christi

Por la vida, el rojo – Vestido Rojo – American Heart Association, Pharr

Walk Across Texas In Potter and Randall County – DSHS Health Service Region 1, Canyon

Hillcrest Wellness Program – Hillcrest Baptist Medical Center, Waco

Outstanding programs received an engraved plaque and recognition on the council website.

Honorable mention programs received a mounted

certificate and recognition on the council website.

## Community Policy and Environmental Change Workgroup

### Heart and Stroke Healthy City Recognition Program

The Heart and Stroke Healthy City Recognition Program was developed in August 2003 by the council in partnership with a group of public and private organizations. This planning group included representatives from health, business, and school settings. The group identified ten community-based indicators that are vital to reducing the burden of heart disease and stroke. The indicators reflect evidence-based strategies for policy, systems, and environmental changes that, when implemented in a community, will have the greatest public health impact.

Members of the group also identified criteria for each community-based indicator to determine the level at which the indicator is considered met, partially met, or not met. The indicators and their criteria represent policy, system, and environmental changes occurring community wide, at worksites, at schools, and within systems of healthcare. The DSHS CHW Program implements the Recognition Program for the council.

### Heart and Stroke Healthy City Indicators

- 1) CVD and stroke media campaigns are provided in the community.
- 2) Physical activity areas are designated, safe, accessible, and promoted.
- 3) Healthy food options are accessible and promoted.
- 4) Public schools (grades K-8) comply with all legislated components of a coordinated school health program and daily physical activity.

- 5) Moderate to strong city smoking ordinances are in place.
- 6) CPR classes are available.
- 7) A plan is in place to reduce disparities in CVD and stroke.
- 8) Defibrillators (manual and/or automated external) are available.
- 9) Stroke is treated as a medical emergency in the community and appropriate acute stroke treatment protocols are in place.
- 10) Healthcare facilities in the community promote primary and secondary prevention of CVD and Stroke.

## Recognition Levels

The CHW Program contacts each city and uses an assessment tool to collect information on each indicator. The council reviews this information and determines if the indicator is met, partially met, or not met in each city. Cities can score between 0 (no indicators met) and 40 (all indicators met). Cities scoring 30 and above may be eligible for a recognition award:

- Gold Level – A perfect score of 40 with all indicators met
- Silver Level – A score of 35 or greater, no “indicator not met,” and no more than two “indicator partially met”
- Bronze Level – A score of 30 or greater, no “indicator not met,” and no more than five “indicator partially met”
- Honorable Mention – A score of 30 or greater and only one “indicator not met”

## 2007 Metropolitan City Assessments:

During 2007, six metropolitan (metro) areas (population  $\geq$  500,000) were assessed: Austin, Dallas, El Paso, Fort Worth, Houston, and San Antonio. This is the third time the metro cities have

been assessed since the program started in 2003.

## Metro Results

Five of the six metro cities demonstrated improvement in their scores since the first assessment in 2003 (23.5 percent increase in combined scores). Two cities demonstrated a steady increase in their scores over the three assessments. One city improved its score between 2003 and 2005 and remained at that level for 2007. Three cities experienced a drop in their overall score between 2005 and 2007.

The metro cities combined demonstrated improvement in four indicators since 2005: accessibility of physical activity areas and programs, coordinated school health and physical activity in schools, availability of CPR classes, and a plan to reduce disparities. Combined scores dropped in five indicators and remained level in one.

All cities continued to provide media campaigns to raise awareness of CVD, stroke, and related risk factors with five meeting all criteria for the indicator. All six cities completely met the indicator for accessibility of physical activity areas and programs. Four of the six cities need to improve access to healthy food options. All but one city is implementing legislative mandates to provide coordinated school health programs, daily physical activity in grades K-8, and active School Health Advisory Councils. One city, Houston, joined El Paso and Austin in having a strong city smoking ordinance. All six cities are providing CPR training using nationally recognized programs. Five of the six cities have a plan in place to address disparities in CVD and stroke. Half of the cities met all criteria for having automated external defibrillators in place and adequate transport times for heart attack and stroke. Half of the cities met all criteria for treating stroke as an emergency and having adequate stroke protocols and treatment centers in place. The other half partially met this indicator and are working to make improvements. In all but one city, healthcare sites met the indicator for promoting primary and secondary prevention of CVD and stroke.

## 2008 Award Presentations:

In 2008, four metro cities were recognized for their levels of achievement. Council members presented awards during city council meetings and a press release announced the awards.

Metro Cities Recognized With an Award:

Gold Level – Austin and Houston

Silver Level – El Paso

Bronze Level – No awardees

Honorable Mention – Fort Worth

## 2008 Small and Mid-Size City Assessments:

During the later part of 2008, fourteen small (population  $\leq 99,999$ ) and ten mid-sized (population 100,000-499,999) cities were scheduled for assessment; however, the assessment of four cities was postponed until 2009 due to Hurricane Ike recovery efforts. The 2008 assessment saw milestones in several areas.

For the first time, a majority of the 2008 assessments were conducted by local stakeholders through a team effort with one local liaison collecting and transferring assessment data

to CHW staff. Several local liaisons, including city health officials, have remarked that their level of awareness of CVD and stroke activities, programs, and policies in their communities has increased. City business leaders are becoming involved in the assessment process with an interest in having their city recognized as a heart and stroke healthy city. Community stakeholders are working actively to increase their scores and cities not a part of the program in the past have asked to be included. One metro city, dissatisfied with its 2007 score, asked to be reassessed based on new information.

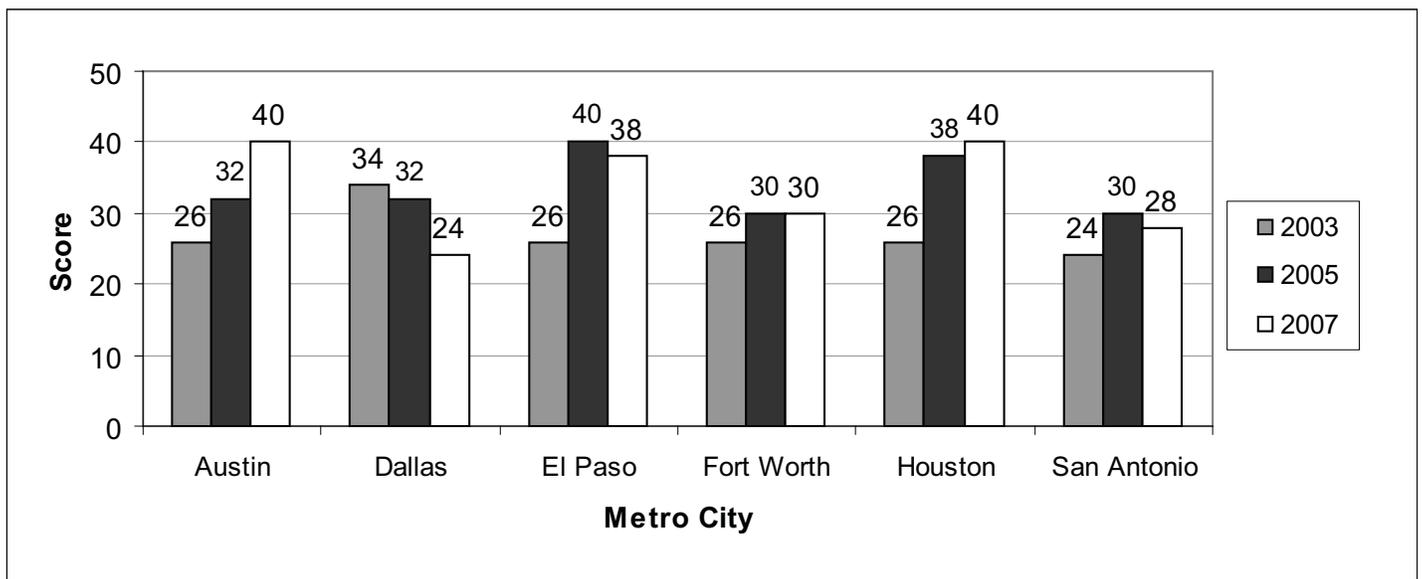
Clearly, the awards bestowed by this program are highly valued by city officials, with increased buy-in from community stakeholders and competition between cities. The awards are valued not only from a health standpoint, but also from a business perspective.

In the early part of 2009, the council will conduct the small and mid-sized city assessments and will present awards to those cities with meritorious scores.

## 2009 Improvements in the Program

During 2008, stakeholders with expertise in each

**Figure 11. Metro Scores 2003, 2005, 2007**



Data source: Cardiovascular Health and Wellness Program, Texas Department of State Health Services, 2003-2007

of the indicator areas were asked to recommend improvements to the criteria based on the most current evidence. The indicators were revised based on these recommendations and will be pilot-tested in two cities in early 2009. Results will be used to make final changes before the 2009 assessment year begins. CHW staff will increase the level of technical assistance made available to cities to assist them in meeting the criteria and increasing their scores. The Heart and Stroke Healthy City Recognition Program Toolkit will be revised to make it easier for cities to self assess, stay engaged, document their indicators more often than every two years, and potentially be recognized annually for their achievements. Regional training provided by the CHW Program will target communities with low scores.

## **Stroke Systems of Care (SSC) Initiative**

An SSC Initiative was created by the CHW Program in collaboration with the DSHS Office of EMS and the American Heart Association – South Central Affiliate. The initiative focuses on the implementation of the recommendations made by the Governor’s EMS and Trauma Advisory Council (GETAC) Stroke Committee. The four recommendations included:

- 1) Developing a state stroke center designation process,
- 2) Development of regional stroke transport plans,
- 3) Providing EMS training on stroke, and
- 4) Implementing public awareness initiatives.

The council is required to work with the GETAC in the development of the recommendations. The CHW Program is working with the 22 Regional Advisory Councils (RACs) that oversee the Trauma Service Areas. The RACs were offered support in developing regional stroke committees, stroke transport protocols, and EMS training.

All 22 RACs participated in the SSC initiative.

Over half of the RACs have developed RAC stroke committees. The CHW Program and AHA offered 5,000 online training programs to EMS personnel. Over 2,500 key codes for educational training have been assigned and over 1,000 trainings have been completed. Key codes are assigned to EMS licensed agencies, 911 dispatchers, EMT - Basic through Intermediate personnel, and to hospital stroke coordinators. DSHS and AHA continue to support the development of stroke transport plans and designated stroke centers.

## ***Clinical Prevention and Treatment Services Workgroup***

### **Texas Cardiovascular (CV) Quality Initiative**

The Texas CV Quality Initiative was created by healthcare stakeholders to develop a statewide consensus on high priority actions to improve treatment of CVD and stroke. Participants identified nationally recognized treatment guidelines that should be adopted by all healthcare providers. Stakeholders also recommended actions to promote the guidelines and increase physician participation in quality improvement programs.

Evidence-based primary and secondary guidelines for the prevention and treatment of CVD and stroke are promoted on the council website at: [www.texascvdcouncil.org](http://www.texascvdcouncil.org).

## **Reaching Uninsured and Underinsured Populations**

### **Secondary Prevention of Heart Disease in the Medicaid Population Project**

The council received \$250,000 in 2004 and 2005 from the Texas Health and Human Services Commission - Medicaid Program to implement the Secondary Prevention of Heart Disease in the

Medicaid Population Project. DSHS acts as the fiscal agent and representative for the council.

The first year's focus was to determine the level of care provided to Medicaid clients by the private healthcare sector. The second year took a more comprehensive focus within the community health center (CHC) setting. The goal is to reduce heart disease and stroke by ensuring that healthcare providers have the knowledge, skills, and tools needed to provide the recommended level of care to their patients.

The most widely accepted set of CVD and stroke measures are those established by the American Heart Association/American Stroke Association/National Committee for Quality Assurance (NCQA) Heart/Stroke Recognition Program (HSRP), which are based on American Heart Association/American Stroke Association clinical guidelines and are listed in Table 1.

web-based learning sessions on clinical system processes and treatment guidelines for heart disease, stroke, and diabetes. Staff entered their clinical and office process information into a data-collection system that provided more real-time feedback to the clinics on the progress of their system development and clinical measures.

In May 2008, centers reported that 56 percent of their clients were uninsured, 14 percent were on Medicaid, 69 percent were Hispanic, 78 percent had hypertension yet only 33 percent were in control, 79 percent had a body mass index of 25 or higher, 69 percent had high blood lipid levels, and 62 percent had diabetes. By August, many of the clinical measures had shown improvement. (See Table 2 on page 21.)

**Table 1. American Heart Association/American Stroke Association Clinical Guidelines**

<i>Measure:</i>	<i>Required % of Patient Sample</i>
1. <i>Blood pressure control &lt;140/90 mm Hg</i>	75%
2. <i>Complete lipid panel</i>	80%
3. <i>LDL control &lt;100 mg/dl</i>	50%
4. <i>Use of aspirin or another antithrombotic</i>	80%
5. <i>Smoking status and cessation advice and treatment</i>	80%

A contract was negotiated with the Texas Association of Community Health Centers (TACHC), in collaboration with the DSHS Diabetes Program, from September 2007 through August 2008. The funding supported the inclusion of five CHCs in a year long system improvement learning collaborative called Optimizing Clinical Care. Centers agreed to collect baseline and monthly clinical measure data on their patients with CVD. The purpose of the collaborative is to improve a patient's health through timely access to a clinic that follows recognized standards of care guidelines.

The participating CHCs were located in Austin, Houston, Midland, San Antonio, and Waco. The clinic staff participated in on-site, email, and

The baseline information entered in the data-collection system provides a snapshot of the current status of heart disease, stroke, and diabetes in these select CHC clinics and is a crucial mechanism for identifying those at high risk for disability and premature death.

### **Awareness, Control, and Treatment of High Blood Pressure in Hispanics Project**

The council conducted a high blood pressure initiative to improve blood pressure control in Hispanics accessing the Gateway CHC in Laredo, Texas. Funding was provided through a \$100,000 one-year grant from the Novartis Pharmaceutical Corporation. The initiative focused

on two populations: 1) clinic clients with high blood pressure and 2) large employers in Laredo.

## Clinic Intervention

Gateway CHC reviewed its current clinic-flow practices to identify patients with uncontrolled high blood pressure. Clinic healthcare providers were then trained on current high blood pressure treatment practices. An educational intervention and physical activity program for patients was developed and clinic providers referred appropriate clients into the program. Results to date include:

- The Gateway CHC saw 23,072 clients between September 2007 and August 2008. Ninety-nine percent were Hispanic and 2,211 were identified as having high blood pressure (HBP).
- One hundred and ninety-seven Hispanic clients with HBP were enrolled in a nine month lifestyle intervention program that taught self management techniques to reduce weight, increase physical activity, eat more nutritious foods, and decrease the use of tobacco.
- At the beginning of the intervention program, 61 percent had uncontrolled HBP, 90 percent were overweight or obese, 68 percent were inactive, 7 percent were current smokers, and 75 percent ate less than the recommended

servings of fruits and vegetables.

- At the conclusion of the intervention program, only 20 percent had uncontrolled HBP and 80 percent had reduced their HBP to meet the target goals. (Target goals are < 140/90 for those with HBP alone and <130/80 for persons with HBP and diabetes.)

Gateway CHC clients are scheduled for follow-up appointments every three months to monitor their conditions.

## Worksite Intervention

Two of the largest employers in Laredo were enrolled in the program – Laredo Independent School System (> 4500 employees) and United Independent School System (> 5900 employees). School administrators and nurses were educated on the following comprehensive worksite approaches to improve employee health and reduce heart disease and stroke: 1) Awareness events (health fairs, Lunch and Learns, etc.); 2) Lifestyle Change Programs (ongoing classes that train on CPR); 3) Weight loss, smoking cessation, and physical activity; 4) Policy and systems changes in the facilities or health benefits (walking trails, healthy food options in the cafeteria, health insurance coverage for screenings and treatment).

**Table 2. Selected CVD Registry Data for the Secondary Prevention of Heart Disease in the Medicaid Population Project, May 2008 and August 2008**

<i>Condition</i>	<i>May 2008</i>	<i>August 2008</i>
<i>CVD</i>	<i>12,166</i>	<i>12,562</i>
<i>Hypertension</i>	<i>9991</i>	<i>10,324</i>
<i>Hypertension documented within last 12 months</i>	<i>8,989</i>	<i>9,206</i>
<i>% with BP taken in last 12 months</i>	<i>74%</i>	<i>89%</i>
<i>Hypertension in control</i>	<i>4143</i>	<i>4,206</i>
<i>% in control</i>	<i>34%</i>	<i>41%</i>
<i>Low-density lipoprotein (LDL) tested</i>	<i>624</i>	<i>697</i>
<i>LDL in control</i>	<i>300</i>	<i>348</i>
<i>% in control</i>	<i>48%</i>	<i>50%</i>

Results include:

- Health risk screening programs were offered to the employees and over 1,243 educational packets on preventing heart disease and stroke were provided at the worksites.
- School administrators are negotiating with their insurance broker to determine the feasibility of offering free or reduced co-pays for lab work and office visits.
- Worksite wellness coordinators were identified at the two school districts and new worksite wellness plans were being developed.

## Media Campaign

A media campaign was aired on the radio in Laredo, and 102 spots ran from July 21, 2008 to August 31, 2008. Public service announcements also ran concurrently during the same time period.

### CAMPAIGN MESSAGE 1

Many people are becoming aware that GOOD HEALTH is not an accident, but the result of a proper lifestyle. The choices we make each day regarding exercise, eating, smoking, drugs, and our mental attitude, all have a profound effect on how long we live and the degree of health we enjoy. Gateway Community Health Center with the collaboration of the Texas Cardiovascular Disease and Stroke Council invite ALL school district employees, board members, and adult family members to participate in their year long education and fitness wellness program. Once again lab work along with glaucoma screenings and a risk assessment will be offered. Do you know your numbers? Cholesterol, glucose, and blood pressure? We can help you learn your numbers. Check your school websites for times and locations.

### CAMPAIGN MESSAGE 2

Do you know the ABC's of high blood pressure?

Awareness, Behavior, and Change.

Awareness: Be aware of the risk factors beyond your control....Family history.

Behavior: You can decrease your chances of getting high blood pressure or making it worse by: Quitting smoking; maintaining a healthy weight; getting 30 minutes of physical activity most days of the week; having no more than two drinks of beer, wine, or hard liquor each day; avoiding stress or at least decreasing it; reducing your salt and sodium intake.

Change: High blood pressure cannot be cured , but you and your doctor can help control or prevent it by: Not smoking or better yet never start, losing weight if you are overweight, using less salt, getting and staying physically active, limit your alcohol use, if prescribed take your medications regularly.

Gateway Community health center with the collaboration of the Texas Cardiovascular and Stroke Council invite all school district employees, board members, and adult family members to participate in their year long education and fitness wellness program. Once again Gateway will be offering lab work and a risk assessment. We can help you learn your ABC'S. Check your school websites for time and locations.

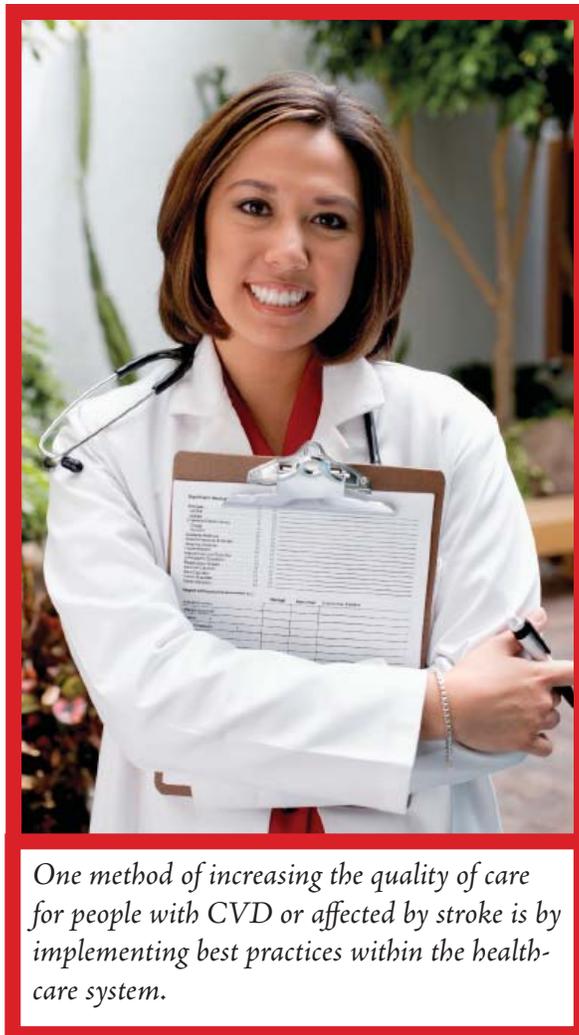
# Duty 2: Database of Clinical Resources

The council and CHW Program continue to support the Texas Cardiovascular Quality and Patient Safety Initiative. The initiative identifies best practices to increase the quality of care for people with CVD or affected by stroke.

The following programs are available for use on the council website at [www.texascvdcouncil.org](http://www.texascvdcouncil.org):

## Promotion of Nationally Recognized Treatment Guidelines

Nationally recognized best practices for the achievement of quality improvement standards are identified on a continual basis. The American Heart Association/American College of Cardiology guidelines for secondary prevention of CVD and stroke continue to be those best suited for promotion in the state. Information and toolkits



for use by healthcare providers and the public include **The Physician Toolkit**, which consists of **Patient Tracking Forms** and **Prescription Pads** to promote primary and secondary prevention methods, and resource links to national organizations that have educational materials available for download or purchase.

## Recognition of Healthcare Providers

Healthcare providers are recognized online through the **Texas Cardiovascular Quality Recognition Program**. The program lists hospitals and healthcare providers that have met the appropriate requirements to achieve national recognition for implementing and meeting

evidence-based quality of care practice standards.

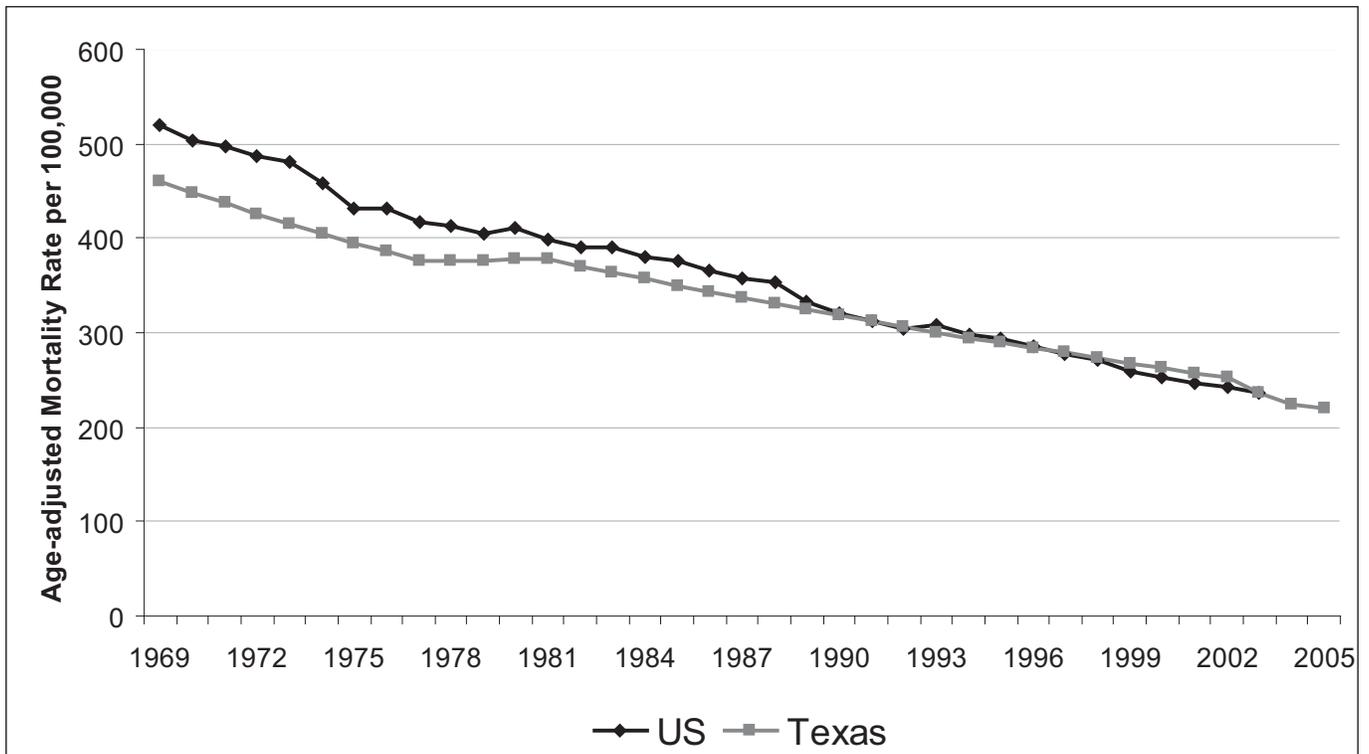
# Duty 3: Data Collection

The council collaborates with the various agencies and organizations currently engaged in collecting, monitoring, and evaluating CVD and stroke health data. The DSHS CHW Program collects, analyzes, and reports on the burden of heart disease and stroke in the state. *The Burden Report: Cardiovascular Disease & Stroke in Texas* was created to report data using BRFSS data, mortality data, hospital discharge data, Medicaid data, and EMS/Trauma registry data. The Executive Summary of the Burden Report provides the following highlights:

## Highlights

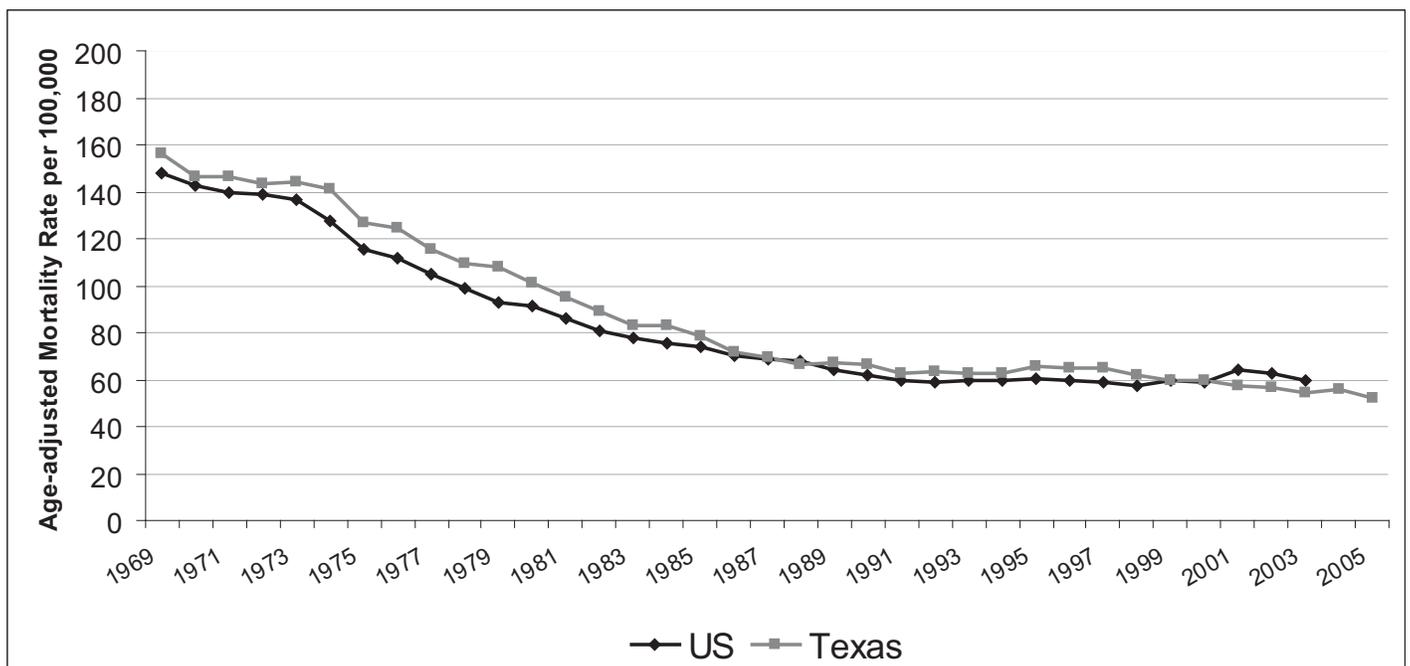
- Cardiovascular disease (CVD) and stroke are serious and costly diseases, costing the Texas Medicaid Program over \$200 million in paid medical claims.
- Heart disease is the leading cause of death in Texas.
- Stroke is the third leading cause of death in Texas.
- 32 percent of all deaths in Texas in 2005 were due to heart disease and stroke, more than any other cause.
- In Texas and the U.S., during the period from 1969-2005, age-adjusted mortality rates for CVD steadily declined.
- Age-adjusted mortality rates for ischemic heart disease declined from 202.4 per 100,000 in 1999 to 151.8 per 100,000 in 2005.
- Age-adjusted mortality rates for stroke declined from 66.3 per 100,000 in 1999 to 52.1 per 100,000 in 2005.
- Overall, hospitalization charges for CVD and stroke in Texas were over \$10 billion in 2007.
- In 2007, 18 percent of adult Texans (18 years and older) with CVD or stroke stated they did not have any type of healthcare coverage, 25 percent could not see a doctor due to the cost, and 20 percent did not have a routine checkup within the past year.
- In 2005, only 9 percent of adult Texans could correctly identify all heart attack signs and symptoms. Eighty-five percent could recognize 911 as the first emergency response option for heart attack and stroke.
- In 2005, only 17 percent of adult Texans could correctly identify all stroke signs and symptoms.
- In 2007, more than 27 percent of adult Texans were diagnosed with high blood pressure.
- In 2007, 38 percent of adult Texans were diagnosed with high blood cholesterol.
- Between 1995 and 2007, the percentage of overweight and obese adults increased from 51.4 percent to 65.7 percent.
- The prevalence of diabetes, a major risk factor for CVD, has nearly doubled over the past decade in Texas.
- In 2003 and 2004, the average emergency medical services (EMS) response time for a suspected cardiac event was approximately 8 minutes from “Call Received Time to Time EMS Arrived on the Scene” and nearly 40 minutes from “Call Received Time to Time EMS Arrived at Destination (hospital).”

**Figure 12. Heart Disease Mortality Trends, US and Texas, 1969-2005**



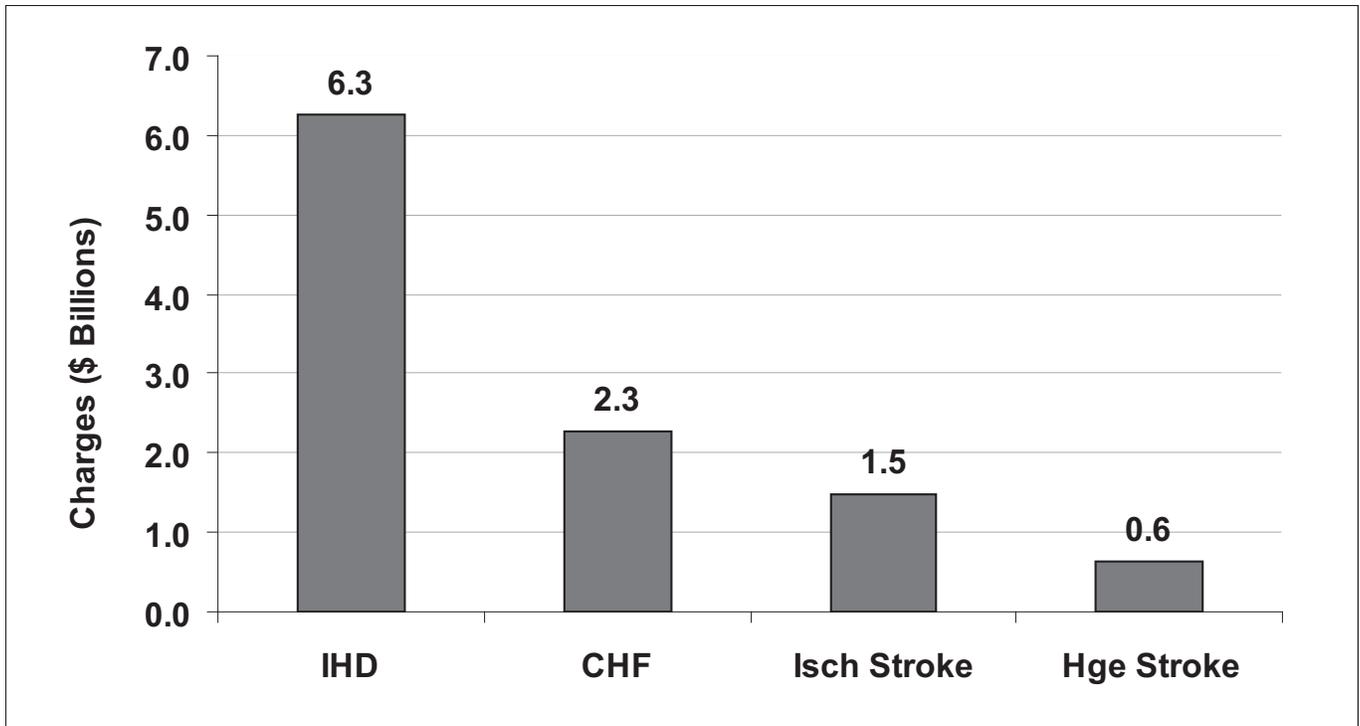
*Data source: Texas Vital Statistical Unit, Texas Department of State Health Services, 1969-2005*

**Figure 13. Stroke Mortality Trends, US and Texas, 1969-2005**



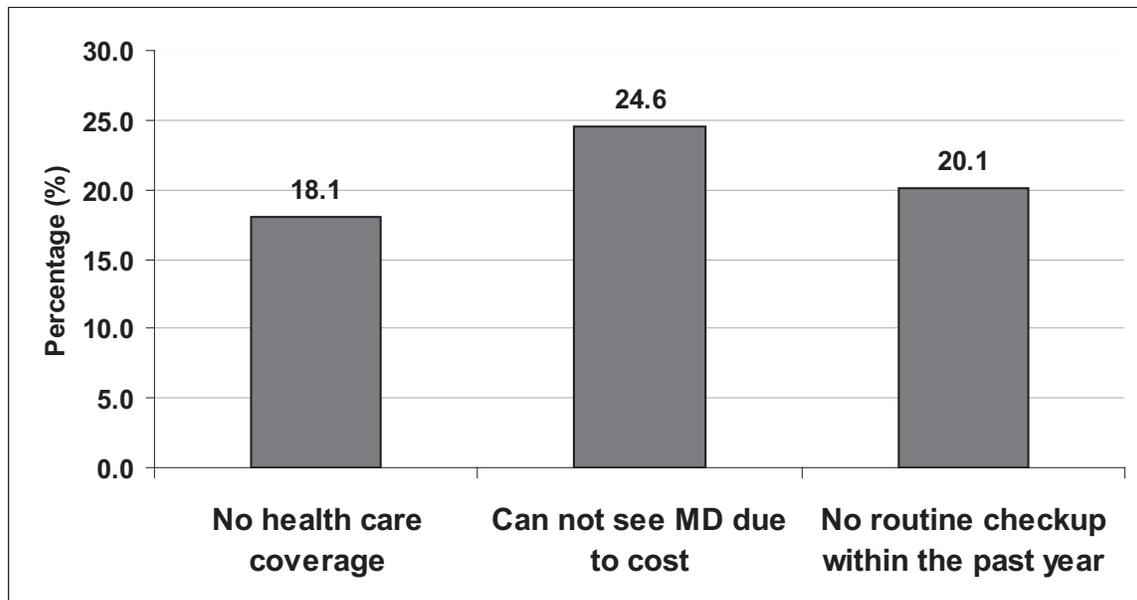
*Data source: Texas Vital Statistical Unit, Texas Department of State Health Services, 1969-2005*

Figure 14. Total Hospital Charges for Selected CVD Diagnoses, Texas 2007



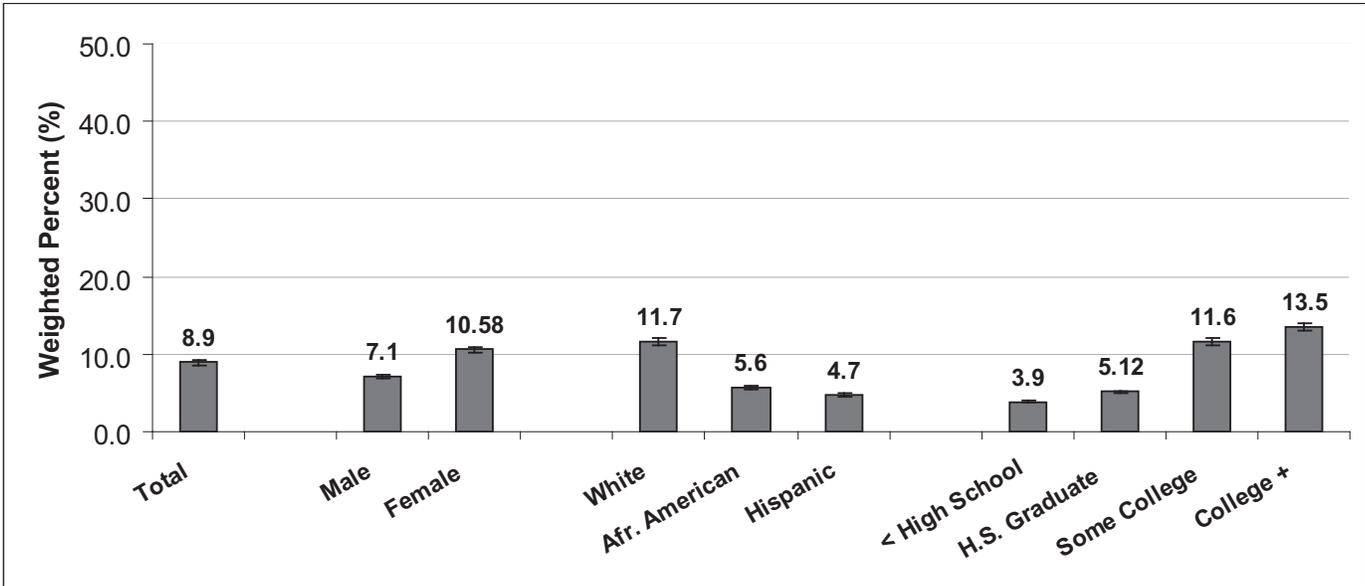
Data source: Texas Healthcare Information Collection, Texas Department of State Health Services, 2007

Figure 15. Percentage of Texans who report no health insurance, can not see doctor due to cost, and no health checkup within the past year, Texas, 2007



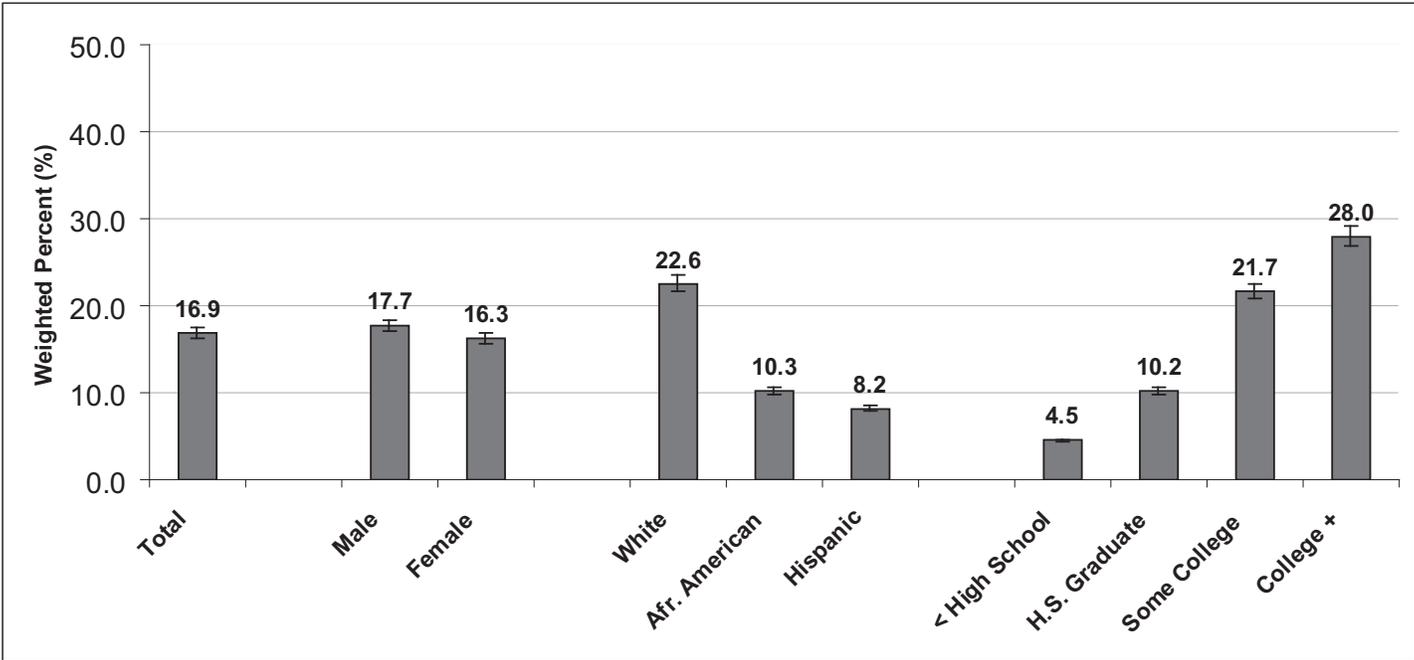
Data source: Texas Behavioral Risk Factor Surveillance System, Texas Department of State Health Services, 2007

**Figure 16. Percentage of Adult Texans who Recognize All Heart Attack Symptoms, Texas, 2005**



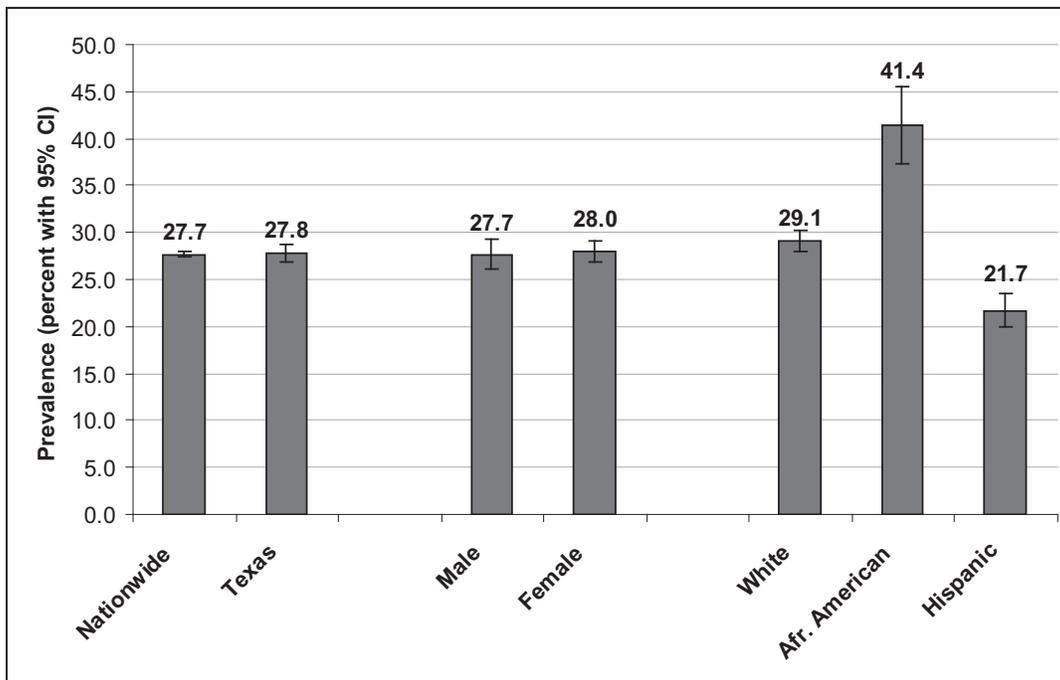
Data source: Texas Behavioral Risk Factor Surveillance System, Texas Department of State Health Services, 2005

**Figure 17. Percent of Adult Texans who Recognize All Stroke Symptoms, Texas, 2005**



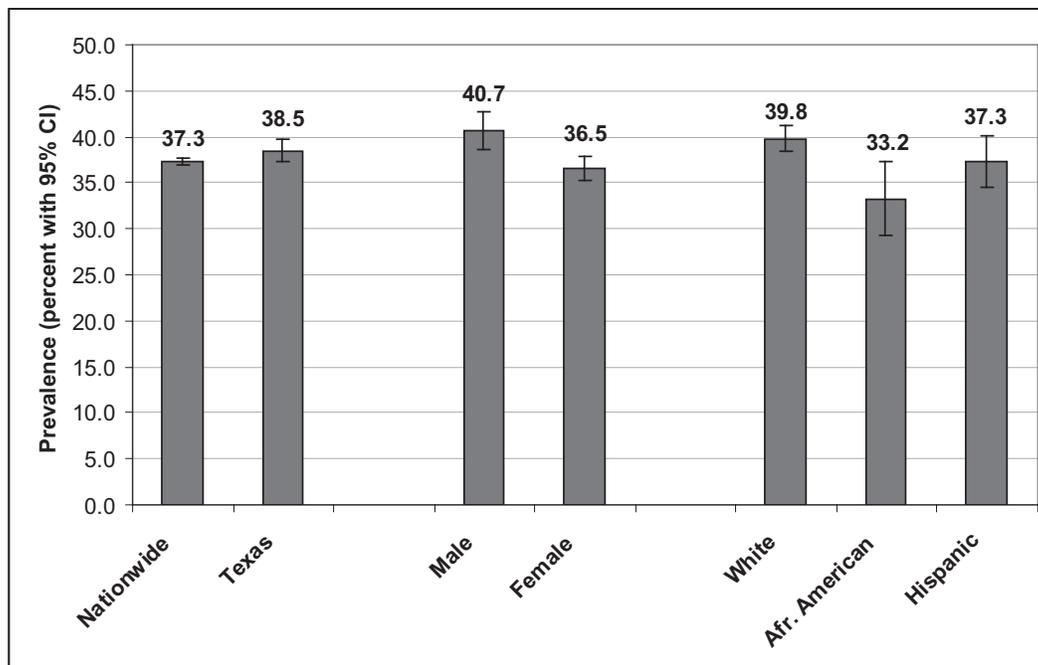
Data source: Texas Behavioral Risk Factor Surveillance System, Texas Department of State Health Services, 2005

**Figure 18. Prevalence of High Blood Pressure by Gender and Race, Texas, 2007**



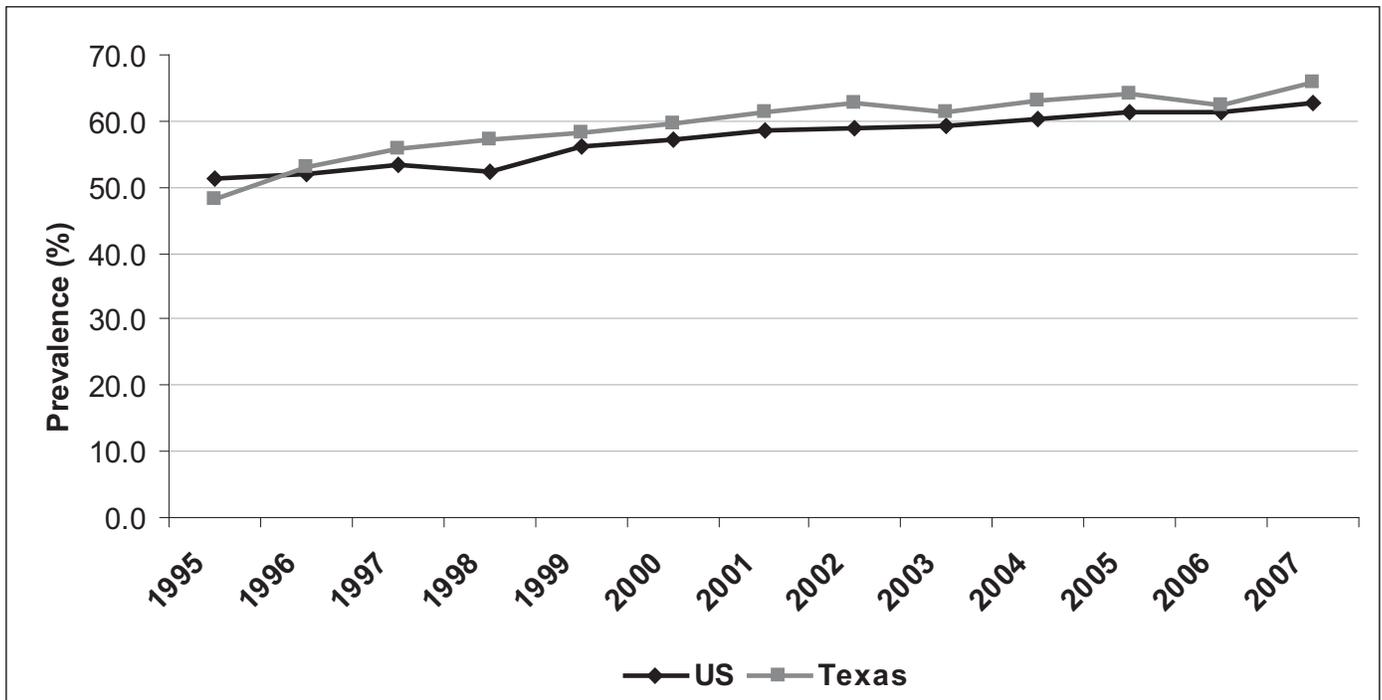
Data source: Texas Behavioral Risk Factor Surveillance System, Texas Department of State Health Services, 2007

**Figure 19. Prevalence of High Blood Cholesterol by Gender and Race, Texas, 2007**



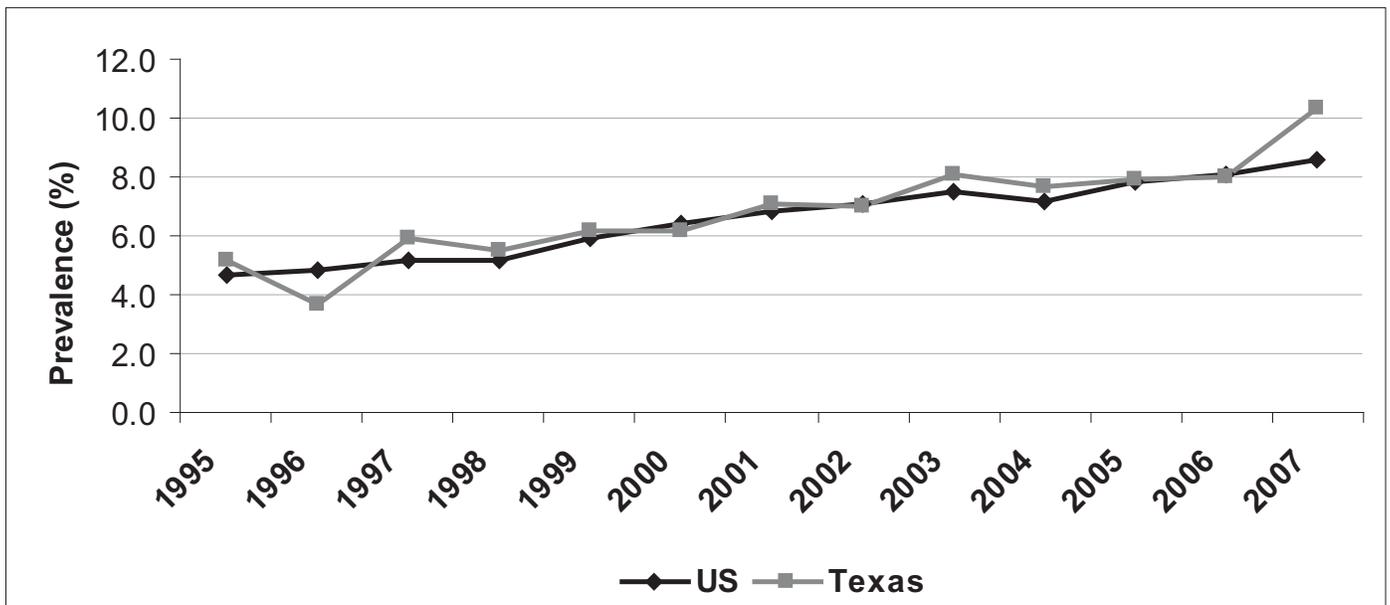
Data source: Texas Behavioral Risk Factor Surveillance System, Texas Department of State Health Services, 2007

**Figure 20. Prevalence of Overweight or Obesity Among Adults, Texas and US, 1995-2007**



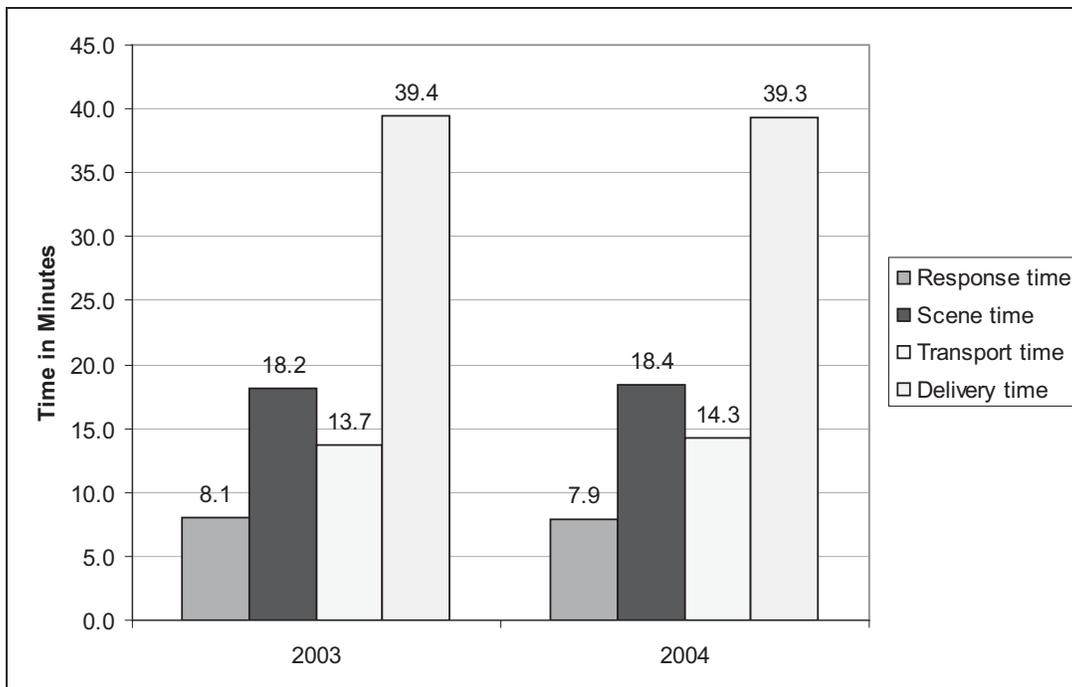
*Data source: Texas Behavioral Risk Factor Surveillance System, Texas Department of State Health Services, 1995-2007*

**Figure 21. Prevalence of Diabetes Among Adults, Texas and US, 1995-2007**



*Data source: Texas Behavioral Risk Factor Surveillance System, Center for Health Statistics, DSHS, 1995-2007*

**Figure 22. EMS Response Time in Minutes for CVD, Texas, 2003 and 2004**



*Data source: Texas EMS/Trauma Registry, 2003, 2004*

# Future Activities of the Council

During 2009, the council will collaborate with the Texas Heart Disease and Stroke Prevention Partnership on the implementation of the new state plan focusing on the objectives identified by the Partnership. The council will also continue with the following activities:

## Action Steps

### Surveillance, Data, and Outcome Management

- Disseminate *The Burden Report: Cardiovascular Disease and Stroke in Texas* and fact sheets.
- Continue reviewing the available data to identify the trends in the burden of heart disease and stroke in Texas and the populations that suffer a disproportionate share of the burden.
- Make recommendations on actions to address noted disparities.

### Health Education and Outreach

- Implement the Cardiovascular Health Promotion Awards.
- Coordinate with various associations to provide chronic disease education programs at educational conferences.
- Develop plans to educate the public on heart disease and stroke.

### Community Policy and Environmental Change

- Continue the Heart and Stroke Healthy City Recognition program.
- Disseminate the Heart and Stroke Healthy City Recognition Program Toolkit to cities for use when planning activities to meet program indicators.
- Collaborate with the American Heart Association - South Central Affiliate to develop task forces in communities that have been assessed and assist cities in meeting the Heart and Stroke Healthy City Indicators.

### Clinical Prevention and Treatment Services

- Implement and evaluate the Secondary Prevention of Heart Disease in the Medicaid Population Project and develop plans for disseminating the best practices of the Awareness, Control, and Treatment of High Blood Pressure in Hispanics Project.
- Continue dissemination of **The Physician Toolkit** for patients and healthcare providers.
- Implement the Texas Quality Improvement Recognition Program for healthcare providers.

# Appendix 1

## **TEXAS COUNCIL ON CARDIOVASCULAR DISEASE AND STROKE**

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**Executive Director**

**Jennifer Smith, MSHP, Manager**

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## COUNCIL MEMBERS

### Term Expiration Dates, Attendance and Categories for 2008 Council Representation

Members	Jan 11	Feb 16	June 6	Sept 6	Dec 12
Walter F. Buell, M.D. Austin, Texas Term Expires-2009 Consumer Member	P	P	P	A	P
Kate Darnell, M.S. Salado, Texas Term Expires-2007 General Public Member	EA	P	P	P	OFF
Michael M. Hawkins, M.D. Austin, Texas Term Expires-2007 Consumer Member	P	P	EA	P	EA
Bob C. Hillert, M.D., F.A.C.C., F.A.C.P., F.A.H.A. Dallas, Texas Term Expires-2009 Licensed Physician-Cardiology	P	P	P	P	EA
Deanna Hoelscher, PhD., R.D., L.D., C.N.S. Austin, Texas Term Expires-2011 Registered Dietitian	P	EA	EA	P	P
Carolyn Hutchinson, R.N., B.S.N. Harlingen, Texas Term Expires-2009 Registered Nurse	EA	P	EA	EA	P
Sue Pope (new) Willis, Texas Term Expires-2013 Public Member					P
Neal Rutledge, M.D. Austin, Texas Term Expires-2011 Licensed Physician-Stroke	P	EA	P	P	P

<b>Members</b>	<b>Jan 11</b>	<b>Feb 16</b>	<b>June 6</b>	<b>Sept 6</b>	<b>Dec 12</b>
<i>Martha Simien, M.Ed. Beaumont, TX Term Expires-2007 Public Health Policy, Research, Practice</i>	EA	P	P	EA	EA
<i>Erica W. Swegler, M.D. Keller, Texas Term Expires-2011 Licensed physician-Primary Care</i>	P	P	P	P	P
<i>Sheila Tello, R.N. Corpus Christi, Texas Term Expires-2007 General Public Member</i>	A	A	A	A	OFF
<i>Thomas E. Tenner, Jr, Ph.D. TTUHSC Lubbock, Texas Term Expires-2009 Public Health Policy, Research, Practice</i>	EA	EA	P	P	P
<i>Louis West (new) Taylor, Texas Term Expires-2013 Public Member</i>					EA
<u>Health Services</u> <i>Barbara Keir Texas Department of State Health Services Austin, Texas</i>	P	P	P	P	P
<u>Education</u> <i>Marissa L. Rathbone Texas Education Agency Austin, Texas</i>	P	P	EA	EA	P
<u>Assistive and Rehabilitative Services</u> <i>Grace Elinsway, M.Ed. DARS Austin, Texas</i>	P	P	P	P	P
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# Appendix 2

## HEALTH & SAFETY CODE CHAPTER 93. PREVENTION OF CARDIOVASCULAR DISEASE AND STROKE

### HEALTH & SAFETY CODE

#### CHAPTER 93. PREVENTION OF CARDIO- VASCULAR DISEASE AND STROKE

##### SUBCHAPTER A. GENERAL PROVISIONS

§ 93.001. DEFINITIONS. In this chapter:

(1) “Cardiovascular disease” means the group of diseases that target the heart and blood vessels and that are the result of complex interactions between multiple inherited traits and environmental factors.

(2) “Council” means the Council on Cardiovascular Disease and Stroke.

Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999.

§ 93.002. APPOINTMENT OF COUNCIL;  
TERMS OF MEMBERS.

(a) The Council on Cardiovascular Disease and Stroke is composed of:

(1) 11 public members appointed by the governor, with the advice and consent of the senate, as follows:

(A) a licensed physician with a specialization in cardiology;

(B) a licensed physician with a specialization in neurology to treat stroke;

(C) a licensed physician employed in a primary care setting;

(D) a registered nurse with a specialization in quality improvement practices for cardiovascular disease and stroke;

(E) a registered and licensed dietitian;  
(F) two persons with experience and training in public health policy, research, or practice;

(G) two consumer members, with special consideration given to persons actively participating in the Texas affiliates of the American Heart Association or American Stroke Association, managed care, or hospital or rehabilitation settings; and

(H) two members from the general public that have or care for persons with cardiovascular disease or stroke; and

(2) one nonvoting member representing each of the state agencies that oversee:

(A) health services;

(B) education;

(C) assistive and rehabilitative services; and

(D) aging and disability services.

(b) In appointing public members under Subsection (a)(1),

the governor shall attempt to appoint female members and members of different minority groups, including African Americans, Hispanic Americans, Native Americans, and Asian Americans.

(c) The head of each agency overseeing services listed in Subsection (a)(2) shall appoint the agency’s representative nonvoting member.

(d) Public members of the council serve staggered six-year terms, with the terms of three or four of the public members expiring February 1 of each odd-numbered year. A nonvoting member representing a state agency serves at the will of the appointing agency.

Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999. Amended by Acts 2003, 78th Leg., ch. 1170, § 6.01, eff. Sept. 1, 2003; Acts 2005, 79th Leg., ch. 732, § 1, eff. Sept. 1, 2005.

§ 93.003. REIMBURSEMENT. (a) Except as provided by Subsection (b), a member of the council may be reimbursed for travel expenses incurred while conducting the business of the council at the same rate provided for state employees in the General Appropriations Act, provided funds are appropriated to the department for this purpose.

(b) If funds are not appropriated to support reimbursement of travel expenses, the commissioner may authorize reimbursement of the travel expenses incurred by a member while conducting the business of the council, as provided in the General Appropriations Act, if the commissioner finds

*on application of the member that travel for council business imposes a financial hardship on the member.*

*Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999. Amended by Acts 2005, 79th Leg., ch. 732, § 2, eff. Sept. 1, 2005.*

§ 93.004. DUTIES OF DEPARTMENT; FUNDS. *The department shall accept funds appropriated for the purposes of this chapter and shall allocate those funds. The council shall make recommendations to the department concerning the allocation of funds.*

*Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999.*

§ 93.005. CONSULTANTS; ADVISORY COMMITTEE. *To advise and assist the council with respect to the council's duties under this chapter, the council may appoint one or more:*

- (1) consultants to the council; or*
- (2) advisory committees under Chapter*

*2110, Government Code.*

*Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999.*

§ 93.006. REPORT TO LEGISLATURE. *(a) Repealed by Acts 2005, 79th Leg., ch. 732, § 7.*

*(b) Not later than January 15 of each year, the council shall report to the governor, the lieutenant governor, and the speaker of the house of representatives on the activities of the council, accounting for all funds received and disbursed by or for the council during the preceding fiscal year.*

*Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999. Amended by Acts 2005, 79th Leg., ch. 732, § 3, 4, 7, eff. Sept. 1, 2005.*

§ 93.007. RESTRICTIONS ON COUNCIL APPOINTMENT, MEMBERSHIP, OR EMPLOYMENT. *(a) A person is not eligible to serve as a public member if the person or the person's spouse:*

- (1) is employed by or participates in the management of a business entity or other organization receiving funds at the council's direction;*
- (2) owns or controls directly or indirectly*

*more than a 10 percent interest in a business entity or other organization receiving funds at the council's direction; or*

*(3) uses or receives a substantial amount of tangible goods, services, or funds from the department at the council's direction, other than compensation or reimbursement authorized by law for council membership, attendance, or expenses.*

*(b) A person who is required to register as a lobbyist under Chapter 305, Government Code, may not serve as a member of the council or act as the general counsel of the council.*

*(c) An officer, employee, or paid consultant of a trade association in the field of healthcare may not be a member or employee of the council. A person who is the spouse of an officer, employee, or paid consultant of a trade association in the field of healthcare may not be a member of the council and may not be an employee, including an employee exempt from the state's position classification plan, who is compensated at or above the amount prescribed by the General Appropriations Act for step 1, salary group A17, of the position classification salary schedule.*

*(d) For purposes of Subsection (c), a trade association is a nonprofit, cooperative, and voluntary association of business or professional competitors designed to assist its members and its industry or profession in dealing with mutual business or professional problems and in promoting their common interests.*

*Added by Acts 2005, 79th Leg., ch. 732, § 5, eff. Sept. 1, 2005.*

§ 93.008. REMOVAL OF COUNCIL MEMBER. *(a) It is a ground for removal from the council if a member:*

- (1) is not eligible for appointment to the council at the time of appointment as provided by Section 93.007(a);*
  - (2) is not eligible to serve on the council as provided by Section 93.007(a);*
  - (3) violates a prohibition established by Section 93.007(b) or (c);*
  - (4) cannot discharge the member's duties for a substantial part of the term for which the member is appointed because of illness or disability; or*
  - (5) is absent from more than half of the regularly scheduled council meetings that the member is eligible to attend during each calendar year, unless the absence is excused by a majority vote of the council.*
- (b) The validity of an action of the council is not affected by the fact that it is taken when a ground for removal of a mem*

ber of the council exists.

(c) If the presiding officer of the council knows that a potential ground for removal exists, the presiding officer shall notify the governor of its existence.

(d) The council shall inform its members as often as necessary of:

(1) the qualifications for office prescribed by this chapter; and

(2) the responsibilities under applicable laws relating to standards of conduct for state officers or employees.

Added by Acts 2005, 79th Leg., ch. 732, § 5, eff. Sept. 1, 2005.

§ 93.009. PRESIDING OFFICER. The governor shall designate a member of the council as the presiding officer of the council to serve in that capacity at the will of the governor.

Added by Acts 2005, 79th Leg., ch. 732, § 5, eff. Sept. 1, 2005.

§ 93.010. STAFF SUPPORT. Each agency represented on the council:

(1) shall provide the council with staff support of specialists as needed; and

(2) may provide staff support to an advisory committee.

Added by Acts 2005, 79th Leg., ch. 732, § 5, eff. Sept. 1, 2005.

§ 93.011. DIVISION OF POLICY AND MANAGEMENT RESPONSIBILITIES. The council shall develop and implement policies that clearly separate the policy-making responsibilities of the council and the management responsibilities of the commissioner and staff of the department.

Added by Acts 2005, 79th Leg., ch. 732, § 5, eff. Sept. 1, 2005.

§ 93.012. MEETINGS. (a) The council shall meet at least quarterly and shall adopt rules for the conduct of its meetings.

(b) An action taken by the council must be approved by a majority of the voting members present.

Added by Acts 2005, 79th Leg., ch. 732, § 5, eff. Sept. 1, 2005.

§ 93.013. GIFTS AND GRANTS. (a) The council may receive gifts and grants from any public or private

source to perform its duties under this chapter. The department shall accept the gifts on behalf of the council and shall deposit any funds accepted under this section to the credit of a special account in the general revenue fund as required by Section 93.014.

(b) The department may retain five percent of any monetary gifts accepted on behalf of the council to cover its costs in administering this section.

Added by Acts 2005, 79th Leg., ch. 732, § 5, eff. Sept. 1, 2005.

#### § 93.014. HEART DISEASE AND STROKE RESOURCE FUND.

(a) The heart disease and stroke resource fund is an account of the general revenue fund.

(b) The legislature may appropriate money deposited to the credit of the heart disease and stroke resource fund only to the council for:

(1) heart disease and stroke prevention, research, and medical care for heart attack and stroke victims; and (2) grants to nonprofit heart disease and stroke organizations.

(c) The council shall develop a policy governing the award of funds for clinical research that follows scientific peer review guidelines for primary and secondary prevention of heart disease or stroke or that follows other review procedures that are designed to distribute those funds on the basis of scientific merit.

(d) Interest earned from the investment of the heart disease and stroke resource fund shall be deposited to the credit of the fund.

Added by Acts 2005, 79th Leg., ch. 732, § 5, eff. Sept. 1, 2005.

#### SUBCHAPTER B. POWERS AND DUTIES OF COUNCIL

§ 93.051. CARDIOVASCULAR DISEASE AND STROKE PREVENTION PLAN; DUTIES OF COUNCIL. (a) The council shall develop an effective and resource-efficient plan to reduce the morbidity, mortality, and economic burden of cardiovascular disease and stroke in this state. The council shall:

(1) conduct health education, public awareness, and community outreach activities that relate to primary and secondary prevention of cardiovascular disease and stroke;

(2) promote, enhance, and coordinate

health education, public awareness, and community outreach activities that relate to primary and secondary prevention of cardiovascular disease and stroke and that are provided by private and other public organizations;

(3) coordinate activities with other entities that are concerned with medical conditions that are similar to cardiovascular disease and stroke or that have similar risk factors;

(4) identify to healthcare providers, employers, schools, community health centers, and other groups the benefits of encouraging treatment, primary and secondary prevention, and public awareness of cardiovascular disease and stroke and recognize innovative and effective programs that achieve the objectives of improved treatment, prevention, and public awareness;

(5) provide guidance regarding the roles and responsibilities of government agencies, healthcare providers, employers, third-party payers, patients, and families of patients in the treatment, primary and secondary prevention, and public awareness of cardiovascular disease and stroke;

(6) improve access to treatment for and primary and secondary prevention of cardiovascular disease and stroke through public awareness programs, including access for uninsured individuals and individuals living in rural or underserved areas;

(7) assist communities to develop comprehensive local cardiovascular disease and stroke prevention programs;

(8) assist the Texas Education Agency and local school districts to promote a public school curriculum that includes physical, nutritional, and health education relating to cardiovascular disease and stroke prevention;

(9) establish appropriate forums, programs, or initiatives designed to educate the public regarding the impact of heart disease and stroke on women's health, with an emphasis on preventive health and healthy lifestyles; and

(10) evaluate and enhance the implementation and effectiveness of the program developed under this chapter.

(b) The council shall make written recommendations for performing its duties under this chapter to the department and the legislature.

(c) The council shall advise the legislature on legislation that is needed to develop further and maintain a state-wide system of quality education services for all persons with cardiovascular disease or stroke. The council may develop and submit legislation to the legislature or comment on pending legislation that affects persons with cardiovascular disease and stroke.

(d) The council shall collaborate with the Governor's

EMS and Trauma Advisory Council, the American Stroke Association, and other stroke experts to make recommendations to the department for rules on the recognition and rapid transportation of stroke patients to healthcare facilities capable of treating strokes 24 hours a day and recording stroke patient outcomes.

Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999. Amended by Acts 2005, 79th Leg., ch. 732, § 6, eff. Sept. 1, 2005.

§ 93.052. DATABASE OF CLINICAL RESOURCES. The council shall review available clinical resources and shall develop a database of recommendations for appropriate care and treatment of patients with cardiovascular disease or who have suffered from or are at risk for stroke. The council shall make the database accessible to the public.

Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999.

§ 93.053. CARDIOVASCULAR DISEASE AND STROKE DATABASE. (a) The council shall collect and analyze information related to cardiovascular disease and stroke at the state and regional level and, to the extent feasible, at the local level. The council shall obtain the information from federal and state agencies and from private and public organizations. The council shall maintain a database of this information.

(b) The database may include:

- (1) information related to behavioral risk factors identified for cardiovascular disease and stroke;
- (2) morbidity and mortality rates for cardiovascular disease and stroke; and
- (3) community indicators relevant to cardiovascular disease and stroke.

(c) In compiling the database, the council may use information available from other sources, such as the Behavioral Risk Factor Surveillance System established by the Centers for Disease Control and Prevention, reports of hospital discharge data, and information included in death certificates.

Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999.

§ 93.054. INFORMATION RECEIVED FROM ANOTHER STATE AGENCY; CONFIDENTIALITY. (a) To perform its duties under

*this chapter, the council may request and receive information in the possession of any state agency. In addition to the restriction imposed by Subsection (b), information provided to the council under this subsection is subject to any restriction on disclosure or use of the information that is imposed by law on the agency from which the council obtained the information.*

*(b) Information in the possession of the council that identifies a patient or that is otherwise confidential under law is confidential, is excepted from required public disclosure under Chapter 552, Government Code, and may not be disclosed for any purpose.*

*Added by Acts 1999, 76th Leg., ch. 1411, § 25.01, eff. Sept. 1, 1999.*

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